Rural and Remote
Division of Family Practice
A GPSC initiative

Rural Group Service Contracts – Discussion Paper Revised Draft

Background

In an effort to provide a plurality of funding options, the Ministry of Health, in consultation with Doctors of BC, released a new Group Service Contract in fall of 2020. For more information on the existing group contracts, click here.

In spring of 2021, the Rural and Remote Division of Family Practice created the first draft of this discussion paper. The Chapter Support Team (Regional and Provincial physician and staff leadership) consulted with our members and the Network of Rural Divisions. We submitted the paper to the Ministry of Health and shared broadly with other entities including GPSC.

In summer of 2022, physician and staff leadership attended the Network of Rural Divisions. We had some rich discussions around health human resources, governance, and longitudinal primary care in a rural context and one of the outcomes was the re-examination of the paper after learning that a renewed discussion is happening about a new Rural Group Service Contract.

On June 29th, 2022, we invited members of the Network, Chapter Physician Leads and special guests Tod MacPherson, Director of Negotiations DOBC and Robin Watt, Primary Care Transformation Partner, GPSC join us to review this paper to validate that it is still current. The following paper is updated with that feedback.

Please note, the Rural and Remote Division does NOT negotiate contracts. As part of the PMA, all physicians are entitled to representation from the Doctors of BC (DOBC) negotiations team. It is a violation of the PMA for a Health Authority to negotiate with a physician without this representation. This service is funded via membership dues. For support negotiating a contract, please email negotiations@dobc.ca.

Purpose

To provide some recommendations to the Ministry of Health and Doctors of BC on some of the ideal attributes of a future rural group service contract. Our objective is to ensure rural contracts meet the needs of our dedicated rural primary care providers, enhances the sustainability of rural primary care and recognizes the unique model of practice in rural communities. There is a distinct 'rural culture' of family medicine that must be respected and honoured.

Desirable Attributes of a Rural Group Service Contract

Attribute	Rationale	Tactics for Consideration
1. A mechanism to harmonize special programs and incentive programs to promote equity among rural communities.	Depending on the community, rural physicians are compensated differently through programs like REAP, REEF, NITAOP. As each community is approved for different program, this leads to inequality for physicians. For example, physicians on Gabriola Island cannot access REAP or REEF because they have no ER, yet they perform procedures in their urgent treatment room identical to what occurs in ERs elsewhere. Physicians in Whistler receive significantly more per hour for ER shifts than a physician in Pemberton for that same hour.	Create a contract that is customizable based on community and providers to fill gaps left by other programs that often create inequality among rural communities. Incorporate RSA status A, B, C or D into the contract to reflect differences in programs available to the community.
2. Ability to negotiate based on unique service delivery models for rural communities	Rural communities vary in size and service delivery model. Some have ERs, others have urgent treatment rooms. There are different models that have evolved historically that form a patchwork. The majority of physicians in rural communities are fee for service. Allowing new grads to integrate into these practices is key for succession planning and to prevent crises.	While consistency is important, including options to adapt for community's ineligible for programs like REEF or who are not fully covered by MOCAP would level the playing field Ability to integrate at least on a time-limited basis with Fee-for-Service Practices.

Attribute	Rationale	Tactics for Consideration
3. Acknowledge the unique burden of afterhours call	The current contract does not distinguish between 9-5 clinic hours and an afterhours airlift at 2:00am. The impact to a physician's personal and professional life responding to these emergencies deserves consideration. The current model disincentivizes providers from taking call thereby decreasing the number of physicians who bear the burden which contributes to burnout.	Consider recognizing after hours call as double time or other additional compensation to ensure that physicians are treated fairly.
4. Align with Culturally Safe Care	Given the population in rural communities, upwards of 40% of community members are from a priority population. This is compared to approximately 5% in the lower mainland. The BC College of Family Physicians requires that members provide culturally safe care.	Ensure that contracts align with the new College standard for Cultural Safety and Humility which requires additional time with each patient.
5. Boost access not attachment	Attachment is a key driver to PCN and other initiatives but isn't as relevant to rural communities	Account for access in rural communities where attachment may not be the most accurate measurement of the quality of care
6. Clearly defined contract minimums and specify which proportion of hours are suitable for admin, ensure a mechanism for physicians to be remunerated for hours outside their contract.	The current contract does not offer complete clarity on the proportion of administrative time that can be attributed to the contract hours, nor does it confirm whether travel time is to be included. Current contracts not speak to the mechanism used when a physician utilizes their hours prior to yearend.	Clarify the types of hours that qualify and consider travel given the frequent demands placed on rural physicians. Provide an 'overtime' pay structure or a top up for relief coverage similar to the Rural Locum program for physicians who have exhausted all their hours prior to year-end.
7. Encourage longer term service to minimize the disruption of primary care services in rural communities by creating more flexible working arrangements to reflect	Rural communities struggle to recruit and retain physicians. Loss of one or two providers can result in a complete disruption of care for a community.	Lower required FTE commitment (e.g., .2) to allow providers to work one week a month in community. Many physicians committed to their communities' desire these working arrangements to allow them to fulfil other responsibilities including leadership with the Division or JCCs or to offer balance for their family responsibilities.

