BRITISH COLUMBIA | Ministry of Health

Primary Care Networks – GP and NP Contracts and Compensation

Contents

Introduction

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 help 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 new these new teams. Divisions of Family Practice, health authorities, First Nations and other community organizations 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 that there will be questions and concerns that come up along the way. One of the main areas of interest has been how physicians and nurse practitioners will be employed.

Part of our strategy includes hiring 200 general practitioners and 200 nurse practitioners, who will work within patient medical homes throughout the PCNs.

Service Objectives and Obligations

Successful candidates for placement in a PCN primary care practice will be engaged through a provincially standardized service contract developed by the Ministry of Health and administered by the regional health authority. Practitioners engaged through these contracts will be independent contractors. They will not be health authority employees.

The three-year service contracts, which were developed in consultation with Doctors of BC and the NP Council of the Nurses and Nurse Practitioners of BC (formerly BCNPA) respectively, will provide income security as the practitioner establishes their practice and builds their patient panel.

As a next step, and in addition to the other alternative compensation models, a new service contract will also be developed and offered to established family physicians with existing patient panels who wish to participate in a team-based PCN primary care practice. The Ministry

is currently working on these contracts and hopes to bring them to the Doctors of BC in the coming weeks.

The answers provided below are based on our current understanding and practices. We know that these contracts are new, and we are taking a quality improvement approach as we implement them. As we learn and make any improvements or changes, we will reflect those in this document. Our goal is to be supportive and make this process and initiative successful.

Frequently Asked Questions

General

What is meant by 'team-based' care?

In general, team-based care refers to a group of providers and staff with complementary skills and competencies that cooperate, collaborate, communicate and integrate services. The composition of a health care team should enable providers to work to an optimized scope of practice to meet community and patient needs, improve patient access to primary care while also supporting continuity of care, and enhance cost effectiveness in the delivery of care.

Team members may include, but are not limited to, physicians, nurse practitioners, registered nurses, psychiatric nurses, licensed practical nurses, pharmacists, physiotherapists, case managers, dietitians, nutritionists, occupational therapists, social workers, midwives, and mental health specialists, depending on the needs of patients in the community.

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 on-site clinical leadership to ensure the team works well together.

What that looks like on the ground is a cohesive team where each provider has their own unique role and scope in the provision of patient care and they work together to make sure that the patient's needs are met in the most effective way possible. We recognize that for many, this structure will be new. However, it is being used effectively at clinics already here in B.C., as well as in other jurisdictions.

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 clinic. As PCNs get 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.

Will the GP/NP contracts be with the Ministry directly or with the health authorities?

Contracts for both GPs and NPs will be held by the health authorities. Practitioners engaged through these contracts will be independent contractors. They will not be health authority employees.

What are the expectations for the administrator of the contract (i.e. attachment, QI, etc.)?

The health authority is the contract administrator and will oversee the contract management process. As the contract administrator, the health authority is responsible for ensuring payments flow in an accurate and timely fashion to the contracted practitioner or designated representative. The contract administrator will also ensure the practitioner reports monthly on their hours worked.

As a participant in the PCN, the contracted practitioner commits to adopting the attributes of the PCN and the Patient Medical Home. The contract administrator is also responsible for ensuring that the contract is in alignment with these initiatives and their related policies.

Do the 7.5 hours per day include time for paperwork or are they all to be patient-based; would teaching be required?

One FTE under the Service Contract is defined as between 1680-2100 hours of services annually for GPs and a minimum of 1680 hours for NPs. Services under the contract, which are laid out in Appendix 2, include both the full scope of primary care services as well as clinical administrative services, including medical co-ordination, participation in multidisciplinary team planning, and participation in the planning of long-term health care delivery goals and health prevention and promotion activities as part of the PCN. Other services may be included as part of the practice agreement between the practitioner and the practice.

Exact hours and days of work are established under the clinic level practice agreement. There is no requirement to work 7.5 hour days; however, to be paid a full FTE, a practitioner must work an annual minimum of 1680 hours and a minimum of 220 days.

What are the on call requirements on this contract?

The contract does not address the specifics of call requirements for patients within the group practice; this is a matter for the group practice to coordinate through the practice agreement. The contract does not provide payment for "availability;" however, practitioners are expected to potentially make themselves available to provide services after-hours, in the context of the practice agreement or any arrangements agreed to as part of joining the PCN. Any services provided that arise from being called in after-hours fall within the scope of this contract and are included in the practitioner's reportable hours.

What happens if I cannot complete the 3-year term? Is there a financial penalty?

There is no financial penalty if a contracted GP or NP cannot complete the 3-year term. The Service Contract stipulates that either party may terminate the contract without cause upon six months written notice to the other party.

In the event the Service Contract is terminated and the practitioner does not intend to maintain the attachment relationship with their patients, the practitioner is obligated under the Service Contract to work with the clinic, the health authority and other health system partners to facilitate continued access to primary care for their patients. The practitioner must abide by their College's respective standards and guidelines for leaving practice.

What are the obligations of existing clinics towards patients who are taken on by these practitioners if they decide to leave the practice?

The College of Physicians and Surgeons of British Columbia and the BC College of Nursing Professionals each have practice standards that set out practice management considerations to ensure continuity of patient care and the preservation of patient records in a situation where a practitioner wishes to leave their practice. The practice standards set out requirements and guidelines around notification and medical records.

In the event the Service Contract is concluded and the practitioner does not intend to maintain the attachment relationship with their patients, the practitioner is obligated under the Service Contract to work with the clinic, the health authority and other health system partners to maintain primary care access for the patients and to attach patients to another family practice. The practitioner must abide by their College's respective standards and guidelines.

Can I switch clinics and still be on the same contract?

Yes, under the Practice Agreement between the practitioner and the clinic, a notice provision can be specified for termination of the Agreement by either the practitioner or the clinic (see Schedule 1 to Appendix 2, item 14). From the Ministry's perspective, there would be no problem in moving to a different group practice so long as a new Practice Agreement is established, primary care access is maintained for the contracted practitioner's attached patients, and College guidelines are followed.

