BRITISH COLUMBIA | Ministry of Health

PRIMARY CARE NETWORKS

New-to-Practice Contract for Family Physicians and Nurse Practitioners

FREQUENTLY ASKED QUESTIONS - MARCH 2022

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BRITISH COLUMBIA | Ministry of Health

Frequently Asked Questions and Answers

Note: For ease of reading this document, the term 'practitioner' may be used to refer to both physicians and nurse practitioners who are providing services as the medical practitioner / primary care provider.

GENERAL

1. **Who was involved in the development of the New to Practice (NTP) family physician (FP)/ nurse practitioner (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 and the health authorities. The process was led by the Ministry of Health and the Health Employers Association of BC.

2. **Who is the contract administrator/agency for the NTP/NP contracts?**

   Contracts for both FPs and NPs are held by the health authorities and each regional health authority is the contract agency. FPs and NPs working under these contracts are independent contractors and are not considered health authority employees.

3. **What are the expectations for the administrator of the contract?**

   The health authority is the contract administrator and oversees the contract. The health authority is responsible for providing payments to the contracted practitioner or designated representative. Practitioners and the health authority will determine whether payment will be made on a biweekly or monthly basis. Payments are made in equal installments throughout the year.

   The health authority also ensures the practitioner reports on their hours worked, attachment and quality improvement (QI) activities.

   The health authority is also responsible for ensuring that the contract is in alignment with the patient medical home (PMH) and primary care network (PCN) initiatives and related policies. This contract is part of a broader strategic direction that encourages the development of PCNs and physician practices that align with the principles of the PMH. Physicians must participate in existing PCN or commit to actively support the development of a PCN in the community, where one is planned.

4. **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 full-time equivalent (FTE), part-time

opportunities may be available. Payments for service contracts under 1.0 FTE are pro-rated accordingly.

5. **Do the services provided under the contract include both clinical and administrative services?**

   Under the NTP contract, one FTE is defined as a minimum of 1,680 hours up to a maximum of 2,100 hours of Services per year for FPs and a minimum of 1,680 hours for NPs. Services provided under the contract, outlined in Appendix 2 of the contract template, include primary care services including but not limited to: direct patient care and indirect patient care, clinically-related teaching and clinically-related research and clinical administrative services.

6. **Can extended workdays be accommodated?**

   The service contract defines one FTE as a minimum of 1,680 hours (NP) or 1,680 to 2,100 hours (FP) of service delivery annually, with a maximum of 90 hours over a two-week period. Beyond these requirements, the contract is not prescriptive on the practitioner's hours of work. Expected days and hours of work are established under the practice agreement between the practitioner and the clinic they are joining or establishing. The contract does not prevent a practitioner from working longer or shorter days as agreed to with their clinic.

7. **What happens if I cannot complete the contract term? Is there a financial penalty?**

   There is no financial penalty if a contracted FP or NP cannot complete the contract term. The service contract stipulates that either party may terminate the contract without cause upon six months' written notice to the other party.

8. **What are the on-call requirements on these contracts?**

   The contracts do not address the specifics of on-call requirements for practitioners within the practice; however, physicians and NPs are required to make themselves available after-hours for their patients and other patients of the Practice. On-call obligations are outlined in the practice agreement.

   The contract does not provide payment for availability; however, practitioners may be expected to provide after-hours services, in accordance with the practice agreement or other arrangements agreed to as part of joining the PCN. Services provided arising from being called after-hours fall within the scope of the contract.

   A contracted practitioner, while on call as a member of a multiple clinic call group (that includes the contracted physician's practice), can report the time spent providing after-hours services under their contract hours, regardless of which clinic the after-hours patient is associated with.

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

Yes, the practice agreement includes a provision to allow for termination of the agreement by either the practitioner or the clinic. A practitioner can move to a different practice as 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.

10. Can a contracted practitioner move between PCNs?

The funding for contracted FPs and NPs, and their associated attachment targets, is linked to an individual PCN approval. If a practitioner wants to move to a different PCN, either within the same health authority or with a different health authority, a new contract would be required which outlines the specific terms of the new arrangement, including a new practice agreement. The practitioner would also have to fill an identified position within an approved PCN service plan for the community they are moving to.

