CITY OF DELTA
Primary Care Needs Assessment

Final Report

March 24, 2026

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Report Objectives & Outcomes

The City of Delta seeks to better understand primary care needs and capacity in the region, as well as options and feasibility for the municipality to play a role in enhancing primary care services.

Objectives

- Conduct **data-driven assessment** to understand primary and urgent care needs and capacity in the City of Delta
- Understand **potential models (UPCCs and others)** that the City of Delta can enable to improve primary care access
- Assess **feasibility and implications** of the City establishing a UPCC, or similar alternative models to improve primary care access

Outcomes

- ✓ **High-level indication of the City of Delta's primary care needs and service gaps**
- ✓ **Understanding of different primary care models and potential role(s) for the City**
- ✓ **Actionable considerations to guide City Council's decisions and future direction**
- ✓ **Foundation for detailed planning**

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Health System Levels of Care

At the highest level, health care delivery is organized into various levels of care, including primary, secondary, and tertiary services, with primary care serving as the foundation and first point of contact[1]. In BC, publicly funded health care is usually delivered through Health Authorities, community programs, and independent providers.

Focus of this report

PRIMARY CARE

Primary care is the "front door" focusing on early assessment, including check-ups, prevention, early diagnosis of common issues, chronic disease management, and navigation/ referrals to the rest of the system.

Primary Care includes:
- Episodic care (Walk-in Clinics)
- Longitudinal/ongoing care (Family Doctor, Nurse Practitioners)
- Team-based Care (Nurses, Social Workers, Counselors, Physical Therapists, Pharmacists, etc.)

SECONDARY CARE

Secondary care is specialist care for issues that require more focused expertise and often referrals from a primary care provider.

Secondary Care includes:
- Care delivered by specialist physicians such as neurologists, dermatologists, cardiologists, etc.
- Delivery of care in specialist clinics and hospital outpatient clinics
- Diagnostics and procedures

TERTIARY CARE

Tertiary care highly specialized, resource intensive care; usually for complex, severe, or life-threatening injuries or conditions. Care is also often emergent, and relies on advanced technologies (i.e. CT, MRI), specialized teams (i.e. surgeons), and hospital infrastructure (i.e. ICU).

Tertiary Care includes:
- Hospital-based care delivery, including diagnostics and procedures
- Advanced diagnostics and procedures

[1] *Grounded in the World Health Organization's Primary Health Care framework, articulated in the Declaration of Alma-Ata (1978)*

EXECUTIVE SUMMARY

Signals from Current-State Data Analysis

Delta's primary care demand, capacity, and access patterns broadly reflect regional and provincial trends, with variation across Delta communities. Delta residents do seek care from neighboring cities, highlighting the regional nature of care access and planning, as well as the potential role of individual choice (e.g., access closer to work or school, or provider preference).

Community Profiles & Health Needs

Delta exhibits **distinct demographic and health profiles** by community, with **faster growth and greater diversity in North Delta** and **older populations in Ladner and Tsawwassen**, alongside elevated chronic disease prevalence across all three communities. This signals **a common need for continuity and chronic disease management**, with differing local emphases.

Attachment & Cross-Boundary Care

Attachment rates vary by community, with **lower reported attachment in North Delta** and **higher attachment in Ladner and Tsawwassen**. A significant share of residents **receive care outside municipal boundaries**, particularly in Surrey, reflecting **Primary Care Network geography, proximity, and resident choice.**

Workforce Capacity & Infrastructure

Limited physician supply and upcoming retirements point to **system-level pressures that affect the region and province**, rather than Delta-specific outliers. Workforce capacity is highly influenced by practice models, work patterns, and infrastructure constraints, rather than municipal boundaries alone.

Access & Emergency Use

Residents access care through a mix of **longitudinal clinics, UPCCs in South Delta and Surrey, EDs, and virtual care**. Episodic (e.g., walk-in) care options for people unattached or with urgent care needs are limited but expanding through UPCCs, both within Delta and nearby in Surrey.

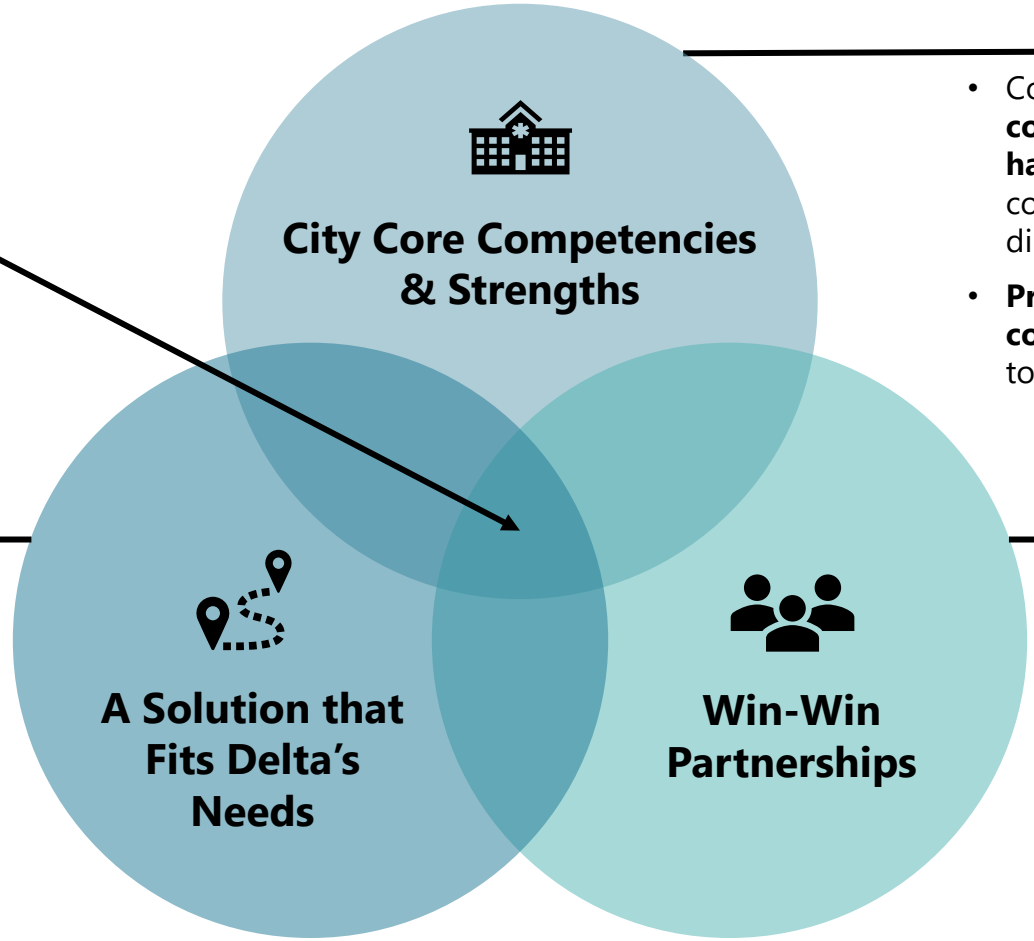
The City of Delta's primary care needs and capacity reflect system-wide challenges across BC., The data suggests an **opportunity for the City to focus its efforts on targeted, place-based actions** that align with existing Primary Care Network plans, **supporting in ways that best leverage a municipality's capacity and strengths, while complementing regional health-sector initiatives**.

EXECUTIVE SUMMARY

Key Considerations for the City of Delta's Role in Enabling Primary Care

To determine where the City could have the most value-add impact on primary care, the City needs to consider what its core competencies are, which targeted areas on which the City wants to make an impact, and what partnership-driven actions the City can take to complement—not duplicate—health sector services and initiatives.

The intersection of these factors identifies priority areas where the City could consider investing time, energy, and funding to support primary care service delivery.



- Consider roles that **align with the City's core competencies** or where the City **could have the strongest impact** (e.g., options could include advocating, enabling, or directly delivering services).
- **Prioritize levers that the City can directly control** (e.g., planning/policy, assets, zoning) to reduce barriers and accelerate action.

- Consider **which primary care needs and gaps the City wants to prioritize in making an impact**, and the **timeframe** in which benefits/outcome will need to be realized.
- These strategic decisions will **inform where the City should direct its investments, resources, and energy** towards a 'Made in Delta' solution.

- Consider opportunities that **align with priorities and interests of residents, providers, the City, and health system partners.**
- Promote continued collaboration and partnerships across relevant parties.
- Focus on place-based solutions that **complement existing regional and provincial health system plans**, while showcasing municipal leadership.

EXECUTIVE SUMMARY

Determining Priority Focus Area and Service Delivery Model

City leadership needs to decide and articulate which aspect(s) of primary care the City wants to prioritize in making an impact and the time frame in which benefits/outcome will need to be realized; this will guide where the City could direct its investments, resources, and energy in enabling primary care.

1 Enhance access to primary care and urgent / non-emergent services **for people who are unattached** or **unable to access their primary care provider**

Focus on

Episodic primary care services, such as:

- Walk-in clinics
- UPCCs (*without longitudinal services*)
- Episodic virtual care services
- Pharmacist–led minor ailments clinics

2 **Promote health** through improved access to a **regular, longitudinal primary care team** that can provide preventative care and chronic disease management

Focus on

Longitudinal, team-based primary care services, such as:

- Family Health Teams
- Community Health Centres

The City **may pursue both approaches in parallel** by taking **near-term actions to address immediate access gaps**, while simultaneously laying the groundwork for **longer-term investments that expand longitudinal primary care capacity**.

It will also be important for the City to collaborate and coordinate **with regional and provincial health system partners to align on actions that are accretive to broader regional/provincial planning.**

EXECUTIVE SUMMARY

Supporting Short-term Episodic Primary Care Needs

The City can help address short-term episodic primary care access gaps by advocating for and enabling local care models that expand urgent and same-day care capacity for residents who are unattached or unable to access timely care.

