Practicing Family Physician Group Contract: Operational Guidelines for Clinics

BC Ministry of Health
Compensation Policy and Programs Branch

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Practicing Family Physician Contract
Clinic Operations Guide

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Expression of Interest and Onboarding

Background Information

Established group practices of three or more full-service family physicians with an interest in the Practicing Family Physician Group (the Contract), are encouraged to visit the Doctors of BC's (DOBC) website and review resources including:

- A Contract backgrounder;
- A recorded Contract Webinar; and,
- A Contract FAQ.

Groups wishing to participate in a formal Expression of Interest (EOI) process for the Contract are required to complete a Ministry EOI Form, available here.

Physician groups are also encouraged to connect with the local DOBC Advocate should they have any questions relating to the Contract.

Expression of Interest Form

The Contract EOI Form contains information identifying the physician group interested in participated in the Contract and their billing information, which is being collected to determine the first Contract year Income Guarantee amount and an estimate of ongoing Contract earnings. The form also contains a declaration, signed by the lead physician in the group, asking interested physician groups to confirm their level of participation and involvement with the Patient Medical Home/Primary Care Network (PMH/PCN) initiative.

Instructions for completing the form, and for the secure encryption and transmission of the form to the Ministry are also available here. All forms should be submitted to the pcn.compensation@gov.bc.ca. Clinics will receive a response email providing instruction on how to provide the encrypted file password to the Ministry, and an estimated timeline for their high-level assessment results, if available.

Documentation and Negotiation

The Ministry will provide the clinic with high level assessment results – eligibility decision, income guarantee amount, continuing contract income estimate – via email, and instruct the clinic to contact their local Health Authority Medical Affairs Department (see Appendix A) should they maintain an interest in onboarding to the Contract. The Health Authority will provide the clinic with a detailed assessment report and, in collaboration with the Ministry, answer any assessment related questions.

Clinics are required to negotiate certain contract elements with the Health Authority prior to onboarding to the contract. Should the clinic require any assistance in negotiating contract elements, they are advised to contact the negotiations team at DOBC.

Onboarding

In advance of onboarding to the contract the physician group will be responsible for providing the Health Authority with copies of contract supporting documentation, including confirming the existence of a group governance agreement, and insurance and liability coverage. The physician group will also be responsible for completing Fee for Service (FFS) Waivers (Appendix 4 of the Contract), signing the Information Sharing Agreement (ISA), located in contract Appendix 9, and confirming their

understanding of the contract deliverables. Prior to onboarding to the contract, the physician group will also be provided with guidance on the contract's reporting elements; and, other contract elements.

Questions about onboarding should be directed to Health Authority Medical Affairs.

Payment

Contract amounts are paid to the clinic by the Health Authority, based on an amount calculated by the Ministry, based on the calculations outlined in Appendix 3 of the contract. Appendix 3 also details the terms around payment frequency – which is negotiated by the clinic and Health Authority prior to onboarding – and the timing of reconciliation.

To support and inform the distribution of contract funds, the Ministry will be creating quarterly reports summarizing the contract activity of each contracted physician group. These reports will be distributed to each clinic by the Health Authority, beginning at the end of the month immediately following the completed quarter. For example, the quarterly report for the January 1 – March 31 quarter will be available for distribution April 30th. At onboarding, and prior to receiving the quarterly activity report, the physician group is encouraged to use the EOI Assessment results to inform funding distribution.

Advance and Reconciliation

Each advance payment made to the clinic by the Health Authority will be derived from an annual advance amount, which the clinic will be informed of prior to the start of each contract year.

At the conclusion of each contract year, the advanced contract amount will be reconciled against the physician group's actual contract activities. Reconciliation will consider each group's contract hours, attachment activities, and QI activities.