How will maternity leave work? Can I 'pause' my contract?

For an expected leave such as maternity leave, you should look for another practitioner to take over services required under the contract for the duration of the leave. If this is not possible due to a lack of availability of alternative providers, you would need to have a discussion with the clinic about coverage for the time away and come to a mutually agreed upon arrangement. The contract arrangement can be reviewed by the health authority and practitioner to consider a maternity leave arrangement where the services being provided are being paid under fee-for-service.

What happens if you have a hard time meeting the deliverables of the contract?

Generally, if a practitioner is having difficulties meeting a deliverable, the expectation will be that they work with the health authority and their group practice to identify strategies to address the concern and meet the deliverable going forward.

I am interested in obtaining a part time position. Is this an option for me?

If you do not currently have a patient panel but are interested in establishing a full-scope primary care practice and working a minimum of 0.5 FTE, part-time opportunities may be available. Payments for Service Contracts under 1.0 FTE are pro-rated accordingly.

What, if any, are the expectations for inpatient care for NPs/GPs within these contracts?

Under the Service Contract, you agree and commit to transitioning your practice towards a Patient Medical Home and to participate in the local Primary Care Network. The core attributes of both PCNs and PMHs include the provision of comprehensive, co-ordinated primary care, which may include inpatient care depending on the community.

The Practice Level Agreement negotiated between you and the clinic you are joining or establishing will outline the agreed upon expectations with respect to call rotations or in-patient care.

Who was involved in the development of the GP/NP contracts?

The Service Contracts were developed in consultation with the Doctors of BC, the Nurse Practitioner Council of the Nurses and Nurse Practitioners of BC (formerly the BC Nurse Practitioners Association), and the health authorities. The process was led by the Ministry and the Health Employers Association of BC.

I understand substantial comments regarding the contract were provided by stakeholders, how was the feedback incorporated into the contracts?

In developing the contracts, the Ministry sought to incorporate feedback gathered from GPs through various forums including the General Practice Services Committee's "Visioning" engagement process as well as resident physician and new graduate physician surveys. Doctors of BC were consulted on the contract templates and payment rates.

The NP contract template was based on the GP contract template and was revised where appropriate to reflect differences in professions. The NP Council of the Nurses and Nurse Practitioners of BC (formerly the BC Nurse Practitioner Association) was consulted on the NP contract template and payment rates.

Moving forward, the Ministry is committed to a quality improvement approach and is undertaking a process to share details about the GP/NP contracts and the rationale underlying the key contract elements, as part of an iterative process. The Ministry is continuing to engage with its key partners to address their concerns.

What does "practitioners will provide longitudinal, full scope primary health care services" mean? NPs have a very different scope than GPs, who include inpatient, emergency and obstetrical care in their "full scope."

The "full scope of primary care services" referred to in the contract language (Appendix 2, item 16 "Primary Care Services") means the scope of practice of GPs and NPs respectively. Emergency and obstetrical care are two areas in which the contract language is different for GPs compared to NPs, which reflects the differences in scope of practice. For example:

- NPs do not provide obstetrical care but do provide pre and post-natal care (GPs and NPs are each required to refer appropriately for obstetrical care if they do not provide it themselves).
- NPs do not assist with major surgeries but do perform minor surgical procedures such as suturing and obtaining biopsies.
- NPs may take on ED and inpatient care roles with additional mentorship and/or training.

The contract template is intended to be flexible enough to accommodate a variety of community-level service needs and requirements. The Ministry's intent is not to destabilize existing services, but to enhance overall service provision. In instances where additional training would enable GPs or NPs to provide additional services (e.g. ED and/or inpatient services), supports will be provided. What these supports look like are still being worked out, but we will provide more information as soon as we have more details.

The Practice Agreement between the contracted GP or NP and the clinic they are joining or establishing lays out the specific services the practitioner is expected to provide, including any additional services, specific service locations, or means of service delivery not already stated in the contract.

Rates, Overhead and Other Funding

How was the GP contract rate set? How was overhead calculated for the GP contract?

The GP service contract rates were established with the intent to be competitive/comparable to incomes of GPs compensated under fee-for-service, with approximately similar work profiles required under the contract (e.g., number of patients per day, days worked, etc.). Like fee-for-service, which provides an overhead component within the fee rates, the service contract rates are an “all-in” amount that includes provision for overhead.

In setting these rates, we also had to take into consideration the requirements under the Physician Master Agreement. The rates set are within the approved Alternative Payments Subsidiary Agreement (APSA) rates for the GP - Full Scope practice categories under the PMA.

Is it possible to have a cost-sharing arrangement for overhead, rather than a fixed overhead amount?

It is up to the practitioner and the clinic they are joining or establishing to determine how they would like to arrange payment for overhead. The contract rates are inclusive of a contribution

for overhead, but the details of the clinic-level contributions are up to the practitioner and the clinic to determine.

How does funding for overhead work under the NP contract?

The overhead payment for NPs under the service contract was set with the intent to be equitable with the salary rates and benefits coverage of NPs currently working in B.C. Currently, NPs are employed by health authorities. For employed NPs, health authorities cover the costs of overhead. As such, a separate block payment for overhead is provided under the service contract to acknowledge that NPs will incur overhead costs in operating their practices.

The rates provided under the service contract ($75,000 for urban/rural and $85,000 for metro) are considered to be reasonable rates for an NP practicing in a group practice and are intended to generally cover the cost of the operational necessities to practice within a primary care clinic/patient medical home. It is important to note that, for the purposes of the NP contracts, the amount provided for "overhead" is meant to include some professional expenses such as liability and continuing education. While these would not normally be considered "overhead" by GPs, we have included them here with the recognition that GPs are able to access supports for these costs from Doctors of BC or the General Practice Services Committee, which NPs are not able to access.