KEY CONSIDERATIONS

This approach:

- Addresses **short-term access needs** without attachment; does not address need for longitudinal care
- Can **address urgent/non-emergent care needs** (for which citizens may otherwise go to ED), rapidly growing population centres, or capacity shocks
- Yields **shorter-term benefits**, such as contributing to reduction of CTAS 4/5 rates in local EDs. The City should therefore consider pursuing this option **in conjunction with efforts to increase attachment to reduce demand for episodic care**

POTENTIAL OPTIONS

1 **Continue to advocate for the opening of a UPCC in North Delta***

Example: City of Delta advocated for the opening of the South Delta Urgent & Primary Care Centre

2 **Contract a private provider to operate a clinic that the City owns***

Example: City of Surrey contracting with Total Life Care Granville Medical to open two new primary care clinics

3 **Promote or contract with private pharmacies to open clinics for minor ailments**

Example: City of Surrey promoted new Pharmacy Care Clinics opened by Shoppers Drug Mart to treat minor ailments

***Note:** Depending on the clinic service model chosen, these options could also address longitudinal care needs*

EXECUTIVE SUMMARY

Improving Long-Term Health through Longitudinal Primary Care

The City may also choose to focus on improving long-term health outcomes by increasing capacity for longitudinal primary care (i.e., for residents to attach to primary care/family medicine teams for prevention, chronic disease management, and continuity of care) through different partnership options or direct service delivery.

KEY CONSIDERATIONS

This approach:

- Addresses needs for **prevention**, **chronic disease management**, and **improved population health**
- Promotes **equitable access to care for underserved populations** who would otherwise be unattached
- Is aligned with **provincial priorities** (e.g., shift to team-based models of care, new SFU medical school, health system productivity)
- Potentially has **longer timeline for benefits realization** and more **complex plan for activation**

POTENTIAL OPTIONS

1 **Own and operate a primary care clinic***

Example: City of Colwood operating the Colwood Clinic

2 **Partner with an academic institution to open a team-based care clinic & training site***

Example: McMaster Family Health Team

3 **Identify and incentivize partners (e.g., non-profit organizations) to create and govern a new community health centre (CHC)***

Example: Lily Lee Community Health Centre, a partnership between Vancouver Coastal Health and the Vancouver Chinatown Foundation

***Note:** Depending on the clinic service model chosen, these options could also address episodic care needs*

EXECUTIVE SUMMARY

City Levers to Enable Growth of Primary Care Capacity

The City can use its municipal core strengths to support the delivery and expansion of primary care services without directly delivering care. **Coordinated action with regional and provincial health partners will be critical to identifying where municipal involvement is most value-add and aligned with broader system planning.**

Infrastructure support: Access to affordable, appropriately zoned clinical space is a key barriers to primary care expansion. The City can offer infrastructure support to accelerate clinic development and enable partners to deliver services where and when they are most needed.

1. **Provide city assets (e.g., infrastructure, land) that could support new or enable existing clinics to expand services**
2. **Leverage Community Amenity Contributions (CACs) to incentivize developers to create infrastructure for clinics**
3. **Leverage city policy levers (e.g., zoning) to support clinics**

Recruitment and retention support: The City can improve the attractiveness and sustainability of primary care practice in Delta by using municipal levers—such as incentives, housing and relocation supports, practice-ready space, and community integration—to help ecosystem partners attract, retain, and stabilize the primary care workforce.

1. **Support recruitment campaigns for new providers**
2. **Offer incentives to support recruitment (e.g., tax incentives, relocation support, subsidies) for new providers**
3. **Subsidize overhead costs of clinic operations**

EXECUTIVE SUMMARY

Activating a Win-Win Partnership: An Illustrative Model

Creation of a longitudinal primary care teaching clinic in Delta, anchored by an academic partner (such as the new SFU Medical School), could be an example of an innovative win-win partnership that enhances care for patients, leverages capabilities and assets of key partners, and addresses strategic priorities of partners involved.

This model would enable delivery of cost-effective team-based care, thereby providing **opportunity for Delta residents to attach to a care team**. This would also serve as a training site to support the development of the **next generation of family physicians**, who would have **interest and desire to live and grow within a community**.

Please note that **this model is presented for illustrative purposes only**. Roles for illustrative partners below have been identified based on partnership models that enable similar academic clinics in other jurisdictions. Illustrative partners have not been consulted to confirm the applicability or feasibility of this model for BC.

Illustrative Partners	Delta	SFU Simon Fraser University	fraserhealth	British Columbia
Potential Role in Activating Model	• Provide a site for a clinic (e.g., city-owned property, or in partnership with a developer) • Consider tax incentives to reduce clinic operating costs	• Recruit primary care physicians • Establish a teaching unit • Recruit a partner to professionally operate the clinic • Establish a plan for the clinic to self-fund operational costs (e.g., 25% overhead fees paid by physicians)	• Provide allied health professional staff (e.g., nurses, social workers, physiotherapists) to enable team-based care at the clinic	• Fund the clinic through existing longitudinal contracts and MSP funded services • Support scope of practice policy to promote delivery of team-based care at the clinic
Possible Key Benefits (that matter for the Partner)	• Longer-term improvement in health outcomes by increasing attachment for Delta residents and improving access to team-based longitudinal care, chronic disease management, and preventative care • Potential recruitment tool for the City, as medical students/residents may be more likely to stay in the community where they train	• Access to a community-based teaching site aligned with the medical school's mandate to train family physicians in the delivery of team-based care • Opportunities for practice-based research and innovation in primary care models and workforce sustainability	• Possible reduction in emergency department use for avoidable visits that could be more cost effectively delivered by primary care services in the community • Possible reduction in acute care demand, as chronic illnesses are better managed more cost effectively in the community	• Advancement in provincial priorities to promote attachment and team-based longitudinal primary care • Shifting care to more cost-effective community and team-based primary care service models • Addressing workforce development and retention by training more family physicians in BC

EXECUTIVE SUMMARY

Broader Health & Social Context

An individual's health and wellness—and a community's population health—are strongly shaped by social determinants of health such as income, housing, transportation, social connection, and cultural safety. **Beyond supporting episodic and longitudinal primary care models, the City can meaningfully improve health outcomes by addressing the social determinants of health within its influence, in alignment with the City's *Social Action Plan*.**

Strategic Opportunity 2.4
Improve walkability

Strategic Opportunity 2.14
Improve coordination in reducing poverty & food insecurity

Strategic Opportunity 5.22
Support seniors to age in place

Strategic Opportunity 6.24
Increase affordable, supportive, and transitional housing options

Strategic Opportunity 7.28
Enhance physical accessibility through the built environment

It is critical to maintain strong partnerships and collaborations with the health sector and community partners, to ensure municipal action is enabling and complementary, rather than duplicative.

Diagram adapted from Comox Valley Community Health Network· Determinants of Health

PART 1

Context & Approach

CONTEXT & APPROACH

Project Background

The City of Delta seeks to better understand primary care needs and capacity in the region, as well as options and feasibility for the municipality to play a role in enhancing primary care services.

Health Challenges identified in the Delta Social Action Plan 2023 – 2028 (*pg 36*):

Primary Care Shortages

Delta family practitioners retiring, challenging to attract new physicians; lack of awareness of existing wraparound supports/services.

Service Provisions

The region is served by two distinct Divisions of Family Practice: North and South Delta. Not all services are available across the two divisions, leading to gaps.

Complexity & Waitlists

Patients have increasingly complex needs; however many remain on waitlists and do not have access to specialized services (incl. culturally relevant/safe care).

Report Objectives & Outcomes

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✓ **High-level indication of the City of Delta's primary care needs and service gaps**

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✓ **Actionable considerations to guide City Council's decisions and future direction**

✓ **Foundation for detailed planning**

CONTEXT & APPROACH

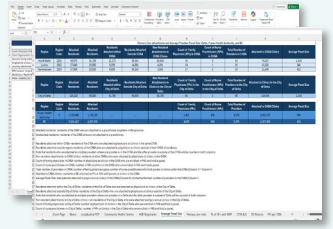
Project Approach

Our approach was informed by document reviews, quantitative data analysis, stakeholder interviews, research on case studies.

Approach

1) **Quantitative Data Analysis:** Collected and analyzed available data to assess current state.
2) **Qualitative Validation:** Contextualized and validated quantitative findings through engagement with North and South Delta Divisions of Family Practice, Fraser Health, and City of Delta social team.
3) **Case Study Interviews:** Interviewed leaders from Gorge UPCC, Colwood Clinic, and Subject Matter Experts to gather lessons learned from existing primary care service models.
4) **Model Options Identification and Validation:** Leveraged research, internal knowledge, and interviews to develop and validate model options in collaboration with City representatives.
5) **Synthesis and Reporting:** Integrated quantitative and qualitative insights to develop the final report.

Quantitative Data Analysis



Quantitative Data Tables

Leveraging data from tables collected from the Ministry of Health, particularly regarding metrics such as:

- Attachment and access (Health Connect Registry, Virtual Care)
- Workforce (Family Physicians, Nurse Practitioners)
- Modalities of Care (Hospital ED Access, Community Health Centres)

Secondary Research

Delta Social Action Plan 2023-2028

An action plan and strategic framework that guides the City's policy interventions, decisions and resource allocations in social planning over the next five years.

- **Case Studies of Primary Care Models**
- **News Articles**
- **Research on City of Delta resources, demographics, and community profile**

CONTEXT & APPROACH

Health System Levels of Care

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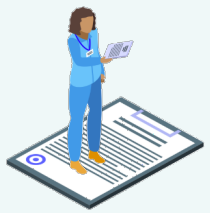
TERTIARY CARE

Tertiary care highly specialized, resource intensive care; usually for complex, severe, or life-threatening injuries or conditions. Care is also often emergent, and relies on advanced technologies (i.e. CT, MRI), specialized teams (i.e. surgeons), and hospital infrastructure (i.e. ICU).

Tertiary Care includes:
- Hospital-based care delivery, including diagnostics and procedures
- Advanced diagnostics and procedures

PATIENT EXAMPLE

Amy sees her family doctor at their clinic because she is noticing allergy symptoms to certain fruits.

