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Guideline

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Primary Care Network Guidelines for Nurse Practitioners

Guideline Objective

In 2018/19, the Ministry of Health launched a transformational primary care strategy to help increase patient attachment and access to high quality, comprehensive, culturally safe and person- and family-centred primary care services throughout the province. This team-based model of primary care will be delivered using a number of different approaches including:

- Family practices/Patient medical homes (PMHs)
- Urgent and Primary Care Centres (UPCCs)
- Community Health Centres (CHCs)
- First Nations Primary Care Centres (FNPCCs)
- Nurse Practitioner Primary Care Clinics (NPPCCs)

These clinical service models and all primary care providers in defined geographical areas will be organized together in Primary Care Networks (PCNs). PCNs will coordinate and leverage health-care providers and comprehensive primary care services to better meet the needs of individuals, families and caregivers to improve population health. As of the end of fiscal year 21/22 there will be 65 PCNs implemented, with the aim of implementing 20 more by the end of fiscal years 22/23-23/24.

This strategy was developed in response to challenges including increasing numbers of British Columbians without a regular primary care provider, fragmented and varied care across multiple providers and increasing levels of clinician and provider burnout.

PCNs are a system of primary care in which teams of providers located throughout the network work together and with primary care services delivered or contracted by health authorities and community-based social and other health service organizations to support patient care. PCNs maintain clear pathways and linkages with specialized community services programs as well as the broader health system. PCNs are designed to provide wraparound primary care services that are person-centred, culturally safe and responsive to the unique needs of the community or region.

At the foundation of PCNs is team-based care that will optimize the skills of valued health-care professionals, where various providers work together to provide comprehensive care to patients. Teams may include family physicians (FPs), nurse practitioners (NPs), registered nurses (RNs), clinical pharmacists and allied health professionals such as physiotherapists, occupational therapists, social workers, psychologists, and mental health and substance use clinicians. The team may also include providers such as Indigenous health providers and Elders. These interdisciplinary teams will work together to improve access, service and care. Interdisciplinary team-based care will enable inquiry and collaboration across all disciplines, promote better engagement with patients, consider the voices of families and caregivers and support cultural safety in care delivery. Interdisciplinary teams will provide person- and family-centred care, improve information and understanding, ensure

informed decisions are made and better support education and self-management strategies for individuals, families and caregivers.

To support NPs in practice, a new remuneration model was introduced to advance team-based care in PCNs: an independent service contract, allowing NPs more flexibility to practice independently in community settings. This guideline is aimed at NPs working in PCN practice settings on a service contract and supports PCN partners to effectively and appropriately recruit and incorporate NPs into PCNs.

Definitions

Attachment: The documented existence of a clear ongoing care relationship between a patient and a most responsible practitioner, a family practice or health authority primary care clinic.

Clinical administrative services: Non-patient care activities that may not be tied to a specific patient but that require the professional expertise of an NP or physician. This may include community and program development work related to health promotion such as attachment services, health-care/service planning activities (e.g., participating in planning of long-term health-care delivery goals for the health service delivery area, specifically in the community and surrounding areas), participating in the evaluation of the efficiency, quality improvement services (e.g., participation in medical audits, peer and interdisciplinary reviews, chart reviews and incident report reviews) and submission of reports to the health authority as reasonably requested (e.g., monthly reports on hours worked). Clinical administrative services are included within the definition of "Services" under an NP service contract and therefore included in the minimum 1,680 service contract hours.

Community health centres (CHCs): Multi-sector organizations providing a community population with primary health care. The community population served by CHCs is typically geographically defined, although a CHC may target their services to a community of specialized need residing across multiple geographical areas. CHCs are community governed with services tailored to meet the health needs of the community.

Community health service area (CHSA): CHSAs are geographic units providing the most granular level of data available at the Ministry of Health. The boundaries of this geography were developed through extensive consultation and are meant to reflect where people live and the communities where they identify themselves as belonging. Where this guideline references community, it is referring to the community residing within the boundaries of a CHSA unless otherwise specified (i.e., a community of specialized need that might be served by a particular CHC but whose patients reside across multiple CHSAs).

