BRITISH COLUMBIA | Ministry of Health

Building Teams in a Primary Care Network

How will teams be hired?

Through the Province's new primary care strategy, we are taking steps to make sure people have faster and better access to the day-to-day health-care services they need by investing in team-based primary care. That means using team-based care to bring doctors, nurse practitioners and other health-care professionals together to deliver comprehensive care for patients.

Primary Care Networks (PCNs) will bring together local providers to care for a community's entire population, supported by these new teams. Divisions of Family Practice, health authorities, First Nations and other community stakeholders will come together to form these PCNs and identify resources needed to close gaps in care.

As we work together to transform primary health care in B.C., and help put these teams in place, we know there will be questions and concerns that come up along the way. One of the main areas of interest has been how we will work to set up team-based care in private practices (Patient Medical Homes) and community-led clinics as part of establishing PCNs.

As partners, the Ministry, health authorities, Family Practice Services Committee (FPSC), Doctors of BC, Divisions of Family Practice, First Nations, First Nations Health Authority (FNHA), unions and individual clinicians will need to work together to bring these teams to life. As we move towards implementation, everyone involved in supporting these teams will need to come together to collaborate through this process. This will be a learning experience for all involved.

B.C.'s healthcare employers have existing policies and collective agreements in place for hiring health professionals, and it is important that these be respected. It is also crucial we respect the need for both continuity of care for patients and for physicians and other partners to participate in the creation of these teams, which will become part of the environment in which they will practice.

To support this work, we have established a guideline and FAQ for health authorities, Divisions of Family Practice, First Nations partners and local clinics.

HR Guideline for PCN Hiring

The partners will work together to create interprofessional teams (e.g., nurses, allied health clinicians, physicians, and nurse practitioners) in a variety of primary care settings, including primary care clinics/patient medical homes, urgent and primary care clinics (UPCCs), community health centres (CHCs), and First Nations-led primary care centres (FNPCCs).

A PCN's funding to hire approved clinical staff will be provided by Ministry to regional HAs and as directed by the PCN Steering Committee, in support of the Service Plan, the health authorities (HAs) will have responsibility of deploying teams to various primary care settings, working in collaboration with local clinics. The HAs will use their established infrastructure, systems, and internal services (e.g., HR, finance, and IT capability) to support, manage and lead a wide variety of professional staff.

In instances where a First Nations community/clinic requests to be the employer of PCN resources allocated to their community(s), the First Nation and the HA will enter into a service contract (and/or Memorandum of Understanding/Agreement) for direct transfer of funding to the nation.

All partners – local physicians, nurse practitioners, health authorities, First Nations, and others – will work together to establish the clinical, administrative and joint leadership structures necessary to support this on-going collaboration. Among other matters that the local partners might choose to jointly address, these items should be considered:

- Clinic and/or partner input into developing the team roles and in the selection process of team members;
- Clinic and/or partner input into the development and provision of orientation to the team, the program, and the clinic;
- Clinic and/or partner input into operating policies, protocols, and practices;
- Key contacts for both the clinic and the HA for on-going coordination and leadership;
- Population information, concerning health trends, and joint assessment of patient population needs, to help determine appropriate clinical team roles and skill set requirements; and
- Mechanisms for information sharing and access to records needed to provide the services.

The following principles and definitions should be used to guide the shared responsibility to deliver quality (i.e., effective, accessible, acceptable, appropriate, and safe) team-based primary care services.

- ***Person-Centred Care:*** A person and family-centred approach that is culturally appropriate, rooted in a commitment to providing longitudinal primary care services across health-care settings.
- ***Team-Based Primary Care:*** An ongoing collaboration among a connected inter-professional group of clinical providers with a particular focus on providing seamless, streamlined, proactive primary care.
- ***Equity, Scalability, Sustainability:*** Equitable allocation of resources amongst primary care networks, scalability across the province, and longer-term sustainability.
- ***Triple Aim:*** Based on achieving the Triple Aim of improved patient and provider experience, population health, and cost effectiveness.
- ***Interprofessional Team (IPT):*** A team of clinicians deployed as and where needed to collaborate with primary care physicians and/or nurse practitioners in the provision of team-based primary care services.
- ***Employer:*** The employer for IPT members will be the health authority, which will retain the employment relationship with each employee, including, but not limited to, role definition, hiring, performance management, development, promotion, compensation/benefits, and scheduling.
- ***Collaboration:*** The details of collaboration may differ across various scenarios but are anticipated to include mechanisms to support regular communication among the collaborating organizations to ensure mutual input in skill mix planning, clinical development, selection processes and team building, in the context of an interdisciplinary team-based approach to care.

