BACKGROUNDER – CONTRACTING 200 NPs INTO PRIMARY CARE NETWORKS

The government of BC recently announced its vision for an integrated system of primary and community care across the province. The new system will improve access to care for patients and their families while maximizing the diverse skills of our health care workforce. At the foundation of the integrated system is team-based care; interdisciplinary teams of practitioners working together in Patient Medical Homes (PMH) to provide wraparound care for their shared panel of patients. The teams will be supported by a Primary Care Network (PCN) that acts as a hub to connect them and their patients to a full range of primary and specialized health care options; streamlining referrals from one provider to another, and providing better support to family physicians, nurse practitioners and other primary health care providers.

The system will be implemented in a phased approach.

Recruitment Initiative

The objective of the first phase of implementation, beginning in 2018, is to increase the number of British Columbians who have access to quality primary care and are attached to a primary care provider.

New funding has been allocated to recruit up to 200 General/Family Practitioners (GP) and 200 Nurse Practitioners (NP) to work as part of a team in the PCN.

Recruitment is initially targeted to GPs and NPs who do not currently have a patient panel.

Service Objectives and Obligations

Successful applicants who are placed 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 (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 primary care providers with existing patient panels who wish to participate in a team-based PCN primary care practice.

The current Service Contract template reflects the following objectives and obligations:

Primary Care Network and Patient Medical Home

- The practitioner will provide longitudinal, full scope primary health care services.
- The practitioner will be required to agree to become part of the PCN in the community and to adopt the attributes of the Patient Medical Home to achieve quality primary care service delivery. Quality primary care is defined by five attributes: effective, accessible, acceptable, appropriate, and safe. Details can be found at: http://www.gpscbc.ca/sites/default/files/uploads/PMH%20graphic%20%2020160920.pdf.

- The practitioner will be expected to join an existing group practice or set up a group practice with other practitioners; however, 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.
- The Practice Agreement between the practitioner and the practice they are joining outlines the respective rights and obligations of each party and will be shared with the health authority in advance of the practitioner and the health authority executing the Service Contract.
- The practitioner must agree to use Advanced Access Scheduling.

Patient Attachment and Patient Panels

- The practitioner must commit to act as the regular and most responsible primary care provider for a minimum patient panel that is balanced in composition (e.g., age, complexity). Panel size targets graduated over the term are set out in the Service Contract as follows:

  Nurse Practitioners

  Year 1 of the Term: panel size of a minimum of 500 patients per 1.0 FTE.
  Year 2 of the Term: panel size of a minimum of 800 patients per 1.0 FTE.
  Year 3 of the Term: panel size of a minimum of 1,000 patients per 1.0 FTE.

- Primary care waitlists can be used to build the patient panel (e.g., waitlists developed by the Division of Family Practice, the Ministry, or any future waitlist designated by the PCN).
- The practitioner will be required to have explicit attachment conversations with patients to outline the team's service commitments to patients and to encourage patients to name the practitioner as their primary care provider.
- The practitioner must commit to engage in appropriate panel management supported by practice support programs, such as the General Practice Services Committee's Understanding Your Patient Panel.

Practice Scope and Hours

- 1.0 FTE of services is defined as a minimum of 1,680 hours and a minimum of 220 days per year.
- Specific hours and days of work, average appointment time, periods of leave, and after hours/out of office availability are established under the Practice Agreement between the clinic and the practitioner.

Compensation

The Service Contract rates are competitively set and provide the NP with the ability to purchase benefits. The rates increase annually over the three-year term as follows:

Year 1 of the Term: $150,000 for 1.0 FTE of services
Year 2 of the Term: $155,000 for 1.0 FTE of services
Year 3 of the Term: $160,000 for 1.0 FTE of services

In addition, an allocation will be provided for the NP's overhead costs, disbursed in equal monthly installments:

$75,000 per year for rural and urban communities
$85,000 per year for metro communities

Arrangements between the practitioner and the clinic regarding overhead costs are to be determined privately among the parties through the Practice Agreement.

FREQUENTLY ASKED QUESTIONS

1. How does this model differ from working for a health authority?

This is a Service Contract, meaning the NP will be an independent contractor and not an employee of the health authority. The health authority will be the other party to the contract and the contract administrator. The contract will allow the practitioner to join an established clinic/practice or establish their own group practice. A Practice Agreement will also be in place for the NP and the clinic to establish further details (see question #3).

2. 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.

3. If I am paid by the health authority but working in the clinic, who am I managed by or accountable to?

As these funds are allocated by the Ministry of Health for the provision of health services, ultimate accountability is to the Ministry for the provision of quality health care. This is a provincial initiative to support the implementation of the PCNs; the Ministry, in consultation with the NP Council (formerly BCNPA), developed the contract template and established the specific terms, but the Service Contract will be administered by regional health authorities. The signatories to the Service Contract are the practitioner and the health authority.

