BRITISH COLUMBIA

1125648

January 29, 2019

Mr. Gursahib Bining
Chief Executive Officer
Seymour Health Centre Inc
1530 West 7th Ave
Vancouver BC V6J 1S3
sabi.bining@seymourhealth.ca

Dear Mr. Bining:

Re: Seymour Urgent Primary Care Center – 1290 Hornby St, Vancouver BC
Application for New Certificate of Approval for Polysomnography Category I

This letter is to advise you of the decision of the Medical Services Commission (the Commission) in respect to your application for a Category I (Fee items 00910, 00911, 11915, 11916, 11919, 11920, 11925, and 11926) Polysomnography Certificate of Approval for a three-bed Sleep Laboratory, to be located at the above-noted address.

The Commission has accepted the recommendation of the Medical Services Commission's Advisory Committee on Diagnostic Facilities (ACDF) and has denied this application.

In making its recommendation, the ACDF took into account the proximity of the existing facilities in the area, and the capability and capacity of these existing facilities. The ACDF reviewed polysomnography waitlist data from three existing polysomnography facilities, one facility (UBC Hospital) was 10 kilometres distant, one facility (Richmond Hospital) was 13 kilometres distant and the third facility (Surrey Sleep Clinic) was 43 kilometres from your intended location. All three facilities indicated they are well within the Commission's polysomnography waitlist benchmarks, have unused capacity and the ability to immediately handle additional patient referrals.

Based on the research conducted, the ACDF concluded there is no demonstrated need for additional Polysomnography services in the Vancouver Health Service Delivery Area at this time. As such, the ACDF recommended denial of this application.

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For your information, as per the ACDF *Subsequent Applications and Like-Applications* policy, the ACDF will not accept or consider a like-application (i.e. for the same modality, in the same geographic catchment area) before a period of 18 months from the original application date has elapsed, if the Commission has denied the original application due to a determination of insufficient medical need within the applicable catchment area.

If, within the applicable 18-month moratorium period, the Commission determines that medical need for a diagnostic service has arisen within the applicable catchment area, the moratorium will be lifted and a general notice posted on the Diagnostic Facilities Administration website to reflect that change.

This period of moratorium is effective October 23, 2018, the date the ACDF received your Vancouver Health Service Delivery Area Polysomnography application, and expires April 22, 2020.

For further detail, please see the *Policies and Guidelines of the Medical Services Commission's Advisory Committee on Diagnostic Facilities*, Part 2, Policy 2.4.2 – Catchment Area, and Part 4 – Subsequent Applications and Like-Applications. A copy of this policy can be found on the Diagnostic Facilities Administration website at:
http://www.gov.bc.ca/diagnosticfacilitiespolicies

If you have any questions regarding the above, please do not hesitate to contact me.

Yours sincerely,

Robin Henneberry (Mrs.)
Manager
Diagnostic Facilities Administration
Email: Robin.Henneberry@gov.bc.ca

pc: Ms. Sarah Bryanton, Secretariat, Medical Services Commission

BRITISH COLUMBIA

1126913

December 21, 2018

Mr. Gursahib Bining
President and Chief Executive Officer
Seymour Urgent Primary Care Center
1290 Hornby St
Vancouver BC V6Z 1W2
sabi.bining@seymourhealth.ca

Dear Mr. Bining:

Re: Seymour Urgent Primary Care Center – 1290 Hornby St, Vancouver BC, V6Z 1W2 - Application for New Certificate of Approval for Radiology Category II, plus Category III Fee items 08500, 08501, 08503, 08504, 08505, 08507, 08508 and 08509

We are writing to advise you of the decision of the Medical Services Commission's Advisory Committee on Diagnostic Facilities with respect to your above-noted application for a New Certificate of Approval at the above mentioned address.

We are pleased to inform you that your application was reviewed at the December 12, 2018 meeting of the Medical Services Commission's Advisory Committee on Diagnostic Facilities and **approved for a New Certificate of Approval for Radiology Category II, plus Category III Fee items 08500, 08501, 08503, 08504, 08505, 08507, 08508 and 08509.**

Approval is limited to:

- Approved radiology services provided to patients who have presented to physicians working within the Urgent Primary Care Centre and been referred for an x-ray.
- Approved radiology services provided to patients who have presented to the Urgent Primary Care Centre after 5:00pm Monday through Friday, anytime Saturday or anytime Sunday with a valid requisition from a referring physician not working within the Urgent Primary Care Centre.
- March 31, 2020, the term of the contract between Vancouver Coastal Health Authority and the Seymour Group to deliver Urgent Primary Care Centre services.

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The approval is subject to the following Conditions of Approval:

- That the facility acquires and maintains facility accreditation with the Diagnostic Accreditation Program of the College of Physicians and Surgeons of British Columbia.
- That once approved services are in effect, they be available on an ongoing basis. An approval may be subject to cancellation if no Medical Services Plan billings are received for an approved service for a period of six consecutive months.
- The approved volume of monthly services (approved capacity) is approximately **1058 services per month** and is subject to Policy 3.4, Significant Change Applications, and the definition of Significant Change, as detailed in the *Policies and Guidelines of the Medical Services Commission's Advisory Committee on Diagnostic Facilities*.

In accordance with the *Policies and Guidelines of the Medical Services Commission's Advisory Committee on Diagnostic Facilities*, Seymour Urgent Primary Care Center has 18 months to notify the Ministry of Health, in writing, that all conditions have been met and the dates that services began or will begin.

If services have not commenced within this 18-month time period, the Medical Services Commission may take action to amend, suspend or cancel approval, in accordance with the *Medicare Protection Act*, S 33(4).

Once we have been advised in writing of the effective date of service for New Certificate of Approval for Radiology Category II, plus Category III Fee items 08500, 08501, 08503, 08504, 08505, 08507, 08508 and 08509, we will update our systems accordingly, in order that billings for approved services may be submitted to the Medical Services Plan.

To bill the Medical Services Plan, an Assignment of Payment form must be submitted for each practitioner who will be providing services at the facility. For more information on the Assignment of Payment process, including directions for completing and submitting the required form, please refer to: http://www.gov.bc.ca/assignmentofpayment.

Please direct all facility communication, including notice of effective date of services, and questions regarding this approval to: DFadmin@gov.bc.ca.

Yours sincerely,

Woodrow (Woody) Turnquist
Director, Diagnostic Services | Ministry of Health

pc: Mr. Tony Bamford, Operations Director, Seymour Urgent Primary Care Center, tony.bamford@seymourhealth.ca
Dr. Darra Murphy, Medical Director, Diagnostic Imaging, Seymour Urgent Primary Care Center, dmurphy@providencehealth.bc.ca

MEDICAL SERVICES COMMISSION
REQUEST FOR DECISION
Seymour Health Center Inc – Seymour Urgent Primary Care Centre Polysomnography
Recommendation for Denial

SUMMARY:

The Medical Services Commission (MSC) has the authority to approve or deny diagnostic facility applications. The Commission has delegated to the Advisory Committee on Diagnostic Facilities (ACDF) the authority to approve diagnostic facility applications, but wishes to review all recommended denials.

PURPOSE:

FOR DECISION – that the Commission review Seymour Health Center's new Polysomnography application for Vancouver, and determine if the ACDF's recommendation for denial should be upheld.

BACKGROUND:

- Seymour Health Center Inc., Seymour Urgent Primary Care Center (UPCC), Vancouver, has requested approval for a new Category I Polysomnography Certificate of Approval, for a three-bed Sleep Lab, to be located at 1290 Hornby St, Vancouver (see Appendix A for a ummary of this application).
- The new Seymour UPCC in Vancouver is a partnership between the Ministry of Health, Vancouver Coastal Health Authority, Providence Health Care, the Vancouver Division of Family Practice, Doctors of BC and Seymour Health Care Inc.
- The UPCC is for people with non-life-threatening conditions who need to see a health care provider within 12-24 hrs but don't require the level of expertise found in emergency depts.
- The UPCC will improve access to care through extended weekend and evening hours. The UPCC opened on November 26, 2018 and is open 7 days/week, 365 days per year, from 8 am to 10 pm, Monday to Saturday, and 9:30 am to 5 pm on Sunday.
- The Centre will offer basic lab and diagnostic Radiology services, and is located between St. Paul's Hospital and Vancouver General Hospital. Polysomnography services are not deemed an urgent service, therefore, not included in the Ministry of Health's Urgent/Primary Care model and list of required services.
- As per MSC/ACDF policy, the catchment area for polysomnography applications is the geographic boundaries of the Health Service Delivery Area within the health authority where the diagnostic facility (applicant) is located[1].
- There are currently two MSC/ACDF approved Polysomnography facilities within the Vancouver Coastal Health Authority (VCHA) catchment area and both are publicly-owned, hospital based facilities – UBC Hospital and Richmond Hospital. The third closest MSC/ACDF approved facility is Surrey Sleep Clinic, a privately-owned facility that falls within the Fraser Health Authority catchment area.

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1 Policies and Guidelines of the Medical Services Commission's Advisory Committee on Diagnostic Facilities – Policy2.4.2:Assessment Criteria:Accessibility

- The applicant's proposed Polysomnography facility falls within the Vancouver Health Services Delivery Area (32), which only includes UBC Hospital but for the purposes of this application the above-noted three closest facilities were assessed.
- To assess whether there is a need for additional Polysomnography capacity in this area, the Committee considered Polysomnography waitlist data from the MSC/ACDF approved three like-facilities located closest to the proposed applicant (see Appendix A for Summary of Polysomnography Waitlist Information for the MSC/ACDF approved existing facilities).
- The Polysomnography waitlist data indicated that all three existing Polysomnography facilities were within the MSC endorsed Provincial Wait Time Benchmarks for each of the three Polysomnography priority levels, and all three facilities were not operating at full bed capacity.
- The Surrey Sleep Clinic's waitlist data indicated they are severely underutilized, which they attributed to insufficient demand.
- It was noted that the applicant's proposed Vancouver location is only 10 Kms from VCHA's UBC Hospital site, which is the closest existing Polysomnography facility and approximately 13 Kms from VCHA's Richmond Hospital site. Surrey Sleep Clinic is 43 Km from the applicant site.

DISCUSSION:

- Upon reviewing the existing Polysomnography facilities waitlist data the ACDF determined that there was no demonstrated need for additional polysomnography services in the Vancouver catchment area.
- Upon reviewing the proximity data for the existing Polysomnography facilities it was determined that VCHA's UBC Hospital, Vancouver, as the closest existing facility (at 10 Kms distant), would be most impacted by the proposed Vancouver facility.
- Upon reviewing beneficiaries' access to Polysomnography services, the ACDF determined that there were no access issues for the Vancouver area.

RECOMMENDATION:

The Advisory Committee on Diagnostic Facilities recommends that this application be denied as there is no demonstrated need for additional Polysomnography capacity, nor are there any access issues, in the Vancouver area at this time.

SUBMITTED BY:
Mariana Diacu
Executive Director
Laboratory and Blood Services Branch
Provincial, Hospital and Laboratory Health Services Division
Ministry of Health

DATE: January 7, 2018

ATTACHMENTS:

1. Appendix A – Seymour Health Center Inc, Seymour Urgent Primary Care Center, Vancouver, Polysomnography Application Summary

APPENDIX A

SEYMOUR HEALTH CENTER INC. – SEYMOUR URGENT PRIMARY CARE CENTER - NEW POLYSOMNOGRAPHY APPLICATION FOR: 1290 HORNBY STREET, VANCOUVER

Application Received: October 23, 2018

Applying for: Polysomnography Category I, for three beds

Health Services Delivery Area: 32-Vancouver (Vancouver Coastal Health Authority)

Like Polysomnography Facilities	Address	Current Distance	Poly Apprv	# of Beds
VCHA-UBC Hospital (S1230)	2211 Wesbrook Mall, Vancouver	10 Km (approx. 12 mins drive)	Cat II	6
VCHA-Richmond Hospital (S1210)	7000 Westminster Hwy, Richmond	13 Km (approx. 16 mins drive)	Cat 1	6
Surrey Sleep Clinic (S0003)	5661A-176A St, Surrey	43 Km (approx. 35 mins drive)	Cat I	6

Proximity: as stated above

Polysomnography Facility Square Footage: 500 sq ft

Equipment: Omnilab Advanced-Phillip Respironics, PSG-CEIL-PTZV-SD-Natul XL TEK, Apnealink Air-ResMed, GT9X Link-ActGraph

Capacity: Category I – 44 MSP billable services/month (Projected Monthly Volume)

Radiology Hours of Operation: Mon-Sat, 9 am – 9 pm, Sun, 9 am – 5 pm

Conflict of Interest: Yes, potential self-referral for Polysomnography testing

Estimated Implementation Date: November 2018

MSC Endorsed Provincial Polysomnography Wait Time Benchmarks:

Priority 1 (Urgent) cases - within 2 to 4 weeks
Priority 2 cases - within 2 months
Priority 3 cases - within 6 months

VCHA-UBC Hospital:

Priority Level	Benchmark	Current Wait Time
Priority 1	2-4 weeks	Within 4 weeks
Priority 2	2 months	Within 2 months
Priority 3	6 months	Within 4 months

VCHA-Richmond Hospital:

Priority Level	Benchmark	Current Wait Time
Priority 1	2-4 weeks	Within 1 week
Priority 2	2 months	Within 3-4 weeks
Priority 3	6 months	Within 2 months

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Vancouver Coastal Health Authority Comments:

- They have 2 Sleep Labs – UBC & Richmond Hospitals, for a total of 12 funded beds,
- At UBC they are funded for 6 beds, however, they have built capacity for 9 beds and will apply to DAP for expansion when the need is warranted.
- The 3 extra beds will allow VCHA to be more responsive to urgent wait lists and expand operations based on triaged waitlists when needed.
- Both VCHA Sleep Labs currently run in 5 days/week, and if needed could expand the functioning days of the week to meet demand.
- Within VCHA all priority level 1 and 2 patients are seen within the MOH benchmarks, and it is their continued goal to see all urgent cases as soon as possible.
- UBC continues to be the only Tertiary and Quaternary sleep program in the province and receives complex referrals from throughout the province.
- At present, in VCHA between both labs they continue to see 30-35% of their referrals from FHA, and are continuing to work with FHA to repatriate patients who do not require tertiary and quaternary services back to their region closer to home where they would be best served.
- RGH has a very minimal waiting list, and their strategy to have MD's refer appropriate patients between both sites within their system has allowed them to use their spaces more effectively. These strategies allow them to meet the current needs for polysomnography in Vancouver.
- There continues to be a shortage of and only one training program for Sleep Technologists in BC. Due to the uniqueness of the role, the demanding night shift hours and limited program intake annually, the recruitment of certified technologists go between sites not only in the region but also in the province.
- Many of their trained staff who hold permanent positions with VCHA also work in the private sector labs on their days off. This raises concerns that the increased physical demands on the limited trained technologists may become a burden within their current system therefore impacting their ability to operationalize their VCHA Tertiary and Quaternary programs.
- It is their continued opinion; there is a need for both appropriately well-defined private and publically funded polysomnography labs in BC. With their resources of a 12 funded beds in VCHA and capacity of 15 when and if they are needed based on waitlist targets, they feel that the needs of this acute population are currently being served for Vancouver.

Surrey Sleep Lab:

Priority Level	Benchmark	Current Wait Time
Priority 1	2-4 weeks	Less than 1 week
Priority 2	2 months	1-2 weeks
Priority 3	6 months	2 weeks

Surrey Sleep Lab Comments:

- The Surrey Sleep Clinic is underutilized because of insufficient demand.
- They are performing 3-6 overnight polysomnograms per night, 5-6 nights a week.
- This is despite the fact that we have a full-time employee visiting physicians' offices to increase awareness about the services available in their clinic.
- The proposed private Vancouver Polysomnography facility will have an adverse effect on Surrey Sleep Clinic by further decreasing their workload.

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- It will also affect their operations adversely by decreasing the availability of Polysomnography Technologist who are already in short supply in the lower mainland area.
- The proposed Vancouver facility will have an adverse effect on Richmond Hospital Sleep Lab as well by further decreasing its workload.
- He refers patients to the Richmond Hospital Lab.
- Their wait time there is less than 3 weeks for Priority 1 studies, and about 5 weeks for Priority 2 and 3. This is according to info his office received from the sleep lab booking clerk.
- The Richmond Hospital Lab is open only 5 nights/week. This is because they have not been receiving enough referrals. They used to be open 7 nights/week previously.

Reasons given for Application (by Applicant):

- Seymour Urgent Primary Care Center (UPCC) is applying for 3 sleep beds to address small number of patients with more complexity so they can access services under the "continuity of care" where UBC Sleep Lab access is not readily available.
- Currently these complex patients are forced to drive long distances to different communities such as Surrey and Nanaimo due to capacity constraints at UBC.
- They would like to offer better access to these patients working under the specific attributes of Primary Care Network.

ACDF Secretariat Comments:

- The new Urgent Primary Care Centre (UPCC) in Vancouver is a partnership between the Ministry of Health, Vancouver Coastal Health Authority, Providence Health Care, the Vancouver Division of Family Practice, Doctors of BC and Seymour Health Care Inc.
- This new UPCC opened on November 26, 2018, and is located between St. Paul's Hospital and Vancouver General Hospital.
- The UPCC is for people with non-life-threatening conditions who need to see a health care provider within 12-24 hrs but don't require the level of expertise found in emergency depts.
- The UPCC will improve access to care through extended weekend and evening hours. Upon opening, the Clinic will be open 7 days/week, 365 days per year, from 8 am to 10 pm, Monday to Saturday, and 9:30 am to 5 pm on Sunday.
- The Centre will offer basic lab and diagnostic imaging services.

Ministry of Health
Policy Instrument

Type:	**Supportive Policy Directive**
Policy Name	**Urgent Primary Care Services**

Version	**4.2draft**
Effective Date:	
Division/Branch:	
Ministry Contact:	
Document Number:	
Date:	**(Oct 11, 2017) (May 4, 2018)** **June 14, 2018**

Deputy Minister
Ministry of Health

BRITISH COLUMBIA

URGENT PRIMARY CARE SERVICES

POLICY OBJECTIVE

Across British Columbia, urgent primary care services will be available as part of a primary care network (PCN) to the population of a Community Health Service Area (CHSA). Urgent primary care services will increase access to person-and-family-centred, culturally safe, quality primary care outside of traditional office hours for unexpected but non-life-threatening health concerns that usually require same-day treatment.

An individual's urgent primary care needs may be met by their patient medical home (PMH), or within the broader network, for example at an urgent primary care centre or extended-hours walk-in clinic or Community Health Centre (CHC). Urgent primary care services will be designed and maintained as part of PCNs to meet the needs of individuals, families and caregivers.

Expected Impact on Health Outcomes and Service Attributes

It is expected that ensuring the availability of urgent primary care services will achieve meaningful health outcomes (effectiveness) and a quality service experience linked to key service attributes (accessibility, appropriateness, acceptability, safety, efficiency). Measurable expected impacts include:

1. *Accessibility:* Process for ensuring all people in a given community have access to quality urgent primary care services/centres, including same day and/or virtual care for urgently needed services.
2. *Appropriateness:* The population within a given community is able to access urgent primary care in the evening, on weekends, early mornings and/or on statutory holidays without accessing care through a hospital emergency department.
3. *Acceptability:* Patient, family and caregiver experience is improved through clear communication about where and how to access to urgent primary care services, including laboratory, diagnostics, and imaging services outside of a hospital emergency department.
4. *Safety:* Information on the urgent primary care received by a patient and necessary follow-up care is shared with a patient's regular primary care provider, , including coordination of care with diagnostic services, hospital care, speciality care and specialized community services for all patients and with particular emphasis on those

with mental health and substance use conditions, those with complex medical conditions and/or frailty and surgical services provided in the community,

5. *Efficiency:* Urgent primary care services/centres will ensure appropriate ambulatory care needs are met by a network of primary care providers and teams through access to expanded primary care services.

DEFINITIONS

Urgent primary care: Primary care for injuries and illnesses that should be seen by a health care provider within 12 to 24 hours but do not require the level of service or expertise found in an emergency department. Urgent primary care tends to be provided outside of traditional primary care office hours.

Person- and family-centred: A way of thinking and doing things with patients, families and caregivers as equal partners in health care, rather than doing things to or for them. To be person-centred the health care culture needs to shift away from being disease-centred and provider/administrator focused. Person-centred care is an approach that puts the patient and their family at the centre of every decision and empowers them to be genuine partners in their care at the level of their choosing. This participation could be partnering with health care professionals, working with community organizations, or getting involved in meaningful efforts to design and improve care. Patients, families and caregivers become both participants and beneficiaries of a health system that responds to their needs, values and preferences in a respectful, empathetic and holistic way.

Culturally safe: Providing care that recognizes and respects the differences in each individual. Providers listen and learn in a way that maintains personal dignity and supports an authentic relationship of trust, respect, and teamwork to ensure people feel safe receiving health care. Culturally safe care supports access to health care services, improved health outcomes, and healthier working relationships.

SCOPE

This policy covers urgent primary care services, which are components of comprehensive primary care delivery (see General Policy Directive: *Establishing Primary Care Networks*), designed to meet urgent primary care needs throughout an individual's life. This policy applies to PCN health care settings that provide urgent primary care, including extended-hours family practices, health authority primary care clinics, urgent primary care centres owned/operated by health authorities (including the First Nations Health Authority), and extended-hours community-based health service organizations (e.g. community health centres, walk-in clinics).

POLICY DIRECTION

Expectations

Efforts will be made to adhere to these principles of urgent primary care; however it is recognized that depending on community variables this may not always be feasible.

Urgent primary care services must:

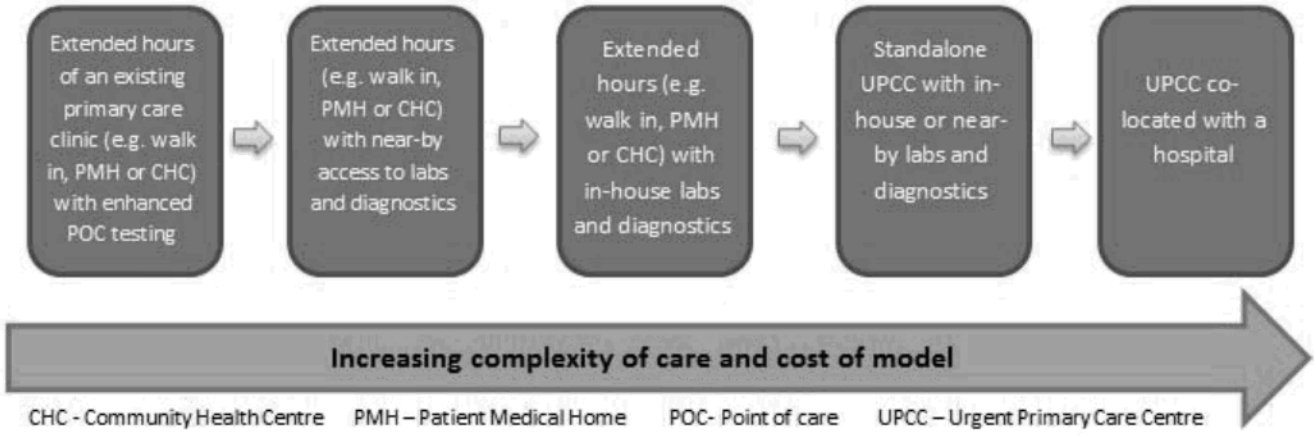
1. Be part of the PCN and support PCN goals.
2. Provide the PCN population with:
   a. Access to advice and direction to care;
   b. Extended hours of care: early mornings, evenings, weekends and holidays;
   c. Accessible urgent primary care services, as a component of comprehensive primary care, in particular :
      - *Basic in-office urgent care services*
        - non-life-threatening illness or injury that needs immediate treatment
        - sprains and simple fractures caused by minor accidents and falls
        - minor bleeding/cuts requiring stitches
        - mild to moderate breathing difficulties
        - minor burns
        - rapid access to MHSU crisis intervention services
      - *Assessment and treatment services for minor illnesses*
        - commonly presenting conditions, e.g. respiratory infections, ear aches, eye irritation/injuries, fever or flu, severe sore throat or cough, headache
        - abdominal pain, vomiting, diarrhea or dehydration
        - mild to moderate back pain and problems
        - skin rashes and infections
        - urinary tract infections
      - *On-site or close-proximity access to diagnostic imaging and laboratory services*
        - electrocardiograms
        - x-rays
        - point-of-care testing
        - blood tests
3. Provide clear mechanisms and protocols for urgent primary care providers to communicate with a patient's regular primary care provider to maintain informational and management continuity of care (e.g. appropriate information sharing, referrals, ongoing coordination, single patient health record), including working towards linked electronic medical records.
4. Identify unattached individuals and families and/or those requiring care to prevent crisis or hospitalization and support their attachment to a PMH using PCN protocol (i.e. centralized primary care waitlist where available).
5. Provide access to timely primary care services without having to attend or be triaged in an emergency department.

