CARGA BC Primary Healthcare Model

Introduction & Purpose

British Columbia is at a pivotal moment in primary healthcare. Too many residents remain unattached to a provider and rely on episodic or emergency services that fail to meet their needs. Even those counted as attached often lack timely access or a sustained relationship with their care team. The problem is most acute in rural, remote, and Indigenous communities, where provider shortages, limited supports, and transportation barriers deepen inequities.

Our purpose is to define a practical, achievable primary care model for swift implementation that can guide reform in BC and serve as an example for Canada. With decisive leadership, BC can create a sustainable, accessible, and equitable system that reflects its people and geography.

This work aligns directly with the Cooperation and Responsible Government Accord (CARGA) and supports its deliverables for primary care reform.

Vision Statement

Primary care in British Columbia will be publicly funded, accessible, equitable, team-based, and community-driven. Every resident, urban, rural, or remote, will have timely, free access to trusted, whole-person care across their lifespan. Care will be rooted in local communities, culturally safe, designed to reduce inequities, and integrated with supports that address the social determinants of health.

Guiding Principles

Our model aligns with the W.H.O.'s "5 Cs" in a BC context:

- **First Contact**: Care is accessible through multiple culturally safe entry points; every door is the right door.
- **Continuity**: Long-term, trauma-informed relationships between patients, providers, and places of care.
- **Comprehensiveness**: Care addresses health and wellness across the lifespan, not isolated conditions.
- **Coordination**: Services are integrated across systems and stakeholders to ensure seamless care.
- **People Centred Care**: Individuals and families are active partners in shaping care to their needs.

Together, these principles define a universal, proactive, and resilient primary care system that improves outcomes, reduces costs, and strengthens wellbeing across BC.

Core Features of Modern Primary Care

A modern primary care system must ensure that every British Columbian can access high-quality, person-centred, community-anchored care across all delivery models.

- **Accessible, patient-centred, holistic care**: Services span physical, mental, and social wellness, grounded in relationships of trust and cultural safety.
- **Community governance and accountability**: Communities directly shape, evaluate, and govern local health services to ensure responsiveness, transparency, and public trust.
- **Guaranteed attachment**: Every resident will be attached to a Patient Medical Home within their community, anchored to a place of care rather than an individual provider. Each Medical Home will offer team-based, longitudinal care that reflects community needs and cultural contexts. Attachment will be automatic through the HealthConnect Registry. Adequate resources must be assured to reduce inequities and enable sustainable, population-based funding that reflects local size and geography.
- **Practice Standards**: Consistent, high-quality care across all communities with timely access (same or next day for urgent needs), continuity with care teams, and integration with supports that address social determinants of health. Every community will include System Navigators who coordinate referrals and access to regional and virtual services. All care will be culturally safe and trauma informed, and responsive to local context, ensuring respect for patients lived experiences.
- **Health Record Standardization and Digital Integration**: Providers and patients will share access to digital health records (Personal Health Records) to improve coordination. Standards will include public accountability through regular community communication and feedback mechanisms. The primary care team will have access to regional electronic medical records to update the patient's cumulative patient profile (CPP) to ensure that episodic care providers (for example, emergency room personnel) have an up-to-date summary to the patient's history. This will decrease the burden on the patient to repeat their history and minimize risk of medical errors.
- **Virtual and Mobile Care**: Virtual and mobile services will be fully integrated to expand access and continuity. Reliable connectivity must be provided for all Patient Medical Homes. Providers will also access peer-to-peer virtual support through Real Time Virtual Support (RTVS). Mobile teams will reach residents with limited connectivity, ensuring technology enhances rather than replaces local care.
- **Quality of Life Care**: Primary care must prioritize wellbeing as a measure of success. It includes access to diagnostics, specialists, prevention, and transport supports that ensure distance never determines outcomes. By linking medical, social, and wellness supports, the system promotes independence and dignity across communities.

Community-Led Governance

Community-led governance ensures that primary care reflects local realities. Whether through Community Health Centres (CHCs), health authority clinics, or other models, every community must have meaningful participation and accountability.

Principles:

- Authentic community voice in design, delivery, and evaluation, reflecting local diversity.
- Shared governance structures: CHCs governed by representative boards; other clinics guided by community advisory committees or community members represented on Society boards.
- Integration with regional planning to align community priorities with Primary Care Networks and Health Authority strategies.
- Transparent annual review of budgets, services, and outcomes with communities.
- Partnership across local and Indigenous governments and community organizations.
- Data-informed decision-making based on attachment, access, and population health data.