Frequently Asked Questions

What does it look like practically for all the health-care providers to work together in teams as part of the PCN?

The vision is for all health-care professionals to work to full scope to meet the needs of the patient population being served, and for interdisciplinary teams to be supported by effective leadership to ensure the team works well together.

The intention is to bring more clarity and integration to the structure and organization of services. Each provider has their own unique role and scope in the provision of patient care, and they will work together to make sure that the patient's needs are met in the most effective way possible. This approach is being used effectively at clinics already here in B.C., as well as in other jurisdictions and is well suited to the provision of truly patient-centred care.

It is important to note that there is space in this model for local needs to be met in a way that best suits the PCN and individual clinics. As PCNs get established and up and running, each of the partners will need to work together to outline how they will work together as a team, in a way that works for everyone.

Each team will look somewhat different as clinics choose to set up their structures in a way that best suits their unique needs. Some clinics may have a person who functions as the clinic manager (not necessarily a health-care provider) who helps to ensure that the team is working well together and works to help resolve any logistical issues. Some may use the role of the PCN clinical services manager to fulfill this function, but not always as some clinics may choose to pay for their own manager on site, as opposed to one who works with all the clinics participating in the PCN.

The PCN clinical services manager will work with each clinic as needed to address concerns or manage issues. They would also work closely with the HA's designated manager to resolve any

staffing issues, ensure adequate coverage (such as for vacation) and troubleshoot any concerns. The HA designated manager is the person responsible for facilitating the hiring of nursing and allied staff that are deployed to the clinic. From an employment perspective the designated manager would be in an administrative supervisory position.

Who receives the funding to hire nursing and allied health providers?

As outlined in the letter of intent, health authorities receive the Ministry funding to employ nursing and allied health employees, on behalf of the PCN.

First Nations, and society-run clinics may receive funds to employ PCN nursing and allied health providers by entering into a service agreement for direct transfer of funds from HAs to the nation or society. A current exception to this is the Nisga'a Valley Health Authority which receives funding from the Ministry as dictated by the Nisga'a Final Agreement of 1999.

How will these staff be hired?

HAs will work with local clinics and/or partners to recruit unionized staff, following collective agreements and based on the needs outlined in the service planning process. There are several ways clinics can participate in the selection process with HAs. First and foremost, clinics and partners can work with the HA to identify job requirements that reflect the specific needs of the clinic, and tailor the job description prior to posting, to better meet the needs of the community and team. As a result, they are directly involved in the development of team skills to best serve the patient populations. Additionally, clinics may participate on the selection panel, provide feedback, and make recommendations to the HA.

HAs will work closely with all clinics to develop processes that work for them and if the clinic would like to be involved, the HA may include them in the recruiting and hiring processes for staff.

HAs will be responsible for payroll and benefits administration, as well as ongoing HR management of employees deployed in a PCN, in accordance with applicable collective agreement requirements. HAs will deploy staff to clinics to support the creation of effective interprofessional teams within the clinics and PCN, following the approved service plan.

Is the HA's designated manager to be costed outside of the PCN planning budget?

Yes, this role is not funded within the service planning process.

Which unions will nurses and allied health professionals be part of? Have these unions been engaged in this process to date?

Nurses will be part of the Nurses Bargaining Association represented by BCNU. Allied Health staff will be part of the Health Sciences Professional Bargaining Association and may be represented by different unions. Representatives from both Associations have been engaged in discussions around this model and are supportive of team-based care. We are still having conversations around which team members will be part of which union, and we will keep you informed and update this document as these issues are clarified.