6. Have ambulance access in the context of the Transport to Alternate Locations initiatives of BC Emergency Health Services and have protocols for ambulance transport and immediate triage at an emergency department in the event a patient's situation becomes an emergency.

Service Design

1. An analysis of the available local, regional and provincial data (e.g. ED usage by hospital by time of day, location of existing walk-in clinics) will determine gaps and opportunities for increased access to urgent primary care services.
2. The following factors will be considered in determining the model for how increased access to urgent primary care services should be provided in a PCN:
   - Geographic location and population need (attachment rates; ED usage and congestion, size of community, etc.);
   - Supportive local primary care providers;
   - Existing infrastructure and health human resources;
   - Proximity and access to diagnostics;
   - Current gaps in accessibility (e.g. hours of service);
   - Opportunities to use technology-enabled solutions; and
   - Existing services in the community relative to demand.
3. A range of service delivery models, depending on the review of existing primary care services and gaps as determined in the PCN gap analyses, will be considered as shown on a spectrum in *Figure 1* – from enhancement of existing services (e.g. extended hours, new providers, access to diagnostics) to a stand-alone and purpose-built urgent primary care centre (e.g. urgent care assessment, resuscitation capabilities, access to diagnostic tools).
4. A variety of urgent primary care services may be associated with each service delivery model across the spectrum depending on whether services for a given community are best concentrated in one site or distributed across the PCN.

Figure 1 – Spectrum of Increased Access to Urgent Primary Care



5. Urgent primary care services will be developed using current infrastructure and resources, and will not be valued or compensated more than other primary care services.

6. An interdisciplinary team-based care approach will be taken, where team deployment is based on a primary care setting rather than an emergency services setting.
7. Urgent primary care will be addressed as part of or aligned with PCN communication plans, including awareness and education for providers, PMH, patients, families and caregivers.
8. Urgent primary care will be addressed as part of or aligned with PCN community/patient engagement plans, including opportunities for patients, families and caregivers to give feedback for quality improvement activities.

LINKAGES

Health Human Resources

Urgent primary care interdisciplinary teams will provide person-centered, culturally safe care using available HHR resources, optimized scopes of practice, and where necessary and appropriate, the use of on call and virtual care to achieve service objectives.

Organizational Capacity

Data Analytics and Reporting

Service delivery data collection and submission should be comprehensive, accurate, and timely to support adequate and thorough understanding of population and patient needs and baseline service levels, and to plan for and assess improvements over time.

Data and analysis will be provided by the Ministry of Health to support service delivery planning at both the Local Health Area and CHSA levels, as part of the broader PCN planning process. Collaboration and dialogue on these products can be used to inform strategic planning, gap analysis and subsequent roll-out in a range of environments. These tools can also be used to understand the baseline for performance.

Integrated analytics will support performance monitoring, reporting and evaluation in line with the strategy for health system performance management.

PERFORMANCE INDICATORS

Initial performance indicators have been developed in collaboration with the Ministry and external stakeholders to measure the expected outcomes of the service attributes of accessibility, appropriateness, acceptability, efficiency. <Insert Number> performance indicators to report on the Primary and Community Care Strategic Initiative include:

1. TBD

In addition to the above indicators, Ministry and external stakeholders will continue to collaborate to identify additional indicators that provide insight into the performance of both the Establish Primary Care Networks General Policy Directive and the Primary and Community Care Strategic Initiative overall.

REVIEW & QUALITY IMPROVEMENT

1. The policy will be refreshed as needed and reviewed three years from the date of implementation and following completion of the summative evaluation.
2. The policy may also be reviewed as determined through consultation between Ministry and external stakeholders.
3. Information from the annual evaluation will be used to understand the performance of the strategic initiative, areas of success and areas for continuous quality improvement.
4. The Ministry will work with the program area to develop a quality improvement plan where necessary and will support the program area to manage the review and quality improvement process.
5. The Ministry will lead any monitoring of outcome measures that are identified in the quality improvement plans developed.

Urgent Primary Care Centres – Compensation Considerations

Last updated: June 5, 2018

Introduction

As an integral part of the Primary Care Network, Urgent Primary Care Centres are being set up to provide same day access for urgently needed care. Services provided are intended to be distinct from those required in an ED and complement those provided by the primary care provider. Key attributes include non-traditional hours, team-based care and access to lab and diagnostics.

The intent of this document is to provide guidance with regards to compensation considerations. The Urgent Care model, by definition will vary depending on community, suggesting that the compensation model may also vary to some degree from one community to another. In the absence of a 'one size fits all' model consideration of the appropriate approach to compensation must start with the patient.

Considerations

Patient Needs	-What is the demographic of the target community? -What is the population age, social/economic situation and disease profile? -What are the patient defined needs that are currently not being met or effectively met? -What are the key community concerns with regards to primary health care?	
Current State	-How are primary care services currently being provided? -Is primary care available through HA run clinics, private practice or both? -What is the demographic of the GP population (gender, age, etc) -How are current physicians in the community being paid, and what is the current income profile? -How close is the ER and what are the patient volumes and profile (CTAS) of the patient visits? -What is the current level of attachment and what is the trend? -How are the needs of specialized sub-populations in the community (First Nations, LGBTQ, etc) being met? - What stage of development is the local Primary Care Network in?	
Gap Analysis	-What are the key gaps between current and desired state? -What are the services/needs that are not being met? What are the top priorities based on impact to the patient? -Are there enough practitioners in the community or is there a workforce gap? -How does the HA envision the Urgent Care model will meet those needs?	

Desired Service Delivery Model	-What is the proposed service delivery model and how does it address identified patient needs? -How will the clinic be run/managed and who is responsible? -What types of practitioners are required to support the model (physicians, NP's, allied practitioners, etc). -What is the role of the physician in the model proposed in terms of staffing, scheduling, oversight, etc. -Will the practitioners be required to directly or indirectly pay overhead costs? -What type of schedule is required – how many resources on what shifts and how will this be managed over time? -How many patients are expected, for which services and at what time of day? - How will the Urgent Primary Care Centre services link with other primary care services (existing and planned)? -What are the identified risks or unintended consequences of this model on the primary care needs of the community and what are the mitigation strategies proposed?	
Physician Recruitment	-What is the target market for recruitment – who is the HA trying to attract and from where (e.g. semi-retired or retired physician for select shifts, full or part-time physicians at beginning or mid-career, local or new physicians, etc.)? - What is the current estimated level of income (taking into consideration payments for overhead, tax status etc.) for these physicians? -Are the targeted physicians satisfied with their current work/income – why or why not? -Is the work in the Urgent Primary Care Centre perceived as attractive or expected to be difficult to staff – why?	

Compensation

Based on the above analysis and information compensation can be considered. The objective is to find the balance in attracting the physicians required to support the model without impacting current primary care services in the community while concurrently considering potential impacts beyond the community and HA borders. Traditional models include:

1. FFS – physicians bill MSP on a FFS basis for services that are performed.
2. Service Contract – time based contract ensuring all services required/defined by the HA are provided
3. Sessional Contract – as per the Service Contract but physicians are paid on a sessional basis where a session equals 3.5 hours of physician services.
4. Salary Agreement – physicians are salaried employees of the HA, with benefits provided by the HA.
5. Income Guarantee – HA guarantees a physician a specific income. Physician bills FFS and, if necessary, the HA 'tops-up' the physician to the income guarantee amount.
6. Population Based Funding – designed to support ongoing longitudinal care of a defined patient panel, this model is being made available as part of the Primary Care Network expression of interest process

In all models, it is important that services provided to patients at the Urgent Primary Care Clinic are reported. This is consistent with Ministry Policy and ensures accountability.

Some pros and cons of these various compensation models as well as some relevant considerations in selecting an appropriate compensation model are set out in the following table:

Model	Pros	Cons
FFS	Incents volumes/efficiency if sufficient volume exists and relevant fee codes are in place Physicians may prefer independent contractor model and resulting tax benefits. Reporting for billable services is inherent in the model.	Physicians operate independently, less integrated with other members of care team No financial incentive to participate in team-based care Difficult to compel physicians to perform non-billable work that is of value to patients/HA
Service Contract	Provides dependable physician income in situations of low or variable service volume. HA can contract for additional services which MSP does not cover. Can include deliverables around quality of services which MSP does not account for. Expectation that physicians will work in an integrated team can be outlined in the contract. If contracting as a group, allows physicians to pay differentials for evening and weekend shifts (within the total contract value) which could be helpful for physician recruitment. Ensures accountability – template contract requires base reporting on services provided which can be expanded to include additional metrics/information as required. Physicians may prefer independent contractor model and resulting tax benefits.	Can result in reduction in productivity unless contract includes terms for monitoring/incenting productivity

Sessional Contract	Same as Service Contract	Same as Service Contract plus: Physicians paid under this modality may find it arduous to report services provided due to system challenges.
Salary Agreement	Due to the nature of the employer/employee relationship, the HA has greater authority to direct work of physicians which provides for greater oversight and accountability. Expectation is that physicians have a set of job responsibilities they need to fulfill as opposed to contractors who bill for every hour or service/encounter provided. Creates an environment that is more conducive to team based integrated care (i.e. compensation barriers removed). Physicians may prefer the employee model and perceived work/life balance (predictable hours/income, vacation, benefits, physicians do not have the responsibility of running their own business).	Can result in reduction in productivity More administratively burdensome for HAs as they will typically be responsible for arranging schedules/physician coverage for the clinic (as opposed to group service/sessional contracts where this responsibility can be delegated to physicians)
Income Guarantee	Good for recruitment to area/service where volumes are low and are expected to grow over time. Should be time-limited and used to transition physicians to FFS later.	Can be challenging to select an agreed income guarantee rate which will incent a transition to FFS later and which will not destabilize primary care service delivery in the community.
Population Based Funding	Supports longitudinal care for a defined patient panel.	Not suitable for episodic acute service delivery.

Additionally and perhaps most importantly, in selecting a compensation model, consideration must be given to the cost of the service ensuring value for money and sustainability in supporting the patient needs.

Once a compensation model is selected, the appropriate rate to be paid under such a model must be considered.

Rate for Service/Sessional/Salary Agreements for Physician Services provided at Urgent Primary Care Centres

Service Contract/Salary Agreement Rate: The PMA defines rates for various practice categories, several of which may, on the surface, appear to apply to GPs providing services in Urgent Primary Care Centres.

The GP Full Scope rates (urban/rural) are reserved for physicians who devote the bulk of their practices to provide longitudinal patient care and do not align with the Urgent Primary Care Centre scope of practice.

The GP Defined Scope rates apply to physicians with a narrower scope of practice however are limited to student health and clinical associates (GP Defined Scope B) or physicians that specialize in a particular area of primary care such as palliative, mental health, etc. (GP Defined Scope A) and as such also do not apply.

It is recommended that the practice category that most closely aligns to the services provided in Urgent Primary Care Centres is GP Defined Scope A at 95% of the range which as of April 1, 2018 is $224,402 for Salary Agreements and $251,331 for Service Contracts. The rationale for the 95% range placement is to recognize and differentiate physicians treating a broad range of patient types and conditions within the urgent primary care setting from physicians providing care in a focused area of practice (criteria for GP Defined Scope A) who will typically have invested time and effort to train and develop a level of expertise in their chosen scope of practice.
Sessional Contract Rate: The PMA defines four distinct rates for physicians working under Sessional Agreements. The appropriate rate to use is that associated with GP's which currently (as of April 1, 2018) is $468.18 per session (3.5 hours).

Monitoring of Contracts for Physician Services at Urgent Primary Care Centres

Because Urgent Primary Care Centres are a new addition to the primary care strategy in the province, it is important that HAs piloting Urgent Primary Care Centres closely monitor the operation of contracts for physician services to see if the compensation model selected is functioning as anticipated or to determine if another model may be more appropriate.

It is therefore critical that appropriate metrics are established as part of the agreement which can be used to measure the success of the Urgent Primary Care model in attaining desired objectives, and by extension assess the suitability of the compensation model.

Health Authorities are expected to work with the Ministry of Health/HEABC in developing the physician compensation structure for all urgent primary care clinics.

1126038

January 17, 2019

Ms. Susan Brown
President and Chief Executive Officer
Interior Health Authority
5th Floor, 505 Doyle Ave.
Kelowna BC V1Y 6V8

Dear Ms. Brown:

We are writing to provide confirmation of operating funding allocations and reporting requirements related to Interior Health Authority's (IHA) first Urgent Primary Care Centre (UPCC) which opened in Kamloops in June, 2018 and the co-located Family Practice Learning Centre (FPLC) which opened in August, 2018.

The Ministry assessed IHA's proposal for the Kamloops UPCC/FPLC based on a standardized funding framework including salary, benefit and overhead rates, to ensure equity among the various health authority UPCC proposals. In addition, consideration for existing family practice clinics and funding sustainability for the overall Primary Care initiative was also part of the Ministry's assessment.

Preliminary funding allocations based on the standardized funding framework were previously shared with your staff. As a result of those discussions 2 FTE Nurse Practitioner positions were approved along with an incremental $408,000. Further, an incremental $350,000 funding adjustment was made on an exception basis. It is the Ministry's expectation that future UPCC funding approvals will be consistent with the standardized funding framework.

OPERATING FUNDING

A summary of the IHA's revised request for the Kamloops UPCC / FPLC and the Ministry's assessment is shown in Table 1.

Table 1	Total Revised Request (Annualized)	MOH Assessment (Annualized)
Urgent Primary Care Centre[1]	$ 2,500,562	$ 2,300,079
Family Practice Learning Centre[1]	$ 1,176,999	$ 1,082,633
Total	$ 3,677,561	$ 3,382,712
1.) "On-going" annual operating costs		

…2

Ministry of Health
Office of the Assistant Deputy Minister
Finance and Corporate Services
PO Box 9647 Stn Prov Govt
Victoria BC V8W 9P4
Facsimile: 250 952-1573

Urgent Primary Care Centre:

- An overall annual funding allocation of $2.3M has been approved by the Ministry for the Kamloops UPCC to provide same day access to urgently needed primary care services and extended hours of care (12 hours per day Monday to Sunday once fully operational in the fall of 2018), as outlined in IHAs proposal. For 2018/19, the funding allocation is $1.3M.

- As shown in Table 2(a) the approval includes resources for the interdisciplinary team of physician, nursing and allied health professionals as requested by IHA. In addition 1 FTE Medical Office Assistant per GP/NP has been funded as part of the GP/NP overhead provision. Non-clinical staff and non-labour costs are to be managed from within the overhead provision included in the total funding provided.

Table 2 (a)

Kamloops UPCC	FTE	Funding/ FTE Including Overhead	Total Annual Funding	2018/19	2019/20 Notional Allocation for Planning Purposes	2020/21 Notional Allocation for Planning Purposes
General Practitioner[1]	3.3	$ 276,331	$ 905,945		$ 905,945	$ 905,945
Medical Office Assistant	3.3	$ 50,000	$ 163,924		$ 163,924	$ 163,924
Funding Adjustments:						
Nurse Practitioner[2]	2.0	$ 154,000	$ 308,000		$ 308,000	$ 308,000
MOA / NP	2.0	$ 50,000	$ 100,000		$ 100,000	$ 100,000
Other			$ 203,237		$ 203,237	$ 203,237
Sub-total	10.6		$ 1,681,106		$ 1,681,106	$ 1,681,106
RN[2]	1.2	$ 114,400	$ 136,713		$ 136,713	$ 136,713
LPN[2]	1.3	$ 85,800	$ 110,252		$ 110,252	$ 110,252
Physiotherapist[2]	1.2	$ 107,800	$ 128,826		$ 128,826	$ 128,826
Occupational Therapist[2]	0.3	$ 107,800	$ 28,415		$ 28,415	$ 28,415
Social Worker[2]	1.3	$ 108,900	$ 139,936		$ 139,936	$ 139,936
Funding Adjustment			$ 74,831		$ 74,831	$ 74,831
Sub-Total	5.2		$ 618,973		$ 618,973	$ 618,973
Total	**15.8**		**$ 2,300,079**	**$ 1,301,821**	**$ 2,300,079**	**$ 2,300,079**

1. Contract GP- Defined Scope A at 95% of range plus overhead.

2. Based on HSCIS 2016 Q4 average salary/ FTE and benefit costs adjusted to April 2018 for general wage increases and economic stability dividends where applicable plus overhead.

Family Practice Learning Centre:

- An overall annual budget of $1.083M has been approved by the Ministry for the Kamloops Family Practice Learning Centre to improve access to primary care services (7 hours per day Monday to Thursday and every second Friday) and support medical residents to be trained and supported in team-based care, as outlined in IHAs proposal. For 2018/19, the funding allocation is $0.915M.

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- As shown in Table 2(b) the approval includes resources for the interdisciplinary team of residents, preceptors, and allied health professionals as requested by IHA. In addition 1 FTE Medical Office Assistant per GP has been funded as part of the GP overhead provision. Non-clinical staff and non-labour costs are to be managed from within the overhead provision included in the total funding provided.

Table 2 (b)

Kamloops FPLC	FTE	Funding/ FTE Including Overhead	Total Annual Funding	2018/19	2019/20 Notional Allocation for Planning Purposes	2020/21 Notional Allocation for Planning Purposes
Overhead for 4 Residents[1]		$ 25,000	$ 100,000		$ 100,000	$ 100,000
Preceptors (Income Guarantee)			$ 200,000		$ 200,000	$ 200,000
Medical Office Assistant	4.0	$ 50,000	$ 200,000		$ 200,000	$ 200,000
Funding Adjustment			$ 35,585		$ 35,585	$ 35,585
Sub-total	4.0		$ 535,585		$ 535,585	$ 535,585
RN[2]	1.1	$ 114,400	$ 128,311		$ 128,311	$ 128,311
LPN[2]	1.2	$ 85,800	$ 103,476		$ 103,476	$ 103,476
Physiotherapist[2]	1.1	$ 107,800	$ 120,909		$ 120,909	$ 120,909
Occupational Therapist[2]	0.2	$ 107,800	$ 26,669		$ 26,669	$ 26,669
Social Worker[2]	1.2	$ 108,900	$ 131,336		$ 131,336	$ 131,336
Funding Adjustment			$ 36,347		$ 36,347	$ 36,347
Sub-total	4.9		$ 547,048		$ 547,048	$ 547,048
Total	**8.9**		**$ 1,082,633**	**$ 915,326**	**$ 1,082,633**	**$ 1,082,633**

1.Paid by UBC

2. Based on HSCIS 2016 Q4 average salary/ FTE and benefit costs adjusted to April 2018 for general wage increases and economic stability dividends where applicable plus overhead.

FUNDING SOURCE

As identified in the "Bilateral Planning and Action Expectations" for April 1, 2018 to March 31, 2019, health authorities are assigned notional funding, available once staffing has occurred, to increase and strengthen primary team-based care services at the community health service area level linked to Primary Care Networks (PCNs) and Urgent Primary Care Centres. This funding is to support management of clients that are identified as being at risk for health decline or health crisis by increasing access to community based professional services (nursing and allied) and improving the quality of and timeliness of care for adults with complex medical conditions. The targeted notional allocation provided to IHA is currently frozen and includes both federal and provincial funding as shown in Table 3.

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Table 3

IHA	2018/19	2019/20	2020/21	3 Yr. Total
Mental Health Federal Funding:				
Increased Mental Health Capacity in PCN	651,910	1,655,820	1,655,820	3,963,550
Seniors' Team Based Primary Care:				
Nursing & Allied Professionals- Ministry	1,940,190	5,228,630	6,192,500	13,361,320
Nursing & Allied Professionals- Federal	2,038,170	2,038,170	2,038,170	6,114,510
Sub-total Seniors	3,978,360	7,266,800	8,230,670	19,475,830
Sub-total Federal Funding	2,690,080	3,693,990	3,693,990	10,078,060
Sub-total Ministry Funding	1,940,190	5,228,630	6,192,500	13,361,320
TOTAL	**4,630,270**	**8,922,620**	**9,886,490**	**23,439,380**

It is the Ministry's expectation that IHA will **first apply eligible UPCC/FPLC costs** against the federal funding allocations noted above, as federal funds will need to be repaid if not fully utilized. The Ministry will work with IHA to determine an allocation methodology to identify UPCC/ FPLC expenditures which are consistent with federal funding criteria.

In 2018/19 IHA is authorized to access up to $2,217,147 ($1,301,821 UPCC and $915,326 FPLC) of targeted frozen federal and provincial funding notionally allocated to IHA for "Seniors' Team Based Primary Care" and "Increased Mental Health Capacity in PCNs" as shown in Table 3. IHA will be required to report-back to the Ministry on the actual expenditure of 2018/19 UPCC/ FPLC costs against the federal and provincial funding allocations.

In 2019/20 and 2020/21 IHA will continue to **first apply all eligible UPCC/FPLC costs** against the federal funding allocation noted in Table 3. A notional allocation, for planning purposes, of net new ministry funding of up to $2,216,691 ($1,681,106 UPCC and $535,585 FPLC) is provided for 2019/20 and 2020/21 for all remaining costs associated with the GP/NP and MOA positions, including overheads, not eligible for federal funding. A notional authorization, for planning purposes, of up to $1,166,021 ($618,973 UPCC and $547,048 FPLC) against the targeted frozen ministry funding notionally allocated for " Seniors' Team Based Primary Care" is provided for all remaining costs associated with registered nursing and allied health care positions, including overheads, not eligible for federal funding.

