PCN BURNABY Primary Care Networks

An Integrated Model for Health and Wellbeing in Burnaby

Presented by the partners of the Burnaby Primary Care Networks

September 2023

Executive Summary

The importance of understanding and addressing social determinants of health — and the value of a community-based integrated approach to health and wellbeing — are increasingly understood as the cornerstones for true system change in health care and beyond.

Addressing upstream issues has been proven to reduce stress on acute care services, to improve the quality of life for those with chronic disease, and to have an immediate and ongoing measurable positive impact on the health and wellbeing of individuals and communities. An engaged community that drives this change is a critical element for successful transformation.

In Burnaby, a collaborative approach to social issues has been undertaken by the social agencies with the support of the City for over 20 years. The Burnaby Primary Care Networks (PCN) is unique from other PCNs in the province in that it prioritizes social determinants of health and identifies the full spectrum of health and wellbeing within its mandate. The Burnaby PCN has capitalized on the strong collaborative culture in Burnaby. Since its inception in 2018, the PCN has worked to support an extended partnership that includes; the social service agencies and City partners, the family doctors in the community, and service providers from Fraser Health, continually seeking to integrate, enhance, and expand services that bridge health and wellbeing. This has led to increased services and improved access across all avenues of health and wellbeing in the city.

Burnaby is what is known as a 'Goldilocks' community, with an urban density that isn't too high or too low — creating the 'just right' conditions for a healthy community. Burnaby's population of 250,000 is extremely diverse in terms of culture, language, and economic status. Strategies and solutions that are enacted here can be scaled and replicated to fit almost any community. All of the work done to-date within the PCN –around collaboration and integration – has been purposefully designed and well documented.

As the next significant step, Burnaby is undertaking the development of a formal model for this integration of health and wellbeing services and supports in the City. Building on the strong partnerships in place and ongoing work, the model will take learnings from other jurisdictions to drive a shift in responsibility of community health. From a system that dictates distributed and hierarchical responsibility, this path has led to shared responsibility. This model defines a goal of collective responsibility, where individuals and organizations alike understand the value of a highly connected, highly supportive community — and take an active role in it.
At the outset, model development will focus on an increased understanding of all available data, including a deeper analysis of identified gaps, of current services and supports available within Burnaby, and of all formal and informal integration initiatives and processes currently being undertaken. From there development will focus on 10 key elements:

- Capitalize on Existing Assets
- Effective Internal communication
- Social Prescription
- Build Social Capital
- Peer Support
- Group education and support
- Active Community Connectors
- Active primary care connectors (Health Navigators)
- Role of physicians and primary care providers
- Role of Social Agencies and City Services

A workplan for each of these will be co-developed by partners from across the City, with clear measurable goals and well-defined outcomes. Through this process, launched at a November 30, 2023 City-wide Symposium, our workplan going forward will emerge. This process will also address:

- Governance
- An achievable plan
- Engaging, Evaluating, and Evolving
- Cohesive Communication Strategy
- A supported common culture

While the PCN partnership — which includes the community through the Burnaby Interagency Council (BIAC), the family doctors through the Division of Family Practice and Fraser Health through local leadership — has been a catalyst in moving to this formal model, it is clearly understood that its success is incumbent on collective ownership. An evolving governance model will be necessary to support that.

In order to bring this model to fruition, support and resources will be required. Significantly, there is an expectation that there will be an increased demand for social supports and services, which can only be met by better supporting the social agencies and organizations within the City.

The business case for this required support is formidable. Based on other jurisdictions, there is reason to believe that health and wellbeing will improve dramatically and relatively quickly through this approach and that overall cost savings, particularly within emergent and acute care, will be realized. Through its demography, the work done to-date and, most importantly, its culture of collaboration, Burnaby presents as a pilot community where programs and solutions can be implemented, evaluated, refined, and shared. The system change that has already begun here can easily evolve and be shared to other communities.

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Introduction

The health challenges facing our communities continue to grow, exacerbated by an overall lack of human resource within the whole of health care. There is a real and ever-expanding crisis in primary care evident in almost every community. At the same time, the understanding that social determinants[1] have a huge impact on health, more than any potential 'cure' or intervention might hope to accomplish, has grown significantly.

In Burnaby this has driven a conscious and purposeful effort to consider the continuum of health and wellbeing.

There is an understanding that better support and connection to non-clinical services that address those social determinants will result in a healthier — more connected — community in both the short and long term. As seen in other jurisdictions (Frome et al), such connection and focus will lead to reduced health issues, less need for health interventions (less use of episodic facilities/ER visits) and an overall reduction in health system cost, along with a significant increase in capacity. Most importantly, it will result in an overall increase in wellbeing across the community.

1 Government of Canada. "Social determinants of health and health inequalities": https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html

1.

The model defined

Building on an already highly collaborative community within the social sphere, the advent of a full spectrum, focused Primary Care Network has driven ongoing integration efforts in Burnaby.

The community within the social and health sector in Burnaby has undertaken significant steps in bridging and integration over the last four years and has reached the point where a more clearly defined integrated system to support health and wellbeing — one that is measurable, scalable and replicable — can be developed and implemented.

This Burnaby model draws on learnings from other jurisdictions in Canada and around the world. The Frome Model[2] in particular has been a source of both information and inspiration, and some of the strategies utilized there are referenced in this document.

This system will connect providers within and across sectors and create multiple avenues through which people in the community can get the help they need when they need it. It will support a community development model to ensure that the right kind of services and supports are readily available. An attribute of this system is an ability to continually evolve through a developmental evaluation approach.

From a system perspective, greater connection between health and social supports will lead to direct and measurable improvement around social determinant issues and resulting improved health outcomes. As seen in other jurisdictions, this will result in a measurable reduction in health service utilization.