Who will manage the ongoing relationship with staff employed at the clinics?

The HAs are responsible for the management of HA staff. HAs will collaborate with physicians/nurse practitioners in private clinics and, where appropriate, other partners to ensure a model of effective team-based care. Each PCN will have an identified HA Manager who will work with the teams to support this work.

The health professionals employed by the HAs will work with the physicians and nurse practitioners to their full scope of practice. Private clinic owners will have the support of the HA in terms of identifying and resolving any issues or concerns that may impact seamless and effective primary care. If they have questions or concerns about the employee, they would contact to the HA designated manager to raise their concerns and work together to identify solutions.

Will the Ministry be providing guidance on job descriptions or qualifications?

There are several pre-existing job descriptions that some HAs and others have used for primary care specific roles. We are happy to provide these as guidance; however, each

PCN is unique and we encourage planners to tailor their job requirements based on their specific needs.

How will issues like overtime, vacation or other leaves be managed?

The HA's designated manager will be responsible for ensuring that the collective agreement is applied. The HA is responsible for scheduling and backfilling of staff and will work with the clinic to determine the appropriate schedule to meet service needs. While each PCN may be different, depending on local discussions, the HA designated manager will work with the PCN clinical service manager to identify the clinics and employee's needs and ensure that they are met appropriately. PCN clinic service managers should establish their own processes to appropriately manage the day-to-day employee and client needs, consistent with the collective agreement, and can consult the HA's designed manager for advice and support as needed.

How can the clinic be confident that there will be continuity in staffing? Is there a risk that HA staff will be subject to "bumping"?

In the experience of HAs, the occurrence of bumping in clinical professions is rare. However, there is general staff turnover. As new opportunities present, staff may choose to exercise opportunities for career development or move on due to personal life changes.
HAs will work with the physicians/nurse practitioners to maintain continuity of service wherever possible.

Generally, bumping occurs when there are staff layoffs, significant schedule / rotation and position changes (e.g., part-time to full-time). HAs have various mechanisms and processes to manage their workforce to minimize the risk of bumping; however, when it does occur, the process must follow the collective agreement language.

Can participating physicians be involved in the hiring of the RNs?

HAs will work with local clinics and/or partners to recruit unionized staff, following collective agreements and based on the needs outlined in the service planning process. This means clinics

and partners can work with the HA to identify job requirements that reflect the specific needs of the clinic, and tailor the job description prior to posting, to better meet the needs of the community and team. The process for hiring nurses will need to follow the collective agreement with the Nurses Bargaining Association. Generally, there will not be a hiring panel involved, and selection will be done from an identified pool of qualified and eligible nurses in the community.

Can non-HA nurses apply for PCN positions?

Where the HA is the employer of PCN nurses, any new vacancies or new positions will be offered to internal, HA-employed nurses prior to being posted for external candidate applications.

Will nurses be subject to a probationary period in a new position?

All nurses in a new position will serve a qualifying period of 90 days. It is during this period where employers can assess a nurse's suitability for the role, based on the competencies and skills required in the job description.

What happens if a clinic already employs a nurse? Would that nurse have to become a HA employee? Will these clinics still be able to participate in this initiative? Will future nurses or allied health providers need to be employed by the HA?

No, if a clinic already employs a nurse, they would not have to become a HA employee. There is no restriction on clinics which already employ a nurse to participate in the PCN process. If additional nursing and/or allied providers are added through the PCN planning and funding process, then yes, they will need to be employed by the HA.

Can a practice contract with other, non-HA employees?

Yes.

How can we ensure equal pay across different employers within the same clinic?

HA employees' total compensation is determined through collective bargaining between the accredited bargaining agent for HAs (the Health Employers Association of B.C.) and the

accredited bargaining agent for health sector staff (the Health Science Professionals Bargaining Association, the Nurses Bargaining Association, etc.). The collective agreements are publicly available documents. Compensation for private clinic staff is determined by the clinic employer. If pay equity is being sought, we would encourage physicians/ clinic owners to consult these agreements when determining pay rates for clinic staff.

Will the HA provide continuing clinical education support?