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STAFF ADMINISTRATIVE REQUIREMENTS

- Targeted team-based staffing must increase and strengthen primary care services for seniors and patients presenting with mental health and substance use issues.
- All physicians, nurses practitioners (NPs), registered nurses (RNs) and licensed practical nurses (LPNs) working in the UPCC, are required to shadow bill or encounter report through the Medical Service Plan Teleplan system for services provided.
    - NP encounter codes can be found here: https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/7-encounter-codes.pdf
    - See *Appendix A* for RN and LPN Encounter Codes
    - Encounter record Submission Procedures for NPs, RNs, and LPNs can be found here: https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/3_encounter_record_submission_procedures_april_2017.pdf
    - For physicians, an Assignment of Payment must be completed to submit shadow billings. The form can be found here: https://www2.gov.bc.ca/assets/gov/health/forms/2875fil.pdf
- The UPCC will require a Y-Status Payee number to submit physician encounter data. To obtain a new Y-Status Payee number, please contact the compensation analyst assigned to your health authority or email hlth.physiciancomp@gov.bc.ca

- The UPCC physicians are not to bill fee-for-service (FFS) for insured health care/ medical services provided to eligible Medical Services Plan (MSP) beneficiaries (or assign billings to the health authority) unless approved by the Ministry. Effective immediately, the above noted FFS billings and assignment to the health authority are to cease and any FFS claims paid by MSP must be remitted to the Ministry.
- For the UPCC, your health authority is required to remit 100% of all direct pay and third-party billings to the Ministry. Using the Y-Status payment number a 50% recovery will automatically be applied to all third-party claims, however the health authority will be required to remit and report payment for the remaining 50%, as well as any direct pay services (services that are benefits under MSP, but rendered to non-beneficiaries and services that are not benefits under MSP).
- Your health authority must work with the Health Employers Association of British Columbia to develop physician service contracts and/or salary agreements.

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REPORTING REQUIREMENTS

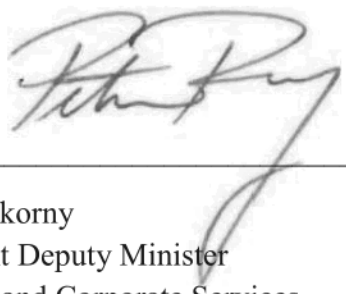
The Ministry is developing a reporting framework to monitor and evaluate the Kamloops UPCC and FPLC against the proposal submitted by IHA, including data such as: hours of operation, patient visits and patient attachment. In addition, IHA will be required to report on actual expenditure of net new funding allocated by the Ministry and targeted funding provided to IHA for seniors' team based primary care and increased mental health capacity in primary care, including the federal funding component. Further information concerning these reporting requirements will be provided under separate cover.

In addition to reporting on the deliverables that will be set out in the physician contracts, your health authority must submit:

- Physician utilization reports indicating direct, indirect hours and other hours worked for all physicians working in the UPCC. UPCC Utilization Reports are to be included with the utilization report submitted for the Alternative Payments Program and global operating funded contracts.
- UPCC Utilization Reports for NPs are to be included with the utilization reports submitted for NPs funded under global operating and NP4BC.

Thank you for your diligence in working to meet both service delivery and financial targets of the UPCC/ FPLC implementation and ongoing operations.

Yours truly,



Peter Pokorny
Assistant Deputy Minister
Finance and Corporate Services

Ted Patterson
Assistant Deputy Minister
Primary & Community Care Policy

cc: Donna Lommer, Chief Financial Officer, IHA
Kerri Harrison, Executive Director, Business Financial Transformation
Shana Ooms, Executive Director, Primary Care Access
Gordon Cross, Executive Director, Regional Grants and Decision Support

Appendix A: Encounter Codes for RNs and LPNs

RN/ LPN ENCOUNTER CODES	
FEE CODE	**TITLE**
IMMUNIZATIONS	
38010	NIPCP IMMUNIZATION-PATIENT <19 YRS-DTAP-IPV
38011	NIPCP IMMUNIZATION-PATIENT <19 YRS-DTAP-IPV-HIB
38012	NIPCP IMMUNIZATION-PATIENT <19 YRS-TD
38013	NIPCP IMMUNIZATION-PATIENT <19 YRS-TD/IPV
38014	NIPCP IMMUNIZATION-PATIENT <19 YRS-TDAP
38015	NIPCP IMMUNIZATION-PATIENT <19 YRS-INFLUENZA (FLU)
38016	NIPCP IMMUNIZATION-PATIENT <19 YRS-HEPATITIS A
38017	NIPCP IMMUNIZATION-PATIENT <19 YRS-HEPATITIS B
38018	NIPCP IMMUNIZATION-PATIENT <19 YRS-HIB
38019	NIPCP IMMUNIZATION-PATIENT <19 YRS-IPV
38020	NIPCP IMMUNIZATION-PATIENT <19 YRS-MEN-C
38021	NIPCP IMMUNIZATION-PATIENT <19 YRS-ACYW135
38022	NIPCP IMMUNIZATION-PATIENT <19 YRS-MMR
38023	NIPCP IMMUNIZATION-PATIENT <19 YRS-PCV13
38024	NIPCP IMMUNIZATION-PATIENT <19 YRS-PPV23
38025	NIPCP IMMUNIZATION-PATIENT <19 YRS-RABIES
38026	NIPCP IMMUNIZATION-PATIENT <19 YRS-VARICELLA
38027	NIPCP IMMUNIZATION-PATIENT <19 YRS-DTAP-HB-IPV-HIB
38028	NIPCP IMMUNIZATION-PATIENT <19 YRS-HPV
38029	NIPCP IMMUNIZATION-PATIENT <19 YRS-ROTAVIRUS
38030	NIPCP IMMUNIZATION-PATIENT <19 YRS-MMR/V
38035	NIPCP IMMUNIZATION-MMR -PATIENT >18 YEARS OF AGE
38038	NIPCP IMMUNIZATION-INFLUENZA- ADULTS WHO QUALIFY FOR FREE VACCINE
38041	NIPCP IMMUNIZATION-PNEUMOCOCCAL POLYSACCHARIDE (PPV23) For pts > 64 yrs of age or pts > 18 years of age whose health conditions qualify them for free vaccine or who reside in residential care or assisted living facilities. (pts < 19 yrs -bill 38024)
38042	NIPCP IMMUNIZATION HEPATITIS A - ADULTS AT RISK
38043	NIPCP IMMUNIZATION HEPATITIS B - ADULTS AT RISK
38044	NIPCP IMMUNIZATION-NOS (NOT OTHERWISE SPECIFIED) (inludes oral polio vaccine, etc.)
38045	NIPCP CLIENT CONTACT FOR ADVERSE EVENT FOLLOWING IMMUNIZATION
MEDICATION	
38060	NIPCP MEDICATION USAGE INTERVENTIONS- The identification of a patient's drug related problems and recommendations for their resolution (ie inappropriate dosing, drug level monitoring, drug interactions, treatment of adverse drug reactions)
38061	NIPCP MEDICATION WORK-UP- The completion of a patient's drug history during a structured interview and through chart and pharmanet searches (upon obtaining patient consent)
38062	NIPCP MEDICATION THERAPY MONITORING-The regular monitoring of a patient's medication adherence and drug toxicity through structured interviews, especially for patients with complex medication regimens or patients that are confused, forgetful or less compliant about medications.
38063	NIPCP MEDICATION THERAPY COORDINATION - Liasing with community and hospital pharmacies in an effort to provide seemless care for a patient (ie coordinating refills, obtaining prescriptions, providing up to date information on the patient's current drug therapy, dispensing medic ation, obtaining approval for medications)
38064	NIPCP MEDICATION INFORMATION- Answering patient-specific medication information questions from health care professionals and patients (ie dosing, adverse effects, drug interactions, suggestions for therapy)
38065	NIPCP MEDICATION THERAPY COUNSELING-Counseling a patient on the appropriate use of the patient's medication(s), adverse effects, and monitoring via a structured interview (ie provision of drug information sheets, setting up weekly dosettes, setting up medication timers). **Claim must state start and end times**

FEE CODE	TITLE
VISIT	
38070	NIPCP REQUESTING ADVICE FROM AN NP/GP - Collaborate with team members to support nurses assessment of patient care
38071	NIPCP REFERRAL TO IN-CLINIC TEAM MEMBER - Reviews assessment with GP/NP and queries action that is outside of scope of practice
38072	NIPCP REFERRAL TO NON HEALTH SERVICE PROVIDER - Referral to community resources (e.g., any service provider that does not require an MSP referral)
38073	NIPCP - GP REFERRAL TO NURSE
38080	NIPCP VISIT - IN OFFICE (AGE 0-1) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38081	NIPCP VISIT - IN OFFICE (AGE 2-49) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38082	NIPCP VISIT - IN OFFICE (AGE 50-59) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38083	NIPCP VISIT - IN OFFICE (AGE 60-69) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38084	NIPCP VISIT - IN OFFICE (AGE 70-79) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38085	NIPCP VISIT - IN OFFICE (AGE 80+) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38195	NIPCP VISIT - CHRONIC DISEASE MANAGEMENT A visit to review ongoing management of a chronic disease. Visit activities include: reviewing patient's care plan; patient's health outcomes; monitoring condition subsequent to an intervention; discussing continuing care strategies; discussing various management options, such as life style/self-care, psychotherapy, phamarcological management; etc. Activities performed in visit are generally brief discussions; however, if more elaborate discussion occurs, bill separate encounter code in addition visit encounter (e.g., education nutrition, medication therapy monitoring, etc.) **Claim must state start and end times.**
38116	NIPCP ROUTINE HEALTH HISTORY - NEW PATIENT-Recording the medical/social history of a new patient
38117	NIPCP BODY COMPOSITION ASSESSMENT-BIOELECTRICAL IMPEDANCE ANALYSIS AND/OR ANTHROPOMETRIC ASSESSMENT (MULTIPLE SITE SKINFOLDS AND CIRCUMFERENCES).
38119	NIPCP PATIENT ASSESSMENT Evaluation of a client's condition, problem or functional status to establish anursing diagnosis and/or identify information to support a clinical diagnosis and/or identify treatment or rehabilitation measures and/or monitor a client's response to an existing treatment/rehabilitation plan. Also includes, where applicable, ordering diagnostic investigations, reviewing results, prescribing medications, counseling patient, coordinating care with other providers or agencies, etc.**Claim must state start and end times.**
38120	NIPCP ROUTINE PELVIC EXAM INCLUDING PAP Routine pelvic examination including Papanicolaou smear.
38123	NIPCP COMMUNICABLE DISEASE FOLLOW UP Evaluation of a client's condition, related to a previously diagnosed communicable disease, and/or monitoring of a client's response to an existing treatment/rehabilitation plan. Also includes, where applicable, ordering diagnostic investigations, reviewing results, prescribing medications, counseling patient, coordinating care with other providers or agencies, etc
38125	NIPCP COMPLETION OF FORMS, NO REIMBURSEMENT Completion of all relevant documentation/forms, where there is no reimbursement from third party or direct billing, required as a result of a specific incident, or to obtain client consent.
38130	NIPCP CASE CONFERENCE Meeting with members of the health care team, representatives of other agencies involved in the management of the client, to plan and coordinate activities and services and to share information necessary to meet the client's needs/goals and expected outcomes. **Claim must state start and end times.**
38131	NIPCP CASE MANAGEMENT Multiple telephone calls to develop a comprehensive service plan, link the client to the required services, coordinate and maintain links with resources/services/supports in the client's environment, and evaluate services provided. May include activities such as searching for the appropriate resources and negotiating with potential providers (eg. probation officers, child and family services, social assistance, education, housing etc.) Claim must state start and end times.
38135	NIPCP FAMILY CONFERENCE - A conference with the patient's family/friend during which client needs are identified (based on previous assessment findings) and strategies are developed to ensure that needs are addressed and expected outcomes will be met. The intervention includes activities such as goal setting and designing resources that are required (patient may or may not be present). **Claim must state start and end**

	times.

FEE CODE	TITLE
EDUCATION	
38140	NIPCP EDUCATION - GROUP - Bill to the PHN for each patient attending the group meeting. Start and end times should be listed for each PHN**Claim must state start and end times.**
38141	NIPCP EDUCATION - CHOLESTEROL **Claim must state start and end times.**
38142	NIPCP EDUCATION - INSULIN STARTS **Claim must state start and end times.**
38143	NIPCP EDUCATION - INHALER USE**Claim must state start and end times.**
38144	NIPCP EDUCATION - RELATED TO SPECIFIC DIAGNOSIS Information provided in a structured format, to enhance knowledge and skill that directly or indirectly assists the client/family to understand, monitor and manage their condition/impairment. Includes, where applicable, provision of educational material such as pamphlets, tapes, books and videos. **Claim must state start and end times.**
38145	NIPCP EDUCATION - HEALTH PROMOTION/DISEASE PREVENT Information provided in a structured format, to enhance knowledge and skill that directly or indirectly promote health or influence changes in unhealthy lifestyles. Includes, where applicable, provision of educational materials such as pamphlets, tapes, books and videos (eg. exercise, nutrition, hygiene, STD education). **Claim must state start and end times.**
38146	NIPCP EDUCATION - FAMILY PLANNING Information about contraception provided in a structured format, to enhance knowledge and skill that directly or indirectly promotes health or influences changes in unhealthy life styles. Includes, where applicable, provision of educational materials such as pamphlets, tapes, books and videos.**Claim must state start and end times.**
38147	NIPCP EDUCATION - SMOKING Therapeutic communication, provided to or on behalf of a client, to identify and evaluate, introduce and/or eliminate, reinforce and/or reduce certain attitudes on the part of the client regarding health risks due to smoking/tobacco use and their potential effect on health status, which could alter attitudes and in turn change/modify behaviour. **Claim must state start and end times.**
38148	NIPCP EDUCATION - SUBSTANCE ABUSE Therapeutic communication, provided to or on behalf of a client, to identify and evaluate, introduce and/or eliminate, reinforce and/or reduce certain attitudes on the part of the client regarding health risks due to drug use/abuse or alcohol consumption and their potential effect on health status, which could alter attitudes and in turn change/modify behavior. **Claim must state start and end times.**
38150	NIPCP EDUCATION - PARENTING Information to improve parenting skills provided in a structured format, to enhance knowledge and skill that directly or indirectly promote health or influence changes in unhealthy life styles. Includes, where applicable, provision of educational materials such as pamphlets, tapes, books, and videos. **Claim must state start and end times.**
38153	NIPCP EDUCATION - ENVIRONMENTAL ISSUES Therapeutic communication, provided to or on behalf of a client, to identify and evaluate, introduce and/or eliminate, reinforce and/or reduce certain attitudes on the part of the client regarding health risks related to environmental risk/injury and their potential effect on health status, which could alter attitudes and in turn change/modify behavior. **Claim must state start and end times.**
38155	NIPCP EDUCATION - NUTRITION Therapeutic communication, provided to or on behalf of a patient, to enhance knowledge and skill that directly or indirectly promote nutritional health status or influence changes in unhealthy lifestyles that impact on nutritional status for the specific patient. Includes, where applicable, provision of educational materials such as pamphlets, tapes, books and videos that pertain specifically to nutrition. **Claim must state start and end times.**
INJECTIONS	
38160	NIPCP INJECTION, INTRAMUSCULAR - Intramuscular medications.
38161	NIPCP INJECTION, VENEPUNCTURE - Venepuncture and dispatch of specimen to laboratory, when no other blood work performed.
38162	NIPCP MEDICATION INJECTION, SUBCUTANEOUS - Subcutaneous medication, including desensitization treatments
MSC PROCEDURES	
38163	NIPCP MINI TRAY FEE
38165	NIPCP GLUCOSE - SEMIQUANTITATIVE (dipstick analyzed visually or by reflectance meter)
38166	NIPCP PREGNANCY TEST, IMMUNOLOGIC, URINE
38167	NIPCP URINALYSIS - SCREENING Urinalysis - Chemical or any part of (screening)
38168	NIPCP SYRINGING – EAR Irrigation of the external auditory meatus.
38169	NIPCP SUTURE/STAPLE REMOVAL Removal of sutures, staples, clips, etc.

38170	NIPCP DRESSING CHANGE Replacement of bandage/dressing.
38171	NIPCP ELECTROSURGERY/CRYOTHERAPY FOR REMOVAL/WARTS Forms of treatment other than excision, x-ray, or grenz ray; such as removal of haemangiomas and warts with electrosurgery, cryotherapy, etc. - per visit
FEE CODE	**TITLE**
MSC PROCEDURES (cont'd)	
38172	NIPCP FOOT CARE
38173	NIPCP SUTURING MINOR LACERATIONS
38174	NIPCP ASSISTING WITH PRODECURES
38175	NIPCP WOUND CARE Includes cleansing, irrigating, probing, debriding, packing and dressing a wound. It also includes suturing a laceration and changing dressings.
38176	NIPCP INR MANAGEMENT
38177	NIPCP ULTRASOUND - Handheld device
38005	NIPCP LIFETIME PREVENTION SCREENING Lifetime Prevention Screening includes initiating any of the clinical prevention services for specific patient groups as outlined in the Lifetime Prevention Schedule. Encounter is used for one or more intervention provided based on patient's demographics (e.g., age, sex).
38006	NIPCP PALLIATIVE/EOL CARE PLANNING
TELEPHONE	
38180	NIPCP PHONE CONTACT WITH PROFESSIONAL CARE PROVIDER Telephone contact to exchange information about a client between service providers, includes a verbal or written follow up communication with the Referring service provider (ag social worker, home care etc.)
38184	NIPCP TELEPHONE CONTACT WITH PATIENT FAMILY/FRIEND A single telephone call to patient's family/friend during which client needs are identified (based on previous assessment findings) and strategies are developed to ensure that needs are addressed and expected outcomes will be met. This intervention includes activities such as goal setting and designing resources and services that are required.
38185	NIPCP TELEPHONE CONSULTATION
38186	NIPCP TELEPHONE FOLLOW-UP Telephone contact with a patient to monitor client's response to an existing treatment/rehabilitation plan. Also includes, where applicable, ordering diagnostic investigations, reviewing results, prescribing medications, counseling patient, etc.
38188	NIPCP TELEPHONE CALL (PHARMACY) Telephone call to initiate prescription or renew the directions and/or instructions for the preparation, dispensing, fabrication, or implementation of the pharmacological agents.
COUNSELING	
38191	NIPCP CRISIS COUNSELING Issue-or incident-specific counseling session with a patient, resulting from self, physician, health or non-health professional referral. **Claim must state start and end times**.
38192	NIPCP SHORT-TERM COUNSELING A counseling session with a patient resulting from self, physician, health or non-health professional referral. **Claim must state start and end times.**

RN/LPN Encounter Codes Updated: 2018-05-18

BRITISH COLUMBIA

1126053

January 17, 2019

Ms. Mary Ackenhusen
President and Chief Executive Officer
Vancouver Coastal Health Authority
11th Floor, 601 W. Broadway
Vancouver BC V5Z 4C2

Dear Ms. Ackenhusen:

We are writing to provide confirmation of operating funding allocations and reporting requirements related to Vancouver Coastal Health Authority's (VCHA) first Urgent Primary Care Centre (UPCC) at Vancouver City Centre, which opened November 26, 2018.

The Ministry assessed VCHA's proposal for the Vancouver City Centre UPCC based on a standardized funding framework, including salary, benefit and overhead rates, to ensure equity among the various health authority UPCC proposals. In addition, consideration for existing family practice clinics and funding sustainability for the overall Primary Care initiative was also part of the Ministry's assessment.

OPERATING FUNDING:
A summary of VCHA's request for the Vancouver City Centre UPCC and the Ministry's assessment is shown in Table 1.

	Table 1	Total Request (Annualized)	MoH Assessment (Annualized)
1	Urgent Primary Care Centre[1]	$ 4,285,000	$ 3,715,761
2	One-time Start-up Costs	$ 2,180,101	$ -
	Total	$ 6,465,101	$ 3,715,761
	1. "On-going" operating costs		

- An overall budget of $3.716M has been approved by the Ministry to establish the Vancouver City Centre UPCC to provide same day access to urgently needed primary care services and extended hours of care (14 hours a day Monday to Saturday and 7.5 hours on Sunday), as outlined in VCHA's proposal.

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Ministry of Health
Office of the Assistant Deputy Minister
Finance and Corporate Services
PO Box 9647 Stn Prov Govt
Victoria BC V8W 9P4
Facsimile: 250 952-1573

- As shown in Table 2 the approval includes clinical resources for the interdisciplinary team as requested by VCHA. In addition a provision of 1 FTE Medical Office Assistant per GP/NP has been funded as part of the GP/NP overhead provision. Non-clinical staff and non-labour costs are to be managed from within the overhead provision included in the total funding provided.

Table 2

Vancouver City Centre UPCC	FTE	Funding/ FTE Including Overhead	Total Annual Funding	2018/19	2019/20 Notional Allocation for Planning Purposes	2020/21 Notional Allocation for Planning Purposes
General Practitioner[1]	4.2	$ 286,331	$ 1,213,328		$ 1,213,328	$ 1,213,328
Nurse Practitioner[2]	3.3	$ 164,000	$ 546,314		$ 546,314	$ 546,314
Medical Office Assistant	7.6	$ 50,000	$ 378,434		$ 378,434	$ 378,434
Sub-total	15.1		$ 2,138,076		$ 2,138,076	$ 2,138,076
RN[2]	10.0	$ 114,400	$ 1,143,262		$ 1,143,262	$ 1,143,262
Social Worker[2]	3.3	$ 108,900	$ 362,766		$ 362,766	$ 362,766
Premiums			$ 71,657		$ 71,657	$ 71,657
Sub-total	13.3		$ 1,577,685		$ 1,577,685	$ 1,577,685
Total	**28.5**		**$ 3,715,761**	**$ 1,580,562**	**$ 3,715,761**	**$ 3,715,761**

1 Contract GP-Defined Scope at 95% of range plus overhead.

2 Based on HSCIS 2016 Q4 average salary/FTE and benefit costs adjusted to April 2018 for general wage increases and economic stability dividends where applicable plus overhead.

- VCHA will be expected to manage tenant improvements costs of $2M to renovate the UPCC space, along with one-time costs of $0.18M for advertising and other costs.

FUNDING SOURCE

As identified in the "Bilateral Planning and Action Expectations" for April 1, 2018 to March 31, 2019, health authorities are assigned notional funding, available once staffing has occurred, to increase and strengthen primary team-based care services at the community health service area level linked to Primary Care Networks (PCNs) and Urgent Primary Care Centres. This funding is to support management of clients that are identified as being at risk for health decline or health crisis by increasing access to community based professional services (nursing and allied) and improving the quality of and timeliness of care for adults with complex medical conditions. The targeted notional allocation provided to VCHA is currently frozen and includes both federal and provincial funding as shown in Table 3.

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Table 3:

VCH	2018/19	2019/20	2020/21	3 Yr Total
Mental Health Federal Funding:				
Increased Mental Health Capacity in PCN	889,840	2,260,780	2,260,780	5,411,400
Seniors' Team Based Primary Care:				
Nursing & Allied Professionals- Ministry	2,648,330	7,138,200	8,454,590	18,241,120
Nursing & Allied Professionals- Federal	2,782,070	2,782,070	2,782,070	8,346,210
Sub-total Seniors	5,430,400	9,920,270	11,236,660	26,587,330
Sub-total Federal Funding	3,671,910	5,042,850	5,042,850	13,757,610
Sub-total Ministry Funding	2,648,330	7,138,200	8,454,590	18,241,120
TOTAL	**6,320,240**	**12,181,050**	**13,497,440**	**31,998,730**

It is the Ministry's expectation that VCHA will **first apply eligible UPCC costs** against the federal funding allocations noted above, as federal funds will need to be repaid if not fully utilized. The Ministry will work with VCHA to determine an allocation methodology to identify UPCC expenditures which are consistent with federal funding criteria.

In 2018/19 VCHA is authorized to access up to $1,580,562 of targeted frozen federal and provincial funding notionally allocated to VCHA for "Seniors' Team Based Primary Care" and "Increased Mental Health Capacity in PCNs" as shown in Table 3. VCHA will be required to report-back to the Ministry on the actual expenditure of 2018/19 UPCC costs against the federal and provincial funding allocations.