How do NPs receive the overhead payment?

The overhead amount will be paid in monthly installments directly to the contracted NP and the NP is responsible for paying their contribution towards overhead to the group practice. The costs covered by the NP's overhead contribution to the group practice may vary depending on the arrangement with the clinic.

The details regarding the specific items provided for a given overhead contribution should be specified within the practice level agreement determined between the NP and the practice. An accounting of actual overhead expenses is not required by the Ministry to receive payment, consistent with GPs paid under fee-for-service and under the GP service contract.

It is the Ministry's expectation that if overhead costs are less than the block payment amount, the remainder is not intended to be used by the NP as an increase to their compensation. Rather, the remainder of the overhead is to be used by the NP to enhance practice and support team-based care within the clinic (e.g.: quality improvement initiatives; maintaining credentials for certification for specific procedures in primary care).

In the case where an NP is contracted within a health authority (or where the NP is employed in the health authority) it is expected that the services/supports required to run a practice are similarly provided from within the NP overhead allocation, and that the amount allocated for professional development or liability protection be specified within the service contract.

When I first heard about this contract, I was told that GPs were to be given separate funding to cover overhead. Why was that changed?

During the contract development process, earlier iterations of the GP contract payment rates were tested with existing GPs through Doctors of BC. One version of the rates included a separate provision for overhead with a lower base payment amount and different treatment of third-party billings.

Through the ongoing development process, we considered an analysis of fee-for-service income for GPs with similar work profiles as those outlined under the contract, as well as feedback from GPs.

Based on all of these components, the final total contract rate offered included overhead as part of the total compensation, commensurate with similar work profiles of physicians who are billing FFS (i.e. number of patients per day, days worked).

Why have overhead costs been supported for NPs but not for GPs?

Rates for GPs and NPs were developed with the intent to provide competitive compensation relative to their professions. Overhead rates have been built into both contracts, but have been reflected differently for each profession.

The service contract rates for GPs were established through an analysis of Medical Services Plan (MSP) billing data for physicians with similar work profiles required under the contract and are within the GP full scope practice categories ranges negotiated under the PMA. Under fee-for-service, provision for overhead is included in the gross fee-for-service rates/income and a similar “all-in” approach was taken under this service contract.

The service contract rates for NPs were established with the objective of providing income and benefits comparable to that of NPs employed in health authorities. To maintain equity with health authority-employed NPs, under the contract a separate allocation is provided for overhead costs as all overhead costs are paid by health authorities for employed NPs.

The PCN I am joining has already established a standardized policy for NP overhead contribution amounts. Is this appropriate?

Some PCNs have indicated the intent to establish policies that standardize the overhead contributions that practitioners on service contract must pay to participating clinics in the PCNs. The Ministry's position is that these issues should be decided at the local level between the PCN planners and the practitioners they are seeking to recruit. It is up to the NP to decide whether the PCN requirements are acceptable to them and if the match is right for them. Regardless of whether a standardized approach to overhead contribution is taken, the details of the overhead contribution and the components provided for that contribution should be outlined in the practice level agreement.

Based on these rates, NPs cost more per patient than GPs. How does this meet the triple aim?

Rates for GPs and NPs were developed separately with the intent to provide competitive compensation relative to their professions, not across professions. The service contract rates for GPs were established through an analysis of MSP billing data for physicians with similar practice models which the contract is designed to support, and in relation to established rates for GP full scope practice categories negotiated under the Physician Master Agreement (PMA). It is important to note that the GP contract was created to target new-to-practice physicians who do not already have a patient panel. We are currently working on a contract for more experienced physicians who already have an established panel, and will be have more of those details in the coming weeks.

The Ministry did not compare per-patient costs across GPs and NPs as part of the contract development. Given that the contracts are intended to compensate providers for time spent delivering services, the Ministry's objective was to provide income relative to what other providers within the same profession are earning for similar work.

Why is there no option for family doctors to obtain medical/dental benefits like NPs have?

Medical and dental benefits for both GPs and NPs are obtained independently and are not provided under the contract.

Does the contract include any additional funding or services to support locum coverage?

There is no separate, additional funding included with the contracts to support locum coverage. Physicians, if eligible, may request locum coverage through existing programs, such as the Rural General Practitioners Locum Program (RGPLP), and the health authority will make reasonable efforts to assist the physician in arranging for locum coverage through the RGPLP. Other fee-for-service physicians, including locums and other physicians at the clinic, who cover the contracted physician's patients can bill FFS for services provided to the contracted physician's patients.

Currently, there are no existing locum programs for NPs. However, if a locum program is established, eligible NPs would be able to request locum coverage through that program.

Is there a requirement to meet the minimum 1680 hours before you are eligible for locum coverage?

The 1680 hours refers to 1.0 FTE of services under the contract and applies to the contracted practitioner only. This translates to 44 weeks per year at 37.5 hours per week.

If a GP or NP arrange coverage through a subcontractor arrangement (another GP or NP covering their panel) it will count towards the contracted hours. Such subcontractors will not be entitled to bill fee-for-service for delivery of the services to either the practitioner's patients or to patients of the practice. Service coverage provided by a short-term locum, through the Rural GP Locum Program (RGPLP) or equivalent provincial locum program in place at the time, or otherwise secured by the practitioner will bill fee-for-service and will not count towards the practitioner's contracted hours.

Short term locums secured through the RGPLP or equivalent provincial locum program will be paid in accordance with the policies of the RGPLP or equivalent provincial locum program. Locums otherwise secured by the practitioner are entitled to bill fee-for-service for Services delivered to the practitioner's patients and Services delivered to the patients of the other physicians in the Practice.

As NPs are unable to bill fee-for-service, NP locum coverage will be funded under the minimum 1680 contracted hours. If the contracted NP is unable to secure another NP to provide locum coverage, a GP locum may be engaged and would bill FFS. Contracted NPs are required to report NP locum hours worked to the health authority as part of the reporting requirements under the contract.