From a provider perspective, this system will allow clinicians and social service providers to connect directly around the needs of neighbourhoods, specific groups and, most importantly, individuals, and to focus their own energies on their work. In the evolution toward team-based primary care, this creates a broader team approach that brings social determinants to their rightful place in the centre of the conversation around individual health.

From a community member perspective, this system will ensure that all people are able to:

- Easily access the services and supports they want and need;
- Feel connected and supported in their community;
- Feel that they have every opportunity to thrive in Burnaby.

2 The Frome Model: https://healthconnectionsmendip.org/

II. Why Burnaby?

a) Community overview

Burnaby presents as an ideal community to undertake such a significant structural system change. With a population of 250,000,[3] it requires the kind of strategies and solutions that are extremely scalable to both smaller and larger communities.

Within that population, the demographic is extremely diverse; as an historic bedroom community it remains the home to many long-term residents, many who have been there for 80 years or more. Its significant growth has come from across the Lower Mainland, but also largely from newcomers and immigrants. There are over 60 languages spoken in Burnaby.[4] Economic diversity is equally significant — the richest and poorest neighbourhoods in BC sit side by side in Burnaby.

As in other communities, there are significant areas of vulnerability within Burnaby's population. The immigrant and newcomer population faces consistent challenges around language and culture that prevent their access to full support. Burnaby has the highest rate of seniors below the poverty line in the province. With two large academic institutions there is a significant transient student population, many of whom are non-English speaking. The number of people in the City who are unhoused and housing-challenged is growing rapidly, as it is in neighbouring municipalities. The opioid crisis has had an extreme impact in Burnaby, and studies undertaken in the last five years point to a population that feels more isolated than many others in BC.

b) Culture of partnership

Burnaby benefits from a highly collaborative and reciprocal culture within the social sector. Supported strongly by the City's social planners, Burnaby's agencies participate in a high functioning Burnaby Inter-Agency Council (BIAC). This enables a collective voice for the social cause, providing partnership opportunities across agencies and with others, allowing for 'sharing' of clients/members and sometimes resources to ensure the best supports for the community.

This collaborative culture exists at both a City-wide and neighbourhood level. Local Inter-Agency Councils exist in each of the four quadrant neighbourhoods, where participation includes leaders from schools, recreation, local doctors and others.

c) The Burnaby Primary Care Networks and its role

Primary Care Networks in BC

A PCN is a clinical network of local primary care service providers located in a geographical area, with patient medical homes (PMHs)[5] as the foundation. A PCN is enabled by a partnership between Divisions of Family Practice, health authorities, First Nations, community partners and patient representatives.

In a PCN, physicians (via patient medical homes), other primary care providers[6], allied health care providers[7], health authority service providers, and community organizations work together to provide all the primary care services a local population requires. Together, they:

- Enhance patient care using a team-based approach to care;
- Support each other and work to their strengths;
- Further link patients to other parts of the system, including the health authority's specialized community services programs for vulnerable patient groups (e.g., frail elderly, mental health and substance use);
- Collectively increase a community's capacity to provide greater access to primary care for people without a primary care provider.[8]

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3 City of Burnaby. Burnaby 2050 Insights Report (Issue 2): Population growth trends in Burnaby: https://www.burnaby.ca/sites/default/files/acquiadam/2022-07/OCP-Insights-Report-Issue-2.pdf

4 Statistics Canada. Burnaby, City, BC, Census Profile, 2021 Census of Population: https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/details/page.cfm?Lang=E&SearchText=Burnaby&DGUIDlist=2021A00055915025&GENDERlist=1,2,3&STATISTIClist=1,4&HEADERlist=0

5 A patient medical home (PMH) is a family practice that operates at an ideal level to provide long-term patient care throughout a patient's life. This means creating therapeutic relationships developed over time between a patient and a Family Physician in which the patient sees this Family Physician for most of their medical care needs.

6 1 Primary health care is a type of medical care that typically involves routine care, care for urgent but minor or common health problems, mental health care, maternity and child care, psychosocial services, liaison with home care, health promotion and disease prevention, and end-of-life care. It is also an important source of chronic disease prevention and management. Primary Care providers are family physicians and nurse practitioners who consult with a wide range of patients including infants, children, teenagers, adults, and seniors. They have a broad knowledge of the body at every stage of life, which is useful for their varied patient base. Also, they know their patient's home/family life, which can help in the diagnosis of several illnesses. (source:https://schcontario.ca/)

7 3 Allied health professionals aim to prevent, diagnose, and treat a range of mental and physical health conditions and illnesses as an additional service in consultation with a Family Physician or Nurse Practitioner.

8 Family Practice Services Committee. Primary Care Networks: https://fpscbc.ca/what-we-do/system-change/primary-care-networks

Each PCN is governed by a multi-partner local leadership table that sets the priorities and is accountable for the operations of primary care services within its geography. For the purposes of this work, the set of primary care services are limited to those funded through the PCN initiatives. Recognizing the degree of patient mobility in Burnaby, the three active PCNs (the fourth one to come online this year) come together to ensure services are aligned within the broader regional context of Burnaby.

The PCN in Burnaby: Fundamental differences

At the core of our Burnaby PCN[9] is our focus on both the health and wellness of our residents and our goal of supporting residents — those with family doctors and those currently without — to stay as healthy as possible in their own communities. This whole-person approach has driven us to restructure how primary care medical services are being delivered in our community and to pull these medical services into alignment with the work of our social support agencies that focus on the social determinants of health (such as food security and housing).

Specifically, Burnaby's PCN has been design-built on three transformational pillars:

1. **Transform Family Physician (FP) practices towards Patient Medical Homes (PMH) and integrate PMHs into FP practice networks**
2. **Transform Health Authority (HA) services to integrate with PMHs and provide nursing and allied health services closer to the population**
3. **Transform community wellness & prevention services to integrate with FP & HA primary care services**

The long-term vision for Burnaby PCNs has always been for primary care and wellness services provided by Family Physicians (FPs), Health Authority (HA) resources and community organizations to be fully integrated and accessible to residents closer to home while working collaboratively in teams to provide optimal care to patients.