In 2019/20 and 2020/21 VCHA will continue to **first apply all eligible UPCC costs** against the federal funding allocation noted in Table 3. A notional allocation, for planning purposes, of net new ministry funding of up to $2,138,076 (as shown in Table 2) is provided for 2019/20 and 2020/21 for all remaining costs associated with the GP/NP and MOA positions, including overheads, not eligible for federal funding. A notional authorization, for planning purposes, of up to $1,577,685 (as shown in Table 2) against the targeted frozen ministry funding notionally allocated for " Seniors' Team Based Primary Care" is provided for all remaining costs associated with registered nursing and allied health care positions, including overheads, not eligible for federal funding.

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STAFF ADMINISTRATIVE REQUIREMENTS:

- Targeted team-based staffing must increase and strengthen primary care services for seniors and patients presenting with mental health and substance use issues.
- All physicians, nurses practitioners (NPs), registered nurses (RNs) and licensed practical nurses (LPNs) working in the UPCC, are required to shadow bill or encounter report through the Medical Service Plan Teleplan system for services provided.
    - NP encounter codes can be found here: https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/7-encounter-codes.pdf
    - See *Appendix A* for RN and LPN Encounter Codes
    - Encounter record Submission Procedures for NPs, RNs, and LPNs can be found here: https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/3_encounter_record_submission_procedures_april_2017.pdf
    - For physicians, an Assignment of Payment must be completed to submit shadow billings. The form can be found here: https://www2.gov.bc.ca/assets/gov/health/forms/2875fil.pdf
- The UPCC will require a Y-Status Payee number to submit physician encounter data. To obtain a new Y-Status Payee number, please contact the compensation analyst assigned to your health authority or email hlth.physiciancomp@gov.bc.ca
- Physicians are not to bill fee-for-service (FFS) for insured health care/ medical services provided to eligible Medical Services Plan (MSP) beneficiaries (or assign billings to the health authority) unless approved by the Ministry
- Your health authority is required to remit 100% of all direct pay and third-party billings to the Ministry. Using the Y-Status payment number a 50% recovery will automatically be applied to all third-party claims, however the health authority will be required to remit and report payment for the remaining 50%, as well as any direct pay services (services that are benefits under MSP, but rendered to non-beneficiaries and services that are not benefits under MSP).
- Your health authority must work with the Health Employers Association of British Columbia to develop physician service contracts and/or salary agreements.

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REPORTING REQUIREMENTS

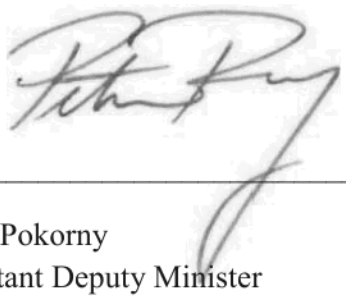
The Ministry is developing a reporting framework to monitor and evaluate the Vancouver City Centre UPCC against the proposal submitted by VCHA, including: hours of operation and patient visits. In addition, VCHA will be required to report on actual expenditure of net new funding allocated by the Ministry and targeted funding provided to VCHA for seniors' team based primary care and increased mental health capacity in primary care, including the federal funding component . Further information concerning these reporting requirements will be provided under separate cover.

In addition to reporting on the deliverables that will be set out in the physician contracts, your health authority must submit:

- Physician utilization reports indicating direct, indirect hours and other hours worked for all physicians working in the UPCC. UPCC Utilization Reports are to be included with the utilization report submitted for the Alternative Payments Program and global operating funded contracts.
- UPCC Utilization Reports for NPs are to be included with the utilization reports submitted for NPs funded under global operating and NP4BC.

Thank you for your diligence in working to meet both service delivery and financial targets of the UPCC implementation and ongoing operations.

Yours truly,



Peter Pokorny
Assistant Deputy Minister
Finance and Corporate Services

Ted Patterson
Assistant Deputy Minister
Primary & Community Care Policy

cc: Glen Copping, Chief Financial Officer, VCHA
Kerri Harrison, Executive Director, Business Financial Transformation
Shana Ooms, Executive Director, Primary Care Access
Gordon Cross, Executive Director, Regional Grants and Decision Support

Ministry of Health
Office of the Assistant Deputy Minister
Finance and Corporate Services
PO Box 9647 Stn Prov Govt
Victoria BC V8W 9P4
Facsimile: 250 952-1573

Appendix A: Encounter Codes for RNs and LPNs

RN/ LPN ENCOUNTER CODES	
FEE CODE	**TITLE**
IMMUNIZATIONS	
38010	NIPCP IMMUNIZATION-PATIENT <19 YRS-DTAP-IPV
38011	NIPCP IMMUNIZATION-PATIENT <19 YRS-DTAP-IPV-HIB
38012	NIPCP IMMUNIZATION-PATIENT <19 YRS-TD
38013	NIPCP IMMUNIZATION-PATIENT <19 YRS-TD/IPV
38014	NIPCP IMMUNIZATION-PATIENT <19 YRS-TDAP
38015	NIPCP IMMUNIZATION-PATIENT <19 YRS-INFLUENZA (FLU)
38016	NIPCP IMMUNIZATION-PATIENT <19 YRS-HEPATITIS A
38017	NIPCP IMMUNIZATION-PATIENT <19 YRS-HEPATITIS B
38018	NIPCP IMMUNIZATION-PATIENT <19 YRS-HIB
38019	NIPCP IMMUNIZATION-PATIENT <19 YRS-IPV
38020	NIPCP IMMUNIZATION-PATIENT <19 YRS-MEN-C
38021	NIPCP IMMUNIZATION-PATIENT <19 YRS-ACYW135
38022	NIPCP IMMUNIZATION-PATIENT <19 YRS-MMR
38023	NIPCP IMMUNIZATION-PATIENT <19 YRS-PCV13
38024	NIPCP IMMUNIZATION-PATIENT <19 YRS-PPV23
38025	NIPCP IMMUNIZATION-PATIENT <19 YRS-RABIES
38026	NIPCP IMMUNIZATION-PATIENT <19 YRS-VARICELLA
38027	NIPCP IMMUNIZATION-PATIENT <19 YRS-DTAP-HB-IPV-HIB
38028	NIPCP IMMUNIZATION-PATIENT <19 YRS-HPV
38029	NIPCP IMMUNIZATION-PATIENT <19 YRS-ROTAVIRUS
38030	NIPCP IMMUNIZATION-PATIENT <19 YRS-MMR/V
38035	NIPCP IMMUNIZATION-MMR -PATIENT >18 YEARS OF AGE
38038	NIPCP IMMUNIZATION-INFLUENZA- ADULTS WHO QUALIFY FOR FREE VACCINE
38041	NIPCP IMMUNIZATION-PNEUMOCOCCAL POLYSACCHARIDE (PPV23) For pts > 64 yrs of age or pts > 18 years of age whose health conditions qualify them for free vaccine or who reside in residential care or assisted living facilities. (pts < 19 yrs -bill 38024)
38042	NIPCP IMMUNIZATION HEPATITIS A - ADULTS AT RISK
38043	NIPCP IMMUNIZATION HEPATITIS B - ADULTS AT RISK
38044	NIPCP IMMUNIZATION-NOS (NOT OTHERWISE SPECIFIED) (inludes oral polio vaccine, etc.)
38045	NIPCP CLIENT CONTACT FOR ADVERSE EVENT FOLLOWING IMMUNIZATION
MEDICATION	
38060	NIPCP MEDICATION USAGE INTERVENTIONS- The identification of a patient's drug related problems and recommendations for their resolution (ie inappropriate dosing, drug level monitoring, drug interactions, treatment of adverse drug reactions)
38061	NIPCP MEDICATION WORK-UP- The completion of a patient's drug history during a structured interview and through chart and pharmanet searches (upon obtaining patient consent)
38062	NIPCP MEDICATION THERAPY MONITORING-The regular monitoring of a patient's medication adherence and drug toxicity through structured interviews, especially for patients with complex medication regimens or patients that are confused, forgetful or less compliant about medications.
38063	NIPCP MEDICATION THERAPY COORDINATION - Liasing with community and hospital pharmacies in an effort to provide seemless care for a patient (ie coordinating refills, obtaining prescriptions, providing up to date information on the patient's current drug therapy, dispensing medic ation, obtaining approval for medications)
38064	NIPCP MEDICATION INFORMATION- Answering patient-specific medication information questions from health care professionals and patients (ie dosing, adverse effects, drug interactions, suggestions for therapy)
38065	NIPCP MEDICATION THERAPY COUNSELING-Counseling a patient on the appropriate use of the patient's medication(s), adverse effects, and monitoring via a structured interview (ie provision of drug information sheets, setting up weekly dosettes, setting up medication timers). **Claim must state start and end times**

FEE CODE	TITLE
VISIT	
38070	NIPCP REQUESTING ADVICE FROM AN NP/GP - Collaborate with team members to support nurses assessment of patient care
38071	NIPCP REFERRAL TO IN-CLINIC TEAM MEMBER - Reviews assessment with GP/NP and queries action that is outside of scope of practice
38072	NIPCP REFERRAL TO NON HEALTH SERVICE PROVIDER - Referral to community resources (e.g., any service provider that does not require an MSP referral)
38073	NIPCP - GP REFERRAL TO NURSE
38080	NIPCP VISIT - IN OFFICE (AGE 0-1) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38081	NIPCP VISIT - IN OFFICE (AGE 2-49) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38082	NIPCP VISIT - IN OFFICE (AGE 50-59) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38083	NIPCP VISIT - IN OFFICE (AGE 60-69) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38084	NIPCP VISIT - IN OFFICE (AGE 70-79) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38085	NIPCP VISIT - IN OFFICE (AGE 80+) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38195	NIPCP VISIT - CHRONIC DISEASE MANAGEMENT A visit to review ongoing management of a chronic disease. Visit activities include: reviewing patient's care plan; patient's health outcomes; monitoring condition subsequent to an intervention; discussing continuing care strategies; discussing various management options, such as life style/self-care, psychotherapy, phamarcological management; etc. Activities performed in visit are generally brief discussions; however, if more elaborate discussion occurs, bill separate encounter code in addition visit encounter (e.g., education nutrition, medication therapy monitoring, etc.) **Claim must state start and end times.**
38116	NIPCP ROUTINE HEALTH HISTORY - NEW PATIENT-Recording the medical/social history of a new patient
38117	NIPCP BODY COMPOSITION ASSESSMENT-BIOELECTRICAL IMPEDANCE ANALYSIS AND/OR ANTHROPOMETRIC ASSESSMENT (MULTIPLE SITE SKINFOLDS AND CIRCUMFERENCES).
38119	NIPCP PATIENT ASSESSMENT Evaluation of a client's condition, problem or functional status to establish anursing diagnosis and/or identify information to support a clinical diagnosis and/or identify treatment or rehabilitation measures and/or monitor a client's response to an existing treatment/rehabilitation plan. Also includes, where applicable, ordering diagnostic investigations, reviewing results, prescribing medications, counseling patient, coordinating care with other providers or agencies, etc.**Claim must state start and end times.**
38120	NIPCP ROUTINE PELVIC EXAM INCLUDING PAP Routine pelvic examination including Papanicolaou smear.
38123	NIPCP COMMUNICABLE DISEASE FOLLOW UP Evaluation of a client's condition, related to a previously diagnosed communicable disease, and/or monitoring of a client's response to an existing treatment/rehabilitation plan. Also includes, where applicable, ordering diagnostic investigations, reviewing results, prescribing medications, counseling patient, coordinating care with other providers or agencies, etc
38125	NIPCP COMPLETION OF FORMS, NO REIMBURSEMENT Completion of all relevant documentation/forms, where there is no reimbursement from third party or direct billing, required as a result of a specific incident, or to obtain client consent.
38130	NIPCP CASE CONFERENCE Meeting with members of the health care team, representatives of other agencies involved in the management of the client, to plan and coordinate activities and services and to share information necessary to meet the client's needs/goals and expected outcomes. **Claim must state start and end times.**
38131	NIPCP CASE MANAGEMENT Multiple telephone calls to develop a comprehensive service plan, link the client to the required services, coordinate and maintain links with resources/services/supports in the client's environment, and evaluate services provided. May include activities such as searching for the appropriate resources and negotiating with potential providers (eg. probation officers, child and family services, social assistance, education, housing etc.) Claim must state start and end times.
38135	NIPCP FAMILY CONFERENCE - A conference with the patient's family/friend during which client needs are identified (based on previous assessment findings) and strategies are developed to ensure that needs are addressed and expected outcomes will be met. The intervention includes activities such as goal setting and

	designing resources that are required (patient may or may not be present). **Claim must state start and end times.**

FEE CODE	TITLE
EDUCATION	
38140	NIPCP EDUCATION - GROUP - Bill to the PHN for each patient attending the group meeting. Start and end times should be listed for each PHN**Claim must state start and end times.**
38141	NIPCP EDUCATION - CHOLESTEROL **Claim must state start and end times.**
38142	NIPCP EDUCATION - INSULIN STARTS **Claim must state start and end times.**
38143	NIPCP EDUCATION - INHALER USE**Claim must state start and end times.**
38144	NIPCP EDUCATION - RELATED TO SPECIFIC DIAGNOSIS Information provided in a structured format, to enhance knowledge and skill that directly or indirectly assists the client/family to understand, monitor and manage their condition/impairment. Includes, where applicable, provision of educational material such as pamphlets, tapes, books and videos. **Claim must state start and end times.**
38145	NIPCP EDUCATION - HEALTH PROMOTION/DISEASE PREVENT Information provided in a structured format, to enhance knowledge and skill that directly or indirectly promote health or influence changes in unhealthy lifestyles. Includes, where applicable, provision of educational materials such as pamphlets, tapes, books and videos (eg. exercise, nutrition, hygiene, STD education). **Claim must state start and end times.**
38146	NIPCP EDUCATION - FAMILY PLANNING Information about contraception provided in a structured format, to enhance knowledge and skill that directly or indirectly promotes health or influences changes in unhealthy life styles. Includes, where applicable, provision of educational materials such as pamphlets, tapes, books and videos.**Claim must state start and end times.**
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MSC PROCEDURES (cont'd)	
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38175	NIPCP WOUND CARE Includes cleansing, irrigating, probing, debriding, packing and dressing a wound. It also includes suturing a laceration and changing dressings.
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TELEPHONE	
38180	NIPCP PHONE CONTACT WITH PROFESSIONAL CARE PROVIDER Telephone contact to exchange information about a client between service providers, includes a verbal or written follow up communication with the Referring service provider (ag social worker, home care etc.)
38184	NIPCP TELEPHONE CONTACT WITH PATIENT FAMILY/FRIEND A single telephone call to patient's family/friend during which client needs are identified (based on previous assessment findings) and strategies are developed to ensure that needs are addressed and expected outcomes will be met. This intervention includes activities such as goal setting and designing resources and services that are required.
38185	NIPCP TELEPHONE CONSULTATION
38186	NIPCP TELEPHONE FOLLOW-UP Telephone contact with a patient to monitor client's response to an existing treatment/rehabilitation plan. Also includes, where applicable, ordering diagnostic investigations, reviewing results, prescribing medications, counseling patient, etc.
38188	NIPCP TELEPHONE CALL (PHARMACY) Telephone call to initiate prescription or renew the directions and/or instructions for the preparation, dispensing, fabrication, or implementation of the pharmacological agents.
COUNSELING	
38191	NIPCP CRISIS COUNSELING Issue-or incident-specific counseling session with a patient, resulting from self, physician, health or non-health professional referral. **Claim must state start and end times**.
38192	NIPCP SHORT-TERM COUNSELING A counseling session with a patient resulting from self, physician, health or non-health professional referral. **Claim must state start and end times.**

RN/LPN Encounter Codes Updated: 2018-05-18

1126052

January 17, 2019

Ms. Kathy MacNeil
President and Chief Executive Officer
Vancouver Island Health Authority
1952 Bay St
Victoria BC V8R 1J8

Dear Ms. MacNeil:

We are writing to provide confirmation of operating funding allocations and reporting requirements related to Vancouver Island Health Authority's (VIHA) first Urgent Primary Care Centre (UPCC) for West Shore communities, which opened on November 5, 2018.

The Ministry assessed VIHA's proposal for the West Shore UPCC based on a standardized funding framework including salary, benefit and overhead rates, to ensure equity among the various health authority UPCC proposals. In addition, consideration for existing family practice clinics and funding sustainability for the overall Primary Care initiative was also part of the Ministry's assessment.

Preliminary funding allocations based on the standardized funding framework were previously shared with your staff and as result of those discussions an incremental $600,000 funding adjustment was made for the West Shore UPCC on an exception basis. It is the Ministry's expectation that future UPCC funding approvals will be consistent with the standardized funding framework.

OPERATING FUNDING

A summary of VIHA's request for the West Shore UPCC and the Ministry's assessment is shown in Table 1.

Table 1	Total Revised Request (Annualized)	MOH Assessment (Annualized)
Urgent Primary Care Centre[1]	$ 4,219,227	$ 4,006,876
MHSU Same Day Access Team[1]	$ 453,840	$ 447,370
One-time Start-up	$ 35,982	$ -
Total	$ 4,673,067	$ 4,454,246
1.) "On-going" annual operating costs		

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An overall annual funding allocation of $4.454M has been approved by the Ministry for the West Shore UPCC and MHSU Same Day Access Team to provide extended hours of care (12 hours a day, 365 days a year at the UPCC) and same day access to urgently needed primary care services, including mental health and substance use support, as outlined in VIHA's proposal.

Urgent Primary Care Centre:

As shown in Table 2(a), the approval includes clinical resources for the interdisciplinary team as requested by VIHA for the UPCC clinic. In addition, a provision of 1 FTE Medical Office Assistant per GP/NP has been funded as part of the GP/NP overhead provision. Non-clinical staff and non-labour costs are to be managed from within the overhead provision included in the total funding provided.

Table 2 (a)

Westshore UPCC	FTE	Funding/ FTE Including Overhead	Total Annual Funding	2018/19	2019/20 Notional Allocation for Planning Purposes	2020/21 Notional Allocation for Planning Purposes
General Practitioner[1]	7.2	$ 276,331	$ 1,989,583		$ 1,989,583	$ 1,989,583
Nurse Practitioner[2]	1.2	$ 154,000	$ 184,800		$ 184,800	$ 184,800
Medical Office Assistant	8.4	$ 50,000	$ 420,000		$ 420,000	$ 420,000
Funding Adjustment			$ 457,538		$ 457,538	$ 457,538
Sub-total	16.8		$ 3,051,921		$ 3,051,921	$ 3,051,921
RN[2]	5.8	$ 114,400	$ 664,664		$ 664,664	$ 664,664
Mental Health Worker[2]	1.2	$ 107,800	$ 129,360		$ 129,360	$ 129,360
Pharmacy Technician[2]	0.2	$ 80,300	$ 18,469		$ 18,469	$ 18,469
Funding Adjustment			$ 142,462		$ 142,462	$ 142,462
Sub-total	7.2		$ 954,955		$ 954,955	$ 954,955
Total	**24.0**		**$ 4,006,876**	**$ 1,945,541**	**$ 4,006,876**	**$ 4,006,876**

1. Contract GP- Defined Scope A at 95% of range plus overhead.

2. Based on HSCIS 2016 Q4 average salary/ FTE and benefit costs adjusted to April 2018 for general wage increases and economic stability dividends where applicable plus overhead.

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MHSU Same Day Access Team:

As shown in Table 2(b), the approval includes resources for the mental health workers requested by VIHA for the MHSU same day access team. Non-labour costs are to be managed from within the overhead provision included in the total funding provided.

Table 2 (b)

MHSU Same Day Access Team	FTE	Funding/ FTE Including Overhead	Total Annual Funding	2018/19	2019/20 Notional Allocation for Planning Purposes	2020/21 Notional Allocation for Planning Purposes
Mental Health Worker[1]	4.2	$ 107,800	$ 447,370	$ 210,821	$ 447,370	$ 447,370
Total	**-**		**$ 447,370**	**$ 210,821**	**$ 447,370**	**$ 447,370**

1. Based on HSCIS 2016 Q4 average salary/ FTE and benefit costs adjusted to April 2018 for general wage increases and economic stability dividends where applicable plus overhead.

- VIHA is expected to manage one-time start-up costs of $0.036M in 2018/19.

FUNDING SOURCE

As identified in the "Bilateral Planning and Action Expectations" for April 1, 2018 to March 31, 2019, health authorities are assigned notional funding, available once staffing has occurred, to increase and strengthen primary team-based care services at the community health service area level linked to Primary Care Networks (PCNs) and Urgent Primary Care Centres. This funding is to support management of clients that are identified as being at risk for health decline or health crisis by increasing access to community based professional services (nursing and allied) and improving the quality of and timeliness of care for adults with complex medical conditions. The targeted notional allocation provided to VIHA is currently frozen and includes both federal and provincial funding as shown in Table 3.

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Table 3:

VIHA	2018/19	2019/20	2020/21	3 Yr. Total
Mental Health Federal Funding:				
Increased Mental Health Capacity in PCN	625,260	1,589,000	1,589,000	3,803,260
Seniors' Team Based Primary Care:				
Nursing & Allied Professionals- Ministry	1,860,880	5,016,600	5,942,670	12,820,150
Nursing & Allied Professionals- Federal	1,954,860	1,954,860	1,954,860	5,864,580
Sub-total Seniors	3,815,740	6,971,460	7,897,530	18,684,730
Sub-total Federal Funding	2,580,120	3,543,860	3,543,860	9,667,840
Sub-total Ministry Funding	1,860,880	5,016,600	5,942,670	12,820,150
TOTAL	**4,441,000**	**8,560,460**	**9,486,530**	**22,487,990**

It is the Ministry's expectation that VIHA will **first apply eligible UPCC/MHSU Same Day Access Team costs** against the federal funding allocations noted above, as federal funds will need to be repaid if not fully utilized. The Ministry will work with VIHA to determine an allocation methodology to identify UPCC/ MHSU Same Day Access Team expenditures which are consistent with federal funding criteria.

In 2018/19 VIHA is authorized to access up to $2,156,362 ($1,945,541 UPCC and $210,821 MHSU Same Day Access Team) of targeted frozen federal and provincial funding notionally allocated to VIHA for "Seniors' Team Based Primary Care" and "Increased Mental Health Capacity in PCNs" as shown in Table 3. VIHA will be required to report-back to the Ministry on the actual expenditure of 2018/19 UPCC/ MHSU Same Day Access Team costs against the federal and provincial funding allocations.

In 2019/20 and 2020/21 VIHA will continue to **first apply all eligible UPCC/MHSU Same Day Access Team costs** against the federal funding allocation noted in Table 3. A notional allocation, for planning purposes, of net new ministry funding of up to $3,051,921 for West Shore UPCC is provided for 2019/20 and 2020/21 for all remaining costs associated with the GP/NP and MOA positions, including overheads, not eligible for federal funding. A notional authorization, for planning purposes, of up to $1,402,325 ($954,955 UPCC and $447,370 MHSU Same Day Access Team) against the targeted frozen ministry funding notionally allocated for " Seniors' Team Based Primary Care" is provided for all remaining costs associated with registered nursing and allied health care positions, including overheads, not eligible for federal funding.

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STAFF ADMINISTRATIVE REQUIREMENTS

Targeted team-based staffing must increase and strengthen primary care services for seniors and patients presenting with mental health and substance use issues.

All physicians, nurses practitioners (NPs), registered nurses (RNs) and licensed practical nurses (LPNs) working in the UPCC, are required to shadow bill or encounter report through the Medical Service Plan Teleplan system for services provided.