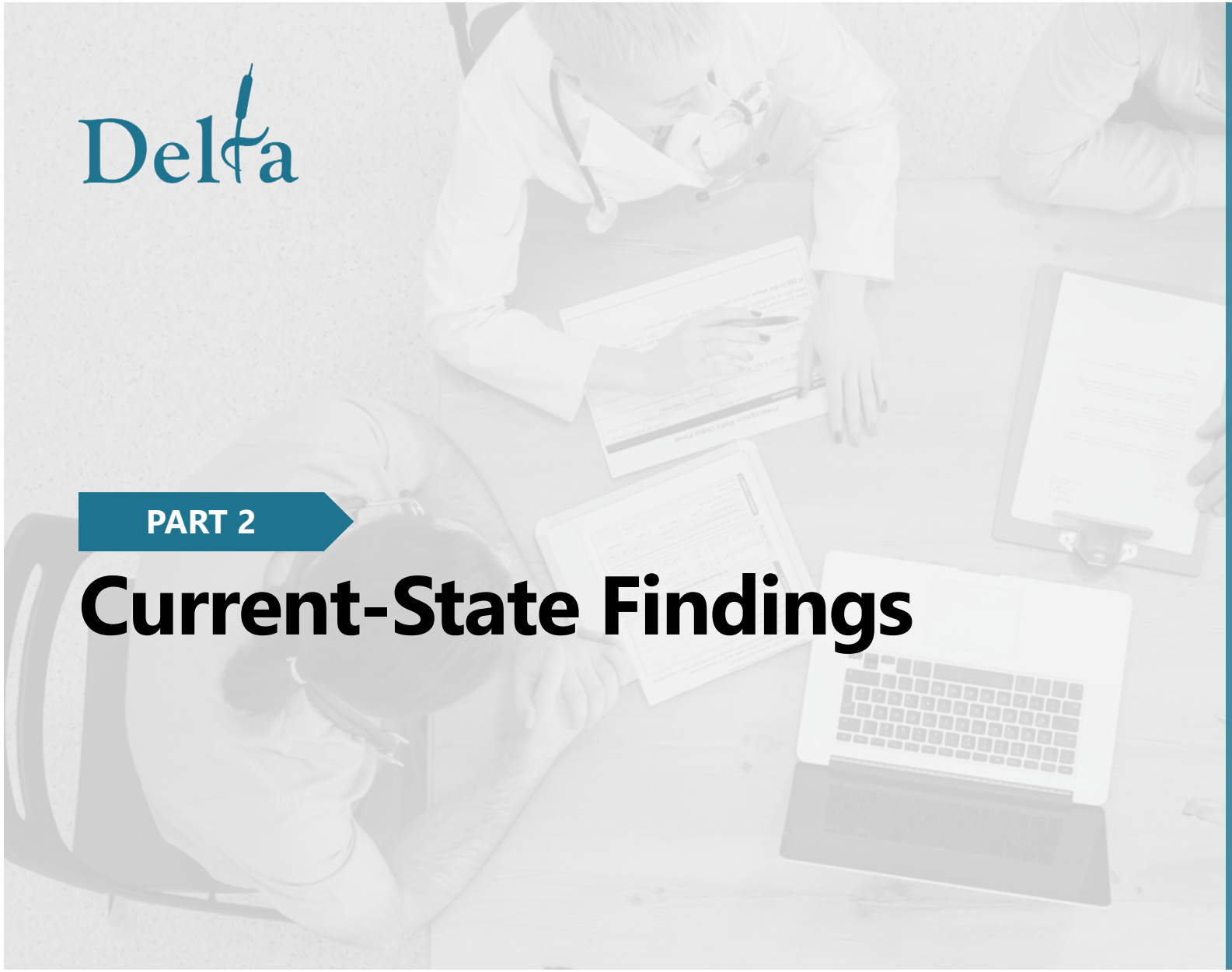


Amy's family doctor refers her to a specialized allergist to determine the cause and severity of her symptoms.

While waiting for her allergist appointment, Amy eats something that triggers an anaphylactic shock. She is taken to hospital by ambulance to treat her emergent symptoms.

Health care spans a continuum, from prevention and harm reduction, to rehabilitation and palliative care. Community supports, such as mental health care, and services related to cultural, housing, transportation, food security, and social connection are all important towards improving community health outcomes.

[1]*Grounded in the World Health Organization's Primary Health Care framework, articulated in the Declaration of Alma-Ata (1978)*



PART 2

Current-State Findings

DATA ASSUMPTIONS & LIMITATIONS

- Findings in this section are based on available administrative and secondary data and a small set of stakeholder engagement (see Appendix A for list of stakeholders consulted).
- Given that primary care delivery is highly complex and contextual, available quantitative indicators alone cannot be used to deduce conclusions on primary care demand, primary care capacity / supply, care quality, or patient experiences.
- Results should be interpreted as indicative signals, not definitive conclusions.
- Further engagement with patients and providers, Ministry of Health, Divisions of Family Practice, Primary Care Networks, Health Authorities, and community partners is recommended to supplement available data, confirm understanding and implications of resource allocations in the City/region, and inform strategies and actions that will best meet community needs.

CURRENT-STATE FINDINGS

City of Delta | Demographic Snapshot

Distinct population and health profiles across Delta create uneven primary care demand: North Delta has a younger, faster-growing, and culturally diverse population; while Ladner and Tsawwassen have growing senior populations.

NORTH DELTA

Population Overview:

- **Highest population growth** in the last decade, with greater proportion of children, youth and working adults[1,2]
- **Large immigrant population (41%) and high proportion of visible minority residents (63%)**, reflecting substantial cultural, ethnic, and linguistic diversity[3]

General Health:

- **Cardiovascular and metabolic condition incidence is higher,** e.g. hypertension (+12% higher than BC) and diabetes (+60% higher than BC)[4]
- 49.6% of adults (18+) reported a strong sense of **community belonging**[4]

LADNER

Population Overview:

- **Slow population growth rate** (3.7% vs 8.5% in North Delta from 2016 - 2021)[2]
- Lower population of immigrants (23%) compared to North Delta[5]
- **Higher share of seniors** (65+) at 23%[5]

General Health:

- **Age-related conditions are prevalent**, including higher heart failure and stroke incidences than BC (+23.1% heart failure, +14.6% hospitalized strokes, +60% MI acute cardiac events)[6]
- **Dementia and Alzheimer's disease burden is notably higher in comparison to BC averages**, with +27% prevalence and +12.7% incidence respectively [6]
- 63.2% adults (18+) reported a strong sense of **community belonging**[6]

TSAWWASSEN

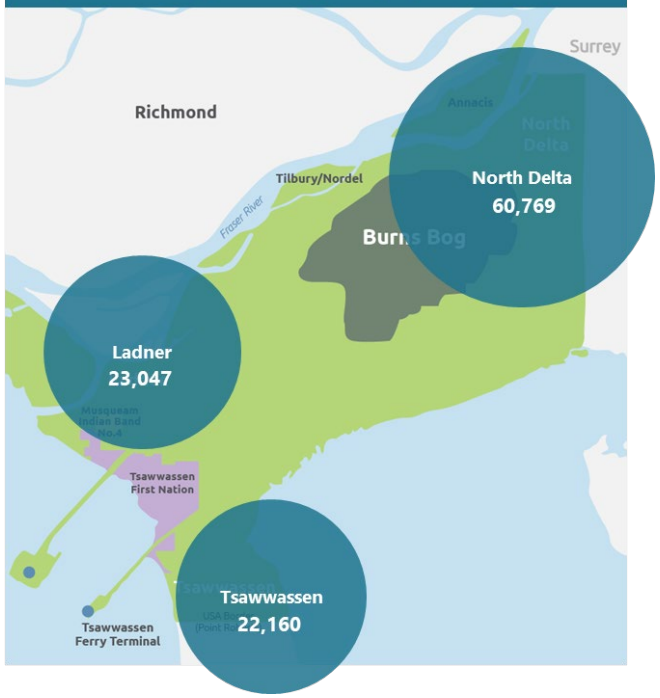
Population Overview:

- **Highest proportion of seniors** (65+) in Delta and compared to BC (28% vs. 19% in BC, or 21% overall in Delta)[7]
- **Increasing population growth**[7] (9.6% from 2016-2021 vs 6.1% in Delta or 7.6% in BC) compared to 0.7% between 2011-2016[7]

General Health:

- **Higher cancer incidences compared to provincial averages** (+34% higher than BC or 750.8 per 100,000 vs 560 per 100,000 in BC)[8]
- 57.5% adults (18+) self-reported a strong sense of **community belonging**[8]

City of Delta Map incl. Regional population size



**Note: Tsawwassen First Nation is a separate Treaty Nation that is surrounded by Delta on three sides.*
Population data collected from MoH - February 2026

Delta's demographic profiles, with 21% aged 65+ (vs. ~17% regionally) and increasing diversity (45% visible minorities and 33% immigrant population)[9], **signal specific needs across each community**.

Data sources: [1] City of Delta Social Action Plan 2023-2028; [2] Census 2021; [3] City of Delta Community Profiles (North Delta), [4] North Delta Community Health Profiles; [5] City of Delta Community Profiles (Ladner), [6] Ladner Community Health Profiles, [7] City of Delta Community Profiles (Tsawwassen), [8] Tsawwassen Community Health Profiles, [9] 2021 Census Data (Metro Vancouver & Delta)

CURRENT-STATE FINDINGS

City of Delta | Overall Health Care Needs

As Delta's population grows and diversifies, and given the chronic disease prevalence within the City, there is a need for reliable primary care support, particularly for residents who are seeking attachment to a family doctor or nurse practitioner. This need mirrors broader regional and provincial trends in BC.

Attachment rates in Delta, defined here as having a Most Responsible Practitioner (MRP), **differ across communities,** with rates slightly lower than provincial averages in North Delta, and higher in South Delta communities[1].

74% ▼
Adults 18+ in **North Delta** report having an MRP

87.9% ▲
Adults 18+ in **Ladner** report having an MRP

85.4% ▲
Adults 18+ in **Tsawwassen** report having an MRP

78.3% Adults 18+ across **FHA** report having an MRP

77.4% Adults 18+ in **BC** report having an MRP

Attachment pattern for North Delta residents both within and outside of the City highlights the regional nature of care access and planning, especially given close proximity of North Delta and Surrey, as well as the potential role of individual choice (e.g., proximity to work/school, or provider preference).[1]

~52k Residents of **North Delta** are attached to an MRP

~13k Residents attached **within** North Delta

~39k Residents attached **outside** of North Delta

~61k Residents of communities outside of North Delta are attached **within** North Delta

While North Delta has the lowest percentage of adults with MRP, its **number of registrants to the Health Connect Registry (HCR)[2] is lower than the provincial average**. Lower HCR registrations seen in Tsawwassen and Ladner align with higher attachment rates in those communities. It's important to note that the HCR is just one component of measuring attachment and is part of the larger Provincial Attachment System (PAS) that also includes a clinic and panel registry[3].