Comprehensive primary care: Within a CHSA, the PCN will provide the population with comprehensive primary care services ensuring that services and care plans are person-centred, culturally safe and responsive to individual needs.

Culturally safe: Providing care based on respectful engagement that recognizes and strives to address power imbalances inherent in the health-care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health-care.

Direct patient care: Clinical intervention with a specific patient present including the concurrent provision of clinically-related teaching and clinically-related research. Direct patient care is included within the definition of "Services" under a service contract and is therefore included in the minimum 1,680 service contract hours.

Indirect patient care: Patient-specific service provided when the patient is not present including the concurrent provision of clinically-related teaching and clinically-related research. Examples of indirect patient care include, but are not limited to: patient-specific conferences, team meetings, telephone consultations, and chart/report writing. Indirect patient care is included within the definition of "Services" under a service contract and is therefore included in the minimum 1,680 service contract hours.

Interdisciplinary team: A group of health-care providers who work together in a coordinated and integrated manner with patients and populations to achieve health-care goals. Effective interdisciplinary teams display collective competency, shared leadership and active participation of each team member involved in patient care.

Longitudinal care: Longitudinal care is when a primary care provider supports a patient's health and builds a relationship with them over their lifetime. This consistent care results in better health outcomes. It can also help improve communication and coordination as patients transition between different health-care professionals as their needs change.

Patient medical homes (PMHs): A family practice or health authority primary care clinic which has a majority of the person-and family-centred service attributes (commitment, contact, comprehensiveness, continuity, coordination) and relational attributes (team-based care and networks) of the B.C. PMH model.

Primary care network (PCN): PCNs are an organized system of primary care where PMHs and other clinical models are networked with each other and with primary care services delivered or contracted by health authorities and community-based social and other health service organizations. Within a PCN, patients, families and caregivers can access comprehensive, person-and family-centred, culturally safe, quality primary care. In their organization and structure, PCNs maintain clear pathways and linkages with specialized community services programs as well as the broader health system.

Team-based care: Multiple health-care providers from different professional backgrounds work together with patients/clients, families, caregivers and communities to deliver comprehensive health services across care settings. Effective teamwork is a critical enabler of safe, high quality care and supports a patient's ongoing relationship with their primary care provider (a family physician or nurse practitioner).

Urgent primary care: Primary care for injuries and illnesses that should be seen by a health-care provider within 12 to 24 hours but do not require the level of service or expertise found in an emergency department. Urgent primary care tends to be provided outside of traditional primary care office hours, however, subject to community needs and patient demands, can also be available during regular business hours. Appropriate follow-up care is expected following each urgent primary care visit, including sharing the record of appointment with a patient's regular primary care provider.

Urgent and primary care centres (UPCCs): A flexible resource to meet both the urgent unplanned and ongoing planned primary care needs of people in communities across the province. UPCCs fulfill service gaps in select urban and metro communities and are a full-service facility with team-based care to provide urgent, non-emergency care to people who need medical attention within 12 to 24 hours. UPCCs may also provide temporary and/or ongoing attachment to patients who do not currently have a regular care provider, and then work to attach them to either to the UPCC or to permanent providers as capacity opens within a broader PCN.

Scope

This document sets out ministry direction to PCN partners to recruit and incorporate NPs into PCNs. The ministry recognizes that the implementation of PCNs is a collaborative process between all partners involved. This guideline applies to PMHs, FP practices, health authority primary care clinics and community-based social and other health service organizations (e.g., CHCs, FNPCCs, walk-in clinics). Since the NP service contract, through which NPs are recruited into PCNs, is the first of its kind in B.C., continuous quality improvement, learning, clarification and refinement will be needed going forward.

Roles and Responsibilities

Collaborative services committees (CSCs): These are partnerships between a health authority and a division of family practice (DoFP), co-led by local health authority primary and community care leadership and the DoFP leadership. They are responsible for:

- Providing collaborative input into local development and implementation of services within the PCN geographical service area;
- Governing local PCNs by forming the PCN steering committee;
- Facilitating broad engagement of providers and key community partnerships including local Indigenous service provider organizations, NPs, community groups and other community service providers; and
- Applying PCN, PMH, NPPCC, UPCC, FNPCCs and CHC policy frameworks to local circumstances, as applicable.