11. What are the obligations of existing clinics towards patients who are attached by a NTP FP or NP if they decide to leave the practice?

The College of Physicians and Surgeons of British Columbia and the B.C. College of Nurses and Midwives each have standards that set out practice management considerations when a practitioner leaves their practice**.** The practice standards set out requirements and guidelines around patient notification and medical records.

In the event the service contract has concluded and the practitioner does not intend to maintain the attachment relationship with their patients, the practitioner is obligated under the contract to work with the clinic, the health authority and other health system partners in an effort to collaboratively maintain primary care access for the patients and to re-attach them to another family practice where possible.

12. How will maternity leave work? Can I pause my contract?

Practitioners who are absent from practice due to maternity leave or for any other reasons (e.g., parental leave, sick leave) are required to arrange coverage for their patients. This may occur through cross coverage by other practitioners within the practice or through the use of locums arranged by the practice. If this is not possible due to a lack of availability of alternative providers, the contracted physician or NP would need to have a discussion with the clinic about an arrangement for coverage for the time away.

13. Is there a requirement to meet the minimum 1,680 hours before an FP or NP is eligible for locum coverage?

There is no requirement to meet the 1,680 hours before an FP or NP is eligible for locum coverage. The 1,680 hours refers to 1.0 FTE of services under the contract.
If an FP or NP arranges coverage through a subcontractor arrangement, it will count towards the contracted hours. Subcontractors will not be entitled to bill FFS for delivery of the services to either the host practitioner's patients or to patients of other practitioners in the practice.

Contracted physicians have two options for securing the services of locums:

- Option 1: The locum can bill and retain fee-for-service (FFS) for all services provided. If this option is selected, the locum does not bill for time to fulfil the host physician's FTE obligations under the FP contract. If the host physician does not fulfill their FTE obligation under the contract, the host physician will need to pay back part of their earnings to the health authority.

- Option 2: The locum can bill for time under the contract and receive payment from the host physician. In this option, the locum's time is counted towards fulfilling the host physician's FTE obligations under the contract.

Short term locums secured through the Rural General Practitioner Locum Program (RGPLP) or equivalent provincial locum program will be paid in accordance with the policies of the program. Locums otherwise secured by the practitioner are entitled to bill FFS 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 FFS, NP locum coverage will be funded under the minimum 1,680 contracted hours. If the contracted NP is unable to secure another NP to provide locum coverage, a FP locum may be engaged and would bill FFS. In this case, hours worked by the FFS physician would not count towards the contract NP's 1,680 hours. Additionally, overhead that would typically flow to the clinic as part of the agreement with that contract NP would pause for the time that the FFS physician is providing coverage. It is expected that a percentage of the FFS physician's billings would contribute to clinic overhead, consistent with typical industry practice. Contracted NPs are required to report NP locum hours worked to the health authority as part of the reporting requirements under the contract.

14. How does subcontracting work?

A subcontracting arrangement is a contract between a party to an original contract and a third party to undertake the work or required in the original contract. As per Article 12 of the FP NTP contract and Article 11 of the NP contract, the practitioner may, with the written consent of the agency (health authority), subcontract or assign any of the services outlined in the contract. The consent of the agency will not be unreasonably withheld. The practitioner will ensure that any contract between the practitioner and a subcontractor will require that the subcontractor comply with all relevant terms of the contract.

15. What are the expectations for inpatient and long term care within the NTP/NP contract?

Under the NTP/NP contract, you agree and commit to transitioning your practice towards a PMH and to participate in the local PCN. 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.

Physicians can bill and retain FFS payments for services provided outside of the clinic setting, excluding virtually delivered community primary care services. Time spent providing such services cannot be attributed to fulfilling the FTE obligations under the contract.