~48.5
HCR registrants per 1K residents **awaiting attachment** in **North Delta**

~36.9
HCR registrants per 1K residents **awaiting attachment** in **Ladner**

~42.0
HCR registrants per 1K residents **awaiting attachment** in **Tsawwassen**

~43.8
HCR registrants per 1K residents **awaiting attachment** across **FHA**

~62.1
HCR registrants per 1K residents **awaiting attachment** in **BC**

What is the Health Connect Registry (HCR)?
A centralized, provincial waiting list to support attachment to a family doctor or nurse practitioner. HCR is a component of BC's Provincial Attachment System, which provides insights into provider capacity.

Attachment rate and demand differ across communities. Delta residents do seek care outside of municipal boundaries (*e.g., those who live close to the Scott Road / 120th Street corridor*), which is a common and intentional feature of BC's regional Primary Care Network design.

[1]Data up to Dec 31, 2025 collected from MoH – Feb 2026; [2]HealthLink BC – Health Connect Registry (HCR); [3]Government of British Columbia – Provincial Attachment System (PAS)

CURRENT-STATE FINDINGS

City of Delta | Health Care Capacity

Delta's primary care capacity largely reflects broader provincial challenges and patterns, with some local variation in physician supply and panel sizes. Local context on physician availability and capacity must also be considered in understanding the quantitative data.

On average, **Delta has lower number of family physicians per resident compared to BC's average**[1]. However, physician capacity should be considered at a regional level, rather than at a municipal level, as physicians in other neighboring municipalities serve Delta residents (e.g. providers along the Scott Road / 120th Street corridor serve both North Delta and Surrey residents).

Delta's patient panel sizes are higher the BC average[1] but aligned with the BC Ministry of Health's attachment target of 1250 patients/physician[2]. Panel size comparisons are highly contextual and influenced by practice models, physician experience, part-time work, and contract arrangements.

Note: *Comparisons between Delta and provincial metrics may not be valid, as provincial averages include NPs and rural physicians, both of whom typically serve smaller panels than urban physicians.*

64.4 ▼
Family physicians per 100,000 people in **North Delta**

86.8 ▲
Family physicians per 100,000 people in **Ladner**

61.8 ▼
Family physicians per 100,000 people in **Tsawwassen**

71.2
Family physicians per 100,000 people in the **City of Delta**

64.2
Family physicians per 100,000 people across **FHA**

81.9
Family physicians per 100,000 people in **BC**

1,645 ▲
Attached Patients per physician in **North Delta**

1,300 ▲
Attached Patients per physician in **South Delta**[4]

995
Attached patients per physician across **FHA**

824
Attached patients per physician in **BC**

Retirement & Recruitment

A cohort of established physicians in **North Delta currently serving ~30,000 patients** are approaching retirement (based on DoFP projections using graduation dates).[3]

While some physicians may elect to extend their overall time in practice to mitigate the impact, this reflects a system-wide workforce challenge that affects Delta, the region, and the province.

Upcoming physician **retirements may create transitional pressures**; however, this is a **system-level pressure, not a Delta-specific outlier**. The impact of retirements will be influenced by regional workforce responses, replacement capacity, and system-level mitigation efforts.

[1]Data up to Dec 31, 2025 provided by MoH – Feb & Mar 2026; [2]Government of British Columbia, Longitudinal Family Practice (LFP) Payment Schedule, Feb 23 2026; [3]SND Division of Family Practice Interview, February 2026; [4]Revised Data Provided by South Delta Division of Family Practice

CURRENT-STATE FINDINGS

City of Delta | Health Care Access & Modalities

Residents of Delta have various entry points into the primary care system, including attachment to a family physician roster for longitudinal care, urgent same-day services in South Delta and in the City of Surry, and virtual care. Infrastructure gaps limit the ability for Primary Care Networks to expand services.

While there are limited options for episodic / walk-in services *within the City,* Delta residents can access care from neighboring facilities such as the two UPCCs in Surrey N. Delta community and clinics on the Scott Road / 120th Street corridor that are near North Delta. Some longitudinal clinics also provide walk-in services.

Delta Community	Total Clinics in the City of Delta [1,2,3]
Ladner	6 Longitudinal, 0 Episodic
Tsawwassen	2 Longitudinal, 1 Episodic (South Delta UPCC)
North Delta	23 Longitudinal, 1 Episodic (walk-in)
City Total	**32 Longitudinal, 2 Episodic**

Infrastructure Gaps

Stakeholders report significant infrastructure constraints for clinics, related to overhead costs and zoning limitations.

Over 40% of all Emergency Department (ED) Visits at Delta Hospital are low acuity; this signal in ED utilization patterns may reflect primary care access challenges, though further analysis is required to determine causation as CTAS 4-5 scores alone are not a sufficient indicator.

44.4%

ED visits are CTAS 4-5 (lower acuity) at **Delta Hospital,** 2024/25

Annual Visits

Average number primary care visits per patient in Delta (**5-6 per year**) matches Fraser Health and BC averages.

Primary care is offered increasingly via virtual modalities[1] (e.g., video, phone) as a compliment to in-person care, providing more access options for patients.

55.1%
Visits in **North Delta** are delivered virtually

49.3%
Visits in **Ladner** are delivered virtually

49.3%
Visits in **Tsawwassen** are delivered virtually

50.8%
Visits in BC are delivered virtually

11.2%

ED visit returns within 72 hrs at **Delta Hospital**

11.1%

ED visit returns within 72 hrs, **across Lower Mainland BC** Facilities

Consistent with patterns across BC, **limited same-day access** for both attached and unattached patients in Delta may be a factor driving demand on emergency services. Efforts are underway to expand episodic, urgent care capacity (South Delta and City of Surrey UPCCs), and to increase longitudinal capacity through provincial investments into the primary care networks that serve Delta residents.[4]

[1]Data up to Dec 31, 2025 provided by MoH – Feb & Mar 2026; [2]Episodic clinic data collected from HealthLinkBC "Find a Clinic Near You", HealthLink BC; [3]South Delta Division of Family Practice Stakeholder Engagement. [4] The Ministry has committed over 34 FTE clinical resources (9 FTE Physicians, 6 FTE NPs, 13 FTE Nurses, 4 FTE Allied Health Providers, and 2 FTE Pharmacists) in Surrey PCN, and over 23 FTEs (7 FTE Physicians, 1 FTE Nurse Practitioner, 6.5 FTE nurses, 5 FTE allied health providers, 2.4 FTE Indigenous resources, and 2 pharmacists) for the South Delta UPCC and PCN.

CURRENT-STATE FINDINGS

Signals from Current-State Data Analysis

Delta's primary care demand, capacity, and access patterns broadly reflect regional and provincial trends, with variation across Delta communities. Delta residents do seek care from neighboring cities, highlighting the regional nature of care access and planning, as well as the potential role of individual choice (e.g., access closer to work or school, or provider preference).

Community Profiles & Health Needs

Delta exhibits **distinct demographic and health profiles** by community, with **faster growth and greater diversity in North Delta** and **older populations in Ladner and Tsawwassen**, alongside elevated chronic disease prevalence across all three communities. This signals **a common need for continuity and chronic disease management**, with differing local emphases.

Attachment & Cross-Boundary Care

Attachment rates vary by community, with **lower reported attachment in North Delta** and **higher attachment in Ladner and Tsawwassen**. A significant share of residents **receive care outside municipal boundaries**, particularly in Surrey, reflecting **Primary Care Network geography, proximity, and resident choice.**

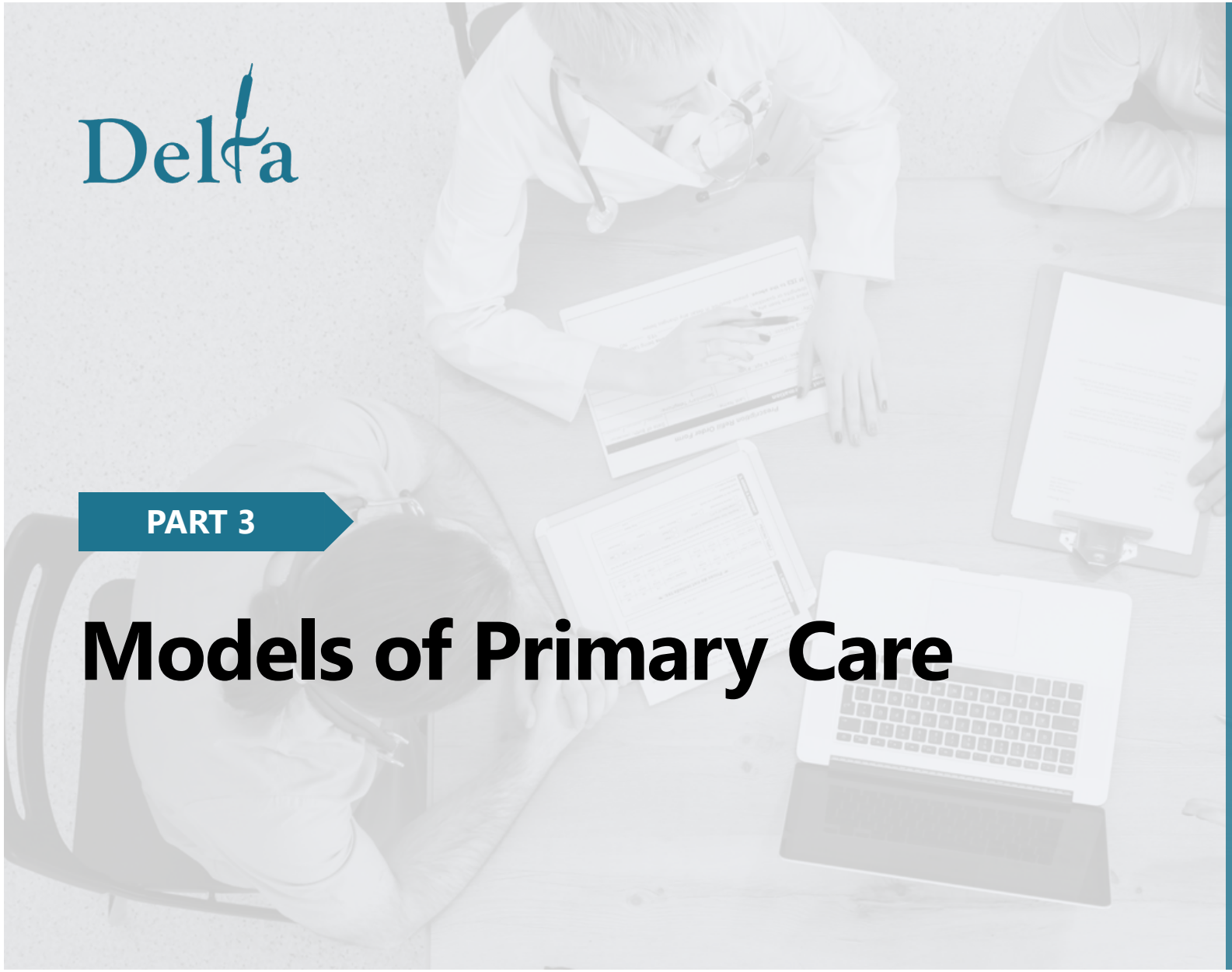
Workforce Capacity & Infrastructure

Limited physician supply and upcoming retirements point to **system-level pressures that affect the region and province**, rather than Delta-specific outliers. Workforce capacity is highly influenced by practice models, work patterns, and infrastructure constraints, rather than municipal boundaries alone.