In a practice with both FFS physicians and contracted – are the FFS physicians able to bill for visits when they see one of the contracted physician's patients (for example, if the regular physician is booked up)?

If a FFS physician provides services to the contracted practitioner's patient because the contracted practitioner is not able to do so (e.g., vacation coverage), the FFS physician may bill FFS for services provided. The contracted physician, however, is still required under the contract to provide the stated number of hours (1680) during the year if they want to receive full remuneration for 1 FTE of work.

Are there sign-on bonuses for entering into a three-year contract?

There is no sign-on bonus offered as part of the contract.

Can I obtain additional employment on a casual or part-time basis while working under a primary care service contract?

Practitioners may commit to other opportunities; however, it is expected that the practitioner will do so only if they are able to fully meet all the obligations under the service contract and the Practice Agreement with the group practice (including any extended/after hours and on-call requirements) and that the work is clearly done outside the service contract required hours and panel commitments.

Are we able to combine our patients/hours worked in other settings (like residential care) to meet the requirements of the contract?

Primary care services under the service contract include support for hospital, home, rehabilitation, and long term-care facilities (so long as appropriate privileges have been obtained). Additional service locations (such as residential care facilities serviced by the clinic) can also be specified under the practice-level agreement between the contracted practitioner and the clinic they are joining or establishing.

Can job sharing be accommodated?

The Service Contract template is structured as a solo contract (e.g. a contract between the Health Authority and an individual practitioner). To provide flexibility, the practitioner may work part time (between 0.5 and 1 FTE) or make use of subcontractors or locums to cover absences. There is currently no group contract template; however, the Ministry is taking a

quality improvement and learning approach and may consider in the future, developing a group contract for scenarios where groups of practitioners wish to collectively assume the contract deliverables.

Can extended work days be accommodated?

The Service Contract defines one FTE as 1680 hours of service delivery annually over a minimum of 220 days. Beyond these requirements, the Ministry is not prescriptive on the practitioner's hours of work. Actual days and hours of work are established under the practice agreement between the practitioner and the clinic they are joining or establishing. Nothing in the contract prevents a practitioner from working longer or shorter days as agreed to with their clinic.

What are the contract stipulations regarding third party billings?

The contracted physician is required to bill the third party (ICBC, WSBC etc.) including when they see their colleagues' patients, or to bill the patient directly for uninsured services. Physicians will be able to retain their third party billings. However, time spent providing these services cannot be counted towards a practitioner's minimum contract hours.

For NPs, the contract stipulates that NPs must remit third party billings to the health authority. The Ministry is currently working with its partners (ICBC and WCB; and HIBC) to enable NPs to bill for ICBC and WCB funded services and to allow third party billings and payments through Teleplan.

Why did you decide on salary vs blended payment model?

The 200 GP and NP service contracts were designed to be one option available to support new-to-practice providers seeking to establish their family practices and build their patient panels. In developing these contracts, the Ministry sought to incorporate feedback gathered from GPs through the General Practice Services Committee's "Visioning" engagement process as well as resident physician and new graduate physician surveys. Feedback received by the Ministry reflected physicians' concerns around clinical autonomy, workload, administrative burden, and team-based care, all of which the contracts seek to address.

As part of the PCN implementation strategy, a new service contract will be developed and offered to established physicians with existing patient panels. The contracts will be offered in

addition to other alternative-to fee-for-service compensation options, such as blended capitation models (e.g. Population-Based Funding) to support the implementation of the PCN service plans.

In our community, physicians provide hospital care for patients. Inpatient care is supported with a GPSC funding initiative. Will the new practitioners be able to access these funds and then participate in our 24-hour patient coverage for inpatients?

The issue of whether physicians on the APP contract can bill or participate in the various GPSC Networking fees (e.g. In-patient, Residential Care and/or maternity networking fee) has been referred to the GPSC Incentive Working Group for review and recommendation to the GPSC. An answer to the question is anticipated in the near future.

Is there a plan to have a blended model of compensation in BC like it currently is in Ontario?

The Ministry is currently supporting two blended funding models which are like those used in Ontario. Population-based funding is an established model in use at nine sites across the lower mainland. Value-based compensation is a prototype model in use at three sites in Fort St. John. Both models are initially being offered through the PCN implementation process in a limited capacity, subject to EMR compatibility and clinic readiness. The Ministry's intention is to continue supporting these models and to build the capacity for wider adoption by interested clinics in BC.

The contract states that provision of "clinical administrative services" including health care/service planning activities for the health service delivery area is part of primary care services in the scope of the contract. Will this exempt me from any payment from Divisions work or other organizations?

Payments from Divisions or other organizations (e.g. health authorities) to attend meetings and professional development events are not considered clinical administrative services, so GPs are able to receive payments for such activities.

Time spent at Divisional meetings and professional development, however, does not count toward the expected direct service hours expected within the contract. Clinical administrative services are defined as paper work, consultations or referrals related to direct patient care. Community and program development work related to health promotion is also included in the

basket of services under the contract and counts towards the contract hours. However, it is important to note the key objective of the contracts is to provide primary care to patients, in accordance with the targeted panel size. Involvement in community and program development work related to health promotion should not come at the expense of providing appropriate and timely patient care.

How does this model differ from Fee-for-Service (FFS)?

Under both payment modalities, GPs are independent, autonomous practitioners; however, the Service Contract better supports the PCN and team-based care. Under FFS, physicians are paid a specified amount for providing services in accordance with the Medical Service Commission Payment Schedule; there are billing restrictions on delegating services and limited ability to bill for team consultations.

Under a Service Contract, time is a major component of payment (e.g., 1,680 to 2,100 hours per year for one FTE) along with other deliverables (e.g., minimum panel target). Compared to FFS, contracted physicians have a more stable and predictable income, which enables them to spend more time with patients and to work in interdisciplinary teams. Contracted physicians will also have reduced administrative burden compared to FFS through simplified encounter reporting.