The PCN has activated around the third pillar, "Transform community wellness & prevention services to integrate with FP & HA primary care services" in a number of ways.

Tripartite Governance

The Burnaby Primary Care Networks exhibits authentic tripartite governance at each level of oversight and operation, with representation and equal voice from the family doctors, the community and Fraser Health at every table and subcommittee. The PCN Steering Committee oversees the whole of the PCN. The community is represented there by leaders from the Burnaby Inter-Agency Council; family doctors by leaders from the Burnaby Division of Family Practice; and Fraser Health by local leaders.

In each of four neighbourhood-specific Primary Care Networks, Local Leadership Tables (LLTs) are comprised of two family doctors from the neighbourhood, two local agency representatives and two Fraser Health representatives. These tables hold significant authority, determining the need within their neighbourhoods and how it should be addressed, including what type of PCN resources will be utilized. To ensure cohesion and consider a sometimes necessary more regional approach, these LLTs also come together as a Regional Local Leadership Table.[10]

This tripartite approach is active at every level of decision making within the PCN — from program design to hiring, to planning and resource deployment. This is a unique model of governance within the roster of PCNs in BC.

Community Working Groups

The PCN has undertaken the development and ongoing support of community-based Working Groups focused on specific issues and/or vulnerable subpopulations within the City. These Working Groups were formed in response to the COVID-19 pandemic to ensure that the social needs of Burnaby's residents could be better met through a connected and collaborative approach. These Working Groups have evolved to become integral within the PCN system. Through its initial resources the PCN has convened and supported the ongoing work of these groups which meet on a biweekly or monthly basis.

Current groups include:

- Food Security
- Homelessness
- Seniors at Home
- Developmental Disabilities
- Social Isolation
- Youth and Teens
- Technology and Digital Literacy

9 Burnaby Primary Care Networks: https://burnabypcn.ca/

10 See Appendix 3 for a visual overview of the Burnaby PCN governance structure.

These groups are open to participants from across sectors including community advocates/people with lived experience and have been extremely successful in the development of collaborative programs, active advocacy and early detection and understanding of emerging issues. A few examples of Working Group initiatives[11] are the Free Fridge program in Burnaby, the Say Hello initiative in the City, a technology initiative that has seen over 500 phones distributed to date, the Guns and Gang and Gang Violence Community of Practice and the funded Social Connectivity in the Time of COVID-19 research project. The working groups were directly involved in the City's Food Security Strategy, and their advocacy led to the City's current development of a Poverty Reduction Strategy.

Information Management

The PCN maintains its own website at www.burnabypcn.ca, where it houses information and links to both PCN programs and those offered by agencies and partners throughout the community. It maintains a significant social media presence through Facebook, Instagram and Twitter, and publishes a monthly e-newsletter sharing public health announcements, news articles and community events and resources. It works closely with partners in community to ensure accuracy and timeliness of all information it provides through these avenues.

DocTalks

DocTalks[12] were launched during the COVID-19 pandemic to provide timely information from a credible source — the family doctors in the community. Initially these hour-long Zoom webinars focused on COVID-19 related topics, geared to specific issues and/or specific subpopulations. The format features a key speaker, generally a family doctor, followed by a moderated Q&A session. Given the multicultural nature of Burnaby, significant effort has been made to ensure broad accessibility. Real time interpretation has been offered in a range of languages. Social agencies have hosted viewing parties to overcome technology challenges and provide interpretation and interpretation has also been provided for the recorded DocTalks, which are posted and viewable on the Burnaby PCN website.

Since COVID-19, DocTalks have evolved to cover a much broader range of issues, with many of the topic ideas coming directly from the community working groups. While many still feature family doctors, the range of presenters has expanded to include other health experts — specialist physicians, pharmacists, social workers and other allied health professionals — as well as subject experts from within the community including educators, housing advocates and many others.

Shared Care

While not a formal part of the Burnaby PCN, the Shared Care projects in Burnaby[13] have directly mirrored and supported the

integration work that is being undertaken. Supported by the Shared Care Committee (one of the Collaborative Committees of Health in BC) Shared Care projects are most often focused on 'sharing care' across clinicians and within the health system — between family doctors and specialists for instance. In Burnaby, the opportunity has been taken to create many projects which share care across health providers and community.

Projects focusing on mental health, access to care for adults with developmental disabilities and overcoming language issues for newcomer and immigrant women have relied heavily on the participation and input of community agency providers as well as family doctors and specialists. They have developed training and process solutions which have been purposely designed to be scalable in terms of both size and scope so they may be easily expanded to include a much broader population. Projects already undertaken will form cornerstone elements for the integrated system development work.

11 See previous Burnaby PCN Highlights documents for further descriptions of community initiatives:
Highlights 2020–21: https://burnabypcn.ca/wp-content/uploads/2023/09/PCN-Highlights-2020–21_web.pdf
Highlights 2021–22: https://burnabypcn.ca/wp-content/uploads/2023/09/PCN-Highlights-2021–22_web.pdf
12 Burnaby PCN DocTalks: https://burnabypcn.ca/news-events/doctalks/
13 Burnaby Division of Family Practice Shared Care projects: https://divisionsbc.ca/burnaby/our-work/shared-care

III.