Yes, continuing clinical education and support will be provided regardless of the clinical setting.

How is the performance of HA staff within the clinic managed? How does the HA manage staff when they are not on-site?

The HA, in consultation with the clinic, is responsible for clearly describing and communicating performance standards for each role and ensuring the appropriate training and orientation, as well as the necessary resources, supplies and equipment, are provided to staff to enable successful performance.

If there are general clinical concerns or questions that physicians, NPs or other health providers at the clinic have about care, then they would discuss those concerns with the employee in the same way as they would with any other colleague. If those discussions do not resolve the concern or if the clinic has any concerns regarding performance, the physician or other provider can reach out to the designated health authority HR representative to discuss the concern(s). This approach allows physicians and/or NPs to focus on providing patient care, and not on managing staff; it also provides access to a wide range of employment and performance resources that HAs already have established.

How does a HA designated manager manage staff when they are charting somewhere that can't be reviewed?

The HA designated manager is not responsible for managing the provision of direct clinical care. It is expected that each team member is responsible for their work, and that they work together to ensure that patients have all their clinical needs met by the team.

Is this the same as the Nurse-in-Practice program?

No, the nurses employed through the PCN planning are not the same model as the nurse-in-practice program, a pilot project which is in place in only a small number of clinics in B.C. In that program, the nurses are employees of the clinic, and the physician is their direct supervisor. In the team-based care model, the nurse or allied health professional is one member of a multi-disciplinary team, who provides care to the patient based on their specific needs, and their scope of practice.

How is information sharing and confidentiality addressed for HA staff who are part of the PCN?

Under current privacy legislation, health-care providers can share patient information with one another for the purposes of clinical care. In addition, PCNs will have access to supports to assist with privacy issues. The FPSC Information Sharing Task Group is developing an Information Sharing Agreement to support work in the PCN, both direct clinical care, and secondary use of data (such as for quality improvement). As part of this, staff will need to sign confidentiality and Information Sharing Agreements to allow data to flow between private physicians/NPs (operating under PIPA), and HA providers (operating under FIPA).

As fee-for-service physicians, will there be limits on how many nursing or allied consultations we can bill per day? How will billing in these instances work?

Beyond the existing billing rules for individual fee items, there is no specific limit on how many nursing and/or allied consultations can be billed by a physician. Having said that, there needs to be a formal need for the consultation directly related to the patient's care and there must not be duplicate billings for the same service.

Are there other models in B.C. where unionized HA staff are working alongside non-union GP-hired staff?

Yes, there are many clinics in B.C. which are already using this model – particularly in the North. They have found that it has worked very well. We are happy to provide more information or details on these clinics, or to look at connecting you with someone who is already doing this work if you have any questions for them. Please reach out to your Ministry of Health liaison for more information.

What about reconciliation with First Nations? In some cases, HAs have agreements with local First Nations that, as part of true reconciliation, the local FN is responsible for hiring their own health providers. How will this work for PCNs?

Any existing agreements between HAs and First Nations will be honored in this process. The FNHA and local First Nations should already be a part of the PCN planning process. As described above, where First Nations have been allocated PCN resources under the PCN service plan and wish to be the employer of those resources rather than the HA, the HA and First Nation should enter into a service agreement whereby the HA transfers the funding it receives from the ministry for PCN to the First Nation for the purposes of employing these PCN resources. If there are any other specific concerns related to First Nations hiring, please contact your Ministry of Health liaison.

Is there a plan in place for rural communities that currently have multiple RN and allied health vacancies (difficulty to recruit and retain)? Will there be a rural or underserved community incentive for individuals to relocate?

We know there are times when it can be challenging to recruit health professionals in a timely manner. The Ministry of Health, in partnership with the Ministry of Advanced Education, Skills and Training, HAs and HEABC are working together (with key partners and stakeholders) to understand and meet the health human resource needs associated with implementing PCNs. There is no plan at this time to introduce new incentives related to recruitment and retention of health-care providers.

Can the RN do group medical visits?

Yes.

Can staff work after hours?

Provided that staff are working within the terms of the applicable collective agreement and service contract, there is no limitation on which hours are worked.