PCN Implementation / Recruitment Process

How many jobs will be made available over the next three years?

New funding has been allocated to recruit up to 200 general/family practitioners and 200 nurse practitioners to work as part of a team in the PCN model. Recruitment is initially targeted to GPs and NPs who do not currently have a patient panel.

Is Health Match able to speak to the supply/interest of nurse practitioners for these upcoming opportunities? How competitive should we expect the job market to be?

Health Match BC continues to see strong responses from nurse practitioners interested in exploring PCNs. In time, and as communities finalize their PCN service plans, we will have a greater understanding of the number and types of regional opportunities attributed towards PCNs.

Some opportunities may prove to be in greater demand than others, but we feel confident that we can match all suitable and eligible candidates to the opportunity that best reflects their needs and the needs of the community they will serve. To ensure early engagement with the community/opportunity of your choice, we highly recommend registering with Health Match BC and speaking with one of their recruitment consultants about your interests.

Do all positions recruited for PCNs need to be signed to the contracts, or are they able to participate and be fee-for-service?

The GP and NP service contracts have been developed for use as part of PCN service planning and are intended to provide an alternative compensation option for interested practitioners. PCNs may choose to focus on recruiting FFS physicians to address their attachment gaps and to meet their communities' service needs. In limited circumstances, health authority-employed NPs may also be integrated into PCN service delivery, but the intent is for the independent NP contract to be the predominant model for longitudinal, full scope primary care services.

When will the start dates be for these contracts?

Each contract will be negotiated based on the PCN planning timeline and the physician or NPs availability. Once a service agreement has been signed between the PCN and the Ministry, the PCN planning committee is able to start hiring, depending on their own internal processes.

Will each PCN share the same EMR?

Currently there are many EMRs available on the market and in use across the province. The Ministry is working to resolve ongoing issues and exploring the feasibility of a single platform in the long term. In the interim, the Ministry is supporting existing approaches.

Where can I find more information on contract employment opportunities?

Contact Health Match BC at 1-877-867-3061 and ask to speak with a recruitment consultant about Primary Care Network opportunities. Alternatively, you can register online with Health Match BC at www.pcn.healthmatchbc.org or email pcn@healthmatchbc.org with a copy of your resume and a note about your interest. Health Match BC will:

- guide you through registration and licensing procedures

- match your skills and interests to job vacancies in regions of your choice
- provide you with information about communities of interest
- connect you with prospective health employers
- connect you with appropriate resources, such as transition to practice supports, throughout the system
- provide personal and professional support to you from the initial stages of expressing interest and through the first year of practice

Is there a way to bypass Health Match BC if a clinic identifies an ideal GP or NP candidate to integrate into their team?

Health Match BC is not the only venue through which to recruit an NP or GP candidate. If a relationship already exists between an interested practitioner and a clinic, within the PCN service plan recruitment can be coordinated through the PCN implementation process instead of Health Match.

What other healthcare professionals will be part of the PCN?

Through the PCN Service Planning process, PCN planning committees identify areas where nursing and/or allied health professionals are needed, both to reduce attachment gaps and to improve the quality of primary care. Each community will determine this strategy differently, depending on what services are required locally.

How will other team members be compensated?

RNs, LPNs, and allied health providers will be health authority employees and will be compensated within the appropriate health authority pay grids.

Are we able to use virtual services (such as teleconsults or Skype) to round out our hours – particularly if the practice we work at does not have physical space for a full-time GP?

Yes, providing care virtually is allowed; however, it must be done in the context of a longitudinal relationship where the GP has an established face-to-face relationship with their patients. The practice-level agreement between the practitioner and the clinic they are joining

or establishing allows the parties to specify additional means of providing services to their patients such as digital/virtual care, where available and appropriate.

How is the Ministry determining where the vacancies are?

Resources required to meet the goals of the PCN are being specified through a service planning process undertaken by PCN Planning Committees in collaboration with the Ministry. Service plans outline the resources needed to support primary care strategies in the community in alignment with the core attributes of the PCN as outlined in the Ministry's policy direction.

Recruitment for GP and NP contract positions is being co-ordinated through Health Match BC. You are encouraged to contact Health Match BC by email at pcn@healthmathcbc.org or by telephone at 604.736.5920 / 1.877.867.3061 for more information on the recruitment process.

Where are the team-based care practitioners going to work? Who pays for the office space?

Office space is generally considered part of overhead costs. The overhead contribution is negotiated and determined under the practice-level agreement between the practitioner and the clinic they are joining or establishing.

As part of the PCN service planning process, PCN Planning Committees are determining where nursing and/or allied health resources are both required and can be accommodated (e.g. in terms of available space).

I've been told that this contract is good for work/life balance, what elements would you point to highlight that?

We have heard from many new residents and new-to-practice family physicians that it is stressful to build a practice under fee-for-service, as they do not have income security while they build their practice, and they are not getting compensated while they do administrative tasks.

The service contract is intended to provide income stability while the practitioner builds their patient panel. The requirement of 1680 hours and 220 days per year for 1.0 FTE of services reflects the objective of providing compensation for longitudinal, full scope primary care. The minimum hours and days translates to 44 weeks per year at 37.5 hours per week, and includes both clinical and administrative tasks, associated with direct patient care. Specific hours and

days of service are established under the practice agreement, which allows the practitioner and the clinic increased planning flexibility.

Are these new grad contracts going to be allocated within PCN planning communities, or randomly around the province?

Rollout of the Service Contract initiative is presently being aligned with PCN implementation.

Through the PCN implementation process, contracts are allocated to sites based on the strategies outlined in the service plan submitted by the PCN Planning Committee. These strategies are intended to address primary care needs in the community, as identified by the Planning Committee.

Practitioners who sign on to the contract are not required to be newly graduated. The contracts are targeted to practitioners who do not have established patient panels.