Realizing existing assets

As discussed, the level of activity and resource in Burnaby is high. A key step in the development of this system will be first better understanding and harnessing existing assets. These assets — be they data, services across the community or current integration work — are the core from which this system is being built.

a) Amalgamated Data

While there is a large amount of data surrounding health and wellbeing available in Burnaby through multiple sources, as in most jurisdictions, this data has never been collectively considered or analyzed. While this is understood to be a significant task, the unrealized potential is huge. In its initial stage an understanding what data points exist and a tool for timely collection and analysis going forward will be targeted. This critical first step will include (but not be limited to) these sources:

- Health data from FH and MoH
- Health data from community practices
- Social data from Community Agencies
- Social data from City
- Social data from the School District
- Social data from Provincial Ministries
- Social data from regional, provincial and federal NGOs
- Health and social data from academic sources

b) A Comprehensive Integrated Picture of Current Work

The level and quality of health and wellness services and social supports available in Burnaby through all the partners is high but somewhat disparate. Through the work of BIAC, the PCN, the City and its offices (including the Burnaby Public Library), there has been ongoing work to identify and map these assets demographically as well as geographically. A critical element will be the formal development and maintenance of a current inventory of these programs and services that can be accessed easily through a range of channels by both providers and people in the community.

This mapping process will provide a picture of the assets and potential service gaps, and serve as the foundation for:

- Health and primary care activities
- Programs, services and activities provided through social agencies
- Programs, services and activities provided through City of Burnaby, including:
  - Parks and Recreation
  - Burnaby Public Library
  - City Services
- School District programs and supports for students, families and lifelong learners

c) Understand Current and Ongoing Integration Work

A significant amount of collaborative work focused on integration of health and wellbeing is already underway in Burnaby. Some of this has emerged directly through the efforts of the Primary Care Networks, while a substantial amount of work between community partners, the Health Authority and the City has been in place for a longer time. Identification, analysis and evaluation of this work will form a cornerstone for future collaborative efforts.

A more global understanding of this activity will provide insight into the necessary support required for success as well as open the door to new avenues of collaboration.

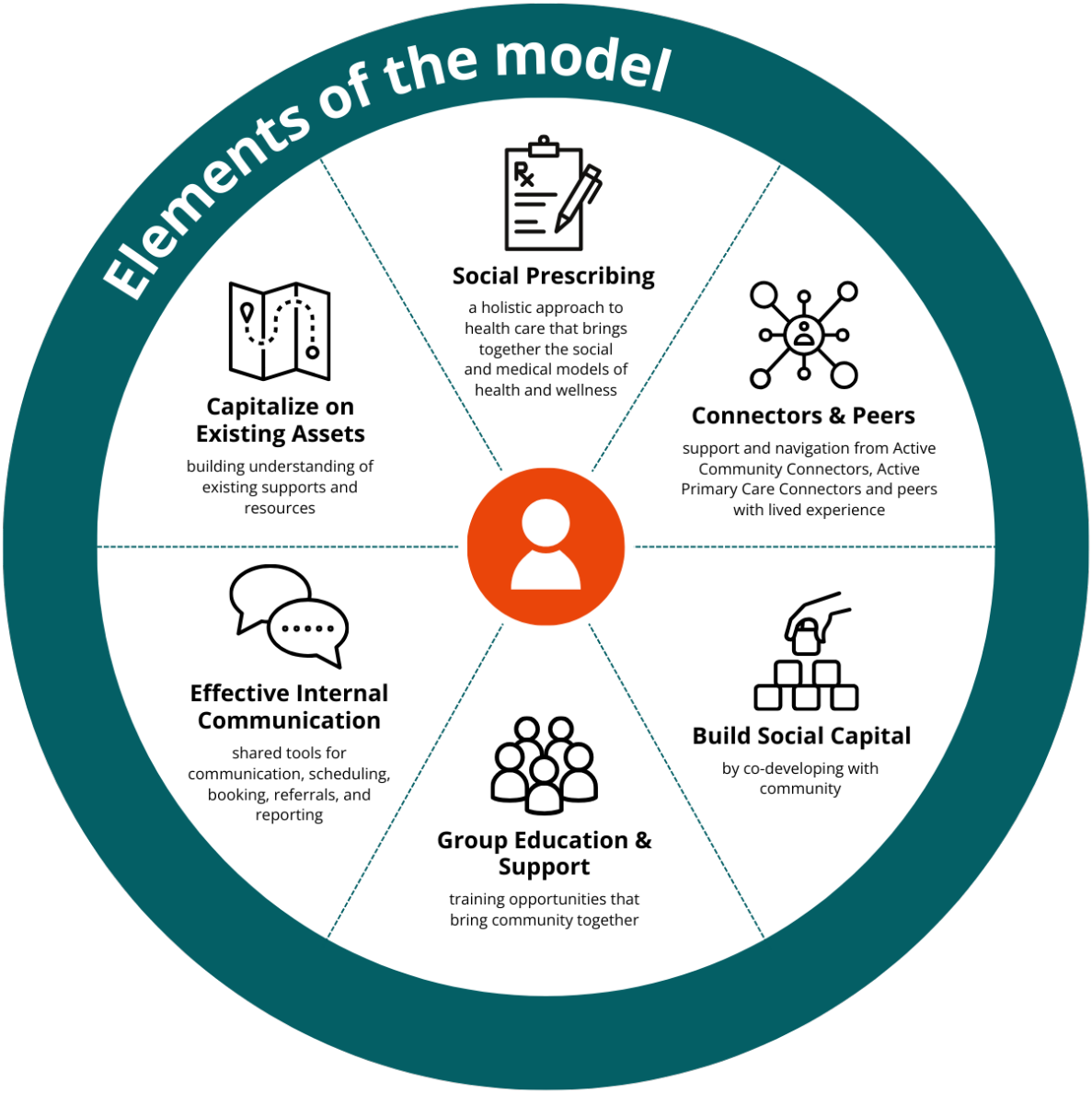

Figure 1. Elements of the integrated model for health and wellbeing in Burnaby.

IV.