- NP encounter codes can be found here: https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/7-encounter-codes.pdf
- See *Appendix A* for RN and LPN Encounter Codes
- Encounter record Submission Procedures for NPs, RNs, and LPNs can be found here: https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/3_encounter_record_submission_procedures_april_2017.pdf
- For physicians, an Assignment of Payment must be completed to submit shadow billings. The form can be found here: https://www2.gov.bc.ca/assets/gov/health/forms/2875fil.pdf

The UPCC will require a Y-Status Payee number to submit physician encounter data. To obtain a new Y-Status Payee number, please contact the compensation analyst assigned to your health authority or email hlth.physiciancomp@gov.bc.ca

Physicians are not to bill fee-for-service (FFS) for insured health care/ medical services provided to eligible Medical Services Plan (MSP) beneficiaries (or assign billings to the health authority) unless approved by the Ministry.

Your health authority is required to remit 100% of all direct pay and third-party billings to the Ministry. Using the Y-Status payment number a 50% recovery will automatically be applied to all third-party claims, however the health authority will be required to remit and report payment for the remaining 50%, as well as any direct pay services (services that are benefits under MSP, but rendered to non-beneficiaries and services that are not benefits under MSP).

Your health authority must work with the Health Employers Association of British Columbia to develop physician service contracts and/or salary agreements.

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REPORTING REQUIREMENTS

The Ministry is developing a reporting framework to monitor and evaluate the West Shore UPCC and MHSU Same Day Access Team against the proposal submitted by VIHA, including data such as hours of operation, patient visits and patient attachment. In addition, VIHA will be required to report on actual expenditure of any net new funding allocated by the Ministry and targeted funding provided to VIHA for seniors' team based primary care and increased mental health capacity in primary care, including the federal funding component. Further information concerning these reporting requirements will be provided under separate cover.

In addition to reporting on the deliverables that will be set out in the physician contracts, your health authority must submit:

- Physician utilization reports indicating direct, indirect hours and other hours worked for all physicians working in the UPCC. UPCC Utilization Reports are to be included with the utilization report submitted for the Alternative Payments Program and global operating funded contracts.
- UPCC Utilization Reports for NPs are to be included with the utilization reports submitted for NPs funded under global operating and NP4BC.

Thank you for your diligence in working to meet both service delivery and financial targets of the UPCC/ MHSU Same Day Access Team implementation and ongoing operations.

Yours truly,

Peter Pokorny
Assistant Deputy Minister
Finance and Corporate Services

Ted Patterson
Assistant Deputy Minister
Primary & Community Care Policy

cc: Kim Kerrone, Chief Financial Officer, VIHA
Kerri Harrison, Executive Director, Business Financial Transformation
Shana Ooms, Executive Director, Primary Care Access
Gordon Cross, Executive Director, Regional Grants and Decision Support

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Appendix A: Encounter Codes for RNs and LPNs

RN/ LPN ENCOUNTER CODES	
FEE CODE	**TITLE**
IMMUNIZATIONS	
38010	NIPCP IMMUNIZATION-PATIENT <19 YRS-DTAP-IPV
38011	NIPCP IMMUNIZATION-PATIENT <19 YRS-DTAP-IPV-HIB
38012	NIPCP IMMUNIZATION-PATIENT <19 YRS-TD
38013	NIPCP IMMUNIZATION-PATIENT <19 YRS-TD/IPV
38014	NIPCP IMMUNIZATION-PATIENT <19 YRS-TDAP
38015	NIPCP IMMUNIZATION-PATIENT <19 YRS-INFLUENZA (FLU)
38016	NIPCP IMMUNIZATION-PATIENT <19 YRS-HEPATITIS A
38017	NIPCP IMMUNIZATION-PATIENT <19 YRS-HEPATITIS B
38018	NIPCP IMMUNIZATION-PATIENT <19 YRS-HIB
38019	NIPCP IMMUNIZATION-PATIENT <19 YRS-IPV
38020	NIPCP IMMUNIZATION-PATIENT <19 YRS-MEN-C
38021	NIPCP IMMUNIZATION-PATIENT <19 YRS-ACYW135
38022	NIPCP IMMUNIZATION-PATIENT <19 YRS-MMR
38023	NIPCP IMMUNIZATION-PATIENT <19 YRS-PCV13
38024	NIPCP IMMUNIZATION-PATIENT <19 YRS-PPV23
38025	NIPCP IMMUNIZATION-PATIENT <19 YRS-RABIES
38026	NIPCP IMMUNIZATION-PATIENT <19 YRS-VARICELLA
38027	NIPCP IMMUNIZATION-PATIENT <19 YRS-DTAP-HB-IPV-HIB
38028	NIPCP IMMUNIZATION-PATIENT <19 YRS-HPV
38029	NIPCP IMMUNIZATION-PATIENT <19 YRS-ROTAVIRUS
38030	NIPCP IMMUNIZATION-PATIENT <19 YRS-MMR/V
38035	NIPCP IMMUNIZATION-MMR -PATIENT >18 YEARS OF AGE
38038	NIPCP IMMUNIZATION-INFLUENZA- ADULTS WHO QUALIFY FOR FREE VACCINE
38041	NIPCP IMMUNIZATION-PNEUMOCOCCAL POLYSACCHARIDE (PPV23) For pts > 64 yrs of age or pts > 18 years of age whose health conditions qualify them for free vaccine or who reside in residential care or assisted living facilities. (pts < 19 yrs -bill 38024)
38042	NIPCP IMMUNIZATION HEPATITIS A - ADULTS AT RISK
38043	NIPCP IMMUNIZATION HEPATITIS B - ADULTS AT RISK
38044	NIPCP IMMUNIZATION-NOS (NOT OTHERWISE SPECIFIED) (inludes oral polio vaccine, etc.)
38045	NIPCP CLIENT CONTACT FOR ADVERSE EVENT FOLLOWING IMMUNIZATION
MEDICATION	
38060	NIPCP MEDICATION USAGE INTERVENTIONS- The identification of a patient's drug related problems and recommendations for their resolution (ie inappropriate dosing, drug level monitoring, drug interactions, treatment of adverse drug reactions)
38061	NIPCP MEDICATION WORK-UP- The completion of a patient's drug history during a structured interview and through chart and pharmanet searches (upon obtaining patient consent)
38062	NIPCP MEDICATION THERAPY MONITORING-The regular monitoring of a patient's medication adherence and drug toxicity through structured interviews, especially for patients with complex medication regimens or patients that are confused, forgetful or less compliant about medications.
38063	NIPCP MEDICATION THERAPY COORDINATION - Liasing with community and hospital pharmacies in an effort to provide seemless care for a patient (ie coordinating refills, obtaining prescriptions, providing up to date information on the patient's current drug therapy, dispensing medic ation, obtaining approval for medications)
38064	NIPCP MEDICATION INFORMATION- Answering patient-specific medication information questions from health care professionals and patients (ie dosing, adverse effects, drug interactions, suggestions for therapy)
38065	NIPCP MEDICATION THERAPY COUNSELING-Counseling a patient on the appropriate use of the patient's medication(s), adverse effects, and monitoring via a structured interview (ie provision of drug information sheets, setting up weekly dosettes, setting up medication timers). **Claim must state start and end times.**
FEE CODE	**TITLE**

VISIT	
38070	NIPCP REQUESTING ADVICE FROM AN NP/GP - Collaborate with team members to support nurses assessment of patient care
38071	NIPCP REFERRAL TO IN-CLINIC TEAM MEMBER - Reviews assessment with GP/NP and queries action that is outside of scope of practice
38072	NIPCP REFERRAL TO NON HEALTH SERVICE PROVIDER - Referral to community resources (e.g., any service provider that does not require an MSP referral)
38073	NIPCP - GP REFERRAL TO NURSE
38080	NIPCP VISIT - IN OFFICE (AGE 0-1) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38081	NIPCP VISIT - IN OFFICE (AGE 2-49) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38082	NIPCP VISIT - IN OFFICE (AGE 50-59) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38083	NIPCP VISIT - IN OFFICE (AGE 60-69) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38084	NIPCP VISIT - IN OFFICE (AGE 70-79) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38085	NIPCP VISIT - IN OFFICE (AGE 80+) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38195	NIPCP VISIT - CHRONIC DISEASE MANAGEMENT A visit to review ongoing management of a chronic disease. Visit activities include: reviewing patient's care plan; patient's health outcomes; monitoring condition subsequent to an intervention; discussing continuing care strategies; discussing various management options, such as life style/self-care, psychotherapy, phamarcological management; etc. Activities performed in visit are generally brief discussions; however, if more elaborate discussion occurs, bill separate encounter code in addition visit encounter (e.g., education nutrition, medication therapy monitoring, etc.) **Claim must state start and end times.**
38116	NIPCP ROUTINE HEALTH HISTORY - NEW PATIENT-Recording the medical/social history of a new patient
38117	NIPCP BODY COMPOSITION ASSESSMENT-BIOELECTRICAL IMPEDANCE ANALYSIS AND/OR ANTHROPOMETRIC ASSESSMENT (MULTIPLE SITE SKINFOLDS AND CIRCUMFERENCES).
38119	NIPCP PATIENT ASSESSMENT Evaluation of a client's condition, problem or functional status to establish anursing diagnosis and/or identify information to support a clinical diagnosis and/or identify treatment or rehabilitation measures and/or monitor a client's response to an existing treatment/rehabilitation plan. Also includes, where applicable, ordering diagnostic investigations, reviewing results, prescribing medications, counseling patient, coordinating care with other providers or agencies, etc.**Claim must state start and end times.**
38120	NIPCP ROUTINE PELVIC EXAM INCLUDING PAP Routine pelvic examination including Papanicolaou smear.
38123	NIPCP COMMUNICABLE DISEASE FOLLOW UP Evaluation of a client's condition, related to a previously diagnosed communicable disease, and/or monitoring of a client's response to an existing treatment/rehabilitation plan. Also includes, where applicable, ordering diagnostic investigations, reviewing results, prescribing medications, counseling patient, coordinating care with other providers or agencies, etc
38125	NIPCP COMPLETION OF FORMS, NO REIMBURSEMENT Completion of all relevant documentation/forms, where there is no reimbursement from third party or direct billing, required as a result of a specific incident, or to obtain client consent.
38130	NIPCP CASE CONFERENCE Meeting with members of the health care team, representatives of other agencies involved in the management of the client, to plan and coordinate activities and services and to share information necessary to meet the client's needs/goals and expected outcomes. **Claim must state start and end times.**
38131	NIPCP CASE MANAGEMENT Multiple telephone calls to develop a comprehensive service plan, link the client to the required services, coordinate and maintain links with resources/services/supports in the client's environment, and evaluate services provided. May include activities such as searching for the appropriate resources and negotiating with potential providers (eg. probation officers, child and family services, social assistance, education, housing etc.) Claim must state start and end times.
38135	NIPCP FAMILY CONFERENCE - A conference with the patient's family/friend during which client needs are identified (based on previous assessment findings) and strategies are developed to ensure that needs are addressed and expected outcomes will be met. The intervention includes activities such as goal setting and designing resources that are required (patient may or may not be present). **Claim must state start and end times.**
FEE CODE	**TITLE**
EDUCATION	

38140	NIPCP EDUCATION - GROUP - Bill to the PHN for each patient attending the group meeting. Start and end times should be listed for each PHN. **Claim must state start and end times.**
38141	NIPCP EDUCATION – CHOLESTEROL. **Claim must state start and end times.**
38142	NIPCP EDUCATION - INSULIN STARTS. **Claim must state start and end times.**
38143	NIPCP EDUCATION - INHALER USE. **Claim must state start and end times.**
38144	NIPCP EDUCATION - RELATED TO SPECIFIC DIAGNOSIS Information provided in a structured format, to enhance knowledge and skill that directly or indirectly assists the client/family to understand, monitor and manage their condition/impairment. Includes, where applicable, provision of educational material such as pamphlets, tapes, books and videos. **Claim must state start and end times.**
38145	NIPCP EDUCATION - HEALTH PROMOTION/DISEASE PREVENT Information provided in a structured format, to enhance knowledge and skill that directly or indirectly promote health or influence changes in unhealthy lifestyles. Includes, where applicable, provision of educational materials such as pamphlets, tapes, books and videos (eg. exercise, nutrition, hygiene, STD education). **Claim must state start and end times.**
38146	NIPCP EDUCATION - FAMILY PLANNING Information about contraception provided in a structured format, to enhance knowledge and skill that directly or indirectly promotes health or influences changes in unhealthy life styles. Includes, where applicable, provision of educational materials such as pamphlets, tapes, books and videos. **Claim must state start and end times.**
38147	NIPCP EDUCATION - SMOKING Therapeutic communication, provided to or on behalf of a client, to identify and evaluate, introduce and/or eliminate, reinforce and/or reduce certain attitudes on the part of the client regarding health risks due to smoking/tobacco use and their potential effect on health status, which could alter attitudes and in turn change/modify behaviour. **Claim must state start and end times.**
38148	NIPCP EDUCATION - SUBSTANCE ABUSE Therapeutic communication, provided to or on behalf of a client, to identify and evaluate, introduce and/or eliminate, reinforce and/or reduce certain attitudes on the part of the client regarding health risks due to drug use/abuse or alcohol consumption and their potential effect on health status, which could alter attitudes and in turn change/modify behavior. **Claim must state start and end times.**
38150	NIPCP EDUCATION - PARENTING Information to improve parenting skills provided in a structured format, to enhance knowledge and skill that directly or indirectly promote health or influence changes in unhealthy life styles. Includes, where applicable, provision of educational materials such as pamphlets, tapes, books, and videos. **Claim must state start and end times.**
38153	NIPCP EDUCATION - ENVIRONMENTAL ISSUES Therapeutic communication, provided to or on behalf of a client, to identify and evaluate, introduce and/or eliminate, reinforce and/or reduce certain attitudes on the part of the client regarding health risks related to environmental risk/injury and their potential effect on health status, which could alter attitudes and in turn change/modify behavior. **Claim must state start and end times.**
38155	NIPCP EDUCATION - NUTRITION Therapeutic communication, provided to or on behalf of a patient, to enhance knowledge and skill that directly or indirectly promote nutritional health status or influence changes in unhealthy lifestyles that impact on nutritional status for the specific patient. Includes, where applicable, provision of educational materials such as pamphlets, tapes, books and videos that pertain specifically to nutrition. **Claim must state start and end times.**
INJECTIONS	
38160	NIPCP INJECTION, INTRAMUSCULAR - Intramuscular medications.
38161	NIPCP INJECTION, VENEPUNCTURE - Venepuncture and dispatch of specimen to laboratory, when no other blood work performed.
38162	NIPCP MEDICATION INJECTION, SUBCUTANEOUS - Subcutaneous medication, including desensitization treatments
MSC PROCEDURES	
38163	NIPCP MINI TRAY FEE
38165	NIPCP GLUCOSE - SEMIQUANTITATIVE (dipstick analyzed visually or by reflectance meter)
38166	NIPCP PREGNANCY TEST, IMMUNOLOGIC, URINE
38167	NIPCP URINALYSIS - SCREENING Urinalysis - Chemical or any part of (screening)
38168	NIPCP SYRINGING – EAR Irrigation of the external auditory meatus.
38169	NIPCP SUTURE/STAPLE REMOVAL Removal of sutures, staples, clips, etc.
38170	NIPCP DRESSING CHANGE Replacement of bandage/dressing.
38171	NIPCP ELECTROSURGERY/CRYOTHERAPY FOR REMOVAL/WARTS Forms of treatment other than excision, x-ray, or grenz ray; such as removal of haemangiomas and warts with electrosurgery, cryotherapy, etc. - per visit
FEE CODE	**TITLE**
MSC PROCEDURES (cont'd)	

38172	NIPCP FOOT CARE
38173	NIPCP SUTURING MINOR LACERATIONS
38174	NIPCP ASSISTING WITH PRODECURES
38175	NIPCP WOUND CARE Includes cleansing, irrigating, probing, debriding, packing and dressing a wound. It also includes suturing a laceration and changing dressings.
38176	NIPCP INR MANAGEMENT
38177	NIPCP ULTRASOUND - Handheld device
38005	NIPCP LIFETIME PREVENTION SCREENING Lifetime Prevention Screening includes initiating any of the clinical prevention services for specific patient groups as outlined in the Lifetime Prevention Schedule. Encounter is used for one or more intervention provided based on patient's demographics (e.g., age, sex).
38006	NIPCP PALLIATIVE/EOL CARE PLANNING
TELEPHONE	
38180	NIPCP PHONE CONTACT WITH PROFESSIONAL CARE PROVIDER Telephone contact to exchange information about a client between service providers, includes a verbal or written follow up communication with the Referring service provider (ag social worker, home care etc.)
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COUNSELING	
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RN/LPN Encounter Codes Updated: 2018-05-18

1126044

January 17, 2019

Dr. Victoria Lee
President and Chief Executive Officer
Fraser Health Authority
Central City Tower
400 -13450 - 102 Ave
Surrey BC V3T 0H1

Dear Dr. Lee:

We are writing to provide confirmation of operating funding allocations and reporting requirements related to Fraser Health Authority's (FHA) first Urgent Primary Care Centre (UPCC) in North Surrey/ Whalley, which opened on November 13, 2018.

The Ministry assessed FHA's proposal for the North Surrey/ Whalley UPCC based on a standardized funding framework including salary, benefit and overhead rates, to ensure equity among the various health authority UPCC proposals. In addition, consideration for existing family practice clinics and funding sustainability for the overall Primary Care initiative was also part of the Ministry's assessment.

Preliminary funding allocations based on the standardized funding framework were previously shared with your staff and as result of those discussions an incremental $600,000 funding adjustment was made on an exception basis. It is the Ministry's expectation that future UPCC funding approvals will be consistent with the standardized funding framework.

OPERATING FUNDING:

A summary of FHA's request for the North Surrey/ Whalley UPCC and the Ministry's assessment is shown in Table 1.

Table 1	Total Request (Annualized)	MOH Assessment (Annualized)
Urgent Primary Care Centre[1]	$ 4,024,000	$ 3,804,418
Expanded Community Service	$ 542,000	Deferred
One-time Start Up Cost	$ 515,000	$ -
Total	$ 5,081,000	$ 3,804,418
1. "On-Going" operating cost		

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- An overall annual funding allocation of $3.804M has been approved by the Ministry for the North Surrey/ Whalley UPCC to provide same day access to urgently needed primary care services, extended hours of care (12 hours a day Monday to Sunday) and new patient attachments, as outlined in FHA's proposal. For 2018/19, the funding allocation is $1.423M.

- As shown in Table 2 the approval includes clinical resources for the interdisciplinary team as requested by FHA. In addition 1 FTE Medical Office Assistant per GP/NP has been funded as part of the GP/NP overhead provision. Non-clinical staff and non-labour costs are to be managed from within the overhead provision included in the total funding provided.

Table 2

North Surrey/ Whalley UPCC	FTE	Funding/ FTE Including Overhead	Total Annual Funding	2018/19	2019/20 Notional Allocation for Planning Purposes	2020/21 Notional Allocation for Planning Purposes
General Practitioner[1]	3.3	$ 306,527	$ 996,213		$ 996,213	$ 996,213
Nurse Practitioner[2]	2.2	$ 164,000	$ 366,627		$ 366,627	$ 366,627
Medical Office Assistant	5.5	$ 50,000	$ 274,276		$ 274,276	$ 274,276
Funding Adjustment			$ 306,536		$ 306,536	$ 306,536
	11.0		$ 1,943,652		$ 1,943,652	$ 1,943,652
RN[2]	6.7	$ 114,400	$ 767,234		$ 767,234	$ 767,234
Social Worker[2]	3.4	$ 108,900	$ 365,174		$ 365,174	$ 365,174
SPO[2]	1.7	$ 108,900	$ 182,587		$ 182,587	$ 182,587
Pharmacist[2]	1.7	$ 134,200	$ 225,006		$ 225,006	$ 225,006
Pharmacist Tech[2]	0.3	$ 80,300	$ 27,302		$ 27,302	$ 27,302
Funding Adjustment			$ 293,464		$ 293,464	$ 293,464
	13.8		$ 1,860,766		$ 1,860,766	$ 1,860,766
Total	**24.7**		**$ 3,804,418**	**$ 1,423,000**	**$ 3,804,418**	**$ 3,804,418**

1. Salaried GP-Defined Scope A at 95% of range plus overhead
2. Based on HSCIS 2016 Q4 average salary/ FTE and benefit costs adjusted to April 2018 for general wage increases and economic stability dividends where applicable plus overhead.

- FHA's request of $0.542M for the expanded community service team is deferred for consideration as part of Surrey's overall PCN/ SCSP Service Plan.

- FHA is expected to manage one-time start-up costs of $0.515M for project management, IMIT, equipment and furniture.

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FUNDING SOURCE:

As identified in the "Bilateral Planning and Action Expectations" for April 1, 2018 to March 31, 2019, health authorities are assigned notional funding, available once staffing has occurred, to increase and strengthen primary team-based care services at the community health service area level linked to Primary Care Networks (PCNs) and Urgent Primary Care Centres. This funding is to support management of clients that are identified as being at risk for health decline or health crisis by increasing access to community based professional services (nursing and allied) and improving the quality of and timeliness of care for adults with complex medical conditions. The targeted notional allocation provided to FHA is currently frozen and includes both federal and provincial funding as shown in Table 3.

Table 3

FHA	2018/19	2019/20	2020/21	3 Yr Total
Mental Health Federal Funding:				
Increased Mental Health Capacity in PCN	1,001,440	2,566,850	2,566,850	6,135,140
Seniors' Team Based Primary Care:				
Nursing & Allied Professionals- Ministry	2,980,520	8,078,220	9,587,150	20,645,890
Nursing & Allied Professionals- Federal	3,131,040	3,131,040	3,131,040	9,393,120
Sub-total Seniors	6,111,560	11,209,260	12,718,190	30,039,010
Sub-total Federal Funding	4,132,480	5,697,890	5,697,890	15,528,260
Sub-total Ministry Funding	2,980,520	8,078,220	9,587,150	20,645,890
TOTAL	**7,113,000**	**13,776,110**	**15,285,040**	**36,174,150**

It is the Ministry's expectation that FHA will **first apply eligible UPCC costs** against the federal funding allocations noted above, as federal funds will need to be repaid if not fully utilized. The Ministry will work with FHA to determine an allocation methodology to identify UPCC expenditures which are consistent with federal funding criteria.

In 2018/19 FHA is authorized to access up to $1,423,000 of targeted frozen federal and provincial funding notionally allocated to FHA for "Seniors' Team Based Primary Care" and "Increased Mental Health Capacity in PCNs" as shown in Table 3. FHA will be required to report-back to the Ministry on the actual expenditure of 2018/19 UPCC costs against the federal and provincial funding allocations.

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In 2019/20 and 2020/21 FHA will continue to **first apply all eligible UPCC costs** against the federal funding allocation noted in Table 3. A notional allocation, for planning purposes, of net new ministry funding of up to $1,943,652 (as shown in Table 2) is provided for 2019/20 and 2020/21 for all remaining costs associated with the GP/NP and MOA positions, including overheads, not eligible for federal funding. A notional authorization, for planning purposes, of up to $1,860,766 (as shown in Table 2) against the targeted frozen ministry funding notionally allocated for " Seniors' Team Based Primary Care" is provided for all remaining costs associated with registered nursing and allied health care positions, including overheads, not eligible for federal funding.