Division of family practice (DoFP): Together with the health authority and other community partners, the DoFP contributes to the design and governance of local PCNs, the development of the PCN service plan and facilitates broad engagement as a co-chair of the CSC. The DoFP

provides a practicing physician co-chair to the PCN SC which is formed by the CSC to provide governance over the operations of the PCN.

General practice service committee (GPSC) engagement partners[1]: These are the local primary contact for the division/Medical Staff Association (MSA) support related to the joint collaborative committees (JCCs). The engagement partners work with Doctors of B.C. (DoBC) staff and external teams in the ministry and health authorities. They provide support through strategic and operational guidance, liaising and building relationships with health authority partners and other stakeholders, assisting division/MSA with issues management and providing two-way feedback and information with their respective parent JCCs. The engagement partner may attend governance table meetings as a guest.

GPSC primary care transformation partners[2]: These are regionally based GPSC staff – multi-faceted change agents and trusted advisors who facilitate the ongoing transformation of the primary care system. Specifically, they:

- Empower effective regional engagement and connection to decision making through collaborative processes and tables (e.g., Interdivisional Strategic Council);
- Provide a direct connection and feedback loop to GPSC as the provincial collaborative space for primary care transformation;
- Act as the primary liaison with the ministry's primary care team to assist implementation of ministry directives with regional implications;
- Identify common issues across divisions and regions to develop and enhance the collective voice of physicians; and
- Provide strategic support guided by the quadruple aim and the DoBC commitment to cultural safety and humility in health services. They work in partnership with the GPSC engagement partners to support the divisions at a local, regional and provincial level for primary care transformation.

Health Employers Association of BC (HEABC): This organization leads the development of provincially standardized contract templates with the ministry, in consultation with the NP Council of Nurses and Nurse Practitioners of BC (NNPBC), DoBC and the health authorities. HEABC participates with the ministry in the review and assessment of proposed compensation models in the context of PCNs, UPCCs and CHCs and provides support to health authorities with respect to the negotiation and drafting of local PCN and UPCC FP and NP contracts.

Ministry of Health: The ministry holds the overall accountability and funding for the health-care system. The ministry is responsible for the policy development, monitoring, reporting, oversight, funding and accountability of PCNs and other clinical models (e.g., PMHs, UPCCs, FNPCCs, CHCs, NPPCCs), team-based care and specialized community service programs. The

[1] Prior to July 2020, Engagement Partners were known as "Facility Engagement Liaisons" for MSAs and "Community Liaisons" for Divisions.
[2] Prior to 2020, Primary Care Transformation Partners were known as "GPSC Regional Liaisons."

ministry provides data for regional and local planning and evaluation and oversees monitoring, evaluation and policy revisions. In addition, the ministry is developing and evaluating new clinician payment models and contracts in support of this work. The ministry also reviews and approves PCN service plans, outlining the funding available for FPs, NPs and other professions within the PCN. Key stakeholders within the ministry include:

- Primary Care Division
- Nursing Policy Secretariat and Compensation Policy and Programs Branch, Health Sector Workforce and Beneficiary Services Division
- Finance and Corporate Services Division
- Health Sector Information, Analysis and Reporting
- Mental Health and Substance Use Branch, Health Services Division
- Population and Public Health Division

Nurses and Nurse Practitioners of BC (NNPBC): NNPBC provides advice to provincial bodies and local PCNs on the implementation of LPN, RPN, RN and NP roles and provides role clarity ongoing to PCN implementation. NNPBC is also responsible for administering the ministry funded NP Regional Leadership Program (RLP), NP Practice Support Program, Continuing Professional Development Program funding, and other defined programs, as outlined in shared cost agreements with the ministry.

NNPBC NP regional leads: Through the RLP, the leads provide regional NP leadership, offering direct support and mentorship to contract NPs across the province who are working within PCNs. They also ensure the implementation and integration of NPs within PCNs is in alignment with the provincial primary health care strategy, including engagement with community, regional and provincial PCN partners.

NP Council Negotiating Team (NPC-NT) of the NNPBC: The NPC-NT is responsible for activities related to NP compensation and contract negotiations, including engaging with labour relations and employment legal counsel on behalf of NP Council. The NPC-NT meets regularly with the ministry and HEABC to discuss these topics. Should the NPC-NT agree to provide such representation, the NPC-NT can also review NP contracts and agreements at the request of NPs, as defined in the service contract and group contract language.