Elements of the Model

a) Capitalize on Existing Assets

With clear understanding of the breadth of services and supports available in Burnaby the system will build around them, creating access routes for primary care providers, system navigators and individuals in the community. These services will become more accessible through the signposts and referral points within the system and will continue to offer self-referral opportunity with the potential to link all activity to each person's health and wellness plan.

b) Effective Internal communication

As an effectively integrated system, there will be clearly defined channels and accessible tools to ensure timely and safe communication between providers in the social agencies and primary care around individual patients, services, groups of patients including:

i. Scheduling, booking and referral tools

Multiple options exist in Burnaby including the Pathways system used by family doctors, the nascent CliniCall tool in development by the Burnaby Division of Family Practice and options being created in the social agency/ social prescription space. Because of its advanced state of integration, Burnaby is seen as a prime candidate for the trial and launch of these emerging tech solutions.

In order to be successful, such tools will need to be universally accessible within the system — by providers in the community, in family doctors' offices and in health authority-run services.

ii. Instant messaging tools

The ability to quickly communicate across providers in a safe and reliable manner will enhance the opportunity to effectively 'share care' and work in an extended team environment. Some of the tools described above provide this level of functionality; the most effective ones have cross-platform capabilities (different EMRs, cell phones, tablets, computers).

iii. Common reporting tools — individual patient care (shared care planning)

With multiple providers from various physical sites and organizations working more effectively together to identify and meet individual needs, a common method of reporting will be critical to ensure that information is readily available to each provider in the circle of care. This could be accomplished through one or more of the tools suggested above or may be built from existing systems utilized by one or more of the partners.

Each of the above has issues around privacy and confidentiality which will need to be overcome. The current shift toward team-based care in Canada and particularly in BC is driving ongoing work around this, and there are good examples of locally held solutions (active patient permission) that can overcome it in the short term.

c) Social Prescription

Directly refer a patient to a service or program in the community that addresses their social determinants of health needs

Social prescription[14] emphasizes co-created solutions to address the social determinants of health and patient outcomes and will be directly embedded within the proposed integrated model. Health care providers will work with Health Navigators and their patients to identify which service or activity will be most beneficial, then a trackable reference will be made that connects the patient to the service/program and provides a reporting channel back to the provider. This 'warm hand off' will ensure continuity of care and enhance the broader team concept.

Burnaby has benefited from initial trials of social prescription practice through the CAREs program sponsored by United Way and through a PCN pilot linking a large family practice with a neighbourhood social agency.[15] These examples focused on a specific population: seniors. To achieve broad understanding and usage from both providers and clients/patients and to realize the full potential impact, social prescribing will be utilized for all patients and clients.

It is important to understand that, while social prescription and cross-provider referral are key facets of the system they do not preclude other avenues – self-referral or service provider direction or consultation. The overall system will provide much deeper awareness and access to the services and supports in the City.

d) Build Social Capital

Ensuring that those who need the services are directly involved in their development

In order to be successful, an authentic sense of community ownership will be essential. Through the Active Community Connectors, the Primary Care Connectors and the Peer Networks and through existing and emerging points of direct contact with people and groups within the community programs, processes and solutions will be co-developed to ensure that they truly address the needs for which they are designed.

Like the Frome Model, the Burnaby system will support groups to come together to build programs or activities to address unmet needs in the community through connection to appropriate social partners, training and mentoring, space and other resources.

This empowerment will support the strength and the spread of the system and provide a continual opportunity for ongoing development within the system.

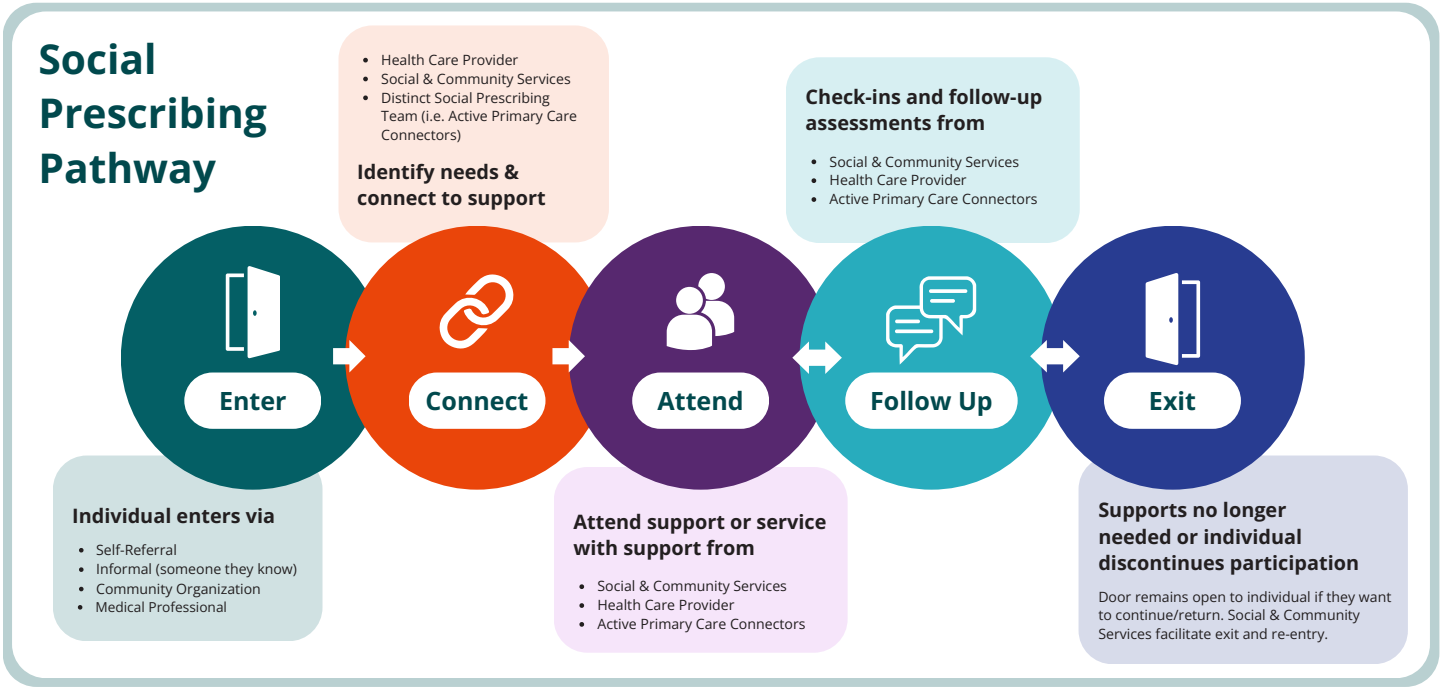

Figure 2. The journey map for an individual to enter and exit the social prescribing pathway, with the option to re-enter at any time.