STAFF ADMINISTRATIVE REQUIREMENTS:

- Targeted team-based staffing must increase and strengthen primary care services for seniors and patients presenting with mental health and substance use issues.
- All physicians, nurses practitioners (NPs), registered nurses (RNs) and licensed practical nurses (LPNs) working in the UPCC, are required to shadow bill or encounter report through the Medical Service Plan Teleplan system for services provided.
    - NP encounter codes can be found here: https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/7-encounter-codes.pdf
    - See *Appendix A* for RN and LPN Encounter Codes
    - Encounter record Submission Procedures for NPs, RNs, and LPNs can be found here: https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/3_encounter_record_submission_procedures_april_2017.pdf
    - For physicians, an Assignment of Payment must be completed to submit shadow billings. The form can be found here: https://www2.gov.bc.ca/assets/gov/health/forms/2875fil.pdf
- The UPCC will require a Y-Status Payee number to submit physician encounter data. To obtain a new Y-Status Payee number, please contact the compensation analyst assigned to your health authority or email hlth.physiciancomp@gov.bc.ca
- Physicians are not to bill fee-for-service (FFS) for insured health care/ medical services provided to eligible Medical Services Plan (MSP) beneficiaries (or assign billings to the health authority) unless approved by the Ministry
- Your health authority is required to remit 100% of all direct pay and third-party billings to the Ministry. Using the Y-Status payment number a 50% recovery will automatically be applied to all third-party claims, however the health authority will be required to remit and report payment for the remaining 50%, as well as any direct pay services (services that are benefits under MSP, but rendered to non-beneficiaries and services that are not benefits under MSP).
- Your health authority must work with the Health Employers Association of British Columbia to develop physician service contracts and /or salary agreements.

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REPORTING REQUIREMENTS

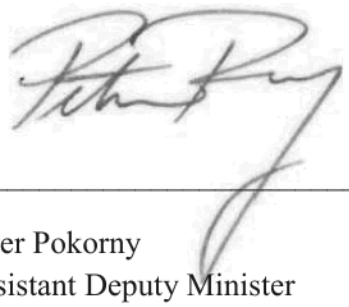
The Ministry is developing a reporting framework to monitor and evaluate the North Surrey/ Whalley UPCC against the proposal submitted by FHA, including data such as: hours of operation, patient visits and new patient attachments. In addition, FHA will be required to report on actual expenditure of net new funding allocated by the Ministry and targeted funding provided to FHA for seniors' team based primary care and increased mental health capacity in primary care, including the federal funding component. Further information concerning these reporting requirements will be provided under separate cover.

In addition to reporting on the deliverables that will be set out in the physician contracts, your health authority must submit:

- Physician utilization reports indicating direct, indirect hours and other hours worked for all physicians working in the UPCC. UPCC Utilization Reports are to be included with the utilization report submitted for the Alternative Payments Program and global operating funded contracts.
- UPCC Utilization Reports for NPs are to be included with the utilization reports submitted for NPs funded under global operating and NP4BC.

Thank you for your diligence in working to meet both service delivery and financial targets of the UPCC implementation and ongoing operations.

Yours truly,



Peter Pokorny
Assistant Deputy Minister
Finance and Corporate Services

Ted Patterson
Assistant Deputy Minister
Primary & Community Care Policy

cc: Brenda Liggett, Chief Financial Officer, FHA
Kerri Harrison, Executive Director, Business Financial Transformation
Shana Ooms, Executive Director, Primary Care Access
Gordon Cross, Executive Director, Regional Grants and Decision Support

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Appendix A: Encounter Codes for RNs and LPNs

RN/ LPN ENCOUNTER CODES	
FEE CODE	**TITLE**
IMMUNIZATIONS	
38010	NIPCP IMMUNIZATION-PATIENT <19 YRS-DTAP-IPV
38011	NIPCP IMMUNIZATION-PATIENT <19 YRS-DTAP-IPV-HIB
38012	NIPCP IMMUNIZATION-PATIENT <19 YRS-TD
38013	NIPCP IMMUNIZATION-PATIENT <19 YRS-TD/IPV
38014	NIPCP IMMUNIZATION-PATIENT <19 YRS-TDAP
38015	NIPCP IMMUNIZATION-PATIENT <19 YRS-INFLUENZA (FLU)
38016	NIPCP IMMUNIZATION-PATIENT <19 YRS-HEPATITIS A
38017	NIPCP IMMUNIZATION-PATIENT <19 YRS-HEPATITIS B
38018	NIPCP IMMUNIZATION-PATIENT <19 YRS-HIB
38019	NIPCP IMMUNIZATION-PATIENT <19 YRS-IPV
38020	NIPCP IMMUNIZATION-PATIENT <19 YRS-MEN-C
38021	NIPCP IMMUNIZATION-PATIENT <19 YRS-ACYW135
38022	NIPCP IMMUNIZATION-PATIENT <19 YRS-MMR
38023	NIPCP IMMUNIZATION-PATIENT <19 YRS-PCV13
38024	NIPCP IMMUNIZATION-PATIENT <19 YRS-PPV23
38025	NIPCP IMMUNIZATION-PATIENT <19 YRS-RABIES
38026	NIPCP IMMUNIZATION-PATIENT <19 YRS-VARICELLA
38027	NIPCP IMMUNIZATION-PATIENT <19 YRS-DTAP-HB-IPV-HIB
38028	NIPCP IMMUNIZATION-PATIENT <19 YRS-HPV
38029	NIPCP IMMUNIZATION-PATIENT <19 YRS-ROTAVIRUS
38030	NIPCP IMMUNIZATION-PATIENT <19 YRS-MMR/V
38035	NIPCP IMMUNIZATION-MMR -PATIENT >18 YEARS OF AGE
38038	NIPCP IMMUNIZATION-INFLUENZA- ADULTS WHO QUALIFY FOR FREE VACCINE
38041	NIPCP IMMUNIZATION-PNEUMOCOCCAL POLYSACCHARIDE (PPV23) For pts > 64 yrs of age or pts > 18 years of age whose health conditions qualify them for free vaccine or who reside in residential care or assisted living facilities. (pts < 19 yrs -bill 38024)
38042	NIPCP IMMUNIZATION HEPATITIS A - ADULTS AT RISK
38043	NIPCP IMMUNIZATION HEPATITIS B - ADULTS AT RISK
38044	NIPCP IMMUNIZATION-NOS (NOT OTHERWISE SPECIFIED) (inludes oral polio vaccine, etc.)
38045	NIPCP CLIENT CONTACT FOR ADVERSE EVENT FOLLOWING IMMUNIZATION
MEDICATION	
38060	NIPCP MEDICATION USAGE INTERVENTIONS- The identification of a patient's drug related problems and recommendations for their resolution (ie inappropriate dosing, drug level monitoring, drug interactions, treatment of adverse drug reactions)
38061	NIPCP MEDICATION WORK-UP- The completion of a patient's drug history during a structured interview and through chart and pharmanet searches (upon obtaining patient consent)
38062	NIPCP MEDICATION THERAPY MONITORING-The regular monitoring of a patient's medication adherence and drug toxicity through structured interviews, especially for patients with complex medication regimens or patients that are confused, forgetful or less compliant about medications.
38063	NIPCP MEDICATION THERAPY COORDINATION - Liasing with community and hospital pharmacies in an effort to provide seemless care for a patient (ie coordinating refills, obtaining prescriptions, providing up to date information on the patient's current drug therapy, dispensing medic ation, obtaining approval for medications)
38064	NIPCP MEDICATION INFORMATION- Answering patient-specific medication information questions from health care professionals and patients (ie dosing, adverse effects, drug interactions, suggestions for therapy)
38065	NIPCP MEDICATION THERAPY COUNSELING-Counseling a patient on the appropriate use of the patient's medication(s), adverse effects, and monitoring via a structured interview (ie provision of drug information sheets, setting up weekly dosettes, setting up medication timers). **Claim must state start and end times**

FEE CODE	TITLE
VISIT	
38070	NIPCP REQUESTING ADVICE FROM AN NP/GP - Collaborate with team members to support nurses assessment of patient care
38071	NIPCP REFERRAL TO IN-CLINIC TEAM MEMBER - Reviews assessment with GP/NP and queries action that is outside of scope of practice
38072	NIPCP REFERRAL TO NON HEALTH SERVICE PROVIDER - Referral to community resources (e.g., any service provider that does not require an MSP referral)
38073	NIPCP - GP REFERRAL TO NURSE
38080	NIPCP VISIT - IN OFFICE (AGE 0-1) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38081	NIPCP VISIT - IN OFFICE (AGE 2-49) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38082	NIPCP VISIT - IN OFFICE (AGE 50-59) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38083	NIPCP VISIT - IN OFFICE (AGE 60-69) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38084	NIPCP VISIT - IN OFFICE (AGE 70-79) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38085	NIPCP VISIT - IN OFFICE (AGE 80+) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38195	NIPCP VISIT - CHRONIC DISEASE MANAGEMENT A visit to review ongoing management of a chronic disease. Visit activities include: reviewing patient's care plan; patient's health outcomes; monitoring condition subsequent to an intervention; discussing continuing care strategies; discussing various management options, such as life style/self-care, psychotherapy, phamarcological management; etc. Activities performed in visit are generally brief discussions; however, if more elaborate discussion occurs, bill separate encounter code in addition visit encounter (e.g., education nutrition, medication therapy monitoring, etc.) **Claim must state start and end times.**
38116	NIPCP ROUTINE HEALTH HISTORY - NEW PATIENT-Recording the medical/social history of a new patient
38117	NIPCP BODY COMPOSITION ASSESSMENT-BIOELECTRICAL IMPEDANCE ANALYSIS AND/OR ANTHROPOMETRIC ASSESSMENT (MULTIPLE SITE SKINFOLDS AND CIRCUMFERENCES).
38119	NIPCP PATIENT ASSESSMENT Evaluation of a client's condition, problem or functional status to establish anursing diagnosis and/or identify information to support a clinical diagnosis and/or identify treatment or rehabilitation measures and/or monitor a client's response to an existing treatment/rehabilitation plan. Also includes, where applicable, ordering diagnostic investigations, reviewing results, prescribing medications, counseling patient, coordinating care with other providers or agencies, etc.**Claim must state start and end times.**
38120	NIPCP ROUTINE PELVIC EXAM INCLUDING PAP Routine pelvic examination including Papanicolaou smear.
38123	NIPCP COMMUNICABLE DISEASE FOLLOW UP Evaluation of a client's condition, related to a previously diagnosed communicable disease, and/or monitoring of a client's response to an existing treatment/rehabilitation plan. Also includes, where applicable, ordering diagnostic investigations, reviewing results, prescribing medications, counseling patient, coordinating care with other providers or agencies, etc
38125	NIPCP COMPLETION OF FORMS, NO REIMBURSEMENT Completion of all relevant documentation/forms, where there is no reimbursement from third party or direct billing, required as a result of a specific incident, or to obtain client consent.
38130	NIPCP CASE CONFERENCE Meeting with members of the health care team, representatives of other agencies involved in the management of the client, to plan and coordinate activities and services and to share information necessary to meet the client's needs/goals and expected outcomes. **Claim must state start and end times.**
38131	NIPCP CASE MANAGEMENT Multiple telephone calls to develop a comprehensive service plan, link the client to the required services, coordinate and maintain links with resources/services/supports in the client's environment, and evaluate services provided. May include activities such as searching for the appropriate resources and negotiating with potential providers (eg. probation officers, child and family services, social assistance, education, housing etc.) Claim must state start and end times.
38135	NIPCP FAMILY CONFERENCE - A conference with the patient's family/friend during which client needs are identified (based on previous assessment findings) and strategies are developed to ensure that needs are addressed and expected outcomes will be met. The intervention includes activities such as goal setting and

	designing resources that are required (patient may or may not be present). **Claim must state start and end times.**

FEE CODE	TITLE
EDUCATION	
38140	NIPCP EDUCATION - GROUP - Bill to the PHN for each patient attending the group meeting. Start and end times should be listed for each PHN**Claim must state start and end times.**
38141	NIPCP EDUCATION - CHOLESTEROL **Claim must state start and end times.**
38142	NIPCP EDUCATION - INSULIN STARTS **Claim must state start and end times.**
38143	NIPCP EDUCATION - INHALER USE**Claim must state start and end times.**
38144	NIPCP EDUCATION - RELATED TO SPECIFIC DIAGNOSIS Information provided in a structured format, to enhance knowledge and skill that directly or indirectly assists the client/family to understand, monitor and manage their condition/impairment. Includes, where applicable, provision of educational material such as pamphlets, tapes, books and videos. **Claim must state start and end times.**
38145	NIPCP EDUCATION - HEALTH PROMOTION/DISEASE PREVENT Information provided in a structured format, to enhance knowledge and skill that directly or indirectly promote health or influence changes in unhealthy lifestyles. Includes, where applicable, provision of educational materials such as pamphlets, tapes, books and videos (eg. exercise, nutrition, hygiene, STD education). **Claim must state start and end times.**
38146	NIPCP EDUCATION - FAMILY PLANNING Information about contraception provided in a structured format, to enhance knowledge and skill that directly or indirectly promotes health or influences changes in unhealthy life styles. Includes, where applicable, provision of educational materials such as pamphlets, tapes, books and videos.**Claim must state start and end times.**
38147	NIPCP EDUCATION - SMOKING Therapeutic communication, provided to or on behalf of a client, to identify and evaluate, introduce and/or eliminate, reinforce and/or reduce certain attitudes on the part of the client regarding health risks due to smoking/tobacco use and their potential effect on health status, which could alter attitudes and in turn change/modify behaviour. **Claim must state start and end times.**
38148	NIPCP EDUCATION - SUBSTANCE ABUSE Therapeutic communication, provided to or on behalf of a client, to identify and evaluate, introduce and/or eliminate, reinforce and/or reduce certain attitudes on the part of the client regarding health risks due to drug use/abuse or alcohol consumption and their potential effect on health status, which could alter attitudes and in turn change/modify behavior. **Claim must state start and end times.**
38150	NIPCP EDUCATION - PARENTING Information to improve parenting skills provided in a structured format, to enhance knowledge and skill that directly or indirectly promote health or influence changes in unhealthy life styles. Includes, where applicable, provision of educational materials such as pamphlets, tapes, books, and videos. **Claim must state start and end times.**
38153	NIPCP EDUCATION - ENVIRONMENTAL ISSUES Therapeutic communication, provided to or on behalf of a client, to identify and evaluate, introduce and/or eliminate, reinforce and/or reduce certain attitudes on the part of the client regarding health risks related to environmental risk/injury and their potential effect on health status, which could alter attitudes and in turn change/modify behavior. **Claim must state start and end times.**
38155	NIPCP EDUCATION - NUTRITION Therapeutic communication, provided to or on behalf of a patient, to enhance knowledge and skill that directly or indirectly promote nutritional health status or influence changes in unhealthy lifestyles that impact on nutritional status for the specific patient. Includes, where applicable, provision of educational materials such as pamphlets, tapes, books and videos that pertain specifically to nutrition. **Claim must state start and end times.**
INJECTIONS	
38160	NIPCP INJECTION, INTRAMUSCULAR - Intramuscular medications.
38161	NIPCP INJECTION, VENEPUNCTURE - Venepuncture and dispatch of specimen to laboratory, when no other blood work performed.
38162	NIPCP MEDICATION INJECTION, SUBCUTANEOUS - Subcutaneous medication, including desensitization treatments
MSC PROCEDURES	
38163	NIPCP MINI TRAY FEE
38165	NIPCP GLUCOSE - SEMIQUANTITATIVE (dipstick analyzed visually or by reflectance meter)
38166	NIPCP PREGNANCY TEST, IMMUNOLOGIC, URINE
38167	NIPCP URINALYSIS - SCREENING Urinalysis - Chemical or any part of (screening)
38168	NIPCP SYRINGING – EAR Irrigation of the external auditory meatus.

38169	NIPCP SUTURE/STAPLE REMOVAL Removal of sutures, staples, clips, etc.
38170	NIPCP DRESSING CHANGE Replacement of bandage/dressing.
38171	NIPCP ELECTROSURGERY/CRYOTHERAPY FOR REMOVAL/WARTS Forms of treatment other than excision, x-ray, or grenz ray; such as removal of haemangiomas and warts with electrosurgery, cryotherapy, etc. - per visit
FEE CODE	**TITLE**
MSC PROCEDURES (cont'd)	
38172	NIPCP FOOT CARE
38173	NIPCP SUTURING MINOR LACERATIONS
38174	NIPCP ASSISTING WITH PRODECURES
38175	NIPCP WOUND CARE Includes cleansing, irrigating, probing, debriding, packing and dressing a wound. It also includes suturing a laceration and changing dressings.
38176	NIPCP INR MANAGEMENT
38177	NIPCP ULTRASOUND - Handheld device
38005	NIPCP LIFETIME PREVENTION SCREENING Lifetime Prevention Screening includes initiating any of the clinical prevention services for specific patient groups as outlined in the Lifetime Prevention Schedule. Encounter is used for one or more intervention provided based on patient's demographics (e.g., age, sex).
38006	NIPCP PALLIATIVE/EOL CARE PLANNING
TELEPHONE	
38180	NIPCP PHONE CONTACT WITH PROFESSIONAL CARE PROVIDER Telephone contact to exchange information about a client between service providers, includes a verbal or written follow up communication with the Referring service provider (ag social worker, home care etc.)
38184	NIPCP TELEPHONE CONTACT WITH PATIENT FAMILY/FRIEND A single telephone call to patient's family/friend during which client needs are identified (based on previous assessment findings) and strategies are developed to ensure that needs are addressed and expected outcomes will be met. This intervention includes activities such as goal setting and designing resources and services that are required.
38185	NIPCP TELEPHONE CONSULTATION
38186	NIPCP TELEPHONE FOLLOW-UP Telephone contact with a patient to monitor client's response to an existing treatment/rehabilitation plan. Also includes, where applicable, ordering diagnostic investigations, reviewing results, prescribing medications, counseling patient, etc.
38188	NIPCP TELEPHONE CALL (PHARMACY) Telephone call to initiate prescription or renew the directions and/or instructions for the preparation, dispensing, fabrication, or implementation of the pharmacological agents.
COUNSELING	
38191	NIPCP CRISIS COUNSELING Issue-or incident-specific counseling session with a patient, resulting from self, physician, health or non-health professional referral. **Claim must state start and end times**.
38192	NIPCP SHORT-TERM COUNSELING A counseling session with a patient resulting from self, physician, health or non-health professional referral. **Claim must state start and end times.**

RN/LPN Encounter Codes Updated: 2018-05-18

FACT SHEET

Urgent Primary Care Centres

ISSUE

The Ministry of Health (the Ministry) is committed to increasing urgent primary care services, as a part of comprehensive primary care services, for the population of BC. Urgent primary care services tend to be provided outside of traditional primary care office hours for injuries and illnesses that are non-life-threatening, i.e., do not require the level of services or expertise found in an emergency department, but should be seen by a health care provider within 12 – 24 hours.

KEY FACTS

- Primary Care Networks (PCNs) will provide access to urgent primary care services, as part of the overall suite of comprehensive primary care services provided through the PCN.[1]
- Urgent primary care services are being designed along a spectrum, depending on community needs, existing resources, and infrastructure. On one end of the spectrum, existing facilities and services will be enhanced through extended hours (i.e. early mornings, evenings and weekends), establishing teams of providers as needed, and having close proximity access to lab and diagnostics. On the other end of the spectrum, a team-based, stand-alone, purpose-built centre with access to on-site lab and diagnostic services may be available.
- Having access to a team of health care professionals when needed helps keep people healthy, and allows them to visit primary care providers rather than emergency departments.
- Locations for the first Urgent Primary Care Centres (UPCCs) are being selected across the province based on review of data, including rates and levels of appropriateness and acuity of emergency department utilization by hospital, and patient attachment rates.
- Each of the five health authorities will identify at least two locations for implementation this fiscal year (2018/2019), either by establishing a net-new UPCC in their health authority, or by leveraging existing primary care service environments by expanding both access and the types of services currently provided in those areas.
    - Interior Health has developed the first UPCC in Kamloops at Royal Inland Hospital, Clinical Services Building to provide urgent primary care services and a resident teaching unit. The Kamloops model fosters partnership with primary care physicians, acute care, and other community services, including allied health professionals such as an Occupational Therapist, Physiotherapist and Social Worker, to provide team-based care to its patients. Patients who are unattached will be supported to find a primary care provider through the medical resident Family Practice Learning Centre. The Kamloops centre opened in the summer of 2018.
    - Fraser Health is developing a UPCC in North Surrey in the community of Whalley that will add primary care services through team-based care, for both urgent primary care and attachment for hard-to-serve populations. The interdisciplinary teams include GPs, Nurse Practitioners, and Registered Nurses supported by a Social Worker, Mental Health Clinician and Clinical Pharmacist.
    - Vancouver Coastal Health is opening its first UPCC in Vancouver City-Centre, close to the existing St. Paul's Hospital. This Centre will have a team of GPs, Nurse Practitioners, Social Workers, Registered Nurses, and will be linked with a future Patient Medical Home in the same building as well as to those in the broader network.
    - Northern Health will open a UPCC in Quesnel, illustrating how urgent primary care services can support a smaller community with a larger catchment area. The team-based staffing complement at the Centre includes GPs, Nurse Practitioners, mental health and substance use (MHSU) Clinicians, Licensed Practical Nurses, and Primary Care Nurses.

[1] See the Primary Care Network fact sheet.

  - Island Health is opening its first UPCC in the Westshore/Langford area, which will include same-day access for MHSU clients. It will be staffed by GPs, Nurse Practitioners, Registered Nurses, MHSU Clinicians, and a Pharmacy Technician.
- The sites for the second five UPCCs, one more in each health authority, are being actively discussed at this time and should be confirmed in October.
- In parallel with the development of these first ten UPCCs across the province, urgent primary care centres/services will be a part of urban and metro PCNs going forward, where the data and community partnerships are strong.

FINANCIAL IMPLICATIONS

As part of Budget 2018, the Ministry of Health received $150 million over three years ($25 million in 2018/19; $50 million in 2019/20; and $75 million in 2020/21) to support the provision of team-based care, including primary care services in UPCCs.

Approved by:
Shana Ooms obo Ted Patterson, ADM Primary and Community Care Policy; October 3, 2018
Kerri Harrison obo Manjit Sidhu, ADM, Finance and Corporate Services; October 10, 2018

URGENT PRIMARY CARE CENTRE 'FIRST FIVE' SITES
BIWEEKLY STATUS REPORT FOR MINISTRY OF HEALTH

Item	Quesnel Urgent Primary Care Centre
Reporting Period	**January 10 – 23, 2019**
Reporting Branch/Division	**Primary Care Division**
Key Contact	**Melissa Murdock**
CLIFF #	**1128445**

BACKGROUND/CENTRE DETAILS

DATE OF OPENING:

- October 31, 2018

HOURS OF OPERATION:

- Monday to Friday 12:00 pm – 8:00 pm (staffed with RN, LPN & MH Clinician)
  - GP/NP Monday to Friday 4:00 pm – 8:00 pm
  - Saturday, Sunday & Stat Holidays 10:00 am – 2:00 pm (Provider & Team)

SERVICES PROVIDED:

- The UPCC provides treatment for non-emergency injuries and illnesses that need medical attention within 12-24 hours, including care from a team of interprofessional health providers such as Mental Health and Substance Use services
- Community providers currently rotating through UPCC, providing GP/NP services for unattached patients who call/present to book an appointment as well as attached patients who have been referred from family GP or Emergency Department for primary care services.
- Expanded Primary Care Services include short term counseling & crisis intervention for MHSU issues, patient education and acute episodic care.
- Walk-in appointments are accepted after 4:00 pm on weekdays when provider is present, otherwise pre-booked appointment arrangements are made.