Access & Emergency Use

Residents access care through a mix of **longitudinal clinics, UPCCs in South Delta and Surrey, EDs, and virtual care**. Episodic (e.g., walk-in) care options for people unattached or with urgent care needs are limited but expanding through UPCCs, both within Delta and nearby in Surrey.

The City of Delta's primary care needs and capacity reflect system-wide challenges across BC., The data suggests an **opportunity for the City to focus its efforts on targeted, place-based actions** that align with existing Primary Care Network plans, **supporting in ways that best leverage a municipality's capacity and strengths, while complementing regional health-sector initiatives**.



PART 3

Models of Primary Care

MODELS OF PRIMARY CARE

Primary Care Service Delivery Models | At-a-Glance

A range of delivery models exist for primary care services, as summarized below. The BC Government is working with partners across the province to establish Primary Care Networks (PCNs) that incorporate each of these service models across different clinic types to improve patient access and outcomes.

Episodic Care

Episodic primary care **emphasizes access, convenience, and speed**, providing short-term, immediate care for acute or minor health issues, such as infections, minor injuries, or sudden illnesses.

Typical Characteristics:
- Problem-focused (e.g., minor injuries, minor illnesses/infections, prescription refills)
- Patients not attached to provider at clinic
- Lack of continuity across visits
- Visits typically scheduled for 5-10min per patient
- Limited prevention support

Examples:
- Urgent and Primary Care Centres (UPCCs)*
- Walk-in clinics
- After hours episodic services
- Phone/Virtual services
- HealthLinkBC 8-1-1 services
- Pharmacist-led clinics at retail pharmacies offering care for minor ailments

Longitudinal FP/NP-led Care

Primary care practice in which **one or more family physicians and/or nurse practitioners** provide care primarily through independent clinician-patient relationships, with responsibility for panels held at the individual provider level.

Typical Characteristics:
- Offers preventive, episodic, and chronic care management
- Patients attached to FP/NP at clinic
- FP/NPs have ongoing responsibility for patient panel, with accountability for follow-up and care coordination
- Visits typically scheduled for 10-20 minutes (longer for complex care)
- Can be supported by the Longitudinal Family Physician (LFP) model by the province

Examples:
- FP/NP-led solo clinics
- FP/NP-led multi-provider clinics (shared space but individual panels)

Longitudinal Team-based Care

A **coordinated group of healthcare professionals and administrative staff** (i.e. physicians, nurses and nurse practitioners, allied health providers, pharmacists) working together to deliver shared care plan tailored to patient needs.

Typical Characteristics:
- Offers preventive, episodic, and chronic care management
- Patients attached to FP/NP/clinic-level team
- Accountability for access, continuity, and follow-up is collectively held by team
- Visits vary in length, with patients generally receiving more time cumulatively across the entire care team than in FP/NP-led clinics
- Aligns with provincial primary care strategy to move towards team-based care to support cost effectiveness and patient outcomes

Examples:
- Team-based care clinics
- Academic-affiliated teaching clinics
- Community Health Centres (CHCs)

**Note: Some UPCCs do provide limited longitudinal care; see Gorge UPCC case study as an example*

MODELS OF PRIMARY CARE

Primary Care Service Delivery Models | Details

High-level, generalized information of various primary care delivery models are provided below. It's important to note that this information is not exhaustive, nor mutually exclusive; primary care can be delivered in various formats, and clinics can combine different types of care.

	Episodic Care	Longitudinal FP/NP-led Care	Longitudinal Team-based Care
Target population	Unattached patients, or attached patients needing same-day urgent, non-emergent care (and unable to access their MRP)	Comprehensive, ongoing primary care provider	Patients with high complexity health/social care needs; attached patients
Service Scope	Urgent non-emergency assessment and treatment; limited follow-up	Full-scope primary care: acute, chronic, preventive, referrals, minor procedures	Full-scope primary care plus embedded allied health, care coordination, outreach
Typical Team Composition	Physicians and/or NPs; nurses; MOAs; UPCCs may include allied health	Led by single or multi physicians or NPs MOA for admin support No allied health professionals	Physicians, NPs, RNs/LPNs, pharmacists, social workers, mental health clinicians, MOAs, clinic manager
Typical hours of service	Normal business hours Some UPCCs offer extended hours, including evenings/weekends and holidays	Normal business hours FPs to ensure patients understand where they can access care after hours	Normal business hours Can provide extended hours and same-day access
Access Method	In-person coverage triaged by urgency; call-back sometimes possible	Booked appointments with regular provider; virtual option may be available	Booked appointments with regular provider; virtual option may be available
Physical Space	Exam rooms w/ high throughput, triage rooms, substantial waiting space	Standard exam rooms and waiting area, administrative space	Blended space allowing for multiple modalities of care; exam rooms, team workspaces
Revenue Model	MSP fee-for-service (FFS) for walk-ins; UPCCs funded by MOH via health authority allocations; physicians and team contracted	MSP FFS or Longitudinal Family Physician (LFP) payment model for physicians; NPs typically contracted / salaried	MSP FFS, LFP, or APA for physicians; other team members funded through Health Authority global funding or are salaried / contracted

MODELS OF PRIMARY CARE

Governance Options to Activate Primary Care Models

Care can be delivered in the province using various governance and funding arrangements. Governance and delivery choices relate to who is accountable for operations and performance, how services are staffed/funded, and how services can be integrated with other levels of care and the broader community.

Governance Type	Description	Examples
Health Authority Operated	Facilities and clinics are owned and operated by a Regional Health Authority, such as Fraser Health Authority or Provincial Health Services Authority. These can include specialized provincial programs used for system-designed access models like Urgent & Primary Care Centres (UPCCs), and some community clinics.	• **Urgent & Primary Care Centres (UPCCs**) which primarily deliver episodic, urgent care (e.g., Fraser Health UPCCs, which focus on episodic care delivery, and the Vancouver Island Gorge UPCC, which offers both episodic and longitudinal care)
Municipality Operated or Partially Funded	Clinic is owned by the municipality (city, town, regional district), either directly as a municipal department, or through a municipally controlled corporation or arms-length entity. Assets (facility, equipment) are publicly owned. Physicians are typically employees of the municipality or municipal entity, or contracted service providers (sessional, salaried, blended models).	• **Municipal operated clinics** employing family practitioners (e.g., Colwood Clinic) • **Municipal contracted or funded clinics** (e.g., the City of Surrey is contracting with a private clinic network to launch and operate primary care clinics across the city)
Publicly Funded, Privately Operated	Privately operated clinics are run by a private or non-government operator (e.g., solo practitioner, group of practitioners, private corporation, or non-profit) that manages staffing (including salaried and contracted providers) and day-to-day operations.	• **Traditional solo or multi-provider practices** • **Pharmacy Clinics** for minor ailments, with care provided by pharmacists (e.g., Shoppers Drug Mart clinics in Surrey) • **Private family medicine clinics** offering longitudinal care at in-person locations (e.g., WELL Health, TELUS Health) • **Virtual primary care clinics** offering episodic care that is funded by MSP payments (e.g., Tia Health from WELL, Telus Health MyCare)
Ecosystem Partnerships	Care models designed and governed via innovation ecosystem partnership models. Partners can include municipalities, community organizations, academic institutions, businesses, non-profit organizations, and others to collaboratively integrate health care with social supports and meet population needs through place-based models of care.	• **Community Health Centres** (CHCs) where non-profit, community-governed organizations are often involved in the delivery of integrated primary care and social services (e.g., Lily Lee Community Health Centre, a partnership between Vancouver Coastal Health and the Vancouver Chinatown Foundation) • **Integrated Family Health Teams** in other jurisdictions, offering team-based primary care (e.g., McMaster Family Health Team in Hamilton, Ontario) • **Non-profit Organizations** supporting primary care deliver (e.g., South Island Primary Care Society, operating primary care clinics to reduce provider overhead costs) • **Foundry Clinics,** integrated health and social services for youth co-led alongside community organizations

Funding Sources & Considerations

Funding implications vary by approach and model, as each option the City may pursue includes different costs and potential funding streams. Potential funding sources for primary care services are highlighted below.