Can contracts be integrated into clinics that serve vulnerable, marginalized, or mental health and substance use (MHSU) populations?

Yes, as long as the services are integrated into the PCN service plan for the community. For specialized populations such as these, the Ministry has considered reduced attachment targets on a case-by-case basis.

What are the responsibilities and expectations of Divisions of Family Practice in supporting GP/NP roles?

The Divisions of Family Practice are key and central partners to the development of the PCN service plans, which includes understanding the attachment gap and patient service needs in the community. The Divisions' role is to identify (with local practitioners) where there are opportunities at a clinic level for GPs and/or NPs to join existing clinics. The Divisions may also lead or support the recruitment of new practitioners into their community. For NPs, the NP Council of the Nurses and Nurse Practitioners of BC (NNPBC) provides advocacy for NPs and will be providing practice supports to NPs engaging in the service contracts throughout the province.

The contracts themselves are funded by the Ministry and administered by the regional health authorities. The specifics of how a practitioner works and manages their practice and the

delivery of services within the clinics are established collaboratively by the practitioner and their group practice. Generally, if a practitioner is having difficulties meeting a deliverable, it is expected that the practitioner works with the health authority and their group practice to identify strategies to address the concern and meet the deliverable moving forward.

The Ministry is currently developing supporting documentation to assist PCN partners and interested practitioners with expectations regarding roles and responsibilities.

What is provided by the Ministry in terms of support - what type of staff/allied health/EMR, etc.

As part of the PCN implementation process, the Ministry works closely with local PCN planning committees, including representatives from Collaborative Services Committees and additional community partners such as First Nations and Indigenous communities, to support their service planning process.

The service plan template and direction from the Ministry encourages planning committees to identify strategies to address the primary care needs of the community to be served by their proposed PCN(s), including patient attachment and primary care access gaps. The Ministry further encourages planning committees to incorporate strategies in their service plans to develop interprofessional team-based care with structural enablers that support enhanced team formation. These structural enablers and change management supports are specific to the local service plans submitted by a community.

How do the contracts align with clinics rostering patients to the clinic as a whole, rather than GPs or NPs individually?

The GP and NP contracts are focused on increasing patient attachment to a Most Responsible Provider within a group practice, rather than to a clinic as a whole. The contracts require practitioners to hold attachment conversations with their patients and to submit administrative attachment codes. Attachment to contracted practitioners will be measured against the stated attachment targets. In the future, the Ministry may contemplate the use of group contracts for practitioners who wish to share an attachment commitment.

In addition to GPs and NPs, services provided by RNs are also expected to contribute to a clinic's attachment capacity, while the presence of LPNs and allied health professionals are expected to

contribute to a higher quality of care. The degree to which these services impact attachment and quality of care will be measured through PCN-level reporting.

What are the stipulations for GPs or NPs in the service contracts for both expected leave (like maternity leave) or unexpected (like sick leave)?

For an expected leave, the GP or NP should look for another practitioner to take over the contract for the duration of the leave. If this is not possible, they should discuss coverage with the clinic and will need to come to a mutually agreed upon arrangement.

For an unexpected leave within a team of care providers which is short-term in nature, and where the team members feel they can cover the contracted practitioner's patients, FFS may be billed for those services. If GP and NP team members are also contracted practitioners, the services would count towards their minimum 1680 hours. For a longer-term unexpected leave, the clinic may choose to secure locum or subcontractor coverage.

What happens if a practitioner leaves the practice?

In the event that the Service Contract is concluded and the practitioner does not intend to maintain the attachment relationship with their patients, the practitioner is obligated under the Service Contract to work with the clinic, the health authority, and the other health system partners to maintain primary care access for the patients and to attach patients to another family practice. The practitioner must abide by their College's respective standards and guidelines.

Evaluation / Reporting

How will attachment be measured?

Practitioners are required to submit an attachment record to the Medical Services Plan/Health Insurance BC via Teleplan on a one-time basis for each patient after the practitioner and patient have completed the attachment conversation and attachment is agreed to by the practitioner and the patient.

Measurement will be supported by the Ministry of Health's Services Information, Analysis and Reporting Division and GPSC's Community Practice and Quality team and Practice Support Program.

How are panel targets affected by practice location? If my practice is in a rural or remote community, am I still expected to meet the same targets as someone in an urban or metro community?

The Ministry is aware that there are an array of service delivery needs and service delivery models in rural communities and that family practitioners in rural communities are often required to participate in broader services beyond office-based family practice (e.g., Emergency Department, Doctor of the Day, outreach).

The Ministry's intent is not to destabilize existing services, but to improve access to primary care within the PCN with consideration of the broader health system needs of the community. With the unique requirements and circumstances in each rural community in mind, guided by the PCN service plan, patient attachment targets may be adjusted to ensure that the health system needs in the community are appropriately addressed. Each rural community will assessed individually.

How will the GPs and NPs on these contracts be held accountable for attaching patients and working the assigned hours?

For GPs and NPs, attachment will be tracked using an administrative attachment code submitted through Teleplan. In addition, practitioners will submit service-based encounter codes. Encounter reporting is required for the Ministry to understand service delivery, for the analysis of population health, and for health system planning. The encounter reporting structure used for contracted GPs is a simplified version of the shadow billing required under other APP service contracts, designed for greater administrative ease. Contracted NPs will initially use the established set of NP encounter codes, with the intent being to transition to the simplified codes in the future. Practitioners will also be required to report their hours worked to the health authority monthly.

Under the GP contract, the physician also agrees to engage in appropriate panel management, including accessing and utilizing the GPSC's Practice Support Program Understanding Your Patient Panel or any future applicable practice support programs as available and appropriate

How do you plan to track access to providers? For example, how far ahead are they booking or is same-day access available? Are patients accessing care at walk-in clinics because they can't get in?