Attribute	Rationale	Tactics for Consideration
rural reality and rural GP interests.	Housing is not available in many rural and remote communities, making a full-time commitment next to impossible. Some rural physicians choose to live outside community to balance the educational and financial needs of children and partners and part time/quarter time models make this sustainable.	Allow for group contracts for communities with fewer than 3 physicians. Adequate supports for physicians to access parental leave. Within the current system, there is no support above and beyond existing funding streams like the Rural Locum Program. This is a barrier for many physicians that disproportionally affects women and discourages rural practice. A mechanism for existing providers with unreasonably high panel sizes to lighten their load.
8. Encourage longitudinal care over episodic care	The current contract model may unintentionally incentivize episodic care via UPCCs etc.	Ensure that contracts are competitive or at minimum equal to contracts providing episodic care including hospitalists, UPCCs etc.
9. Incentivize physicians for the broader scope of rural practice	Rural physicians are more likely to provide obstetrical, newborn, pediatric, occupational, palliative, and mental health care than urban family physicians, and are more likely to see patients in the hospitals or long-term care facilities and to conduct home visits. This broader scope of practice is necessary in rural areas where there are fewer options to access more specialized medical services.	Panel sizes designed to deliver primary, acute and community care for a given population, while ensuring a work-life balance. Panel sizes that reflect the patient population of rural communities that may be over 40% priority populations. Physicians with larger panels should not be disadvantaged in the contract or incentivized to release patients. There needs to be a means to recognize their larger panel and workload.

Attribute	Rationale	Tactics for Consideration
		The Ministry needs a way to recognize out of province patients who live part time in rural border communities and are not recognized in panels at the moment. For communities with hospitals, panel sizes that consider the number of physicians required to be fully staffed without undue call burden. Compensation must be adequate to reflect full scope of rural practice and must consider the unique practice circumstances of some rural communities (i.e. helicopter travel to remote Indigenous communities). The contract needs a flexible range of services. We recommend the ability to develop an a la carte selection of services provided in the contract. E.g., clinic primary care, obstetrics, in patients, ER, anesthesia, etc. Rural FPs provide a range of services, and it can vary between providers and communities.
10. Motivate physicians to take medical students	FFS physicians are paid to supervise medical students. Under the existing contracts physicians are no longer eligible for these payments disincentivizing rural physicians to take students. The more students have a positive rural experience, the more likely it is they will practice in a rural setting.	Allow physicians under rural contract to collect payments related to training students.
11. Prioritize future wave PCN Communities	Rural communities are often behind with the PCN planning due to capacity and group contracts may increase capacity.	Allow for a rolling intake so rural communities can benefit regardless of PCN status.

Attribute	Rationale	Tactics for Consideration
12. Recognize that the acute care and primary care is inextricably linked in rural communities and include low volume ER shifts as part of the contract.	Almost without exception, rural providers work in ER or urgent treatment centres. Scheduling clinic hours and ER shifts can be challenging. To make do, some physicians rapidly travel back to clinic during ER shifts which reduces the quality of the critical care being delivered. In addition, due to low volume, some physicians may not earn enough to cover their expenses. Providing optimal care should be the main priority.	Consider including low volume ER shifts as part of the contract and compensating physicians appropriately when they provide this coverage for small communities.
13. Support PRA and IMG physicians	40% of the members of the Rural and Remote Division are IMGs. Many IMGs are people of colour and may face systemic discrimination PRAs or IMGs may be disadvantaged because of having fewer options to move communities as their ROS contract ties them to one community	Be transparent and equitable with PRAs and IMGs and allow some agency or choice in the contract
14. Support to explore non-traditional practice models including but not limited to Community Health Centers and Health Authority owned clinics	While it depends on the preference of the physician, business ownership and the operational/managerial responsibilities require considerable time and capacity for already stretched rural primary care providers. Additionally, research demonstrates that new to practice physicians prefer to work in team-based care environments where business management and ownership are not an expectation.	Consider including overhead direct and indirect costs (time to administer and manage and direct costs like staff) in the contracts or a mechanism to support physicians with overhead burden during physician shortages or vacancies. Include seed funding to support physicians to explore this concept (distinct from the GPSC stream to merge practices)

Next Steps

- Finalize the revised discussion paper
- Share with audiences including but not limited to GPSC, JSC, DOBC Negotiations Team, Ministry of Health