Where a physician bills FFS on the same day as the physician is billing time under the contract, the physician, whether or not required by Medical Services Plan (MSP) or other paying agency, must enter start and stop times of the patient encounter on their FFS claims for any services provided outside the scope of this contract. In communities where the provision of inpatient care services by all FPs/NPs is crucial to service stability, an alternative contract model may be offered which would include these services.

The practice agreement negotiated between the FP/NP and the clinic they are joining will outline the agreed upon expectations with respect to call rotations or in-patient care.

Overhead and Other Funding

16. 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. Health authorities cover the costs of overhead for these NPs. 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 a 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/PMH. For additional information on overhead for contracted NPs please refer to: https://www.nnpbc.com/np-content/index.php/resource/considering-a-pcn-position/

17. 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 to the group practice. The costs covered by the NP's overhead contribution to the practice may vary depending on the arrangement with the clinic.

The details and 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 FPs paid under FFS and under the FP 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 NPs overhead allocation, and that the amount allocated for professional development or liability protection be specified within the service contract.

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

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/cross-coverage), the FFS physician may bill FFS for services provided. However, the contracted physician is still required under the contract to provide the stated number of hours (1,680) during the year in order to receive full remuneration for 1.0 FTE of work. For clarity, the contracted physician cannot claim hours worked by a FFS physician seeing their patients towards the contracted physician's required hours.

19. 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 scope of the contract and contracted panel commitments.

20. What are the contract stipulations regarding third party billings?

The contracted practitioners are required to bill third parties (e.g., ICBC, WorkSafeBC, etc.) including when they see their colleagues' patients. Practitioners are also required to bill the patient directly for uninsured services.
Practitioners will be able to retain their third-party billings. However, time spent providing these services cannot be counted towards a physician's contract hours.

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

Under both payment models, FPs are independent practitioners. However, the ministry believes that the NTP 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. At present, there are FFS billing restrictions on delegating services and limited ability to bill FFS for team consultations.

The NTP contract provides physicians with more choice regarding how they are compensated and how they choose to practice. This supports the ministry's and Doctors of BC's commitment to a plurality of payment options to match physicians individual practice styles and circumstances. It is specifically designed to support the PMH/PCN model of practice, so they respond to a developing need among our family practice physicians and are aligned with General Practice Services Committee (GPSC) priorities.

Additionally, the NTP contract provides stable funding to physicians whose practice (patient count) is in its initial stages of growth, (e.g., the physician has two years of continuous income to build the practice up to 1,250 patients, which is considered a full panel. The contracts also compensate for the care provided to patients within a specific time frame, not specific services. This gives physicians greater clinical freedom to provide appropriate care to patients, especially for services not specifically covered by MSP fees. It also compensates physicians for time spent on preventative care activities, coordination of care, etc.

22. Can a FFS FP bill GPSC incentive codes when a contracted practitioner consults with them?

Billing rules with respect to GPSC incentive fees and payments for FFS FPs have not changed. If a FFS FP consults with a contracted FP, the FFS FP is still eligible for any applicable GPSC incentives.

PCN Implementation / Recruitment Process

23. Where can I find more information on contract employment opportunities?

FPs/ NPs are encouraged to seek more information regarding current opportunities posted on Health Match BC's website or the PCN jobs web page.

FPs/NPs who are interested in working in a community which has a PCN should contact their PCN through their Division of Family Practice (https://divisionsbc.ca/divisions-in-bc) to explore opportunities. If the community of interest does not yet have a PCN, requests may be explored by the local division and health authority ahead of PCN service planning.

24. How do you determine if a physician or nurse practitioner already has a panel or not?

The PCN service contracts are available to practitioners who do not already have a patient panel and who wish to establish a new longitudinal full-service family practice. Practitioners whose work has been primarily at walk-in clinics or in locum roles would not be considered to have already-established full-scope family practices and would be eligible for the contract. Contracted physicians may offer to attach patients they previously saw regularly in a walk-in or locum capacity (and who are unattached), given that under the contract they are committing to a longitudinal attachment relationship.