The reconciliation of each contract year will be completed within 120 days of the completion of the contract year. The results of the reconciliation will be detailed in a reconciliation report, which will be provided to the physician group by the Health Authority. To reduce the time period to reconciliation, physician groups are strongly encouraged to submit their hours templates and QI activity reports to the Health Authority as soon as possible at the completion of each contract year.

Disbursement

The clinic is responsible for distributing the contract amount across physicians who are party to the contract, and reporting on that distribution on a quarterly basis as part of their submissions of the hours reporting to the Health Authority. Rules and principles regarding income distribution should be articulated in the practice's intra-group governance agreement.

Physician-level reports will be created quarterly by the Ministry of Health and shared with the clinic, via Health Authority, to facilitate the disbursement of physician-level payments. Reports will include physician panel: Size, ACG Cost, Complexity Weight, Panel Size Expectation per FTE, and Overall Weight.

Clinic Reporting

Teleplan - Encounter Reporting

Direct clinical care services provided during contract time must be submitted using the simplified encounter codes, submitted via Teleplan to the Medical Services Plan (MSP) / Health Insurance BC (HIBC) as $0 Encounter Records (payment mode E). Services outside the contract must be submitted as FFS claims.

Contracted physicians and any resident under the supervision of a contracted physician must submit simplified encounter codes using the supervising physician's Practitioner Number under the Clinic's group payee/payment number. Encounter Records must include the following data elements:

a. MSP Payee Number (clinic payee number under Contract)
b. Practitioner Number
c. Patient's/Client's Personal Health Number (PHN)
d. Patient/Client Name
e. Date of Service
f. Encounter Code
g. ICD-9 diagnostic codes (1 code mandatory, 3 maximum)
h. Location Code (A – Practitioner's Office in Community)
i. Note
j. Referring/Referred practitioner # (if the physician is referring patient to or receiving a referral from another practitioner)

A list of simplified encounter codes, and a payment schedule translation is available in a separate document posted on the PCN Toolkit Website (https://www.pcnbc.ca/pcn), or available from your Health Authority.

Services outside the Scope of the Contract

When physicians provide services outside the scope of the contract, the services may be submitted as FFS. All FFS submissions made by a physician during a contract shift must include start and end times.

Hours Reporting - Teleplan and Health Authority

Physicians on the contract are required to report contract hours through two methods:

1) Teleplan Shift Code Reporting - Daily
2) Health Authority Hours Reporting - Quarterly (Daily Hours)

Teleplan - Shift Code Reporting

Shift hours must be recorded using a Teleplan $0 administrative fee code. Submissions of the Teleplan fee item will be used to monitor contracted physician's contract activity, and to support the Ministry's quarterly reporting obligations to clinics.

Contracted clinic physicians, including locums, must submit via Teleplan fee item **97570 – Contracted Clinical Shift** and include the following data elements:

a) MSP Payee Number - (clinic payee/payment number under Contract)
b) Practitioner Number – each contracted physician
c) Patient's Personal Health Number (PHN) - the first patient's PHN seen during the shift
d) Patient Name - the name of the first patient seen during the shift
e) Date - for the shift
f) Start Time - for the shift
g) End Time - for the shift
h) Billed Service Units – '000' three-digit number for the time units per 15-minute increments (or greater portion thereof) spent providing services under the contract (maximum 96)
i) ICD-9 diagnostic code - 780 (General Symptoms)
j) Location Code - A

Additional detail on the shift code is available through the PCN Toolkit website: https://www.pcnbc.ca/pcn.

While the source of truth regarding contract hours worked is the quarterly hours templates submitted to the Health Authority, regular and appropriate use of the Teleplan Clinical Shift code will reduce the clinic's audit risk.

Health Authority Hours Reporting

Contracted clinics will be expected to complete and submit a quarterly hours reporting template to the Health Authority within 30 days of the end of the completed quarter. The reporting template is specific to the Contract, and contains information on the Contract services provided by each clinic physician during the preceding quarter.

The template and detailed instruction for its completion is available from the Health Authority.