TEAM-BASED STAFFING COMPLEMENT

The UPCC provides the above services via a team of the following care providers:

- Primary Care Registered Nurse
- Primary Care Licensed Practical Nurse
- Mental Health & Substance Use Clinician
- Rotating Community GP's & NP's
- Primary Care Assistant (MOA)

LABS AND DIAGNOSTIC IMAGING ACCESS

- LABS LOCATION/DISTANCE FROM UPCC:
  - Located within same facility (GR Baker Memorial Hospital)
- HOURS OF OPERATION FOR ON-SITE OR NEARBY LABS:
  - 6:00 am – 5:00 pm
- DIAGNOSTIC IMAGING LOCATION/DISTANCE FROM UPCC:
  - Located within same facility (GR Baker Memorial Hospital)
- HOURS OF OPERATION FOR ON-SITE OR NEARBY DIAGNOSTIC IMAGING:
  - Non-emergent diagnostic imaging available Monday – Friday, 8:00 am – 4:00 pm.

URGENT PRIMARY CARE CENTRE 'FIRST FIVE' SITES
BIWEEKLY STATUS REPORT FOR MINISTRY OF HEALTH

RECRUITMENT UPDATE[1] *(TWO-WEEK PERIOD: January 10 – 23, 2019)*

HIRED TO DATE:

Provider Type	Number of hires (including casuals)	Total FTEs
GP	N/A (currently operating with rotating community physicians providing coverage)	
NP	N/A (currently operating with rotating community NP providing coverage)	
RN	1 full time UPCC dedicated RN with Community Primary Care Nurses rotating through for coverage (approx. 21 available RN's within pool)	1.0 FTE
Care Coordinator	1 Urgent Primary Care Clinic Coordinator	1.0 Term FTE
MHSU Clinican	1 Full Time MHSU (Monday – Friday)	1.0 FTE
Social Worker	N/A	
LPN	4 rotating LPN orientated to UPCC (+2 FT Community LPN available for coverage)	1.32 FTE
Nursing Assistant	N/A	
MOA	1 position filled with another currently vacant	0.98 FTE (2 x 0.49 FTE)
Pharmacist	N/A	
Physiotherapist	N/A	
Unit Aide	N/A	

IN PROGRESS:

- All vacant positions currently posted and actively being recruited to fill.
- Physician site visits to the community have been ongoing for the past few months in the hopes of filling the vacant positions.
- NP recruitment is currently ongoing at this time

PATIENT CARE UPDATE *(TWO-WEEK PERIOD: January 10 – 23, 2019)*

NUMBER OF PATIENT VISITS

- TOTAL IN TWO-WEEK PERIOD: **90**
- AVERAGE PER DAY IN TWO-WEEK PERIOD: **7**
- TOTAL TO DATE (SINCE OPENING): **560**

[1] Note that the data that follows is reported by the Health Authority and cannot be independently verified with Ministry of Health data. More robust reporting is in development by the Ministry and Health Authority stakeholders.

URGENT PRIMARY CARE CENTRE 'FIRST FIVE' SITES
BIWEEKLY STATUS REPORT FOR MINISTRY OF HEALTH

AVERAGE PATIENT VISITS PER DAY PER EACH PROVIDER TYPE IN TWO-WEEK PERIOD:

Provider Type	Average visits/day Per 1 FTE
GP	**6.43 per 0.50 FTE (4 hrs/day)**
NP	**As per GP Average**
RN/LPN	**.25 per day (1.0 FTE)**
MHSU Clincian / Clinical Counsellor	**0.36 per day (1.0 FTE mondy-Friday only)**
Social Worker	**N/A**

APPROXIMATE HOUR OF DAY WITH HIGHEST PATIENT VOLUMES AT UPCC (e.g. 12pm-1pm)

- IN TWO-WEEK PERIOD: **5:00 pm – 6:00 pm Monday - Friday**

APPROXIMATE TIME OF DAY THAT FULL CAPACITY IS REACHED (ie. Stop taking patients)

- IN TWO-WEEK PERIOD (ON AVERAGE):
  - **7:45 pm (Monday – Friday)**
  - **1:45 pm (Saturday, Sunday & Stat)**

OBSERVED USE OF UPCC *(TWO-WEEK PERIOD: January 10 – 23, 2019)*

TYPES OF VISITS/PRESENTING COMPLAINTS

- % OF VISITS THAT WERE 'URGENT' IN TWO-WEEK PERIOD: **88%** of appointments considered urgent (to be seen within 24 hrs). Remaining 12% of appointments were pre-booked appointments for medication refill/review or follow-up appointments

ADDITIONAL DETAIL ON HOW THE UPCC CLASSIFIES URGENCY OF PRESENTATION

- Urgency is based upon details and/or patient presentation to the centre. If the patient needs fall within non-life-threatening needs that require same day care (i.e. headaches, earaches, infections, nausea/vomiting, womens health, flu symptoms, anxiety/depression, substance use concerns) and the patient either does not have a family provider or they are unable to access their family provider in a timely manner they meet the current requirements of the UPCC at this time.

PATIENT DEMOGRAPHICS IN TWO-WEEK PERIOD

- % OF VISITS BY PATIENTS UNATTACHED TO A REGULAR PRIMARY CARE PROVIDER**: 31%** for last 2 weeks, **37%** average since opening date
- APPROXIMATE % OF VISITS BY SENIORS (AGED 65+): **10%**
- APPROXIMATE % OF VISITS FOR MILD-MODERATE MHSU CONCERNS: **10%**

NUMBER OF PATIENTS SENT TO EMERGENCY FROM UPCC

- TOTAL IN TWO-WEEK PERIOD: **0**
- TOTAL TO DATE (SINCE OPENING): **6** (presenting with chest pain or requesting treatments not done at UPCC at this time)

NUMBER OF PATIENTS AT UPCC RECEIVED FROM EMERGENCY

- TOTAL IN TWO-WEEK PERIOD: **7** (suture removals, MH concerns, catheter changes)

- TOTAL TO DATE (SINCE OPENING): **20**
    - *Additional note: UPCC is not actively advertising to re-direct patients from Emergency at this time, however some patients are presenting to UPCC independently from ER when the department is busy and wait times are longer.

ATTACHMENT *(TWO-WEEK PERIOD: January 10 – 23, 2019)*

NUMBER OF PATIENTS WHO BECAME ATTACHED TO PRIMARY CARE PROVIDER AT UPCC ITSELF

- TOTAL IN TWO-WEEK PERIOD: **unknown at this time**
- TOTAL TO DATE (SINCE OPENING): **unknown at this time**

NUMBER OF UNATTACHED PATIENTS IDENTIFIED AS SEEKING ATTACHMENT AND WHOSE ATTACHMENT WAS FACILIATED BY THE UPCC (i.e. ADDED TO AN ATTACHMENT WAITLIST OR BECAME ATTACHED TO A LOCAL PRACTICE IN COMMUNITY)

- TOTAL IN TWO-WEEK PERIOD: **30**
    - 30 patients have been identified as unattached and have been provided information regarding which local physician clinics are currently accepting new patients, as well as direction to connect directly with the clinic(s) in question in person or via telephone call to inquire to process. Ongoing.
- TOTAL TO DATE: **206**

ADDITIONAL DETAIL ON HOW THE UPCC IS TRACKING ATTACHMENT *(e.g., upcc-specific waitlist, centralized waitlist, registration with local practice):*

- UNDER DEVELOPMENT: At this time we are currently working towards identifying providers accepting patients and developing a process which works for the community.

IMPLEMENTATION - ACTIVITIES TO BE UNDERTAKEN

1 MONTH:

- Continued development of UPCC processes (currently working with Primary Care Process Coach)
- Continued development of orientation process for additional casual employees.
- Recruitment and retention of permanent providers for UPCC
- Communication & education regarding UPCC with all stakeholders (community partners, general public, facility departments).
- Attachment process development
- Rapid Response process development.

2-6 MONTHS:

- Increased staffing capacity (including casual pools) for PCN, LPN Rapid Response & PCA.
- Continued development of orientation process for additional casual employees.
- Recruitment and retention of permanent providers for UPCC
- Communication & education regarding UPCC with all stakeholders (community partners, general public, facility departments).
- Attachment process development
- Rapid Response process development.

URGENT PRIMARY CARE CENTRE 'FIRST FIVE' SITES
BIWEEKLY STATUS REPORT FOR MINISTRY OF HEALTH

Item	Surrey Urgent Primary Care Centre
Reporting Period	**January 10 - 23, 2019**
Reporting Branch/Division	**Primary Care Division**
Key Contact	**Melissa Murdock**
CLIFF #	**1128446**

BACKGROUND/CENTRE DETAILS

DATE OF OPENING:

- November 8, 2018

HOURS OF OPERATION:

- 10:00 am – 9:00 pm 7 days per week

SERVICES PROVIDED:

- The UPCC provides treatment for non-emergency injuries and illnesses that need medical attention within 12-24 hours, including care from a team of interprofessional health providers such as Mental Health and Substance Use and Pharmacist services
- Walk-in and booked appointments available during hours of operation
- Primary Care appointments for attached patients

TEAM-BASED STAFFING COMPLEMENT

The UPCC provides the above services via a team of the following care providers:

- GP, NP, Social Work, Clinical Counsellor, Pharmacist & Registered Nurses

LABS AND DIAGNOSTIC IMAGING ACCESS

- LABS LOCATION/DISTANCE FROM UPCC:
  - Across the Street (Outpatient Lab) at Surrey Memorial Hospital,
    Jim Pattison Outpatient Care and Surgery Centre (JPOCSC) – 1 Km away
    LifeLabs – approx. 1 km away

- HOURS OF OPERATION FOR ON-SITE OR NEARBY LABS:
  - 7:30 am - 5:00 pm – Mon- Friday for Surrey Memorial Hospital
  - 7:00 am - 5:00 pm – Mon- Friday, 9:00 am – 5:00 pm Sat. and Sun. for JPOCSC
  - 7:30 am – 4:00 pm – Mon- Friday, 6:30 am – 12:00 pm on Sat. for LifeLabs

- DIAGNOSTIC IMAGING LOCATION/DISTANCE FROM UPCC:
  - Wescana – next door. Private – X-Rays only
  - JPOCSC – 1 km away – full suite of Medical Imaging

- HOURS OF OPERATION FOR ON-SITE OR NEARBY DIAGNOSTIC IMAGING:
  - 8:30 am – 5:00 pm for Wescana
  - 8:00 am – 8:00 pm Mon – Friday, 9:00 am – 5:00 pm Sat, Sunday at JPOCSC

URGENT PRIMARY CARE CENTRE 'FIRST FIVE' SITES
BIWEEKLY STATUS REPORT FOR MINISTRY OF HEALTH

RECRUITMENT UPDATE[1]

HIRED TO DATE:

Provider Type	Number of hires (including casuals)	Total FTEs
GP	3	2.46
NP	3 + 1 casual	1.86
RN	5 + 1 casual	3.9
Care Coordinator	2	2.0
MHSU Clinican	2	1.47
Social Worker	3	2.65
LPN	N/A	N/A
Nursing Assistant	N/A	N/A
MOA	6 + 1 casual	4.5
Pharmacist	1	0.8
Physiotherapist	NA	NA
Unit Aide	1	1.0

IN PROGRESS:

- Interviews for MOAs in progress
- GP reference checks for 0.52 FTE in progress
- NPs – 2 x 0.5 FTE hires – January and March start

RECRUITMENT ISSUES:

- MOAs in BCGEU - are paid ~$2.00/hr less than acute counterparts
- Shortage of Social Workers - many will not consider extended hours & weekends
- Pharmacist leaders are reworking the hours and number of weekends to align with the other allied positions – this will improve recruitment

PATIENT CARE UPDATE *(TWO-WEEK PERIOD: January 10 - 23, 2019)*

NUMBER OF PATIENT VISITS

- TOTAL IN TWO-WEEK PERIOD: **722**
- AVERAGE PER DAY IN TWO-WEEK PERIOD: **51.8**
- TOTAL TO DATE (SINCE OPENING): **2178**

[1] Note that the data that follows is reported by the Health Authority and cannot be independently verified with Ministry of Health data. More robust reporting is in development by the Ministry and Health Authority stakeholders.

URGENT PRIMARY CARE CENTRE 'FIRST FIVE' SITES
BIWEEKLY STATUS REPORT FOR MINISTRY OF HEALTH

AVERAGE PATIENT VISITS PER DAY PER EACH PROVIDER TYPE IN TWO-WEEK PERIOD:

Provider Type	Average visits/day Per 1 FTE
GP	**18.5**
NP	**6.2**
RN	**23.5**
MHSU Clincian / Clinical Counsellor	**1.1**
Social Worker	**1**
Pharmacist	**.4**

Note: The average number of patient appts per provider is calculated based on number of days the centre is open and does not take into account whether each provider types was staffed on a given day. This is why numbers are low for SW, Pharmacist and Clinical Counsellor.

APPROXIMATE HOURS OF DAY WITH HIGHEST PATIENT VOLUMES AT UPCC

- IN TWO-WEEK PERIOD: **12:00 – 3:00 pm**

APPROXIMATE TIME OF DAY THAT FULL CAPACITY IS REACHED (ie. Stop taking patients)

- IN TWO-WEEK PERIOD (ON AVERAGE): **Capacity is only reached within the last hour before closing**

OBSERVED USE OF UPCC *(TWO-WEEK PERIOD: (January 10 - 23, 2019)*

TYPES OF VISITS/PRESENTING COMPLAINTS

- % OF VISITS THAT WERE 'URGENT' IN TWO-WEEK PERIOD: **35% - majority with viruses**

Additional detail on how the UPCC classifies urgency of presentation:

- The Site uses a listing of symptoms that are deemed to require assessment within 24 hours

PATIENT DEMOGRAPHICS IN TWO-WEEK PERIOD

- % OF VISITS BY PATIENTS UNATTACHED TO A REGULAR PRIMARY CARE PROVIDER: **54.4 % of patients** (not visits)
- APPROXIMATE % OF VISITS BY SENIORS (AGED 65+): **15.4 %**
- APPROXIMATE % OF VISITS FOR MILD-MODERATE MHSU CONCERNS: **11%**
  Data is being collected manually. MHSU concerns not always identified/disclosed at admission.

NUMBER OF PATIENTS SENT TO EMERGENCY FROM UPCC

- TOTAL IN TWO-WEEK PERIOD: **21**
- TOTAL TO DATE (SINCE OPENING): **37**

Note: Interesting spike in two-week period, and has dropped off since this report. Reasons relate to the acuity of presentations and/or limited equipment for diagnosing: several with chest pain, GI bleed, hematuria with clots, high likelihood of fracture, query appendicitis, acute pediatric infant.

URGENT PRIMARY CARE CENTRE 'FIRST FIVE' SITES
BIWEEKLY STATUS REPORT FOR MINISTRY OF HEALTH

NUMBER OF PATIENTS AT UPCC RECEIVED FROM EMERGENCY

- TOTAL IN TWO-WEEK PERIOD: **2**
- TOTAL TO DATE (SINCE OPENING): **12**

ATTACHMENT *(TWO-WEEK PERIOD: January 10 - 23, 2019)*

NUMBER OF PATIENTS WHO BECAME ATTACHED TO PRIMARY CARE PROVIDER AT UPCC ITSELF

- TOTAL IN TWO-WEEK PERIOD: **43**
- TOTAL TO DATE (SINCE OPENING): **99**

NUMBER OF UNATTACHED PATIENTS IDENTIFIED AS SEEKING ATTACHMENT AND WHOSE ATTACHMENT WAS FACILIATED BY THE UPCC (i.e. ADDED TO AN ATTACHMENT WAITLIST OR BECAME ATTACHED TO A LOCAL PRACTICE IN COMMUNITY)

- TOTAL IN TWO-WEEK PERIOD: **N/A**
- TOTAL TO DATE: **N/A**

Additional detail on how the UPCC is tracking attachment (e.g. UPCC-specific waitlist, centralized waitlist, registration with local practice):

- If patient is within our catchment we are attaching directly to the UPCC GP or NP. Some referrals for attachment are sent to the Primary Care Clinic at the Jim Pattison Outpatient Care and Surgery Centre and some are provided the Surrey/ North Delta Division of Family Practice information (i.e., web link and phone number) to locate a GP in their area.

IMPLEMENTATION - ACTIVITIES TO BE UNDERTAKEN

1 MONTH:

- Communication Plan roll out including tweets to the public and dissemination of UPCC information to community stakeholders and physical locations (e.g., pharmacies, physiotherapists offices)
- Continuing recruitment of GP, MOAs, Pharmacist and Social Workers
- GPs and NPs developing TransCare knowledge
- OAT maintenance planning on hold until DAP Accreditation issue for point of care testing is resolved
- Work started with Laboratory leadership on applying for DAP Accreditation

2-6 MONTHS:

- RN Home Visits
- Development of nursing expertise areas (e.g., diabetes, pap tests, STI education)

GENERAL COMMENTS

- Planning underway for contracting GP locums for vacation, leave coverages

URGENT PRIMARY CARE CENTRE 'FIRST FIVE' SITES
BIWEEKLY STATUS REPORT FOR MINISTRY OF HEALTH

Item	City Centre Urgent Primary Care Centre
Reporting Period	**January 10 – 23, 2019**
Reporting Branch/Division	**Primary Care Division**
Key Contact	**Melissa Murdock**
CLIFF #	**1128436**

BACKGROUND/CENTRE DETAILS

DATE OF OPENING:

- November 26, 2018

HOURS OF OPERATION:

- Monday – Saturday 8:00 am - 10:00 pm
- Sunday 9:00 am - 5:00 pm

SERVICES PROVIDED:

- The UPCC provides treatment for non-emergency injuries and illnesses that need medical attention within 12-24 hours, including care from a team of interprofessional health providers such as Mental Health and Substance Use and Pharmacist services
- Services include: sprains and strains; cuts, wounds or skin conditions; high fever; infections, including chest, ear and urinary tract; asthma attacks; new or worsening pain; dehydration/constipation; and less serious child illness and injury. Our staff is fully trained in Advanced Care and Life Support and they have years of medical experience in acute settings.
- Patients are seen on a walk-in basis only. Any patient presenting will be seen regardless of their circumstance or acuity, and each will be assessed by a triage nurse and a CTAS score of acuity will be determined.

TEAM-BASED STAFFING COMPLEMENT

The UPCC provides the above services via a team of the following care providers:

- GPs, NPs and Emergency Doctors working together with Registered Nurses, MHSU Clinicians and Pharmacists.

LABS AND DIAGNOSTIC IMAGING ACCESS:

- LABS LOCATION/DISTANCE FROM UPCC:
  - It is anticipated that lab on site will be available in the new year. Life Labs is nearby but their hours of operaton do not align with UPCC hours as noted below:
- HOURS OF OPERATION FOR ON-SITE OR NEARBY LABS:
  - Monday - Friday 8:00 am to 4:00 pm
  - Saturday 8:00 am to 1:00 pm
  - Sunday closed
- DIAGNOSTIC IMAGING LOCATION/DISTANCE FROM UPCC:
  - WestCoast Medical Imaging (X-rays): 1144 Burrard Street (260 m from UPCC - 4 minutes walking distance)
  - St Paul's Hospital (US): 1081 Burrard Street(450m from UPCC - 6 minutes walking distance)
- HOURS OF OPERATION FOR ON-SITE OR NEARBY DIAGNOSTIC IMAGING:

On site DI is not open yet. Nearby DI opening hours are:

- Westcoast Medical Imaging: Monday - Friday 8:30 am - 5:30 pm

RECRUITMENT UPDATE[1]

HIRED TO DATE:

Provider Type	Number of hires (including casuals)	Total FTEs
GP	12	4.7
NP	1	0.9
RN	7	5.1
Care Coordinator	3	2.4
MHSU Clinican	1	0.4
Social Worker	N/A	N/A
LPN	1	0
Nursing Assistant	N/A	N/A
MOA	10	3.4
Pharmacist	3	N/A
Physiotherapist	N/A	N/A
Unit Aide	N/A	N/A

IN PROGRESS:

- 1 FTE Nurse Practitioner

RECRUITMENT ISSUES:

- Psychiatric Nurse recruitment has been difficult

PATIENT CARE UPDATE *(TWO-WEEK PERIOD: January 10 – 23, 2019)*

NUMBER OF PATIENT VISITS

- TOTAL IN TWO-WEEK PERIOD: **244**
- AVERAGE PER DAY IN TWO-WEEK PERIOD: **17.4**
- TOTAL TO DATE (SINCE OPENING): **835**

AVERAGE PATIENT VISITS PER DAY PER EACH PROVIDER TYPE IN TWO-WEEK PERIOD:

Provider Type	Average visits/day Per 1 FTE
GP	3.0
NP	1.9
RN	3.4
MHSU Clincian / Clinical Counsellor	2.8

[1] Note that the data that follows is reported by the Health Authority and cannot be independently verified with Ministry of Health data. More robust reporting is in development by the Ministry and Health Authority stakeholders.

Social Worker	N/A

APPROXIMATE HOUR OF DAY WITH HIGHEST PATIENT VOLUMES AT UPCC (e.g. 12pm-1pm)

- IN TWO-WEEK PERIOD: **1:30 pm - 5:30 pm**

APPROXIMATE TIME OF DAY THAT FULL CAPACITY IS REACHED (ie. Stop taking patients)

- IN TWO-WEEK PERIOD (ON AVERAGE): **N/A we have not been at full capacity yet.**

OBSERVED USE OF UPCC *(TWO-WEEK PERIOD: January 10 – 23, 2019)*

TYPES OF VISITS/PRESENTING COMPLAINTS

- % OF VISITS THAT WERE 'URGENT' IN TWO-WEEK PERIOD: **CTAS score 3 – 10.2%**
  CTAS score 4 – 49.1%
  CTAS score 5 – 39.7%

ADDITIONAL DETAIL ON HOW THE UPCC CLASSIFIES URGENCY OF PRESENTATION

- The City Centre UPCC uses the Canadian Triage and Acuity Scale, which is a national triage standard, to assess and determine severity of patient's presenting complaints. The triage nurse is the first point of contact to the patients coming to the UPCC and they are able to provide the "critical look" in order to evaluate the patient's health condition. After that, the triage nurse can take the patient to the triage room and complete the assessment, assigning the patient a CTAS score related to the acuity of the present complaint.

PATIENT DEMOGRAPHICS IN TWO-WEEK PERIOD

- % OF VISITS BY PATIENTS UNATTACHED TO A REGULAR PRIMARY CARE PROVIDER: **25.8%** of Vancouver residents patients were unattached to a primary care provider.
- APPROXIMATE % OF VISITS BY SENIORS (AGED 65+): **11.8%**
- APPROXIMATE % OF VISITS FOR MILD-MODERATE MHSU CONCERNS: **1.2%**

NUMBER OF PATIENTS SENT TO EMERGENCY FROM UPCC

- TOTAL IN TWO-WEEK PERIOD: **13**
- TOTAL TO DATE (SINCE OPENING): **41**

NUMBER OF PATIENTS AT UPCC RECEIVED FROM EMERGENCY

- TOTAL IN TWO-WEEK PERIOD: **3**
- TOTAL TO DATE (SINCE OPENING): **11**

ATTACHMENT *(TWO-WEEK PERIOD: January 10 – 23, 2019)*

NUMBER OF PATIENTS WHO BECAME ATTACHED TO PRIMARY CARE PROVIDER AT UPCC ITSELF

- **TOTAL IN TWO-WEEK PERIOD:** N/A
- **TOTAL TO DATE (SINCE OPENING):** We are not attaching patients directly at UPCC. We are referring them to the patient attachment initiative through Vancouver Division of Family practice or the primary care clinic at Three Bridges Community Centre.