14 Social prescribing resources – Canadian Institute for Social Prescribing: https://www.socialprescribing.ca/resources

15 See pages 23-28 of the Burnaby PCN's 2021–22 Highlights document to learn more about these local initiatives: https://burnabypcn.ca/wp-content/uploads/2023/09/PCN-Highlights-2021–22_web.pdf

e) Peer Support

Activating peers (lived experience) in peer networks to connect with and support vulnerable populations on the ground

The development and support of effective peer networks is an important facet of the proposed system. Peers with lived experience provide a critical avenue to linking the most vulnerable — homeless, immigrants, (LGBTQIA2S+), youth and teens, seniors, substance using and neurodiverse populations, as examples. Peer networks already exist within some of these populations, while others have tremendous potential for supported development.

Peer networks are a key component of the Social Capital development strategy. In addition to the invaluable support they give their cohorts, they are an avenue for people to access the integrated system of services. They also provide a direct point of engagement that serves to not only understand the issues of their peers, but to co-develop services or solutions to effectively respond to those issues. In Burnaby there is an existing substance use peer network, a smaller seniors' peer group as well as numerous peer-based youth networks. These have been supported to participate in PCN integration work and have become advocates for the developing system.

As seen in neighbouring jurisdictions, peer networks can be actively supported with:

- Physical space
- Administrative support
- In-kind resources, such as access to computers and Wi-Fi
- Ongoing learning and mentoring opportunities

Self-identifying peer groups can be supported to develop through provision of meeting space, communication tools and, where appropriate coaching and mentoring. The value of peers is becoming widely recognized, as is the understanding that their contribution must be tangibly recognized — that they should be paid for their participation and efforts.

f) Group education and support

Through the Burnaby PCN and Shared Care projects, the PCN has already facilitated training opportunities for organizations across the network for education and training around stigma, Mental Health First Aid, health resource navigation and others. While some organizations in the City have their own training programs for some of these, the benefit of providing them centrally is seen as much more than just the training. Where the issues being addressed are common, like these, there is tremendous advantage in creating common curriculum and it is equally valuable to have participants from across the City's organizations learn together.

There is an opportunity to build from best practices and to expand processes and programs already developed within Burnaby's respective organizations. This is supported by and builds upon the collaborative culture in the City.

g) Active Community Connectors

The concept of Active Community Connectors (as witnessed in the Frome Model) works to build social capital and create and strengthen ties within the community at a personal level. Active Community Connectors act as system evangelists, bringing some knowledge of the kind of programs, supports and services and more importantly a clear understanding of how to easily access them to their own networks of family, friends, and colleagues in the community. Provided with a minimal amount of training (2 hours) and ongoing support, these unpaid community members do more than spread the word, they become the foundation of the model, acting at a grass roots level.

In Burnaby, work has already been done to develop these roles within specific sectors, most notably for seniors, and through the work of the local agencies and Shared Care initiatives, training modules and processes are in place.

In Frome, the number of community connectors continues to grow, with over 500 now active, coming from a wide range of backgrounds. Many are seen as local leaders — teachers, coaches, law enforcement and emergency services providers to name a few. Their position of trust enhances their ability to effectively connect the community to the integrated network of care. They also act as conduit back into the system to help define what works, what doesn't, and what gaps may exist in services and supports. With a highly collaborative social agency community in place, the potential to build a fulsome and effective network of Active Community Connectors is huge.

Given Burnaby's highly multicultural nature it will be critical that there is a broad cross section of language and culture within the community connector cohort. The local agencies who work in the arena are a critical partner in identifying these connectors.

h) Active primary care connectors (Health Navigators)

The health navigator role that exists in other jurisdictions, in some neighbouring communities and to a small extent in Burnaby, is a critical element for effectively achieving integration across health and wellness. These paid professionals — social workers, health coaches or others — will take on the relational role of interface between providers and patients and the respective services and supports within the community. They have an understanding of what social services and supports are available within the community and work with patient/clients to determine the most appropriate option to address their needs (often as identified or referred by a physician, nurse practitioner of other primary care provider). They also act as a conduit between providers, ensuring that referring clinicians are aware of the choices and paths their patients follow and providing direct linkage between agency and clinical staff as required.

These roles may be developed in multiple ways in Burnaby — as dedicated funded roles within community-based clinics, the PCN team or the emerging Community Health Centres, or as a supported facet of existing roles within PCN resources, community-based organizations or municipally-run recreation or wellness programs. This kind of work could be augmented through internship or experiential learning programs.

i) Role of physicians and primary care providers

Primary care providers take a key role based on both trusted relationships with their patients and the expertise they bring to the table which often extends beyond their medical training. Family doctors and nurse practitioners are often most aware of the social and wellbeing needs of their patients but with little avenue or opportunity to help address them. In this integrated model, these primary care providers will continue to take on the 'quarterback' role that they hold within the health care system and will be able to extend that with the supported of dedicated navigators to connect patients to critical social supports within Burnaby.

This system will extend the role that family doctors already take in linking their patients to appropriate specialists. They will also enable a link from specialists and their patients to the social services within the community, providing an immediate connection to fitness and rehabilitation programs and supports, moderate mental health supports and opportunities to address isolation, as examples.