PCN manager: Overseen by the PCN steering committee, this role manages PCN operations and is the primary point of contact for the PCN. The PCN manager works in collaboration with the local health authority operations manager, the local DoFP, and, at times, health authority medical affairs to manage the resolution of issues raised by FPs, NPs, RNs and allied health providers. If there are general clinical concerns or questions that FPs, NPs or other health-care providers at the clinic or in the community have about the service delivery, they should engage with the PCN manager to address them. If these discussions do not resolve the concern, the health authority HR manager can be involved when these concerns are related to health authority employees at a PCN setting. This approach allows clinicians (FPs and NPs) to focus on providing patient care, and not on managing health authority staff. The PCN manager works

with the PCN steering committee and relevant professional practice teams (and the health authority HR manager where appropriate) to develop, share and distribute change management tools, professional practice support and development, and materials covering the communications, expectations and execution of team-based care. Ideally, the FP/NP plays a key role in identifying optimal use of change management and other resources at the clinic and regional level. If a FP/NP is embedded in a clinic, the scheduling activity may be delegated to the clinic (working within the parameters of the service contract).

PCN steering committee: Established by the local CSC, the PCN steering committee oversees the establishment and ongoing operations of the PCN in accordance with the approved PCN service plan for the purpose of implementing and coordinating the operations of the PCN. The committee reports to the CSC to ensure ongoing community coordination and partnership, and is minimally comprised of groups and clinicians who are impacted or will be implemented in the PCN. This may include local patient representatives, local First Nations representatives, NP representatives (particularly when NPs will be part of the eventual PCN service plan allotment), physician representatives from local primary care practices, the DoFP and the local regional health authority. The steering committees are responsible for developing community and partner engagement and communications plans for their local PCNs, including identification of stakeholders, development of local key messages in collaboration with their local health authority's communications team and establishment of review and approval processes for communications materials. PCN steering committees are also responsible for recruiting and matching FPs, NPs, RNs and allied professionals to the PCNs, in collaboration with the DoFP and the local health authority.

Regional health authorities: Regional health authorities act as a co-chair of the local CSC and participate in the PCN steering committee. As the service contract administrator, regional health authorities also provide fund administration and contract management for clinical providers including RNs and allied health providers, as well as new FP and NP service contracts. Health authorities are responsible for ensuring that:

- Payments flow in an accurate and timely fashion to the contracted practitioners;
- Practitioners fulfill their contract deliverables; and
- Practitioners provide the required reporting under their contracts, including on their hours worked.

Health authorities are also a signatory to information and data sharing agreements in support of the PCNs.

Health authority operations manager: The health authority operations manager works collaboratively with the PCN Manager and is their primary point of contact with the health authority. This role provides the PCN Manager with template job descriptions and ensures that submitted job descriptions do not violate collective bargaining agreements or any existing contractual obligations.

Health authority medical affairs: Medical affairs (also described as health authority contract managers) is responsible for ensuring that proposed compensation models and contracts for PCN services and UPCCs fit within those models approved by the ministry for use in PCNs/UPCCs and, with the assistance of HEABC as required, for negotiating and drafting FP and NP service contracts. Some health authorities may have a contracted services team supporting NP contracts instead.

Recruitment

Process for Recruitment of PCN NPs

Through the PCN implementation process, contracts are allocated to practices and clinics based on the strategies outlined in the service plan submitted by the PCN steering committee. These strategies are intended to address primary care needs in the community, as identified by the PCN SC, including the number of NPs required in the community to meet patient needs.

The ministry expects at a minimum that the following criteria are in place for PCN settings to obtain a contract NP:

- Demonstrated need for the clinical service, supported by the local health authority;
- Adequate space for the NP and medical office assistant (MOA) (with consideration given to potential preceptoring of NP students);
- Proper equipment to deliver full scope primary care; and
- Desire to adopt a team-based care model.