Funding Considerations & Options

Primary care across BC is financed through **multiple, complementary levers**. Funding sources cities may leverage depend on:

- **Type of primary care service** the city intends to support (e.g., episodic or longitudinal)
- **City's preferred level of involvement** (e.g., city owned and operated with salaried staff)
- **Type of support the city plans to provide** (e.g., buildings or infrastructure, grants, tax incentives)
- **Potential partnerships** the city can cultivate (e.g., non-profit foundations, private developers)

Potential Funding Sources	Sample Types of Funding & Investment/Partnership Opportunities
Ministry of Health / Provincial Funding	Most primary care service delivery in BC is funded through the Ministry of Health, via programs including: • Physician Compensation Plans, such as: MSP Fee For Service (FFS), Sessional, Alternative Payment Plan (APP), New-to-Practice Contracts, and Longitudinal Family Physician (LFP) Payment Model • Service Contracts managed by Health Authorities, Primary Care Networks (PCNs), or other governance structures to support salaried providers (e.g., nurse in practice program) and capital costs for some facilities
Insurance (Public & Private)	• A small proportion of services are funded through payment by insurance companies, including public insurance (e.g., ICBC and WorkSafeBC) and private insurance (e.g., insurance for non-permanent residents)
Public/Private Partnerships	• Partnerships with private developers (e.g., leveraging community amenity contributions to build clinic infrastructure) • Synergistic partnerships with private corporations (e.g., co-locating clinics at retail pharmacies with existing infrastructure)
Non-Profit Organizations and Private Philanthropy	• Partnerships with non-profit organizations to operate health services (e.g., partial funding of capital and operating costs for community health centres) or co-locate wrap-around social services with primary care services • Private donations to partially fund capital and operating costs for primary care services (e.g., Lilly Lee Community Health Centre, funded by the Vancouver Chinatown Foundation and private philanthropic donations)
Municipalities	• Initial capital costs (e.g., infrastructure) to establish municipal-led clinics or incentivize other organizations (e.g., private practioners, community organizations) to establish and operate clinics • Municipal operating subsidies to fund municipal-led clinics or reduce overhead costs for private clinics • Municipal incentivizes (e.g., reduced property taxes) to reduce overhead costs for private clinics

MODELS OF PRIMARY CARE

UPCC Case Study | Gorge Road Urgent & Primary Care Centre[1]

The Gorge Road Urgent & Primary Care Centre (UPCC) is a team-based clinic that provides both same-day, non-emergent, urgent care services as well as longitudinal services for patients in the Victoria area.

Service Scope	~70% urgent care and ~30% longitudinal care—a result of deliberate negotiations with the MOH. Clinic is designed to flex along the urgent–longitudinal spectrum based on community need.
Team Composition	Team-based model including social worker, mental health/substance use consultant, and ratio of 1 Registered Nurse & 1 Medical Office Assistant (MOA) per Nurse Practitioner/Family Physician.
Access	By appointment; 7days/wk 8am-8pm. Complex patients can become attached, and patients can be referred across team based on need.
Physical Space	Purpose-built design, shared collaborative layouts, and flexible, safety-ready facilities are foundational to making team-based, urgent + longitudinal care work at scale. Key features include (i) "cloned" (i.e. standardized) exam rooms to support consistency, safety, and efficiency; (ii) large co-located workspace for physicians and other clinicians to enable team-based care and foster collaborative professional dynamic; (iii) Flexible space designed to shift between urgent care and longitudinal care based on community needs; (iv) two exam room with negative pressure systems and external to the building entrances to support infection control practices.
Partnerships	UPCC owned and operated by Vancouver Island Health Authority (VIHA). Close collaboration with MOH, Primary Care Networks (PCN), Divisions of Family Practice, and community & social service organizations.
Revenue Model[2]	The clinic (both space and staff) is publicly funded by the Ministry of Health through a dedicated UPCC service contract administered by VIHA. Funding is not tied to throughput (e.g. x patients per hour, visit counts, or billing volume), but there are clinic visit targets and clinic attachment targets set based on the staffing complement and service model. This revenue model is a key feature that enables flexibility in visit length, case complexity, follow-up and continuity. MoH funding includes capital costs to support the enablement of purpose-built spaces. Total Operating Cost: ~$4.4m (based on publicly available FY23/24 data) • Clinical: ~$3.5m (80% of total); ~$1.1m for Physicians, ~$0.5m for NPs, ~$1.6m for Nursing, ~$0.3m for MHSU • Overhead: ~$0.9m (20% of total)

Key Takeaways

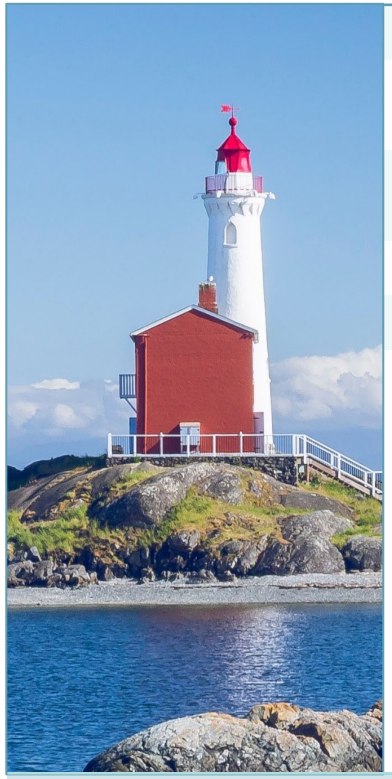
- **Early policy and service contracting decisions matter.** This case study illustrates a UPCC model that integrates urgent and longitudinal care, enabled by early, explicit discussions with the Ministry of Health on service mix, contracting, and expectations.
- **Purpose-built capital design is a critical enabler, not a nice-to-have.** The model underscores that intentional, clinician-designed space is essential to enable team-based care, flexibility between urgent and longitudinal work, safety, and collaboration.
- **Funding and partnerships must be aligned to support complexity, not volume**. A service-contract funding approach (not per-visit), combined with strong partnerships with the Health Authority, PCN, and clinical leaders, allowed the UPCC to focus on complex patients, attachment, and equity, rather than throughput.

[1]Information collected from interviews and follow-up with Gorge UPCC Stakeholders; [2] UPCC Financial Data obtained through FOI Request, FY23/24

MODELS OF PRIMARY CARE

Municipal-led Clinic Case Study | Colwood Clinic[1]

The Colwood Clinic is a novel Municipally-led primary care clinic designed to attach Colwood residents without a family doctor to longitudinal family physicians through the Health Connect Registry (HCR).



Service Scope	Longitudinal care, attaching Colwood residents to a family physician.
Team Composition	2 family physicians employed (1 FT, 0.7FT), 2 physicians pending (2026 target is 5 for current space available); 1 Clinic Manager; 1 Medical Office Assistant (2026 target is 2); 1 Medical Director.
Access	8:30am to 4:30pm Mondays to Fridays in-person at the clinic (limited remote care); Patients are attached via Health Connect Registry with priority given to Colwood residents.
Physical Space	Clinic has 6 standard exam rooms within leased space that was part of a new development in Colwood.
Partnerships	City owns/operates the clinic, with municipal staff providing administrative and support functions (e.g., IT, HR, Finance).

Revenue Model[2]	The Clinic is owned & operated by the City of Colwood. Physicians are hired by City and receive a salary funded by standard billing and contracts to provincial program. The City funds the clinic with a city grant to make up for revenue shortfalls, with a goal of breaking even in future years (based on projections of 8 providers operating out of the space).
	Draft Operating Budget: ~1.8m (FY26 budget)
	• Expenses:
	  ○ Clinical: ~$1.4m (78% of total; all physicians)
	  ○ Overhead: $0.4m (22% of total; $0.3m clinic support staff; $0.1m lease and other)
	• Revenue:
	  ○ Billing: ~$1.45m (MSP Fee for Service), ~$0.05 (other insurance / direct payment)
	  ○ Revenue transfer: ~$0.3m (from City reserves)

Key Takeaways	• **Municipal ownership can accelerate attachment to longitudinal care.** The Colwood Clinic illustrates how a city-owned model can attach residents without a family doctor by reducing provider overhead, administrative burden, and employment risk. • **Financial sustainability depends on scale and municipal risk tolerance.** While provincial billings support provider salaries and overhead costs, the City absorbs early-stage operating risk and may need to cover revenue shortfalls. Achieving long-term viability requires sufficient provider scale and fit-for-purpose clinic space to move toward break-even. • **This model involves high involvement from municipality.** As a result, the model is best suited to municipalities willing to act as operators and co-invest alongside the province; otherwise, municipalities can also focus their effort on enabling or influencing care delivery.

[1]Data collected interview with Colwood representative and desk research; [2]City of Colwood Mar 12, 2026 Council Agenda item 5.1 Appendix 10.

MODELS OF PRIMARY CARE

Academic-led Team-Based Clinic Case Study | McMaster Family Health Team

The McMaster Family Health Team consists of academic, interprofessional teams affiliated with McMaster University, providing comprehensive, longitudinal primary care across multiple sites while training future health professionals.

Service Scope	Comprehensive primary care services specializing in family and community health for over 40k patients across 2 sites, comprised of the McMaster Family Practice (MFP), Stonechurch Family Health Centre (SFHC), and the Maternity Centre of Hamilton (MCH), providing education for physicians and other health professionals, and research in family medicine.[1]
Team Composition	Interprofessional team of Family Doctors (30) & Residents (32), Nurse Practitioners, Nurses, Physician Assistants, Dieticians, Pharmacists, Social Workers, OT/PT, Lactation Consultants, System Navigators, and Administrative Support Staff. Leadership works in Dyad Model (faculty lead +administrator).[1,2] Family physicians spend 40% of clinic time monitoring resident-patient interactions.
Access	Regular services available on Mon, Tue, Thu 8:30am-8pm; and Wed, Fri 8:30am-5pm. Open for urgent, same-day appointments on Sat-Sun & Holidays from 10am-2pm[1]. Services are for registered/rostered patients, with access to interprofessional teams and 24/7 phone availability; Maternity Centre patients do not need to be rostered.
Physical Space	2 cross-functional sites – Stonechurch Family Health Centre and McMaster Family Practice & Maternity Centre – plus one maternity care centre within the Greater Hamilton Area in Ontario. A total of 41 examination rooms.
Partnerships	Affiliated with McMaster University department of Family Medicine (via academic partnership and MOU w/ Hamilton Health Sciences Corporation and the McMaster Family Health Organization Association). All FHTs in Ontario are required to be not-for-profit and governed by a Board, with McMaster's Board and the department's Health Services Operations Group acting in this capacity.[2]
Revenue Model	Clinic revenue is received through Ontario Ministry of Health funding, under the Family Health Organization (FHO) program[3]. Physicians are compensated primarily through capitation, with an enhanced Fee-for-Service model including incentives tied to patient enrolment, prevention, and after-hours care. Patient services covered through the Ontario Health Insurance Plan (OHIP)[4]. Physical Space: Stonechurch Family Health Centre – funded by $1.5M from Ontario Ministry of Health and $1.5M mortgage from department's Clinical Practice Plan, with the McMaster Department of Family Medicine as owner/operator; David Braley Health Sciences Centre is managed by the Faculty of Health Sciences, with $3M from Department, $12M Post-graduate expansion capital funding, $10M David Braley donation, and $20M from City of Hamilton to support patients served in downtown core.[2]

Key Takeaways

- **Team-based, longitudinal care improves outcomes for complex populations.** Interprofessional teams enable coordinated management of chronic conditions, prevention, and continuity across patient journeys, delivering care in a sustainable, cost-effective model. This approach also allows care to be delivered by the most appropriate provider, improving access, efficiency, provider workload, and patient experience.
- **Academic partnerships strengthen workforce sustainability.** Integrating training with service delivery supports recruitment, retention, and long-term capacity. Teaching environments create structured pipelines for future providers while reinforcing evidence-informed practice and innovation.
- **Clear governance and stable provincial partnerships are essential.** Defined accountability, not-for-profit governance, and predictable funding enable scale, quality, and alignment with broader health system objectives and plans. This reduces operational risk and supports consistent performance over time.