URGENT PRIMARY CARE CENTRE 'FIRST FIVE' SITES
BIWEEKLY STATUS REPORT FOR MINISTRY OF HEALTH

NUMBER OF UNATTACHED PATIENTS IDENTIFIED AS SEEKING ATTACHMENT AND WHOSE ATTACHMENT WAS FACILIATED BY THE UPCC (i.e. ADDED TO AN ATTACHMENT WAITLIST OR BECAME ATTACHED TO A LOCAL PRACTICE IN COMMUNITY)

- **TOTAL IN TWO-WEEK PERIOD: 57.** We have given 55 Hotline cards to the Patient Attachment Initiative (from Vancouver Division of Family Practice) and we have sent 2 referrals to Three Bridges Primary Care Clinic throught the Central Intake line.
- **TOTAL TO DATE: 151**

ADDITIONAL DETAIL ON HOW THE UPCC IS TRACKING ATTACHMENT *(e.g., upcc-specific waitlist, centralized waitlist, registration with local practice):*

- We are referring unattached Vancouver's resident patients to the patient attachment initiative from Vancouver Division of Family practice and to the Three Bridges Community Centre Primary Care Clinic either by Hotline cards or referrals. The UPCC has an internal database to track the attachment process that we are initiating from our clinic.

Summary **Vancouver DoFP Attachment Details**		**Dec 30 - Jan 11 2019**	**Jan 12 - Jan 25, 2019**	**Since Inception**
Referrals		15	10	25
Ineligible/unable to match		2	0	2
Eligible		13	10	23
Matched		1	9	10
Pending		12	1	13

IMPLEMENTATION - ACTIVITIES TO BE UNDERTAKEN

1 MONTH:

- The DAP audit for the Seymour Lab will be completed on January, 25 2019
- Diagnostic Imaging to commence services to the public on Monday, January 28, 2019
- Pharmacy to be open at the end of January 2019
- Lab to be open at the end of January 2019

2-6 MONTHS:

- Seymour Health to initiate discussions on Virtual Health scoping/planning with key stakeholders

URGENT PRIMARY CARE CENTRE 'FIRST FIVE' SITES
BIWEEKLY STATUS REPORT FOR MINISTRY OF HEALTH

Item	Westshore Urgent Primary Care Centre
Reporting Period	**January 10 – 23, 2019**
Reporting Branch/Division	**Primary Care Division**
Key Contact	**Melissa Murdock**
CLIFF #	**1128440**

BACKGROUND/CENTRE DETAILS

DATE OF OPENING:

- November 5, 2018

HOURS OF OPERATION:

- 8:00 am - 8:00 pm; 365 days a year

SERVICES PROVIDED:

- The UPCC provides treatment for non-emergency injuries and illnesses that need medical attention within 12-24 hours, including care from a team of interprofessional health providers such as Mental Health and Substance Use services
- ENT and Ophthalmology: corneal abrasions, tinnitus-ear syringing, eye exam using slit lamp, epistaxis
- Orthopedics-strains, sprains, simple fractures
- Dermatology- wart and skin lesion biopsy/excision
- Minor Trauma-laceration-suturing and treatment
- Infectious Disease-Cellulitis treatment with IV antibiotics
- Neurology: Migraine treatment-IV Maxeran
- Gastro-intestinal: Nausea, vomiting, abdominal pain-treat with IV and IM analgesics and anti-emetics, diagnostic work-up
- Respiratory –asthma, COPD, infectious-treatment with nebulizer, oxygen, suction available
- Mental Health-anxiety and depression assessment and treatment
- Internal Medicine-deep vein thrombosis-anticoagulation
- Cardiac: chest pain-12 lead ECG and transfer, if required
- All PCPs providing same-day access appointments during this time period

TEAM-BASED STAFFING COMPLEMENT

The UPCC provides the above services via a team of the following care providers:

- Physicians, Nurse practitioner, Registered Nurses, Mental Health Substance Abuse consultant, Nursing Unit assistants, Office coordinators.

LABS AND DIAGNOSTIC IMAGING ACCESS

- LABS LOCATION/DISTANCE FROM UPCC:
  - On site
- HOURS OF OPERATION FOR ON-SITE OR NEARBY LABS:
  - Life Labs phlebotomy only M-F 6:30 am - 5:00 pm and Sat 7:00 am – 3:00 pm; closed evenings, Sundays and stats; results 1-2 business days
- DIAGNOSTIC IMAGING LOCATION/DISTANCE FROM UPCC:
  - Westcoast Medical Imaging-On-site; -results 1-2 business days

  - Victoria General Hospital outpatients- 10 min drive; results available online same day. stat within 1-2 hr
- HOURS OF OPERATION FOR ON-SITE OR NEARBY DIAGNOSTIC IMAGING:
  - Westcoast Medical Imaging M-F 8:30 am – 5:00 pm, closed evenings, weekends and stats
  - Victoria General Hospital Medical Imaging (output) 10 min drive- 8:00 am – 8:00 pm seven days/wk

RECRUITMENT UPDATE[1]

HIRED TO DATE:

Provider Type	Number of hires (including casuals)	Total FTEs
GP	30	3.5
NP	1	1.2
RN	9	5.8
Care Coordinator	-	-
MHSU Clinician	1	1
Social Worker	-	-
LPN	-	-
Nursing Assistant	3	1.46
MOA	9	5.8
Pharmacist	-	-
Physiotherapist	-	-
Unit Aide	-	-

IN PROGRESS:

- GP recruitment is ongoing
- NP casuals
- RN casuals

RECRUITMENT ISSUES:

- Physician recruitment is affected by a lack of completed physician contract. Current Letter of agreement ends February 18.

PATIENT CARE UPDATE *(TWO-WEEK PERIOD: January 10 – 23, 2019)*

NUMBER OF PATIENT VISITS

- TOTAL IN TWO-WEEK PERIOD: **677**
- AVERAGE PER DAY IN TWO-WEEK PERIOD: **48.4**
- TOTAL TO DATE (SINCE OPENING): **3908**

AVERAGE PATIENT VISITS PER DAY PER EACH PROVIDER TYPE IN TWO-WEEK PERIOD:

[1] Note that the data that follows is reported by the Health Authority and cannot be independently verified with Ministry of Health data. More robust reporting is in development by the Ministry and Health Authority stakeholders.

Provider Type	Average visits/day Per 1 FTE
GP	**20.8**
NP	**13**
RN	**13.4**
MHSU Clinician / Clinical Counsellor	**2.9**
Social Worker	**N/A**

Note: Westshore UPCC only has 5 day a week coverage for the NP and MHSA consultant with no coverage during stat holidays. Daily Averages reflect days worked not 7 days per week.
Average number of visits seen by RN is calculated based on the RN seeing every patient, as that is our current model. Not number of patients seen exclusively by the RN.

APPROXIMATE HOUR OF DAY WITH HIGHEST PATIENT VOLUMES AT UPCC (e.g. 12:00 pm – 1:00 pm)

- IN TWO-WEEK PERIOD: **12:00 pm – 1:00 pm**

APPROXIMATE TIME OF DAY THAT FULL CAPACITY IS REACHED (i.e. Stop taking patients)

- IN TWO-WEEK PERIOD (ON AVERAGE): **5:00 pm – 6:00 pm**

OBSERVED USE OF UPCC *(TWO-WEEK PERIOD: January 10 – 23, 2019)*

TYPES OF VISITS/PRESENTING COMPLAINTS

- % OF VISITS THAT WERE 'URGENT' IN TWO-WEEK PERIOD: WUPCC does not use a triage CTAS system for categorizing patients. Patients are not marked as urgent or non-urgent, only for presenting complaint. Ministry has asked VIHA to give approximate percentage, based on the "needed to be seen within 12-24hours" criteria.
- Additional detail on how the UPCC classifies urgency of presentational**:** Patients are screened by an MOA at registration those that present with acute symptoms are then assessed by an RN to be determine if the patient needs to be seen immediately.

PATIENT DEMOGRAPHICS IN TWO-WEEK PERIOD

- % OF VISITS BY PATIENTS UNATTACHED TO A REGULAR PRIMARY CARE PROVIDER: **43.9%**
- APPROXIMATE % OF VISITS BY SENIORS (AGED 65+): **14.95%**
- APPROXIMATE % OF VISITS FOR MILD-MODERATE MHSU CONCERNS: **3.8%**

Note: % of vists for mild/moderate MHSU concerns is calculated by total number of visits in the clinic against the total number seen by MHSU. Previous report was the approximate percentage of people seen by MHSU that had mild-moderate concerns.

NUMBER OF PATIENTS SENT TO EMERGENCY FROM UPCC

- TOTAL IN TWO-WEEK PERIOD: **15**
- TOTAL TO DATE (SINCE OPENING): **76**

NUMBER OF PATIENTS AT UPCC RECEIVED FROM EMERGENCY

- TOTAL IN TWO-WEEK PERIOD: **N/A at this time we are not receiving patients from ER**

- TOTAL TO DATE (SINCE OPENING): **N/A**

ATTACHMENT *(TWO-WEEK PERIOD: January 10 – 23, 2019)*

NUMBER OF PATIENTS WHO BECAME ATTACHED TO PRIMARY CARE PROVIDER AT UPCC ITSELF

- TOTAL IN TWO-WEEK PERIOD: **N/A**
- TOTAL TO DATE (SINCE OPENING): **N/A**

NUMBER OF UNATTACHED PATIENTS IDENTIFIED AS SEEKING ATTACHMENT AND WHOSE ATTACHMENT WAS FACILIATED BY THE UPCC (i.e. ADDED TO AN ATTACHMENT WAITLIST OR BECAME ATTACHED TO A LOCAL PRACTICE IN COMMUNITY)

- TOTAL IN TWO-WEEK PERIOD: **N/A**
- TOTAL TO DATE: **N/A**

ADDITIONAL DETAIL ON HOW THE UPCC IS TRACKING ATTACHMENT (e.g. UPCC-specific waitlist, centralized waitlist, registration with local practice):

- We are currently awaiting approval of the PCN service contract and establishment of the PCN to be able to provide attachment to providers.
- Presently there are no PCPs accepting attachment in the community to be referred to.
- We are not collecting data at this time as the UPCC is not attaching patients. Attachment will be made by the PCN pods currently being renovated.

IMPLEMENTATION - ACTIVITIES TO BE UNDERTAKEN

1 MONTH:

- We are awaiting further implementation of a provincial registry.

2-6 MONTHS:

- Construction and renovations continue on two office connected to the UPCC for primary care. The first is expected to be completed in Mid February. The second is expected to be completed in May. These offices will offer attachment based on funding and availability of PCPs.

URGENT PRIMARY CARE CENTRE 'FIRST FIVE' SITES
BIWEEKLY STATUS REPORT FOR MINISTRY OF HEALTH

Item	Kamloops Urgent Primary Care Centre
Reporting Period	**January 10 – 23, 2019**
Reporting Branch/Division	**Primary Care Division**
Key Contact	**Melissa Murdock**
CLIFF #	**1128443**

BACKGROUND/CENTRE DETAILS

DATE OF OPENING:

- June 12, 2018 (UPCC)
- August 27, 2018 (FPLC)

HOURS OF OPERATION:

- Monday to Sunday, 10am-10pm. GP services available 5:00 pm – 9:00 pm; sometimes 1:00 pm – 5:00 pm. Nursing Day services and Physiotherapy, and as of this reporting period, Social Work services are available daily between 1030am-10pm.
- Additional detail: Dependent upon physician availability, the UPCC is staffed by physicians from 1:00 pm – 5:00 pm in addition to the regular 5:00 pm – 9:00 pm shifts. Physicians have the option to work afternoons, evenings or combine both to work 1:00 pm – 9:00 pm. These expanded options are offered with the understanding that it is unlikely that current physician availability will cover all available shifts.

SERVICES PROVIDED:

- The UPCC provides treatment for non-emergency injuries and illnesses that need medical attention within 12-24 hours, including care from a team of interprofessional health providers such as Social Workers and Physiotherapists.
-
- Nurses (RN & LPN Ortho Tech) provide assessment, treatment, patient sorting, referral, IV therapy, wound Care, suture removal, casting services, injections, etc.
- Physiotherapists provide assessment, short term treatment, education, self-management strategies, referrals, etc.
- Social Workers provide assessment, short term interventions, MHSU services, referral, etc.
- Medical Office Assistants provide appointment scheduling, initial screening, rooming of patients, vital signs, EMR documentation, follow up appointments, etc.
- Referrals are made by appointment only.

TEAM-BASED STAFFING COMPLEMENT

The UPCC provides the above services via a team of the following care providers:

- Physicians**,** Nurses (RN & LPN Ortho Techs)**,** Physiotherapists**,** Social Workers**,** Medical Office Assistants
- Two social workers and one additional physiotherapist began at the clinic during this period.

LABS AND DIAGNOSTIC IMAGING ACCESS

- LABS LOCATION/DISTANCE FROM UPCC:

  - Patients are referred to the Royal Inland Hospital (RIH) Outpatient Lab or a community Lab.
  - Distance from UPCC to RIH Lab ~100m.

- HOURS OF OPERATION FOR ON-SITE OR NEARBY LABS:
  - RIH Outpatient Lab Hours: 7:00 am —5:00 pm weekdays, 9:00 am—2:00 pm weekends.
  - Community Labs: Hours vary but include 8:00 am — 4:00 pm, 7:30 am — 3:15 pm, 8:00 am — 3:00 pm, 7:00 am – 4:00 pm. Weekend hours also vary.

- DIAGNOSTIC IMAGING LOCATION/DISTANCE FROM UPCC:
  - Patients are referred to the Royal Inland Hospital (RIH) Medical Imaging Dept or community Medical Imaging.
  - Distance from UPCC to RIH Medical Imaging ~220m; to RIH Diagnostic Imaging ~150m.

- HOURS OF OPERATION FOR ON-SITE OR NEARBY DIAGNOSTIC IMAGING:
  - RIH Medical Imaging Hours: 7:30 am — 4:00 pm weekdays, after-hours and weekends processed by after-hours registration prior to X-ray.
  - Other community Medical Imaging: Hours vary.

RECRUITMENT UPDATE[1]

UPCC HIRED TO DATE (does not include FPLC):

Provider Type	Number of hires (including casuals)	Total current FTEs
GP (UPCC)	13 regular GPs	1.64
GP (FPLC)	GPs and UBC Residents	0.93
NP	N/A	N/A
RN/Care Coordinator	2	2.0
MHSU Clinican	N/A	N/A
Social Worker (includes MHSU component)	2	2.0
LPN	2 (1 vacant)	0.72
Nursing Assistant	N/A	N/A
MOA	5 (2 vacant)	4.25
Pharmacist	N/A	N/A
Physiotherapist	2	2.0
Unit Aide	N/A	N/A

IN PROGRESS:

- Models of incorporating NPs into the site are being explored.

[1] Note that the data that follows is reported by the Health Authority and cannot be independently verified with Ministry of Health data. More robust reporting is in development by the Ministry and Health Authority stakeholders.

URGENT PRIMARY CARE CENTRE 'FIRST FIVE' SITES
BIWEEKLY STATUS REPORT FOR MINISTRY OF HEALTH

RECRUITMENT ISSUES:

- Casual RN/Team Leads (only one currently)
- Casual Physiotherapists (none currently)

PATIENT CARE UPDATE *(TWO-WEEK PERIOD: January 10 – 23, 2019)*

NUMBER OF PATIENT VISITS:

UPCC

- TOTAL IN TWO-WEEK PERIOD: **366** (391 10 minute appt slots)
- AVERAGE PER DAY IN TWO-WEEK PERIOD: **26.1** (27.9 10 minute appt slots)
- TOTAL TO DATE (SINCE OPENING): **3,556** (4,352 10 minute appt slots)
- NURSING DAY SERVICES IN TWO-WEEK PERIOD: **69**
- NURSING DAY SERVICES TO DATE: **331**
- PHYSIOTHERAPY IN TWO-WEEK PERIOD: **28**
- PHYSIOTHERAPY TO DATE: **87**

FPLC

- TOTAL IN TWO-WEEK PERIOD: **133**
- AVERAGE PER DAY IN TWO-WEEK PERIOD: **14.8** (open 8 days during 2 week period)
- TOTAL TO DATE (SINCE OPENING): **1,454**

Note: Totals for UPCC and FPLC on January 9 update accidentally included January 10 numbers, resulting in a discrepancy.That has been corrected here.

AVERAGE UPCC PATIENT VISITS PER DAY PER EACH PROVIDER TYPE IN TWO-WEEK PERIOD:

Provider Type	Average visits/day Per 1 FTE
GP (UPCC)	13.5
GP (FPLC)	18.1
NP	-
RN	15.5
MHSU Clincian / Clinical Counsellor	-
Social Worker	-

Note: Two social workers and one additional physiotherapist began at the clinic during this period. Stats will begin to be provided in the next biweekly update.

APPROXIMATE HOUR OF DAY WITH HIGHEST PATIENT VOLUMES AT UPCC (e.g. 12pm-1pm)

- IN TWO-WEEK PERIOD: UPCC is mostly full while open, from 5PM-9PM (also full if open 1PM-5PM) – half of days in period had 1-2 openings. 2 appointments are being held for ED patients each day

APPROXIMATE TIME OF DAY THAT FULL CAPACITY IS REACHED (ie. Stop taking patients)

- IN TWO-WEEK PERIOD (ON AVERAGE): within 30 minutes to 2 hours of opening (by noon); occasionally UPCC was not quite fully booked

URGENT PRIMARY CARE CENTRE 'FIRST FIVE' SITES
BIWEEKLY STATUS REPORT FOR MINISTRY OF HEALTH

OBSERVED USE OF UPCC *(TWO-WEEK PERIOD: January 10 – 23, 2019)*

TYPES OF VISITS/PRESENTING COMPLAINTS

- % OF VISITS THAT WERE 'URGENT' IN TWO-WEEK PERIOD: **~90%** are considered urgent (to be seen within 24-48 hours)
- Additional detail on how the UPCC classifies urgency of presentation: the Kamloops UPCC uses inclusion criteria to determine appropriateness of patient. MOAs review criteria and nurses complete nursing patient sorting.

PATIENT DEMOGRAPHICS IN TWO-WEEK PERIOD

- % OF VISITS BY PATIENTS UNATTACHED TO A REGULAR PRIMARY CARE PROVIDER: **47%**
- APPROXIMATE % OF VISITS BY SENIORS (AGED 65+): **~14%**
- APPROXIMATE % OF VISITS FOR MILD-MODERATE MHSU CONCERNS: **~4%**

NUMBER OF PATIENTS SENT TO EMERGENCY FROM UPCC

- TOTAL IN TWO-WEEK PERIOD: **2** patients were transferred from the Kamloops UPCC to the RIH ED during this two week period.
- TOTAL TO DATE (SINCE OPENING): This number has not been formally tracked since opening.

NUMBER OF PATIENTS AT UPCC RECEIVED FROM EMERGENCY

- TOTAL IN TWO-WEEK PERIOD: **12**
- TOTAL TO DATE (SINCE OPENING): **~2,000**

ATTACHMENT *(TWO-WEEK PERIOD: January 10 – 23, 2019)*

NUMBER OF PATIENTS WHO BECAME ATTACHED TO PRIMARY CARE PROVIDER AT UPCC ITSELF

- TOTAL IN TWO-WEEK PERIOD: **N/A**
- TOTAL TO DATE (SINCE OPENING): **N/A**

NUMBER OF UNATTACHED PATIENTS IDENTIFIED AS SEEKING ATTACHMENT AND WHOSE ATTACHMENT WAS FACILIATED BY THE UPCC (i.e. ADDED TO AN ATTACHMENT WAITLIST OR BECAME ATTACHED TO A LOCAL PRACTICE IN COMMUNITY)

- TOTAL IN TWO-WEEK PERIOD: **173**
- TOTAL TO DATE: **~1,450**
- All unattached patients who utilize the Kamloops UPCC are informed of the 811 waiting list and given the necessary information to join the waiting list; the totals above are the number of unattached patients who have come to the UPCC and been given this information so they can become attached through the 811 list if they choose.
- The Family Practice Learning Centre (a shared space with the UPCC) is actively attaching patients through the 811 list from the Kamloops UPCC.

IMPLEMENTATION - ACTIVITIES TO BE UNDERTAKEN

1 MONTH:

- Team Based Care (TBC) Facilitator orientating 2 days/week and building relationships with staff. Together with Lean consultant, will work with team to enhance team-based care.

- Team Based Care Training January 29-30, 2019
- Kiosks to be installed in Royal Inland ED to assist with UPCC appointment booking. Staff training scheduled for January 2019
- Physiotherapist Working Group (Physiotherapists, Allied Health Professional Practice Leads, TBC Facilitator, LEAN Manager, UPCC Manager) to review physiotherapy roles/responsibilities, determine referral process, daytime services, etc.

2-6 MONTHS:

- January/February 2019 shifting, when possible, to offering UPCC GP services from 1PM to 9PM (will still operate 5PM-9PM on days this not possible)

BRITISH COLUMBIA

CORE MESSAGING

Updated: August 2018 Ministry of Health

Winter Surge

- We know that during the winter months we see more patients presenting in emergency departments across BC, due to influenza, injuries and other ailments.
- Emergency department wait times are a concern for many British Columbians, especially in the winter.
- The solution here is multifaceted – in order to decongest emergency departments we must improve efficiency in hospitals, help patients avoid visiting hospital when they don't need to, and ensure elderly patients have access to long term care beds and care aides when they need them.
- We know there are times when visits to the emergency department can be avoided, and it is important that patients have the confidence to make an informed decision about if it's appropriate to go to the hospital or whether they can be treated by their family doctor or at a walk-in clinic.
- When it is not appropriate to go to the hospital people need better access to comprehensive health services in the community including care 'after hours'.
- That's why we will increase access to urgent primary care services, and other flexible primary and community care options.
- This is a priority for this government and one of the mandates given to me by the Premier.
- We will implement team-based care in Urgent Primary Care Centres, which will provide comprehensive primary care services 'after hours' for non-life threating illnesses or injuries. The centres will be designed to meet the needs of local communities, and will be part of a primary care network that

connects with patients' family doctor, nurse practitioner, community health centre, or helps people find what type of care works best for them.

- The Ministry has begun work in partnership with health authorities, divisions of family practice, and local agencies to develop Urgent Primary Care Centres across the province, with targeted opening dates this year.
- HealthLinkBC can also help patients determine whether they need to visit a hospital. Information is available any time of the day or night, every day of the year by phone and online. Patients can be connected to a nurse, pharmacist, registered dietician, or exercise professional.
- Emergency department visits are sometimes needed and unavoidable. To make sure patients are getting the care they need, hospitals use a number of strategies including:
    - Rapid assessment zones, which fast-track patients with uncomplicated conditions, such as people who need basic stitches or splinting; and
    - Special units for people with more complex conditions who may or may not need to be admitted. These units give staff time to make that decision, while not blocking emergency department beds.
- There are also community-based teams that:
    - assist patients with accessing services like substance use treatment
    - help seniors recover and stay in their homes longer
    - develop care plans for those who make frequent trips to the emergency department.
- To further minimize emergency department congestion, and based on clinical evidence, BC Emergency Health Services is developing care models that will enable advanced care paramedics to "treat and release" patients from the scene when

appropriate. As our population continues to age, it's important that we support seniors to live independently in their own home for as long as possible and if required, provide the best possible residential care.

- We will strengthen supports for family and friends caring for loved ones by increasing the number of respite beds, expanding adult day programs and strengthening seniors' centres and other community-based services around the province.
- Because we know that supporting community-based seniors' services and unpaid caregivers are some of the most efficient ways to help seniors stay at home longer.
- By adding these critical resources, we can help to ensure patients are treated in the appropriate setting, whether that's the emergency department, a doctor's office at home or in long term care.
- The issue of hospital overcrowding is complex, and it will take time to make meaningful change, but we are committed to doing that work.