PrimaryCare NETWORKS

Primary Care Network Info Sheet

Goals, Core Services and Core Features of Manitoba's Primary Care Networks

What is a Primary Care Network?

Primary Care Networks (PCN) include regional health authorities (RHA), independent primary care practices and community organizations who work together to plan, deliver and continuously improve enhanced, local primary care services.

What are Manitoba's Goals for Primary Care Networks?

- Improve access to primary care for all Manitobans, and in particular, those without a regular primary care provider.
- Demonstrate quality and safety in primary care.
- Strengthen the emphasis on comprehensive person and patient-centred care, including chronic disease management.
- Enhance continuity in primary care.
- Build a coordinated primary care system, contributing to the sustainability of Manitoba's broader health system.

What Can Manitobans Expect from Primary Care Networks?

Core Features of PCN Services

Accessible Primary Care: Networks will reach out to Manitoba's most vulnerable and marginalized populations and provide care to an incrementally larger proportion of "unattached" Manitobans. By 2015, Networks will strive to provide access to a primary care service that coordinates care with the patient's home clinic within 24-48 hours. By 2020, Networks will strive to provide access to a primary care provider within the patient's home clinic within 24-48 hours. In communities where there is reliance on emergency departments for treatment of low-acuity conditions, Networks will provide access to a primary care provider during extended hours, including evenings and weekends. Entry points to Network services will not be restricted to scheduled appointments. A QuickCare Clinic, linked to the PCN, is one example of an approach to addressing this service expectation.

Comprehensive Patient-Centered Care: Networks will provide comprehensive, planned care with an approach that considers the context of the patient's family and community. Networks will support the whole patient, not just illness, and focus on wellness, not just treatment. PCN services will emphasize health promotion, chronic disease prevention and risk reduction, early detection of health problems, self-care, and evidence-informed chronic disease management, including mental illness. PCNs will develop patient-centred strategies to ensure patients can make informed choices and are partners in care planning and management.

Coordinated Care: Networks will provide case management, integrated chronic disease management and will coordinate seamless transitions in care, especially for patients with complex health needs and multiple providers. RHAs will play the lead role in developing transition protocols to support care coordination, within and across health regions, as well as across levels of care.

Continuous Care: Each patient will have a "home clinic" within the broader Network that accepts the patient for an ongoing, continuous care relationship. The home clinic will act as a home base for its patients' health care needs, and will coordinate care with other Network or health system services when necessary. Each patient's affiliation with a home clinic will be confirmed through an enrolment conversation, in which both the patient and clinic mutually agree to the relationship. Continuous care relationships -- and where possible, a specific provider who knows the patient -- can contribute to improved health outcomes, reduced health system costs, and higher levels of patient satisfaction.

How will Primary Care Networks Make it Happen?

Core Features of PCNs

Collaboration: PCNs developed or expanded through provincial support, will be comprised of an RHA, one or more community organizations, and some or all of the independent primary care practices operating within the health region. These organizations will collaborate as equals. They will share decision-making and responsibility for PCN planning, resources and services. PCN decisions will be guided by a Steering Committee with representation from all members. Some PCNs may span more than one health region, and involve more than one RHA, where appropriate. Other members or informal stakeholders might include local government, First Nations, specialist providers, auxiliary services, and/or private enterprise such as retail pharmacies. The composition of Networks should reflect the characteristics and needs of the area and population.

Interprofessional Teams: Interprofessional PCN teams will build capacity within primary care practices and help free family physician time, ensuring they are more accessible to those who need them, when they need them. Examples of Network services that might be supported by PCN teams include: an after-hours primary care service; QuickCare; mobile and outreach services; health promotion and wellness; chronic disease management; group sessions and mental health services. Potential team members include nurses/nurse practitioners (NP), physician assistants, dietitians, exercise specialists, pharmacists, mental health workers, social workers, and spiritual care providers.

Community Engagement: Networks will engage and be responsive to the needs of their community. Networks will tap into the expertise of community members and involve them in determining the priorities, strategies and programming of the Network. Networks will also collaborate with community-led organizations in order reach underserved, marginalized populations and ensure network services reflect the unique needs of their communities.

Planning Based on Population Health Needs: PCN services will be designed to address the unique health needs of the PCN's base population. Networks will be particularly encouraged to target their services and programming to under-served and hard-to-reach populations. Examples are patients who experience barriers to care due to language (e.g. newcomers), ability (e.g. visually-impaired), geography (e.g. Northern Manitobans), or social circumstances (e.g. homeless populations).

Use of Information, Technology, and Quality Measurement: Most primary care clinics and group practices participating in PCNs will use qualified Electronic Medical Record systems (EMRs), leveraging the Province's existing EMR Adoption Program. They will use EMRs in a manner that supports their ability to track patients' care needs, and enables the extraction of meaningful data to enable quality and performance measurement, which in turn, will inform continuous quality improvement and service enhancements within the PCN.