Decisions regarding recruitment of NPs will be made through the CSC and the PCN steering committee. The PCN Manager will work with local health authority staff responsible for NP contracts (e.g., medical affairs) to recruit NPs through the existing Health Match BC system, following established processes. Health Match BC is not the only venue through which to recruit NPs. If a relationship already exists between an interested practitioner and a clinic within the PCN Service Plan recruitment can also be coordinated through the PCN instead of Health Match BC. NPs engaged through service contracts will be independent contractors, not health authority employees.

Health authorities (through their departments of human resources) working with local clinics are responsible for hiring staff for all positions other than FPs and NPs, in accordance with collective agreements and based on the needs outlined by the PCN partners in the service planning process. Health authorities will work closely with all of their PCN partners to develop collaborative processes that are mutually acceptable and will include all stakeholders in recruitment and selection. A focus on continuous improvement will guide the approach to recruitment, retention and management of staff to enable team-based primary care.

Criteria for Early Draws

An early draw on a PCN allotment can occur in a community or region in pre or early PCN planning. This will result in an eventual draw down on the final PCN service plan allotment.

As part of the consultation process for approval of early draw NPs, the ministry assesses whether the following readiness criteria have been met:

1. The CSC co-chairs are aware and supportive of the request;
2. There is a sufficient attachment gap in the community to accommodate the request;
3. There is an NP identified and readily available;
4. There is adequate space and resources available to add an NP to a clinic;
5. The NP will be a most responsible provider and attaching new patients;
6. The NP joins the PCN if/when it is implemented in the community; and
7. A site visit or teleconference has occurred to confirm the location, role and scope.

Service Contracts

Successful NP applicants who are placed in a PCN primary care practice will be engaged through a provincially standardized service contract developed by the ministry and HEABC in consultation with the NP Council of NNPBC. These contracts engage the practitioners as independent contractors and provide increasing compensation as the practitioners establish their practices and build their patient panels. The health authority is the administrator of the service contract. Health authorities and PCN SCs do not have authority to make material changes to service contracts without consultation with the ministry and HEABC.

The engagement of NPs as independent contractors rather than as employees reflects the independent nature of these new positions as community-based primary care providers with dedicated patient panels. Additionally, engagement of NPs as independent contractors provides more flexibility for the provision of team-based care.

Objectives and Obligations

The current NP service contract template reflects the following objectives and obligations:

<u>General objectives and obligations</u>

- The practitioner will provide longitudinal, full-scope primary health-care services.
- The practitioner will agree to become part of the PCN in the community and to adopt the attributes of the PMH to achieve quality primary care service delivery. It is expected that PMHs will help patients improve their health outcomes and provide high quality, accessible, appropriate, culturally safe and efficient care.
- The practitioner will join an existing group practice or set up a group practice with other practitioners. The service contract is conditional upon the practitioner entering into a practice agreement (PA) with a group practice that uses an electronic medical record and has indicated willingness to join the PCN once it is established.
- The PA between the practitioner and the practice outlines the 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 agrees to use best practices in scheduling in order to provide patients with timely access to appointments.

Objectives and obligations related to patient attachment and patient panels

- The NP 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). NP panel size targets in urban areas are graduated over the term as set out in the service contract:
    - Year 1 of the term: Panel size of a minimum of 500 patients per 1.0 FTE.
    - Year 2 of the term: Panel size of a minimum of 800 patients per 1.0 FTE.
    - Year 3 of the term: Panel size of a minimum of 1,000 patients per 1.0 FTE.
- Due to the nature and complexity of different populations, the ministry has approved reduced NP panel sizes for the following scenarios, to be approved by the ministry on a case-by-case basis following verification of geographic and population data:
    - Rural communities: Panel size of a minimum of 800 patients per 1.0 FTE by year 3.
    - Vulnerable populations: Panel size of a minimum of 600-700 patients per 1.0 FTE by year 3.
- The ministry has communicated broadly that the attachment targets in the service contract are targets and not firm goal posts. The targets will be reviewed through a continuous quality improvement process. The ministry notes that there are many recent mitigating circumstances (e.g., redeployment, attaching particularly complex patients in the early phase of attachment, etc.), which might prevent an NP from achieving the targets outlined in the service contract.
- Primary care waitlists can be used to build the patient panel (e.g., waitlists developed by the DoFP or the ministry (Health Connect Registry)).
- The NP 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.