As part of a comprehensive monitoring and evaluation plan for PCNs, access will be tracked through patient and provider surveys as well as annual reporting from the PCN Steering Committee on extended hours and same day access at clinics providing care as part of the PCN.

Will the NP or GP be penalized if a patient seeks primary care services elsewhere?

There are no payment deductions under the contracts if/when a patient seeks services elsewhere (typically referred to as outflows). However, the objective is for providers to establish a relationship with the patient to ensure they identify them as their Most Responsible Provider (MRP).

Is patient satisfaction and evaluation supported by the Ministry or is this part of the overhead?

Patient satisfaction and evaluation of the PCN initiative will be the responsibility of the Ministry. Under the contract, the practitioner is required to participate in evaluation activities, but they are not required to conduct these activities themselves or to pay for them.

Other: GP-Specific

Will GPs who are on these contracts remain eligible for Doctors of BC matching RRSP benefits?

Contracted GPs will remain eligible for all negotiated benefits under the Physician Master Agreement.

Which GPSC incentives, if any, contracted general practitioners eligible for?

Under the current service contract template, contracted GPs will not be eligible for GPSC incentives.

However, the issue of whether physicians on the APP contract can bill or participate in the various GPSC Networking fees (e.g. In-patient, Residential Care and maternity networking fee) has been referred to the GPSC Incentive Working Group for review and recommendation to the GPSC. An answer to the question is anticipated soon.

What about liability in team-based practice? Who is responsible if something goes wrong?

Medico-legal liability concerns are often cited as being barriers to team-based care. In Collaborative Care: A Medical Liability Perspective, the Canadian Medical Protective Association (CMPA) believes that the medico-legal liability system that currently protects the interests of patients and individual providers can also protect team-based care practices.

The General Practice Services Committee has good information available to GPs on how to ensure they are protected from a liability perspective, while participating in team-based care. Generally speaking, each practitioner has their own liability insurance as part of a practicing health professional.

How do you respond to those who have been discouraging GP or NPs from signing these contracts?

We have had many good conversations with our partners and stakeholders to understand their concerns and explain the process by which we have developed these contracts, and we continue to dialogue with them. This is a new process for us all, and we are committed to following a quality improvement approach to these contracts, and to being transparent and open about the process.

A series of webinars have also been conducted for interested applicants and PCN communities to provide opportunities for questions and dialogue. The Ministry is also continuing to engage with other key partners such as the Doctors of BC and the Society of General Practitioners to hear their views and develop an approach which is considerate of them.

How will the patient complexities be managed to ensure GPs have balanced rosters?

Under the service contract, the practitioner agrees to act as the regular and most responsible primary care provider for a minimum patient panel that is broad with respect to factors such as age and complexity, unless a different panel composition is agreed to by the practitioner, the

agency, and the practice to service a particular population need.

I understand from the contracts that new GPs are intended to be attached to an existing practice. Does that preclude establishing a new service, such as an attachment clinic with a new contract GP?

The service contracts are targeted towards GPs and NPs who do not currently have a patient panel and who are looking to establish longitudinal, primary care practices. These practitioners can either join an existing practice or establish a new practice with other practitioners. There is no requirement to join an existing practice.

Will the same contracts be used with Urgent Primary Care Center (UPCC) physicians?

Physicians working in UPCCs are currently engaged through a separate Alternative Payment Program service or salary contract. In situations where longitudinal attachment is part of the UPCC clinical services model, the new GP service contract may be considered.

What are the differences between the GP contract template shared by the Ministry in October 2018 and the GP contract template shared in May 2019?

In April 2019, the government of BC and the Doctors of BC ratified a new Physician Master Agreement (PMA). A number of small modifications to the GP contract template were made to reflect changes in the new PMA and to clarify language and/or provide additional details about contract provisions. The general terms of the contract, as well as the services required and the compensation structure, remain unchanged.

Pursuant to the PMA, the GP Service Contract payment rates have been incrementally adjusted to include the Economic Stability Dividend (February 2019, 0.75%) and the General Lift (April 2019, 0.5%). This is consistent with adjustments made to the GP Full Scope practice category under the Alternative Payments Subsidiary Agreement to the PMA.

Other: NP-Specific

Can an NP open a solo practice to start?

The contract is not intended to support solo practitioners. Team-based care is one of the 12 attributes of the Patient Medical Home model, which serves as the foundation of Primary Care Networks. As such, the practitioner will be expected to join an existing group practice or set up a group practice with other practitioners. Additionally, the Service Contract is conditional upon the practitioner entering into a Practice Agreement with a group practice that has indicated willingness to join the PCN.

Who is eligible for the NP contracts?

The Service Contract opportunities are open to all NPs who are interested in establishing a patient panel. NPs must also maintain:

- registered membership in good standing with the BC College of Nursing Professionals and the Nurse Practitioner will conduct their practice consistent with the conditions of such registration;
- enrolment in the Medical Services Plan for the purposes of Encounter Reporting; and
- all other licences, qualifications, privileges and credentials required to deliver the services laid out in the contract

Why would I choose this model over working for a health authority?

This is an exciting opportunity to increase patient access to NP services. If you want to work as an independent primary care provider to deliver full service primary care and support the implementation of the PCNs, you may be well-suited to this opportunity.

Under a service contract you will be able to work to your full scope of practice as determined by the BC College of Nursing Professionals (formerly CRNBC), have flexibility in how you run your practice, and work with clinics to meet the needs of patients in the community. This opportunity will not be for everyone but is intended to provide an alternative compensation model for NPs delivering primary health care.

Divisions of Family Practice are generally exclusive of NPs. What is the Ministry doing to address this?

The Ministry is committed to working with its health care partners across the province to increase patient access to primary care, and we believe there is room for GPs and NPs to work alongside one another collaboratively.

The model of contracted GPs and NPs working alongside one another (and alongside FFS GPs) is new for most practitioners, and for some it brings uncertainty. The Ministry has committed to taking a quality improvement and learning approach and will continue to engage with its partners throughout the implementation process.