In circumstances where the Physicians have not complied with the hours reporting requirements the Health Authority may withhold the next installment payment until the reporting requirements is met. Where discrepancies exist between the Contracted Clinical Shift Code Hours submitted through Teleplan and the Health Authority hours template, the latter will be considered the accurate source of information.

Teleplan – Attachment

For physicians on the Contract, patient attachment records will inform the calculation of the Contract panel and complexity premium payment. The attachment record is a $0 administrative fee code unique to each PCN, submitted through Teleplan.

Attachment records should be submitted once per patient, per year and should be submitted only when attachment has been established or re-confirmed through explicit attachment conversations with the patient (presented below). The submission of an attachment record for a patient should also be supplemented by the provision of information to that patient about the process and mechanisms for confirming their attachment to the clinic and provider. Please note that for existing patients – i.e. patients for whom attachment is not new – the physician should submit the non-PCN specific attachment code; for

newly attached patients, the PCN specific code should be submitted. It is acceptable to submit an attachment code for existing patients prior to the attachment conversation; however, the first time the patient visits the physician an attachment conversation must be undertaken.

A detailed instructional guide on the use of attachment records, which includes a list of each PCN's attachment fee code, is available through the PCN Toolkit Website: https://www.pcnbc.ca/pcn.

Please note that because the attachment record is administrative, the Contract physician should submit a separate encounter record or FFS claim is a service was provided as part of the care episode during which attachment was discussed and confirmed.

The following must be addressed in each attachment conversation:

As your **primary care provider**, I, along with my practice team, agree to:

- Provide you with safe and appropriate care
- Coordinate any specialty care you may need
- Offer you timely access to care, to the best of my ability and as reasonably possible in the circumstances
- Maintain an ongoing record of your health
- Keep you updated on any changes to services offered at my clinic
- Communicate with you honestly and openly so we can best address your health care needs

As my **patient** I ask that you:

- Seek your health care from me and my team whenever possible and, in my absence, through my colleague(s)
- Name me as your primary care provider if you have to visit an emergency facility or another provider
- Communicate with me honestly and openly so we can best address your health care needs

Access – Third Next Available Appointment

The third next available appointment is an established best practice measure of patient access. Each contract clinic is required to submit monthly estimates of the time to third available appointment on a quarterly basis to the Health Authority (e.g. the quarterly submission for the first Fiscal Year quarter will contain estimates for April, May, and June). Estimates will be entered into a template, provided by the Health Authority to each contracted clinic, and are due within 15 days of the end of the most recently completed quarter.

Clinic's are encouraged to contact GPSC's Practice Support Program (PSP) for assistance on how to measure, or standardize measurement of time to third available appointment. The PSP is available at: psp@doctorsofbc.ca.

Quality Improvement Activity

The Contract includes a Quality Improvement (QI) payments stream that makes an annual $20,000 per Full Time Equivalent (FTE) Contract payment available to contracted clinics who participate and successfully complete Quality Improvement (QI) activities throughout the Contract term. In order to receive the payment, which is calculated and paid at the physician group level, QI activities must be undertaken by any physician claiming hours for services provided under the contract.

There are two mandatory QI improvement activities that all physician group physicians must actively participate in:

- Implementing the General Practice Services Committee (GPSC) Patient Experience Survey; and,
- Engaging in the Phases of Panel Measurement portion of GPSC's Panel Development Incentive.