25. Do provisionally licensed FPs and NPs qualify for this contract?

FPS and NPs registered as having a provisional license are eligible for the PCN service contracts as long as they are fulfilling the requirements and obligations of their provisional registration, including having appropriate supervision, and they meet the other eligibility criteria for the contract. Contracts for provisional practitioners contain additional provisions/sections related to their provisional status.

New graduates with provisional licenses will still be required to abide by the conditions of the College of Physicians and Surgeons relating to their practice.

26. Who is required to sign the practice agreement and why?

All FPs and NPs who provide regular services in the group practice are required to sign the practice agreement. The practice agreement is part of the contracts in order to:

- Ensure alignment between the physician/NP and other practitioners in group
- Include a commitment to cross coverage arrangements of patients served by the practice
- Identify the practitioner's expected schedule
- Outline the practitioner's overhead contribution
- Describe the nature of the services to be provided by the practitioner

To be absolutely clear, the practice agreement does not make the other practitioners responsible for the contracted FP's or NP's practice.

27. How will other team members be compensated?

Registered nurses (RNs), licensed practical nurses (LPNs) and allied health providers will be health authority employees and will be compensated within the appropriate health authority pay grids.

28. 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).

29. Can a mix of in-person and virtual services (such as telehealth consults or Skype) be provided – particularly if the practice does not have physical space for a full-time FP or NP?

Yes, providing care virtually is allowed. However, it must be done in the context of a longitudinal relationship where the FP or NP 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.

30. Is the NTP contract good for work/life balance? How?

New residents and new-to-practice FPs have reported that it is sometimes stressful to establish a practice under fee-for-service, as they do not have income security while they build their practice and are not compensated for administrative tasks.

The NTP contract is intended to provide work/life balance through income stability while the practitioner builds their patient panel. The requirement of a minimum of 1,680 hours to a maximum of 2,100 hours for 1.0 FTE of services reflects the objective of providing compensation for longitudinal, full scope primary care.

To ensure continuity of care over the year, each full-time FP may work a maximum of 90 hours over a two-week period, including both clinical and administrative tasks associated with patient care. Expected hours and days worked are established in the practice agreement, which allows the practitioner and the clinic increased scheduling flexibility.

31. Can contracts be integrated into clinics that serve vulnerable, marginalized or mental health and substance use 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 panel size targets on a case-by-case basis to reflect patient complexity.

32. What are the responsibilities and expectations of the various roles including Divisions of Family Practice, the Ministry of Health and Doctors of BC in supporting FP/NP roles?

The Divisions of Family Practice are key and central partners to the development of 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 FPs 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 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 General Practice Services Committee has provided a "PCN Roles and Responsibilities" document to guide PCN partners and interested practitioners.

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.

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

The FP 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 addition to FPs and NPs, services provided by RNs are also expected to contribute to a clinic's attachment capacity, while the presence of licensed practical nurses 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.

34. Does the contract allow for a focused family practice with these contracts (for example, a new immigrant focus with rolling attachment)?

If the clinic is part of the PCN service plan and the contracted practitioner commits to provide longitudinal, full-scope family practice services for their attached patients (e.g., for whatever length of time they choose to remain attached to the practitioner), then the ministry would support the use of the service contracts as an appropriate compensation mechanism.

In addition, the NTP physician eligible to bill FFS for the provision of specialized services to patients referred from practitioners outside of the group practice.

Evaluation and Reporting

35. How will attachment be measured?

Patient attachment is established through an attachment conversation between a physician/NP and the patient, as outlined in the contract. Once attachment has been established, the physician/NP submits an attachment record for the patient through Teleplan. For more information on attachment reporting, please see the guidance document "Attachment Reporting and Attachment Records" on the PCN Toolkit.

36. How are panel targets affected by practice location? Are practitioners serving rural or remote communities expected to meet the same targets as a FP/NP 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, the First Nations Virtual Doctor of the Day program and outreach).

The ministry's intent is not to destabilize existing services, but rather 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 be assessed individually.

