BACKGROUNDER – CONTRACTING 200 GPs 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 model to support this goal.

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 three-year Service Contract.

The Service Contracts were developed by the Ministry of Health in consultation with Doctors of BC to provide income security as the practitioner establishes their practice and builds their patient panel.

The Service Contracts will be administered by the regional health authority; however, practitioners engaged through these contracts will be independent contractors. They will not be health authority employees.

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:
    - Year 1 of the Term: panel size of a minimum of 800 patients per 1.0 FTE.
    - Year 2 and 3 of the Term: panel size of a minimum of 1,250 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 1,680 to 2,100 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 increase over the term of the contract. The annual rates are intended to also cover overhead costs. GPs choosing to practice in communities eligible under the Rural Practice Subsidiary Agreement may be eligible for additional payments and incentives.

Practice Category	Year 1	Years 2 & 3
GP (Non-JSC)	$250, 000	$265, 000
GP (JSC) A	$276, 000	$295, 000
GP (JSC) B	$267, 000	$285, 000
GP (JSC) C	$262, 000	$280, 000

General Practitioners will also be able to retain third party billings (e.g., WCB, ICBC). However, time spent providing these services cannot to be counted towards a practitioner's minimum hours required under the Service Contract.

Arrangements between the practitioners and the clinics regarding overhead costs are to be determined privately among the parties.

FREQUENTLY ASKED QUESTIONS

1. **How will the 200 GPs be sourced?**

As the primary objective of this initiative is to increase patient attachment across the province, recruitment will initially target GPs who do not have a patient panel, including, but not limited to, new and recent graduates. The province's ability to retain recent graduates of family medicine, by providing opportunities that align with their professional interests, will also be an important aspect of this recruitment strategy.

2. **I am a physician with a busy practice and I am interested in transitioning to an alternative pay model. Is this opportunity available to me?**

The objective of this initiative is to increase patient attachment across the province and as such, this initiative is targeted to practitioners who do not currently have a patient panel. Over the coming months, other Service Contracts will be developed to support physicians with existing patient panels to transition to alternative compensation options as part of the PCN process.

3. **I am a physician who has been doing locums for the last three years. Will I be considered for one of these new positions?**

The objective of this initiative is to increase patient attachment across the province. If you currently do not have a practice with a patient panel but are interested in establishing a family practice and building your own patient panel, you are encouraged to apply.

4. **Will this opportunity be open to International Medical Graduates?**

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

5. **Do physicians 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.

6. **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 a 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 will be fully established and that they will have a full patient panel. Practitioners will be able to choose between staying on a Service Contract or transition to one of the compensation options that support PCNs and team based care.

7. 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 family practice and working a minimum of 0.5 FTE, part-time opportunities may be available.

8. 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 they 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 the work is clearly done outside the Service Contract required hours and panel commitments.

9. 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 that arise 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 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 hours or service requirement.

10. Who am I managed by or accountable to as I am paid by the health authority but working in the clinic?

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 developed the contract template and established the specific terms in consultation with Doctors of BC and the NP Council (formerly BCNPA), but the contract will be administered by regional health authorities (i.e., the signatories 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.

11. What funding is provided to cover the practitioner'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, and take into consideration overhead and other costs such as purchasing benefits.

Similar to fee-for-service, which is a gross payment amount inclusive of overhead, the all-in compensation rates include a provision for overhead and are competitive. The rates are within the approved APSA rates for the GP - Full Scope practice categories.

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

The Service Contract requires that the practitioner have 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. If a practitioner is joining an established practice, this coverage may already be in place.

The practitioner must also have adequate professional liability coverage for a GP through CMPA or a comparable insurance plan. Purchasing additional insurance over and above the contract requirements is at the discretion of the GP.

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

Under both payment modalities, the GPs are independent, autonomous practitioners; however, the Service Contract better supports the PCN and team-based care. Under FFS, physicians are paid a specified amount for providing services in accordance with the Medical Service Commission Payment Schedule; there are billing restrictions on delegating services and limited ability to bill for team consultations. Under a Service Contract, time is a major component of payment (e.g., 1,680 to 2,100 hours per year for one FTE) along with other deliverables (e.g., minimum panel target). Compared to FFS, contracted physicians have a more stable and predictable income, which enables them to spend more time with patients and to work in interdisciplinary teams. Contracted physicians will also have reduced administrative burden compared to FFS through simplified encounter reporting.

14. 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.

15. 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.

16. If a new practitioner joins an existing practice that is on FFS and they provide services to their colleague's patient, can the new practitioner bill FFS for the services provided?

Within the scope of the Service Contract, a contracted physician is not allowed to bill MSP FFS for any insured services, so the new practitioner would not be able to bill FFS for services provided to their colleague's patient.

For any third party billings, the contracted physician is required to bill the third party (ICBC, WSBC etc.) including when they see their colleague's patients. Practitioners will be able to retain their third party billings (e.g., WCB, ICBC); however time spent providing these services cannot be counted towards a practitioner's minimum contract hours.

17. 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, it is expected that the practitioner works 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.

18. 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 has reported against the minimum required hours for which they were paid. If the practitioner worked fewer 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 required to repay the calculated overpayments to the health authority.

19. If I have a full panel, what happens if I need to leave the clinic temporarily (maternity for example)?

For an expected leave, the GP should look for another GP 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.

20. What happens to my panel if my contract is terminated?

In the event the Service Contract is terminated and the practitioner does not intend to maintain the attachment relationship with their patients, the practitioner is obligated under the Service Contract to work with the clinic, the health authority and other health system partners to 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.

21. What is the process if I want to leave the practice?

The board of the College of Physicians and Surgeons of British Columbia has a practice standard that sets out practice management considerations to ensure continuity of patient care and the preservation of patient records in a situation where a physician wishes to leave their practice. The practice standard sets out rules and recommendations around notification and medical records.

Further information can be found at: https://www.cpsbc.ca/files/pdf/PSG-Leaving-Practice.pdf.

22. 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.