Structural Changes Needed

British Columbia must modernize how primary care is organized and supported to ensure equitable, team-based, and community-anchored access across all regions.

- Expand and align models of care: Support the growth of CHCs, First Nations-led and Nurse Practitioner-led clinics, and other integrated primary care models. Policy and funding should reflect community needs and avoid duplication.
- Create sustainable funding mechanisms: Establish transparent, model-specific funding independent of Health Authorities. Resources must be assured to achieve universal access for all residents.
- Coordinate networks of care: Ensure all providers work to full scope within interprofessional teams supported by shared infrastructure, system navigators, and standardized service agreements.
- Integrate digital systems and quality improvement: Implement a provincial digital infrastructure with secure, connected records and shared metrics measuring access, attachment, and patient experience.
- Address equity and workforce distribution: Prioritize rural and underserved communities through targeted investments, flexible staffing, and improved HealthMatch BC metrics. Empower and resource local recruitment leads in Divisions of Family Practice, CHCs, and partner organizations.
- Develop coordinated workforce planning: Collaborate with professional associations, regulatory colleges, universities, and ministries to forecast workforce needs and ensure equitable training and placement.

- Build accountability through data: Create a provincial data repository with shared governance to track outcomes, inform policy, and support improvement at all levels.

Implementation Roadmap

The following roadmap outlines how the Ministry of Health can operationalize CARGA's commitment to fund, evaluate, and expand Community Health Centres across the province.

What:

The Ministry of Health, with BCACHC and partners, will develop and strengthen community-governed CHCs as the foundation of equitable, team-based primary care. This fulfills CARGA's commitment to measurable improvement in attachment, continuity, and access, prioritizing rural and underserved areas.

Who:

Funding for the implementation of new and strengthened CHCs will be placed within the BCACHC under a dedicated agreement with the Ministry of Health. BCACHC will administer funds transparently, ensuring accountability, fiscal reporting, and equity in distribution across selected communities.

Oversight will be provided through a new **Provincial Primary Care Implementation Table** chaired by the Ministry and co-chaired by BCACHC, with representation from key stakeholders.

This Table will guide community selection, approve funding disbursements, monitor timelines, and ensure that reporting and evaluation are shared publicly through quarterly progress reports.

How:

- Allocate up to $5 million for infrastructure development (readiness and needs assessments, community engagement, data tools, support services, and governance and accountability structures which would include creation and operation of Provincial Primary Care Implementation Table.)
- Direct up to $5million to existing CHC operations, staffing, and ensuring stabilization for the next 24 months.
- Direct up to $5million to new CHC creation based on targets set through community engagement and needs assessment processes (above).
- Use interoperable EMRs with patient portal access linked to PharmaNet and CareConnect funded through existing primary care implementation strategies (Ministry of Health Digital Health Strategy) and system level partnerships.
- Apply transparent evaluation and reporting standards through the Implementation Table to ensure data integrity and accountability.

When:

- 0–6 months: Confirm community selection using assessments, release planning funds, finalize oversight and development teams.

- 3–12 months: Provide stabilization funding, complete new CHC planning, governance setup, and announce new CHC locations.
- 12–24 months: Evaluate results and develop long-term operational funding for continued CHC operations and expansions.

Accountability and Outcomes

Metrics for success: Key indicators include attachment and continuity, timely access, provider recruitment and retention, satisfaction, preventive health outcomes, substance use and mental health access, cost efficiency, and number of CHCs or alternate models opened in 2025–2026.

Transparency and feedback: Performance data must be publicly reported through a provincial dashboard with quarterly review by the Ministry, Health Authorities, and partners. Feedback must be accessible and barrier-free to ensure communities and providers can safely contribute to improvement.

Evidence-informed action: The need is urgent to secure sustainable funding for CHCs and expand other proven models. Evidence from *OurCare* (2024), the *BCCFP Vision for Family Practice*, and the *UBC Centre for Rural Health Research* papers on engagement and rural access together define clear priorities for action. Government must act on this collective knowledge to deliver an accountable, transparent, and equitable system.

Conclusion

British Columbia stands at a defining moment for primary care. The evidence is clear, the models are proven, and the partnerships required to implement them already exist. What is needed now is coordinated provincial leadership to act on what communities, providers, and researchers have long known.