37. Will rural physicians working under the contract receive Rural Retention Program premiums?

Yes, rural physicians will receive additional payments equivalent to the Rural Retention Program Fee premium and flat premium for the applicable community.

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

For FPs 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 FPs is a simplified version of the shadow billing required under other APP service contracts designed for greater administrative ease. Contracted NPs have been using the NP simplified encounter codes since May 1st, 2021. Practitioners will also be required to report their hours worked to the health authority monthly.

Under the FP contract, the physician also agrees to engage in appropriate panel management, including accessing and utilizing the GPSC's Practice Support Program (PSP) Understanding Your Patient Panel or any future applicable PSPs, as available and appropriate.

39. How is access to providers tracked?

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.

40. Will the FP or NP be penalized if a patient seeks primary care services elsewhere?

There are no payment deductions under the contracts if or 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 physician.

41. Practitioners are required to work a minimum of 1,680 hours per FTE. What is the delineation of those hours between actual clinical care and doing non-clinical activities, such as charting, administrative reporting, etc.?

There is no specific delineation of hours between direct patient care, indirect patient care and clinical administrative services in the service contract. However, as it is expected that clinical care consumes the bulk of the contracted hours. Practitioners are required to report the hours of service by the nature of the service (e.g., direct patient care, indirect patient care, clinical administrative services). Charting is included under the definition of indirect patient care (Article 1). The practitioner's administrative reporting obligations (Article 14 for NTP and Article 13 for NPs) are included under the definition of clinical administrative services (Appendix 2, Section 10(m) for NTP and Appendix 2, Section 16 (c.) for NPs).

42. Does training and/or clinic orientation count towards the contract hours?

Contract payments are for clinical services only. The services outlined under the contract do not include any training or clinic orientation activities.

43. What happens if a contracted practitioner does not meet the attachment targets outlined in 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. The Division of Family Practice may also be able to provide support for these discussions.

As per the wording in the NTP/NP 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 physician or NP, the agency and the practice to service a particular population need.

The intent of the attachment targets is to outline a specific commitment on the part of the practitioner towards reducing the PCN's overall attachment gap. Under the NTP contract, if the FP fails to meet the targets as outlined in year 1 of the contract term, they are not entitled to the QI payment. However, the expectation would be that the parties work collaboratively to assess the issue and, if appropriate, identify strategies to support the practitioner in meeting the targets.

NTP physicians may also be asked to attach patients from existing local primary care waitlist used by the Division of Family Practice or the agency and from any future provincial primary care waitlist if they are below their panel size targets.

44. The services outlined in the NTP contract and NP contract include health- care/service planning activities for the health service delivery area which fall within the scope of the contract. Will this exempt me from any payment for work with the Divisions of Family Practice 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 under the contract, so FPs or NPs are able to receive payments for these activities.

Time spent at divisional meetings and professional development does not count toward the direct service hours expected within the contract. Clinical administrative services are non-patient care activities that may not be patient-specific but require the professional expertise of a physician including attachment services and QI services.

Community and program development work related to health promotion is also included 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.

Other: FP-Specific

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

The FP 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.

46. Will FPs who are on these contracts remain eligible for Doctors of BC matching Registered Retirement Savings Plan benefits?

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

47. How are QI activities reported?

You are required to report annually to your health authority the QI activities you engaged in using Appendix 5 – Reporting guidelines. At the end of the contract year PSP will provide

the health authorities with a report outlining QI activities that have been completed during the contract year.

48. Do quality improvement activities count towards the hours under the contract?

Yes, you may claim up to one hour per week (up to 52 hours per year) each year for QI services performed.

49. 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), it is proposed 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 information available to FPs 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.

50. I am a physician with a commitment to return service in B.C. How will the New-to-Practice (NTP) contract align with my Return-of-Service (ROS) contract?