Mandatory QI activities must be completed within the first contract year and continued throughout the contract term. Physicians on the Contract are also responsible for participating in and completing an additional one or two QI activities each year, based their expected contribution to the clinic's overall FTE contract amount. Each clinic physician expected to provide 0.75 FTE or more under the Contract must engage in two additional QI activities annually; each clinic physician expected to provide less than 0.75 FTE must engage in a single additional QI activity annually. Additional QI activities are to be selected from the following list:

1. Complete the Patient Medical Home (PMH) assessment tool – electronic self-assessment designed to identify practice strengths and opportunities in relation to the 12 attributes of the PMH in BC.
2. Participate in practice facilitation cycles – includes in-practice visits, learning sessions, completion of assessments and other practice improvement tools, time spent developing and implementing the action plan.
3. Optimize the Practice EMR – includes electronic assessment, tailored group learning opportunities and EMR-enabled clinical and practice management tools.
4. Participate in team-based care small group learning sessions through the Practice Support Program (PSP).
5. Participate in other small group learning sessions and learning opportunities – facilitated sessions to help physicians and their practice team stay up-to-date on the most current information and best practices in key areas of clinical and practice management.
6. Participate in San'yas Indigenous Cultural Safety Training.
7. Any activity approved by the GPSC Practice Support Program (PSP).

All Contract QI activities are administered through GPSC's PSP. Each Contract clinic is encouraged to engage with PSP early, at the beginning of the contract and at the beginning of each Contract year, to

ensure enrollment in both the mandatory and additional QI activities. Each Contract clinic should also ensure the reporting on QI activities is submitted to the Health Authority within 30 days of each Contract year end.

Separate documentation and instruction on the QI aspects of the Contract are available from the Health Authority.

Notification: New or Departing Physicians

Departing Physicians

The clinic is responsible for notifying, as soon as possible and in accordance with Article 24 of the Contract, the HA of any physician additions or departures during the contract term. Options for managing physician departures or unanticipated leaves include:

- Recruiting a new or replacement physician, including the potential to recruit a new physician using the New to Practice (NTP) contract;
- On a short-term basis, utilizing locum physicians; or,
- Distributing of existing patient attachment among the remaining physicians.

The clinic is required to notify the HA, providing the reason for the physician's departure (retirement/leave/leaving community/leaving practice but staying within the community); and, the clinic's plan for addressing the departure, including plans to redistribute workload among remaining physicians. Any redistribution of workload must not violate the contract restrictions relating to per physician FTE.

Where the departure of a physician cannot be adequately managed by the clinic, the clinic must review Contract *Article 11 - Service Requirements* and consider reducing the number of Contract FTE. Changes to FTE allocations should be in quarter-FTE increments only.

New Physicians

Any replacement or new physician that the clinic proposes to add are subject to approval by the HA. In addition, the physicians and the HA must agree on any adjustment to the FTE under the Contract, and execute all appropriate Contract amendments.

The clinic must ensure that *Appendix 7 – New Physician Agreement to Join* is completed for each new physician, and that the documentation required of any physician that is party to the Contract is also in place and, where necessary, provided to the HA.

Primary Care Network Resources

Clinics on the Contract are eligible to receive PCN resources. It must be noted, however, that PCN resources are allocated to clinics and providers within each PCN in a process entirely separate from the Contract.

Appendix A – Health Authority Medical Affairs Contacts

Health Authority	Contact Full Name	Position	Email	Phone Number
FHA	Danny Giglio	Analyst, Physician Contracts	Daniel.Giglio@fraserhealth.ca	604-613-6247
IHA	Marlis Gauvin	Director (interim) Medical Program Transformation	marlis.gauvin@interiorhealth.ca	250 469-7070 ext 12385
NHA	Elizabeth Whittles	Regional Manager, Medical Affairs	elizabeth.whittles@northernhealth.ca	
PHSA	Carmen Cheung	Executive Director, Physician Compensation, Finance and Negotiation Support	Ccheung5@phsa.ca	604-875-7104
VCHA	Christine Pietrzyk	Regional Leader, Contracted Physician Services	Christine.Pietrzyk@vch.ca	604-984-5720
VCHA	Michael Ducie	Executive Director, Physician Engagement and Strat	micheal.ducie@vch.ca	
VIHA	Christine Jeffrey	Director, Medical Staff Contracts, Compensation & Practice Design	christine.jeffrey@viha.ca	250-519-7700 (ext 53152)