BC Primary Care must reflect collaboration among physicians, nurse practitioners, allied health professionals, and community partners committed to an equitable and sustainable system. It integrates community governance, team-based care, and evidence-informed policy consistent with the CARGA Accord and the Ministry's Terms of Reference.

By strategically investing the $15 million commitment to expand and strengthen CHCs and other local models, the Ministry of Health can deliver immediate progress in equitable access, improved attachment, and measurable health outcomes.

Implementation of this model will demonstrate measurable results within two years and lay the groundwork for expansion in subsequent CARGA budget cycles.

The people of British Columbia have been clear through years of consultation and lived experience. They want timely access to trusted primary care close to home, delivered by teams who know their communities. With this plan, that goal is within reach.

Glossary of Terms:

Accountability – The obligation of health system partners to ensure that decisions, resources, and actions are transparent, evidence informed and directed toward achieving health system goals established by the Ministry of Health.

Allied Health Professionals - Members of the allied health workforce deliver, support, or inform direct patient care and have completed occupation-specific education or training. Allied health professionals include a wide range of disciplines such as physiotherapists, occupational therapists, dietitians, pharmacists, social workers, medical laboratory technologists, respiratory therapists, diagnostic imaging technologists, speech-language pathologists, and other regulated and unregulated practitioners who contribute to comprehensive, team-based health service delivery.
Source: Ministry of Health, 2022.

Attachment – A documented, ongoing care relationship between a patient and a most responsible practitioner, practice, or clinic that provides continuity and follow up care.
Source: BC Ministry of Health, PCN and UPCC Policy (2019).

Community Health Centre (CHC) – A team based, community governed entity that integrates primary health care and social services tailored to local needs. CHCs are legally constituted nonprofit organizations that provide comprehensive, culturally safe, and equitable care, often focusing on populations facing barriers to access.
Source: BC Ministry of Health CHC Policy (referenced in BCACHC Starter Kit, 2023, and HealthLinkBC, 2025).

Community Led Governance – Decision making authority held by community-based boards or societies representing local populations, responsible for overseeing service delivery and ensuring accountability to community needs.
Source: BC Ministry of Health, Community Health Centre Policy Framework.

Connectivity (in healthcare) – Reliable internet and telecommunications infrastructure that enables the delivery of virtual health services, access to digital health records, and participation in peer-to-peer clinical networks such as RTVS.
Source: BC Ministry of Health, Digital Health Strategy, 2023.

Continuity (Longitudinal Care) – Continuous, relationship based primary care delivered over time by a consistent provider or team that addresses the full spectrum of patient needs.
Source: BC Primary Care Strategy, 2018.

Cultural Safety – An outcome based on respectful engagement that recognizes and addresses power imbalances, systemic inequities, and Indigenous specific racism, resulting in an environment where people feel safe and respected.
Source: PHSA Cultural Safety and Humility Policy; In Plain Sight Report, 2020.

Digital Health – The use of digital technologies, including electronic health records, virtual care, and data systems, to improve access, coordination, and quality of health services across British Columbia.
Source: BC Ministry of Health, Provincial Digital Health Strategy, 2023.

Electronic Health Record (EHR) – A secure, longitudinal record of a person's health information that can be shared among authorized healthcare providers to support coordinated care.
Source: BC Ministry of Health, eHealth and Health Gateway Program.

Health Authority – A public body established under the Health Authorities Act responsible for planning, managing, and delivering health services within a defined geographic area, or province wide in the case of the Provincial Health Services Authority and the First Nations Health Authority.
Source: Health Authorities Act (RSBC 1996, c.180).

Health Connect Registry – A provincial Ministry of Health program that matches individuals who do not have a primary care provider with a family doctor or nurse practitioner accepting patients in their community.
Source: HealthLinkBC, 2025.

HealthMatch BC – A provincial recruitment service operated by the Provincial Health Services Authority that assists physicians, nurses, and allied health professionals in relocating and registering to practice in British Columbia.
Source: HealthMatch BC, PHSA, 2025.

Integrated Care – The coordinated delivery of health and social services across providers, sectors, and settings to ensure continuity and improve health outcomes.
Source: BC Ministry of Health, Primary Care Strategy, 2018.

Longitudinal Care – See Continuity.

Ministry of Health (BC MoH) – The provincial government body responsible for setting health policy direction, allocating resources, stewarding the health system, and ensuring equitable access to services for all British Columbians.
Source: Government of British Columbia, Ministry of Health Mandate.