ROS physicians are eligible to work under the NTP contract. However, the ROS contract and NTP contract are separate agreements, each with their own terms, conditions and obligations. For information on the ROS contract, contact ReturnOfService@gov.bc.ca

51. How is work done outside of the contract differentiated and tracked?

The ministry has provided a "Clinic Setup for Encounter Reporting" guidance document which outlines the technical process for setting up contracted FPs and other PCN-funded practitioners in Teleplan for the purposes of encounter reporting. Contracted FPs will complete an assignment of payment to a PCN site-specific payee number for each site in the PCN where they deliver services under their contract. Contracted FPs will then submit their encounter records through these payee numbers, which will be used only for PCN encounter reporting. Contracted FPs will also use a new set of simplified encounter records which have mandatory shift start and end times.

FFS work done outside the contract, including services paid for by third parties, will be billed to either the physician's personal payee number or to a separate payee number.

Other: NP-Specific

52. 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 Nurses and Midwives and the NP will conduct their practice consistent with the conditions of such registration;
- Enrolment in the MSP for the purposes of encounter reporting; and
- All other licences, qualifications, privileges and credentials required to deliver the services laid out in the contract.

53. 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 Nurses and Midwives, 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.

54. Divisions of Family Practice are generally exclusive of NPs. What is the Ministry of Health 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 FPs and NPs to work alongside one another collaboratively.

The model of contracted FPs and NPs working alongside one another (and with FFS FPs) 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.

55. Can overhead be used for insurance?

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.

NNPBC can assist NPs who have questions about specific overhead costs, such as insurance. More information can be found at: Considering a PCN Position

56. 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 FP) will need to determine what benefits are most relevant for their own personal situation.

57. 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.

58. Can the NP authorize a representative, such as a clinic, to receive the overhead payments?

Article 12 of the PCN service contract allows the NP to designate an authorized representative to receive the payments as outlined in Appendix 3. This arrangement should be specified as part of the practice agreement between the NP and the clinic.

59. If the contracted NP goes on maternity leave, do the overhead payments continue?

For an expected leave such as maternity leave, the practitioner and the clinic should look for another practitioner to take over the contract for the duration of the leave.

If a NP arranges coverage through a subcontractor arrangement (another NP covering their panel), the services provided by the subcontractor will count towards the contracted hours. In this case, the overhead payments would continue.

If coverage is arranged through a FP billing fee-for-service, the contract payments including overhead would cease for the duration of the leave. It is expected that a percentage of the FFS physician's billings would contribute to clinic overhead, consistent with typical industry practice.

60. For NPs wanting to set up a group practice, how do they 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.

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.

61. 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. 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.

62. If the NP takes a larger panel size (e.g., 1,250+) is there any opportunity for further compensation?

The service contract rates for NPs were established with the objective of providing income comparable to that of NPs employed in health authorities. To maintain equity, 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.

63. Will contracted NPs be eligible for WorkSafe BC coverage and employment insurance?

Yes, contracted NPs are eligible for WorkSafeBC coverage and employment insurance and must contribute to those payments/deductions.

64. Is there the potential to destabilize health authority 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. The ministry is constantly monitoring and evaluating potential impacts towards vacancy rates and recruitment between PCN NP roles and HA employed NP positions.

65. 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 graduates. The ministry has funded the NNPBC to administer a Regional Leadership Program to support all PCN contract NPs, including those who are new grads. To contact an NP PSP representative please see: Regional Leads https://www.nnpbc.com/contact-us/

66. 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, 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.

67. Normally when an employee goes on maternity/parental leave, they receive a percentage of their salary, will that happen for the NP?

The NP engaged under the service contract is an independent contractor, not an employee, and there are no maternity leave benefits provided under the contract. Annual payments under the contract will reflect achievement of the contract requirements (e.g., number of hours worked reported). Payments will be prorated if a full FTE is not worked in a given year.

68. NPs may now retain third party billings. Is there an option to assign third party billings in Community Health Care Centres (CHCs) or Urgent and Primary Care Centres (UPCCs)?

The NP contract now allows NPs to bill third parties (ICBC, WorkSafeBC, etc.) and retain payment, instead of remitting payments to the health authority and billing the time under the contract hours. Under the new contract, NPs are not able to assign third party billings in CHC or UPCC settings.