Will salary and overhead be dispersed as lump sum as done with GPs?

The Service Contract rate and the overhead rate for NPs are separate payments. The payment for services may be paid to the NP bi-weekly or monthly or by some other interval arrangement with the health authority, and the overhead will be paid to the NP in equal monthly installments.

Can overhead be used for insurances?

Yes. The overhead payment is a block amount and the Ministry is not being prescriptive about how the NP uses the overhead funding. The Practice Agreement between the NP and the practice they are joining or establishing determines the specifics of their overhead contribution and will be determined by the NP and the clinic.

Nurses and Nurse Practitioners of BC (NNPBC) can assist NPs who have questions about specific overhead costs.

Can the overhead be used for personal benefits?

No. The overhead allocation is intended to provide funding for aspects of running a practice. Benefits such as maternity benefits, medical, dental, disability are to be obtained from the salary component of the funding. Since these benefits are normally provided by the health authority for employed NPs, the NP contract payment rates were competitively set to provide the contracted NP with the ability to purchase their own benefits. Each NP (or GP) will need to determine what benefits are most relevant for their own personal situation.

For NPs wanting to set up a group practice, who/how do we submit a proposal?

NP clinics are welcomed as part of the strategies outlined in the PCN service plan, where there is interest from NPs and a demonstrated need in the community. NPs should work with the PCN Planning Committee to discuss how this strategy can fit within the PCN service plan.

Nurses and Nurse Practitioners of BC (NNPBC) is also working on ways to support NPs who want to set up an independent group practice. You can find contact info on the NNPBC website at https://www.nnpbc.com/

Is it possible to join a clinic that is not involved in PCN planning?

Health Match BC can match primary care providers to clinics whether or not they are a part of a PCN and each health authority also posts positions for their employed NPs. However, the Service Contract was developed with intent to be used in clinics which are part of PCNs.

If the NP takes a larger panel size (e.g. 1250+) is there any opportunity for further compensation?

The service contract rates for NPs were established with the objective of providing income comparable to that earned by NPs employed in health authorities. To maintain equity with health authority-employed NPs, the service contract rates are adjusted to recognize benefits and other costs that are borne by the health authority as the employer, such as medical and dental benefits, medical liability coverage, professional development, disability insurance, parental leave, and pension/retirement savings plan. There are currently no opportunities for further compensation under the NP contract beyond the amount in the third year of the term.

Will NPs receive benefits and/or pension?

Benefits are not provided under the NP contract and must be obtained separately by the NP.

The service contract rates for NPs were established with the objective of providing income comparable to that earned by NPs employed in health authorities. To maintain equity with health authority-employed NPs, the service contract rates are adjusted to recognize benefits and other costs that are borne by the health authority as the employer, such as medical and dental benefits, medical liability coverage, professional development, disability insurance, parental leave, and pension/retirement savings plan.

Will contracted NPs be eligible for WCB and EI?

Yes, contracted NPs are eligible for WCB and EI, and must contribute to those payments/deductions.

Will NPs be taxed on the overhead amount? Are taxes deducted on payment or are NPs responsible for paying them separately?

NPs engaged under a service contract are independent contractors and thus taxes will not be deducted by the health authority as they would for employees; as independent contractors, NPs are responsible for paying their own taxes. The Ministry is not in a position to answer questions about taxes, and encourages NPs to seek the advice of an accountant. NPs may also connect with the NNPBC as they are providing support to NPs considering working under service contracts.

Are provisional NPs able to enter into the contract?

Yes, as long as sufficient supports are in place to allow the provisionally licensed NP to practice (for example, provisionally licensed NPs are required to have supervision of a fully licensed NP or MD). Hiring of the NP will be a decision of the interview panel and it will depend on the context and needs of the practice and the NP (i.e. NP experience, timeline of expected completion of exams etc.), to determine an appropriate fit.

Is there the potential to destabilize HA NPs?

The NP Service Contracts were based on environmental scans locally and across the country and provide one option for NP employment. This model may or may not suit all NPs. There are many reasons why an NP may choose to work within a health authority employee model. The new NP contract is about meeting public need for primary care services and creating alternatives for NPs with respect to where and how they want to work.

Will there be practice supports for new grads?

The Ministry recognizes that practice supports will be required for NPs who are new to primary care including new grads, and is currently working with NNPBC to explore how these will be made available.

Can NPs choose which patients they decide to attach or will patients be assigned to them?

The NP agrees to attach patients as appropriate, based on the nature and scope of the NP's practice and the composition of the NP's patient panel. Patients can be referred from any existing local primary care waitlist used by the Division of Family Practice or the health authority and from any future provincial primary care waitlist, using those patient attachment mechanisms available during the Term, including any designated by the PCN.

If desired, a specific sub-population may be identified based on community needs. This would be negotiated within the practice level agreement and have to be agreed-upon by the NP.

Ultimately though, both patients and providers have choice on whether they work together. Either a patient or a provider can choose at any time not to continue to see one another.

Will the same contracts be used with Urgent Primary Care Center (UPCC) NPs?

Currently, NPs working in UPCCs are employees of health authorities. As the UPCC initiative is rolled out, other compensation models may be explored to engage NPs who wish to work in UPCCs. In situations where longitudinal attachment is part of the UPCC clinical services model, the NP service contracts may be utilized.

What are the differences between the NP contract template shared by the Ministry in October, 2018 and the NP contract template shared in May, 2019?

Changes to the 2018 NP contract template resulted from an additional review and feedback from the Nurses and Nurse Practitioners of BC (NNPBC). Most of these changes involved clarifying language and/or providing additional details about contract provisions. The new NP contract template includes some minor changes to the dispute resolution process and includes optional representation for the contracted practitioner by the NP Council of NNPBC.

No changes were made to the general terms of the NP Service Contract, including the services required, the compensation structure, and the payment rates.