Mobile Care – Delivery of healthcare services through mobile clinics, outreach teams, or travelling providers who bring primary and preventive care directly to people in their communities, particularly in rural and remote regions
Source: BC Ministry of Health, Primary Care Strategy, 2018.

Patient Medical Home (PMH) – A family practice that provides longitudinal, comprehensive and coordinated primary care in which primary care providers work in teams with other health care professionals to provide accessible, high-quality care for their patients.
Source: Adapted from t*he College of Family Physicians of Canada (CFPC) and the Doctors of BC*

People Centred Care – An approach to health service design and delivery that respects and responds to the preferences, needs, and values of individuals, families, and communities.
Source: World Health Organization, adapted by BC Ministry of Health, 2018.

Personal Health Record (PHR) – A secure, digital record that allows individuals to view, manage, and share their own health information collected from multiple sources, such as laboratory results, medication histories, and immunizations. In British Columbia, personal health records are accessed through the Health Gateway, which provides residents with online access to their health data and supports coordination of care.
Source: BC Ministry of Health, Health Gateway Program; Provincial Digital Health Strategy, 2023.

Population Based Funding – A method of allocating health system resources based on the demographic and health needs of a defined population.
Source: BC Treasury Board and Ministry of Health Planning Framework.

Primary Care – The first level of contact in the healthcare system, usually delivered by family doctors, nurse practitioners, or interdisciplinary teams, providing preventive, diagnostic, treatment, and coordination services.
Source: HealthLinkBC, 2025.

Primary Health Care – A broader concept that includes primary care as well as health promotion, disease prevention, community development, and intersectoral action to improve population health.
Source: World Health Organization; BC Primary Care Strategy, 2018.

Primary Care Network (PCN) – A collaborative structure within a geographic area that connects family practices, community clinics, health authorities, and allied providers to deliver team based, coordinated care.
Source: BC Ministry of Health, Primary Care Strategy, 2018, and PCN Policy, 2019.

Public Body – A ministry, local government body, health care body, or other agency listed under Schedules 2 and 3 of the Freedom of Information and Protection of Privacy Act.
Source: BCEA Policy and Procedure Manual, Definitions Master List.

Quality Improvement (QI) – A continuous, data driven process for improving health system performance, patient outcomes, and service delivery.
Source: BC Patient Safety and Quality Council.

Real Time Virtual Support (RTVS) – A network of on call virtual clinical supports operated by the Rural Coordination Centre of BC that enables rural and remote providers to access immediate peer consultation from specialists.
Source: RCCbc, 2024.

Rural and Remote Health Services – Health services delivered to communities classified as rural or remote under British Columbia's Rural Practice Subsidiary Agreement, often supported by dedicated incentives and programs to ensure access and equity.
Source: BC Ministry of Health and Doctors of BC, RSA Framework.

Scope of Practice – The activities regulated health professionals are authorized and competent to perform, as defined by their regulatory college under the Health Professions and Occupations Act.
Source: BC College of Nurses and Midwives; College of Physicians and Surgeons of BC.

Social Determinants of Health (SDOH) – The social, economic, and environmental conditions such as income, education, employment, and housing that influence individual and population health.
Source: BC Centre for Disease Control; BC Ministry of Health, Population and Public Health Division.

Sustainable Funding – Long term, predictable financial support for health services that ensures operational stability, staff retention, and community accountability.
Source: BC Ministry of Health, Primary Care Funding Framework.

System Navigator – A trained health or social services professional who assists patients in navigating the healthcare system and related community supports. System Navigators help coordinate care across providers and settings, assist with scheduling and referrals, provide education about available services, and support patients in overcoming barriers such as geography, literacy, cost, or cultural unfamiliarity.
Source: Adapted from BC Ministry of Health Primary Care Strategy, 2018; HealthLink BC; and BC Cancer Patient Navigation Program

Team Based Care – A coordinated approach where physicians, nurse practitioners, nurses, allied health professionals, and other providers collaborate to deliver comprehensive care to patients.
Source: BC Ministry of Health, Primary Care Strategy, 2018.

Trauma Informed Practice – An approach that recognizes the prevalence and impact of trauma and integrates that understanding into all aspects of care to promote safety, choice, and collaboration.
Source: BC Ministry of Mental Health and Addictions; PHSA Provincial Violence Prevention Framework.