[1]*McMaster Family Health Team Website | https://fht.mcmaster.ca/;* [2]*McMaster Family Medicine Status Report, 2021-25;* [3]*Government of Ontario | Primary Care Payment Models in Ontario;* [4]*Similar to MSP in BC*

PART 4

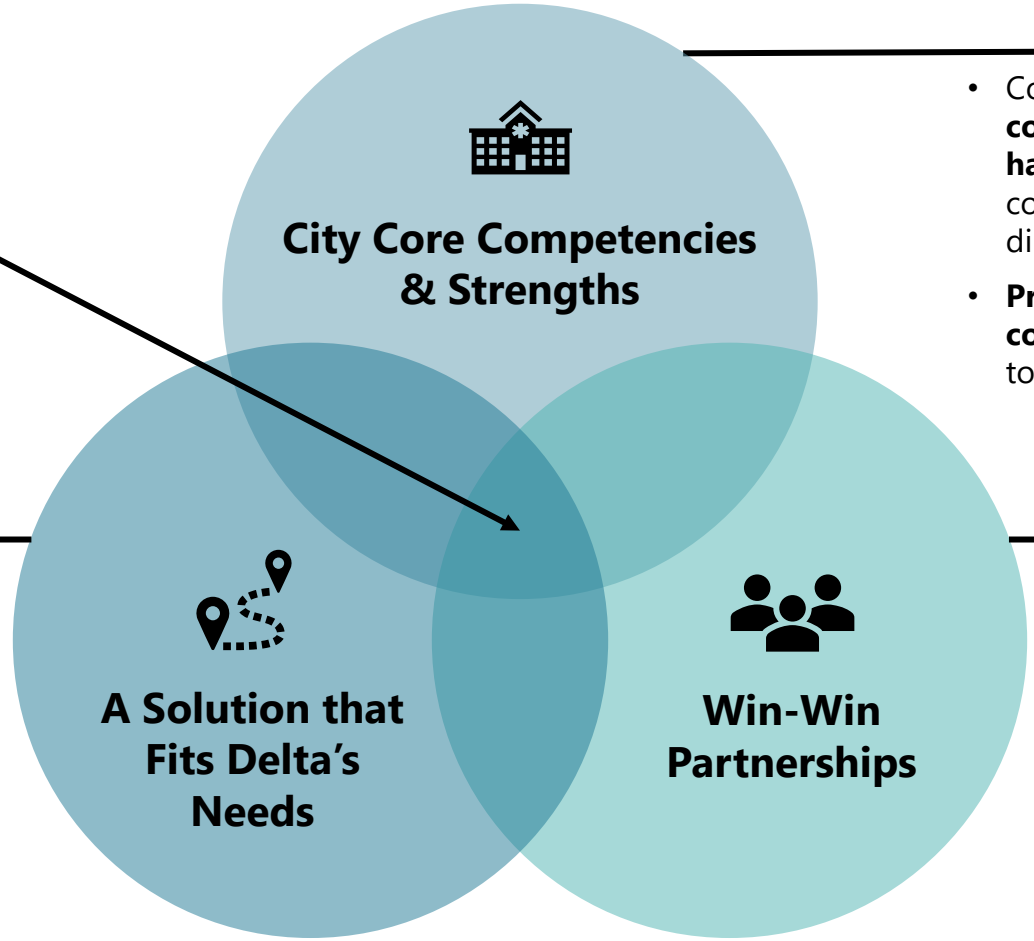
Considerations & Next Steps

CONSIDERATIONS & NEXT STEPS

Key Considerations for the City of Delta's Role in Enabling Primary Care

To determine where the City could have the most value-add impact on primary care, the City needs to consider what its core competencies are, which targeted areas on which the City wants to make an impact, and what partnership-driven actions the City can take to complement—not duplicate—health sector services and initiatives.

The intersection of these factors identifies priority areas where the City could consider investing time, energy, and funding to support primary care service delivery.



- Consider roles that **align with the City's core competencies** or where the City **could have the strongest impact** (e.g., options could include advocating, enabling, or directly delivering services).
- **Prioritize levers that the City can directly control** (e.g., planning/policy, assets, zoning) to reduce barriers and accelerate action.

- Consider **which primary care needs and gaps the City wants to prioritize in making an impact**, and the **timeframe** in which benefits/outcome will need to be realized.
- These strategic decisions will **inform where the City should direct its investments, resources, and energy** towards a 'Made in Delta' solution.

- Consider opportunities that **align with priorities and interests of residents, providers, the City, and health system partners.**
- Promote continued collaboration and partnerships across relevant parties.
- Focus on place-based solutions that **complement existing regional and provincial health system plans**, while showcasing municipal leadership.

CONSIDERATIONS & NEXT STEPS

Determining Priority Focus Area and Service Delivery Model

City leadership needs to decide and articulate which aspect(s) of primary care the City wants to prioritize in making an impact and the time frame in which benefits/outcome will need to be realized; this will guide where the City could direct its investments, resources, and energy in enabling primary care.

1 Enhance access to primary care and urgent / non-emergent services **for people who are unattached** or **unable to access their primary care provider**

Focus on

Episodic primary care services, such as:

- Walk-in clinics
- UPCCs (*without longitudinal services*)
- Episodic virtual care services
- Pharmacist–led minor ailments clinics

2 **Promote health** through improved access to a **regular, longitudinal primary care team** that can provide preventative care and chronic disease management

Focus on

Longitudinal, team-based primary care services, such as:

- Family Health Teams
- Community Health Centres

The City **may pursue both approaches in parallel** by taking **near-term actions to address immediate access gaps**, while simultaneously laying the groundwork for **longer-term investments that expand longitudinal primary care capacity**.

It will also be important for the City to collaborate and coordinate **with regional and provincial health system partners to align on actions that are accretive to broader regional/provincial planning.**

CONSIDERATIONS & NEXT STEPS

Supporting Short-term Episodic Primary Care Needs

The City can help address short-term episodic primary care access gaps by advocating for and enabling local care models that expand urgent and same-day care capacity for residents who are unattached or unable to access timely care.

KEY CONSIDERATIONS

This approach:

- Addresses **short-term access needs** without attachment; does not address need for longitudinal care
- Can **address urgent/non-emergent care needs** (for which citizens may otherwise go to ED), rapidly growing population centres, or capacity shocks
- Yields **shorter-term benefits**, such as contributing to reduction of CTAS 4/5 rates in local EDs. The City should therefore consider pursuing this option **in conjunction with efforts to increase attachment to reduce demand for episodic care**

POTENTIAL OPTIONS

1 **Continue to advocate for the opening of a UPCC in North Delta***

Example: City of Delta advocated for the opening of the South Delta Urgent & Primary Care Centre

2 **Contract a private provider to operate a clinic that the City owns***

Example: City of Surrey contracting with Total Life Care Granville Medical to open two new primary care clinics

3 **Promote or contract with private pharmacies to open clinics for minor ailments**

Example: City of Surrey promoted new Pharmacy Care Clinics opened by Shoppers Drug Mart to treat minor ailments

***Note:** Depending on the clinic service model chosen, these options could also address longitudinal care needs*

CONSIDERATIONS & NEXT STEPS

Improving Long-Term Health through Longitudinal Primary Care

The City may also choose to focus on improving long-term health outcomes by increasing capacity for longitudinal primary care (i.e., for residents to attach to primary care/family medicine teams for prevention, chronic disease management, and continuity of care) through different partnership options or direct service delivery.

KEY CONSIDERATIONS

This approach:

- Addresses needs for **prevention**, **chronic disease management**, and **improved population health**
- Promotes **equitable access to care for underserved populations** who would otherwise be unattached
- Is aligned with **provincial priorities** (e.g., shift to team-based models of care, new SFU medical school, health system productivity)
- Potentially has **longer timeline for benefits realization** and more **complex plan for activation**

POTENTIAL OPTIONS

1 **Own and operate a primary care clinic***

Example: City of Colwood operating the Colwood Clinic

2 **Partner with an academic institution to open a team-based care clinic & training site***

Example: McMaster Family Health Team

3 **Identify and incentivize partners (e.g., non-profit organizations) to create and govern a new community health centre (CHC)***

Example: Lily Lee Community Health Centre, a partnership between Vancouver Coastal Health and the Vancouver Chinatown Foundation

***Note:** Depending on the clinic service model chosen, these options could also address episodic care needs*

CONSIDERATIONS & NEXT STEPS

City Levers to Enable Growth of Primary Care Capacity

The City can use its municipal core strengths to support the delivery and expansion of primary care services without directly delivering care. **Coordinated action with regional and provincial health partners will be critical to identifying where municipal involvement is most value-add and aligned with broader system planning.**

Infrastructure support: Access to affordable, appropriately zoned clinical space is a key barriers to primary care expansion. The City can offer infrastructure support to accelerate clinic development and enable partners to deliver services where and when they are most needed.