Already within the PCN programming, family doctors are able to access allied health services. The advent of a broader system will extend this to easily include service offerings by other community health providers (physio, foot care, counsellors, community pharmacists).

Likewise, private enterprises in the city focused on health and wellbeing may be connected, including fitness centres and other active lifestyle businesses.

On a day-to-day basis, family doctors find themselves addressing the social issues faced by their patients. With few exceptions, they have had little or no avenue to effectively support them. Already in Burnaby linkages have been made that allow doctors to get some patients the help they need, the fully realized system will significantly expand both the referral pathways for providers and the ease with which they can refer them.

j) Role of Social Agencies and City Services

Many if not most of the social support services in Burnaby are provided by the social agencies. As such, they have a direct relationship with a significant number of the vulnerable and at-risk people in Burnaby and provide an avenue to inclusion. They can ensure that their cohort can adequately access the services they need. As well, they will be the provider of many of the referred services.

At the outset, this points to a challenge surrounding capacity. The social agencies are narrowly funded for the programs they offer and many of these highly valuable offerings are at or near capacity. To effectively meet what will likely be a significant increase in demand, these social agencies will need to be supported with additional programming resources.

The system will require an active partnership with the agencies, which will also require additional resources. While effective communication tools will be brought in, there will be a need for immediate and ongoing training as well as an agency-dedicated resource in order to fully participate.

V.

Realization of an Integrated System

a) Governance

Ownership of this model will, in its essence, be held by community. At the outset, the Burnaby Primary Care Networks Steering Committee will oversee the development and implementation of the System Plan. The Steering Committee is a tripartite body with equal representation for the family doctors through the Division of Family Practice, from publicly funded health services through Fraser Health, from the community agencies through the Burnaby Inter Agency Council, from the City through senior staff and from the First Nations Health Authority. The committee will provide oversight in direct consultation with all partners across the community including the Healthy Community Partnership Table that is stewarded by the City and Fraser Health.

As the system plan comes to fruition, a new governance model may emerge that more effectively oversees the ongoing system operation.

b) An achievable plan

The planning process will set clear timelines and measurable outcomes. This plan, codesigned by organizations and individuals from across the City, will focus on the individual elements within the system but also consider the collective impact of the system and of the participating partners.

c) Engaging, Evaluating and Evolving

Integral to the planning, development and implementation are ongoing assessment and evaluation. A developmental evaluation approach will be adopted and utilized as a means of ongoing engagement with stakeholders/partners, funders and with the community as a whole.

In order to achieve this, a comprehensive evaluation framework will be supported by common reporting tools that can be easily utilized across organizations and individuals.

d) Cohesive Communication Strategy

Effective communication within and beyond the system is critical for success. Elements described below encompass a fulsome communication strategy which can be expanded and evolved as the system comes more fully into place.

Foundational to this is a clear story that will be further co-developed — a simple way to describe the system and desired outcomes that can be used by advocates, by connectors, by service providers and, eventually, by the community as a whole.

A technological backbone will also be required — one that is clearly defined, highly accessible and universally utilized.

Inclusive of website, social media, and communication tools (such as Slack, Basecamp) this will form the credible source for information that all partners can utilize through their own channels.

All communication tools and strategies will necessarily understand, respect and easily integrate with those of the organizations within Burnaby. This applies to both policy and technology.

Included within this will be avenues for effective communication between partners (beyond the system that will support patient/person-focused inter-provider communication).

e) A supported common culture

While organizations across the City and the System will hold their own 'corporate' culture, the development and ongoing support of a common approach will engender cohesion and drive ongoing integration. In order to achieve this we will:

i. Strive to Collaborate

While collaboration is already well supported in Burnaby, an active stance that it is a necessary element for any project will be continuously taken. Any given project, strategy or initiative will be developed and collectively held by all interested partners.

ii. Create Common Language

Too often, sectors and organizations talk about the same thing — same issues, same mechanisms, same strategies — using different words or, perhaps worse, different acronyms. This creates confusion internally and between organizations and is even more daunting from without. By creating a common lexicon, the ability to communicate internally and externally is exponentially enhanced.

iii. Seek alignment in strategies and approaches

Organizations across Burnaby have active strategies and programs addressing many common issues — stigma and racism, support for mental health, even tech training to name only a few. Each has methods of training and support around these that are effective, but they are often disparate. Understanding and rationalizing these approaches will create real integration, enhance efficiency and create collective strength and value.

VI. Steps to Implementation

Date	Funding	Planning	Implementation
September 2023	Identify potential funders Initial meetings with key internal (Burnaby) stakeholders Initial meetings with external funds	Plan initial large meeting (symposium) Identify existing data sources	
October 2023	Targeted funder engagement » Confirm potential funding for Model Development and Launch » Confirm funding sources for implementation and operations	Planning Symposium » Define work and timeline for model development and implementation » Refine required resources for development of key elements » Identify potential internal and external key parnerships	
November 2023	Secure funding required for model development	Element Working Groups: » Create workplans and begin process Governance/Oversight » Confirm Governance/ Oversight model » Develop or adapt Burnaby-wide and Neighbourhood/Quadrant-based tables as required	
December 2023	Secure funding for implementation/ launch Identify funding and resource sources necessary for first year operation	Element Working Groups: » Prepare for implementation	» Create detailed plan for implementation across all elements » Launch communication strategy
March 2024			Launch formal model (staged approach)
October 2024	Reconvene Broader Collective	Evaluation to date	Identify areas of focus/change

VII. Required Supports

In order to achieve a structured integrated system of health and wellbeing, concrete and in-kind resources are required in the following areas:

	Type of resource required	Start up/ implementation	Ongoing operation (annual cost)	Opportunity for in-kind resources
System planning and development	Contract, engagment planning, convening	●		●
System Management — leadership and administration	Human Resource	●	●	
Support for social agencies to integrate			●	
Support for social agencies to meet increased demand	Funding for increased capacity	●	●	
Support for peer group development and participation			●	
Support for active participation of people with lived experience			●	
Information Management	Technology development and implementation	●	●	●
Community Connector Network				
» Recruitment, Training, and Coordination	Human Resource	●	●	●
Technology — acquisition, development, implementation, support	Capital cost/implementation/ tech support	●	●	
Health Care Navigator roles (2 per quadrant/neighbourhood)			●	
Communications				
» Tools development and implementation	Contract	●		●
» Strategy implementation	Human Resource	●		
» Communication ongoing	Human Resource		●	
Evaluation Framework Development	Contract	●		
Evaluation Tools	Acquisition/Development	●		●
Evaluation process	Human Resource		●	
Governance Support	Human Resource	●	●	●

VIII.