Urgent and Primary Care Centre (UPCC) – Centres providing same day, urgent, non-emergency primary care for people who need medical attention within 12 to 24 hours but do not require emergency department services.
Source: BC Ministry of Health, UPCC Policy Framework.

Virtual Care – Any remote interaction between patients and providers using communication or information technologies to deliver or enhance care. Virtual care must meet the same professional and ethical standards as in person care.
Source: College of Physicians and Surgeons of BC, Practice Standard, 2024.

Workforce Planning – The process of forecasting, training, and deploying the health workforce to meet population needs through collaboration among ministries, health authorities, and professional colleges.
Source: BC Ministry of Health, Health Human Resources Strategy.

Contributors

Leslie Keenan, Executive Director, Shoreline Medical Society

Prior to joining Shoreline Medical in October/24, Leslie spent 13 years leading the South Island, Nanaimo, and North Shore Divisions of Family Practice. All of these experiences provided her with insights into what drives innovation and satisfaction in the delivery of primary care. Leslie was a registered nurse for over 40 years (license retired 2023) with a bachelor's degree - Leadership in Justice and Public Safety, SFU. Additionally, her background includes teaching at the Justice Institute of BC; Chief Licensing Officer, Vancouver Coastal Health; Manager Licensing Investigations, MoH; Manager Assisted Living for Richmond, North Shore & Sunshine Coast, VCH; Program Auditor, Interior Health. She lives on the Peninsula, enjoys yoga, hiking & kayaking, often with her pup Ollie.

Curt J. Firestone

Former Deputy Director: San Mateo County Mental Health Services; former Executive Director: North Coast Regional Development Disabilities Center; Founder and first President: Salt Spring Community Health Society; Former Board member: BC Rural Health Network and BC Health Care Matters; Founding team member: Salt Spring Health Advancement Coalition. Arriving in British Columbia only to learn that BC did not offer all residents a primary care provider, Curt and his wife found themselves actively involved in healthcare advocacy. 19 years later, basic improvements still motivate Curt. He wants to witness a time when every resident has a patient care home, when team healthcare is universal, when health professionals get diagnostic information in less than 24 hours and when quality of BC life is not ruined by the absence of timely specialty services. His hope is that BC will provide 21st century healthcare universally.

Paul Adams, Executive Director, BC Rural Health Network

As Executive Director of the BC Rural Health Network (BCRHN), Paul is committed to advancing equitable access to health care for rural, remote, and Indigenous communities across British Columbia. His professional path has evolved through community leadership, systems innovation, and policy advocacy, always rooted in the lived realities of rural people. Paul lives, works and plays on the unceded homelands of the Sylix people in the Upper Similkameen region of BC. A husband, father and grandfather, Paul is determined to leave a legacy of health and wellness for future generations.

Valerie St John, Executive Director, BC Association of Community Health Centres

Valerie St. John has served as the Executive Director of the BC Association of Community Health Centres (BCACHC) since July,2020. She has worked in a number of capacities in B.C.'s health sector for 15 years prior to joining BCACHC holding roles such as Assistant Deputy Minister – Health HR Planning, Ministry of Health, Assistant Deputy Minister – Technology Solutions, Shared Services BC, and Chief Executive Officer -Nurses and Nurse Practitioners Association of BC.. Val's passion is a focus on system level change in support of health service excellence and thriving communities. She brings this passion to the work she leads at BCACHC and values the relationships and connections she has made along the way. She sits on the Boards of the BC Rural Health Network and previously sat on the Steering Committee of the BC Health Coalition. Val holds a Master of Arts Degree – Conflict Analysis and Management (Royal Roads University) and strives to identify shared values and goals as a way to build the necessary collaborations required for complex system transformation.

Dr. Tahmeena Ali, President, Family Doctors of BC

Dr. Tahmeena Ali has practiced full-scope family medicine since 2002. She started her career in rural Alberta where she did everything from obstetrics (without c-section back up!) to emergency room shifts and hospital care. Since moving to British Columbia in 2012, she continues to practice hospital based and longitudinal community family medicine in a clinic that she co-owns and is medical director of. Her medical leadership reflects her diverse interests and practice settings: from chief of medical staff of a rural hospital to past president of BC Family Doctors and past chair of the White Rock/South Surrey Division of Family Practice. She often consults as a medical expert on medicolegal cases and for the Ministry of Health's billing integrity program. Outside of medicine, she enjoys spending time with her 3 teenagers, her husband, rowing on the Nikomekl river and writing fiction and non-fiction.