The practitioner is an independent provider and the health authority will not direct how the practitioner works or manages their practice. The specifics of how the practitioner works and manages their practice and delivery of services within the clinic are up to the practitioner and their group practice. The Service Contract requires the practitioner to enter into a Practice Agreement with the group practice which outlines the relationship at the practice level.

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

If a practitioner currently does not have a patient panel but is interested in establishing a full-scope primary care practice and working a minimum of 0.5 FTE, part-time opportunities may be available.

5. Do I have the ability to 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.

6. **Will this opportunity be open to International NPs?**

On August 22, 2018, Health Match BC launched a marketing strategy initially focused on NPs in BC who do not currently have a patient panel. Marketing and recruitment will be expanded to suitable candidates in the rest of Canada and internationally in a phased approach.

7. **Is there a term to the contract? What happens when the term ends?**

The term of the Service Contract is three years.

Compensation options, alternative to fee-for-service and employment arrangements, are currently being implemented in a phased approach to support the PCN service plans. This includes the development of a Service Contract for established practitioners with an existing patient panel, and the expansion of population-based funding models.

At the end of the contract term, it is expected that the practitioner's practice would be fully established and that they would have a full patient panel. Similar to their established colleagues, practitioners would then be able to choose to remain on a Service Contract or transition to one of the compensation options that support PCNs and team-based care.

8. **Will I be expected to provide extended hours of services or be "on call"?**

Practitioners are expected to make themselves available to provide services after-hours. Any services provided arising from being called in after-hours fall within the scope of this contract and are included in the practitioner's reportable hours.

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. The contract also does not provide payment for "availability"; however, any services provided while on-call can be included in the hours under the contract and will count towards the minimum contract hours or service requirement.

9. **What if I am having a hard time meeting certain deliverables such as the minimum panel size?**

Generally, if a practitioner is having difficulties meeting a deliverable, the expectation is that the practitioner will work with the health authority and/or their group practice to identify strategies to address the concern and meet the deliverable going forward. The Ministry will be taking a learning and quality improvement approach.

10. **What if I am unable to meet my minimum required hours of service for the year?**

At the end of each year of the contract, the health authority will reconcile the hours the practitioner reported against the minimum required hours for which they were paid. If the practitioner worked less than the required hours, an adjustment will be made to their next contract payment to reflect the actual FTE provided during the previous year. If the contract has expired, the practitioner will be responsible to repay the calculated overpayments to the health authority.

11. What funding is provided to cover the NP's overhead costs?

The Service Contract rates are competitively set for BC to provide income security while the new practitioner establishes their practice and builds their patient panel.

The compensation rates are set based on the salary grid rates for NPs employed by the health authorities, with consideration for the differences associated with being an independent contractor versus an employee (e.g., benefits, pension). Recognizing that overhead costs are paid by health authorities for their NP employees, a separate overhead allocation ($75,000 for rural and urban communities and $85,000 for metro communities) is provided.

12. What, if any services, is the NP allowed to bill and can they retain the income?

The NP is required to bill for all services funded by third parties (e.g., ICBC, WSBC, uninsured patients). The proceeds of the billings must be remitted to the health authority.

13. What level of insurance am I required to have?

It is a requirement of the contract that the NP has comprehensive or commercial general liability insurance of not less than $2,000,000 if they own or rent the premises where the services will be provided (this may already be in place if joining an existing practice), and must also have adequate professional liability coverage via CNPS. Purchasing additional insurance over and above the contract requirements is at the discretion of the NP.

14. What happens to my panel if my contract is terminated or I leave permanently?

In the event the Service Contract is terminated and the NP 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.

Further information can be found at:
https://www.bccnp.ca/Standards/RN_NP/FAQs/Pages/BeingNurse.aspx?subcategory=Nurse%20Practitioner

15. If an NP has a full panel, what happens if they leave the clinic temporarily (maternity for example)?

For an expected leave, the NP should look for another NP to take over the contract for the duration of the leave. If this is not possible due to a lack of availability of alternative providers, a discussion with the clinic about coverage for the time away will need to occur and a mutually agreed upon arrangement decided.

16. Should I seek advice before signing this contract?

It is the practitioner's right to seek advice, including independent legal or financial counsel. You may also wish to consult with your professional association.

17. Do NPs need to be incorporated?

There is no requirement to be incorporated. Whether it is advantageous to incorporate or not is a matter that the practitioner will have to determine on their own. Practitioners may wish to seek independent legal and financial advice.

18. How do you see embedding these contracted practitioners into clinics where the current physicians are paid under FFS?

It is acknowledged that there may be some operational concerns arising from practitioners in a group practice being paid through different modalities. The rationale for having a Practice Agreement as part of the contract is to ensure clarity between the new practitioner and a primary care practice with respect to their relationship, clinic operations and management of the practice.

19. If a new practitioner joins an existing practice that is on FFS, will the FFS physicians be able to bill FFS if they provide services to patients of the new practitioner?

If a FFS physician provides services to the new practitioner's patient because the new practitioner is not able to do so (e.g., vacation coverage), the FFS physician may bill FFS for services provided.