Resource Links

Here you will find a shortlist of resources we have compiled, in addition to the footnotes throughout this document. Contact us at burnabypcn@burnabydivision.ca if you are interested in more resources and practical tools related to social prescribing.

- Health Connections Mendip (Frome Model): https://healthconnectionsmendip.org/
- Current State of Social Prescribing in Canada – Bridgeable: https://www.bridgeable.com/wp-content/uploads/Bridgeable-CISP-Social-Prescribing-Phase-1-Summary-Report.pdf
- Strengthening community connections: the future of public health is at the neighbourhood scale — National Collaborating Centre for Determinants of Health: https://nccdh.ca/resources/entry/strengthening-community-connections-the-future-of-public-health-is-at-the-neighbourhood-scale
- Social prescribing resources – Canadian Institute for Social Prescribing: https://www.socialprescribing.ca/resources
- Case Study: The Frome Model of Enhanced Primary Care – Shift: https://shiftdesign.org/case-study-compassionate-frome/
- Social Prescribing's Role in Improving Population Health — Ontario Hospital Association: https://www.oha.com/news/social-prescribing%E2%80%99s-role-in-improving-population-health
- Social Prescribing course — OpenWHO: https://openwho.org/courses/social-prescribing-WPRO
- Social Prescribing — Centre for Effective Practice: https://cep.health/clinical-products/social-prescribing/#pc_page_1849
- Burnaby Primary Care Networks: https://burnabypcn.ca/
- PCN Highlights 2020–21: https://burnabypcn.ca/wp-content/uploads/2023/09/PCN-Highlights-2020–21_web.pdf
- PCN Highlights 2021–21: https://burnabypcn.ca/wp-content/uploads/2023/09/PCN-Highlights-2021–22_web.pdf

Burnaby Primary Care Networks respectfully and gratefully acknowledges that the work we do takes place on the unceded, traditional, and ancestral lands of the hən̓q̓əmin̓əm̓ [HUN-kuh-MEE-num] and sḵwx̱wú7mesh [Squ-HO-o-meesh] speaking people.

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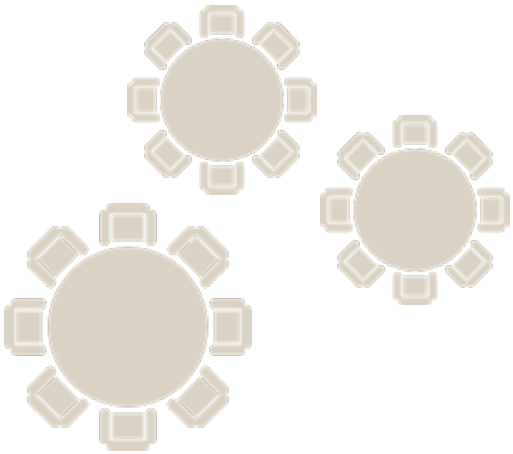
IX. Appendices

Appendix 1. Burnaby Population Overview (based on 2021 census)

Appendix 2. Burnaby PCN's model of team-based care

Appendix 3. Burnaby PCN governance structure + Community Working Group overview

PCN Governance



Collaborative Services Committee
Co-chairs: BDFP Board Chair, FHA ED
Membership (13): MHSU, PPH, 2 MSA 2 FPSC, 2 Pt Advisors, BDFP, NGO, First Nations, Community, City Councillor

↓

PCN Steering Committee
Co-chairs: BDFP ED, FHA ED (or designate), Community Rep (BIAC)
Membership (20): BDFP Board Chair, DoFP Director, 4 Medical Leads, 4 FH Reps, 1 NP Integration, 2 Pt Advisors, First Nation, Community NGO, 3 PCN Managers

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Regional Leadership Table
Metrotown LLT, Edmonds LLT, Hastings-Brentwood LLT, Working Group Reps

↑

Local Leadership Tables (LLTs)
For each: PCN Leadership, 2 Physician Reps, 2 FHA Reps, 2 Community Reps

Metrotown | Edmonds | Hastings-Brentwood | Lougheed in development

Local Leadership & Network Links

Metrotown LLT	Hastings-Brentwood LLT	Edmonds LLT	Lougheed in development
Metrotown FP Neighbourhood Network Meetings	Hastings-Brentwood FP Neighbourhood Network Meetings	Edmonds FP Neighbourhood Network Meetings	
Metrotown Allied Health Neighbourhood Meetings	Hastings-Brentwood Allied Health Neighbourhood Meetings	Edmonds Allied Health Neighbourhood Meetings	

PCN Neighbourhood Level Networks
Facilitated by: PCN Managers

Physician Networks
Facilitated by: Burnaby Division of Family Practice-PCN Director

Allied Health Clinician Networks
Facilitated by: PCN Managers

PCN Community Working Groups

Working Groups are facilitated by PCN Community Engagement Leads

Food Security	Social Isolation	Technology	Homeless & Underhoused	Emergency Response
Seniors	Youth & Teens	Children & Families*	Developmental Disabilities	Financial Supports*

**No longer active*