1. **Provide city assets (e.g., infrastructure, land) that could support new or enable existing clinics to expand services**
2. **Leverage Community Amenity Contributions (CACs) to incentivize developers to create infrastructure for clinics**
3. **Leverage city policy levers (e.g., zoning) to support clinics**

Recruitment and retention support: The City can improve the attractiveness and sustainability of primary care practice in Delta by using municipal levers—such as incentives, housing and relocation supports, practice-ready space, and community integration—to help ecosystem partners attract, retain, and stabilize the primary care workforce.

1. **Support recruitment campaigns for new providers**
2. **Offer incentives to support recruitment (e.g., tax incentives, relocation support, subsidies) for new providers**
3. **Subsidize overhead costs of clinic operations**

CONSIDERATIONS & NEXT STEPS

Activating a Win-Win Partnership: An Illustrative Model

Creation of a longitudinal primary care teaching clinic in Delta, anchored by an academic partner (such as the new SFU Medical School), could be an example of an innovative win-win partnership that enhances care for patients, leverages capabilities and assets of key partners, and addresses strategic priorities of partners involved.

This model would enable delivery of cost-effective team-based care, thereby providing **opportunity for Delta residents to attach to a care team**. This would also serve as a training site to support the development of the **next generation of family physicians**, who would have **interest and desire to live and grow within a community**.

Please note that **this model is presented for illustrative purposes only**. Roles for illustrative partners below have been identified based on partnership models that enable similar academic clinics in other jurisdictions. Illustrative partners have not been consulted to confirm the applicability or feasibility of this model for BC.

Illustrative Partners	Delta	SFU Simon Fraser University	fraserhealth	British Columbia
Potential Role in Activating Model	• Provide a site for a clinic (e.g., city-owned property, or in partnership with a developer) • Consider tax incentives to reduce clinic operating costs	• Recruit primary care physicians • Establish a teaching unit • Recruit a partner to professionally operate the clinic • Establish a plan for the clinic to self-fund operational costs (e.g., 25% overhead fees paid by physicians)	• Provide allied health professional staff (e.g., nurses, social workers, physiotherapists) to enable team-based care at the clinic	• Fund the clinic through existing longitudinal contracts and MSP funded services • Support scope of practice policy to promote delivery of team-based care at the clinic
Possible Key Benefits (that matter for the Partner)	• Longer-term improvement in health outcomes by increasing attachment for Delta residents and improving access to team-based longitudinal care, chronic disease management, and preventative care • Potential recruitment tool for the City, as medical students/residents may be more likely to stay in the community where they train	• Access to a community-based teaching site aligned with the medical school's mandate to train family physicians in the delivery of team-based care • Opportunities for practice-based research and innovation in primary care models and workforce sustainability	• Possible reduction in emergency department use for avoidable visits that could be more cost effectively delivered by primary care services in the community • Possible reduction in acute care demand, as chronic illnesses are better managed more cost effectively in the community	• Advancement in provincial priorities to promote attachment and team-based longitudinal primary care • Shifting care to more cost-effective community and team-based primary care service models • Addressing workforce development and retention by training more family physicians in BC

CONSIDERATIONS & NEXT STEPS

Spectrum of Roles for the City of Delta

While there are various models and approaches to primary care service delivery, the approach must align with what is known about the current state and needs of the population, along with the short and long-term goals of the City.

Below is a continuum that shows increasing levels of direct involvement in delivering health care services within the City, aligned to the needs identified within the report:[1]

	INFLUENCE	ENABLE	DIRECT
ROLE	**Advocate, Raise Awareness, Researcher**	**Funder/Assets, Convener, Planning/Policy**	**Service Delivery, Employer**
DESCRIPTION	Shape conditions for better access to primary care through supporting navigation, awareness of pathways, and local support for system change.	Reduce barriers to care delivery by contributing assets or operational support, i.e. capital, infrastructure, ensure city planning and policy is aligned with health care needs of residents and providers, and work with community partners to coordinate delivery.	Launch or host service delivery, and/or actively support recruitment and retention of physicians and allied health professionals to enhance regional access.

The next slide translates these approaches into potential actions and roles the City can take depending on its desired target state.

[1] *Adapted from Delta Social Action Plan 2023-2028*

CONSIDERATIONS & NEXT STEPS

City Roles Across Different Potential Actions

There are multiple actions, both direct and indirect, that the City may choose to play to support the delivery of primary care in Delta. This table below summarizes key actions the City can take, leveraging its different potential roles.

		CITY ROLE							
		INFLUENCE			ENABLE		DIRECT		
	Potential Actions	Advocate	Raise Awareness	Researcher	Convener	Planning/ Policy	Funder / Assets	Service Delivery	Employer
CLINIC CAPACITY	Continue to advocate for the opening of a UPCC in North Delta	✓	✓		✓	✓			
	Own and operate a primary care clinic		✓		✓	✓	✓	✓	✓
	Contract private provider to operate a clinic that the City owns		✓		✓	✓	✓		
	Partner with academic institution to open a clinic & training site		✓		✓	✓	✓		
	Identify and incentivize partners (e.g., non-profit organizations) to create and govern a new community health centre (CHC)	✓	✓		✓	✓	✓		
	Promote or contract with private pharmacies to open clinics for minor ailments		✓		✓	✓			
INFRASTRUCTURE	Provide city assets (e.g., infrastructure, land) that could support new or enable existing clinics to expand services				✓	✓	✓		
	Leverage Community Amenity Contributions (CACs) to incentivize developers to create infrastructure for clinics				✓	✓			
	Leverage city policy levers (e.g., zoning) to support clinics				✓	✓			
RECRUITMENT & RETENTION	Support recruitment campaigns for new providers		✓		✓	✓			
	Offer incentives to support recruitment (e.g., tax incentives, relocation support, subsidies) for new providers		✓		✓	✓	✓		
	Subsidize overhead costs of clinic operations		✓		✓	✓	✓		

Legend: Episodic Service | Longitudinal Service

CONSIDERATIONS & NEXT STEPS

Broader Health & Social Context

An individual's health and wellness—and a community's population health—are strongly shaped by social determinants of health such as income, housing, transportation, social connection, and cultural safety. **Beyond supporting episodic and longitudinal primary care models, the City can meaningfully improve health outcomes by addressing the social determinants of health within its influence, in alignment with the City's *Social Action Plan*.**

Strategic Opportunity 2.4
Improve walkability

Walkable communities support daily activity, lowering chronic disease risk. Adults living in the most walkable neighbourhoods in Canada had **nearly 50% lower rates of obesity**[1].

Strategic Opportunity 2.14
Improve coordination in reducing poverty & food insecurity

Food security reduces cardiometabolic risk and improves diabetes control. Adults experiencing food insecurity are **2× more likely** to live with type 2 diabetes[2].

Strategic Opportunity 5.22
Support seniors to age in place

Seniors experiencing isolation are at greater risk of chronic health conditions, disability, dementia, and premature death, and generally incur significant health care costs[3].

Strategic Opportunity 6.24
Increase affordable, supportive, and transitional housing options

Stable housing is foundational to mental health and reduces crisis-driven service use. 60% of people experiencing homelessness self-report a mental health issue[4].

Strategic Opportunity 7.28
Enhance physical accessibility through the built environment

A Canadian suburban study shows **34.5% reported transportation-related barriers leading to delayed/missed primary care or postponed vaccination[5]**.

It is critical to maintain strong partnerships and collaborations with the health sector and community partners, to ensure municipal action is enabling and complementary rather than duplicative.

 Diagram adapted from Comox Valley Community Health Network: Determinants of Health

[1]*Statistics Canada (2019) Walkable Neighbourhoods and Physical Activity in Canada; [2]Diabetes Canada (2022) Diabetes & Food Insecurity; [3]Public Health Agency of Canada (2020) Aging & Chronic Diseases: A profile of Canadian seniors; [4]Housing, Infrastructure, and Communities Canada (2024) Homelessness Data Snapshot (2020-2022 PiT Counts); [5]Lyeo, Tiznado-Aitken, Farber, Brown, & Spence (2023) Predictors of transportation-related barriers to healthcare access in a North American suburb*

APPENDICES

Appendix A – Stakeholder Engagement List

APPENDIX

Stakeholders Engaged

Various stakeholders were engaged to gather and validate information, findings, and analysis in this report.

BC Ministry of Health	• **Kelly McQuillen**, Executive Director for Primary Care Planning & Implementation Oversight • **Yashna Sharma**, Regional Director for Fraser Health, Primary Care Planning and Implementation Oversight • **Kiran Biran**, Regional Manager for Fraser Health, Primary Care Planning and Implementation Oversight • **Rhiannon Pretty**, Executive Director, Integrated Analytics, Primary Care, Acute Care & Workforce • **Rob Cowan-Douglas**, Senior Director, Primary Care Strategic Priorities
Fraser Health	• **Natalie McCarthy**, Vice President, Regional Care Integration • **Teresa O'Callaghan**, Interim Vice President, Community Hospitals and Health Services • **Anne Brownlee**, Interim Executive Director, Delta Hospital • **Cheryl Beach**, Executive Director, Primary Care & Chronic Disease Management • **Anamaria Gidolfavi**, Director, Primary Care & Chronic Disease Management • **Justin LoChang**, Director, Clinical Operations, Primary Care • **Dr. Timothy Foggin**, Medical Director, Cloverdale UPCC and South Delta Urgent & Primary Care Centre
South Delta Division of Family Practice	• **Geri McGrath**, Executive Director
Surrey/North Delta Division of Family Practice	• **Tomas Reyes**, Executive Director • **Victoria Rotaru**, Director, Care Networks and Strategic Partnerships • **Jody Friesen**, Director, Physician Services and Practice Sustainability • **Dr. Sujatha Nilavar**, Co-chair • **Dr. Mohammad Hurmat Ali,** Member at Large
Delta Hospital and Community Health Foundation	• **Lisa Hoglund**, Chief Executive Officer
Island Health	• **Dr. William Cunningham**, Department Head, Primary Care, Family Practice • **Dr. Tia Pham**, Site Medical Leader, Gorge Road Urgent & Primary Care Centre • **Dr. Javed Alloo**, Family Physician, Gorge Road Urgent & Primary Care Centre • **Amber Hay**, Director, New Site Development and Operations Support, Regional Primary Care
City of Colwood	• **Jenn Hepting**, Deputy Chief Administrative Officer