Objectives and obligations related to practice scope, hours and call

- 1.0 FTE of services is defined as a minimum of 1,680 hours per year. To ensure continuity of care for patients, no more than 90 hours of services can be provided during any two-week period.
- Expected hours and days of work are established under the PA between the clinic and the practitioner.
- As primary care practitioners, NPs have an obligation to be available to provide ongoing medical care to their patient panel after-hours (e.g., to provide timely follow-up on lab results) and this obligation is also reflected in the contract. NPs may work with other practitioners to share availability for on-call as needed, sometimes referred to as a call group. Practices may make a variety of arrangements to provide reasonable after-hours availability to patients, based on patient needs, for the purposes of continuity of care.
- Hours spent on-call but not delivering services do not count towards the hours under the contract and should not be invoiced to the contract. However, if the NP is engaged to provide services during the on-call period, the actual hours spent providing services do count towards the hours under the contract and should be invoiced to the contract.
- NPs do not receive additional compensation for after-hours availability since it is an obligation for all primary care practitioners and is a deliverable in the contract that is

remunerated by the annual rates. Some NPs may wonder about the Medical On-Call Availability Program (MOCAP) used by some physicians. MOCAP is for physicians who are engaged to be available for new or unattached patients, other than their own or their call group's. Primary care physicians and NPs alike do not receive additional compensation for after-hours availability for their own patient panel.

Compensation

The service contract rates are competitively set and increase annually over the three-year term as follows:

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

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

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

Arrangements between the NP and the clinic regarding overhead costs are to be determined privately among the parties through the PA.

Locum Coverage

NPs may subcontract service coverage to a locum. Service coverage provided by another NP will be paid under the service contract and will count towards the minimum 1,680 contract hours. Service coverage provided by a FP will be paid through fee-for-service and will not count towards the minimum 1,680 contract hours. Further, the fee-for-service FP would be expected to contribute an appropriate portion of their billings for overhead. Overhead would cease flowing to the clinic during the time the FP is providing locum coverage. Additionally, the NP should note the potential impact of a longer period of locum coverage by an FP on their requirements for delivery of services. For instance, if a fee-for-service FP covers a practice for four weeks, the NP will still need to fulfill 1,680 hours in the remainder of the year.

When securing locum coverage, the service contract NP should ensure that their locum will be able to provide timely access and continuity of care to their patient panel. Consideration should be given to the patient population (e.g., specialty populations, marginalized groups, mental health and substance use services, etc.) and the contract NP should ensure that the locum is appropriately skilled to provide the comprehensive primary care services that their patients require.

Group Contracts

Occasionally, PCN service plans have included requests for group service contracts that involve the sharing of hourly requirements and panel targets among a group of NPs. Group service contracts are currently being reviewed and approved by the ministry on an exceptions' basis. To date, they have been approved only for the urgent care portion of UPCCs.

Practice Agreement

The PA is entered into between the contracted NP and other FPs/NPs at the clinic (and in some circumstances the clinic itself) that they are joining or establishing. The purpose of the PA is to help ensure the contracted NP can successfully fulfill their obligations under the service contract. The PA is not intended to address matters outside of its scope, such as business arrangements between practitioners. Those should be addressed in a separate agreement between the parties. The PA will cover the specific services the NP is expected to provide, including any additional services, specific service locations or means of service delivery not already stated in the service contract.

The specifics of each PA, and any minor additions to the form of PA found in the template service contract, are matters to negotiate between the NP, the other clinic practitioners (i.e., FPs and NPs) and the clinic owner, if applicable. Therefore, the majority of negotiations around the PAs will remain between these parties. Further variations in PA specifics may also exist depending on clinic model (e.g., PMH, UPCC, CHC). This includes minor changes such as the types of patients that the NP will see or the number of hours worked per week. These issues do not need to come through HEABC or the ministry.

More substantial changes to PAs should come through HEABC and the ministry for approval. This includes requests for a clinic owner to sign the PA on behalf of all the other clinicians. Upon receiving a request from a clinic for this change, the health authority should request that the clinic owner/lead physician answer the PA exception eligibility questions (appendix A) and provide their responses to HEABC and the ministry. This will be used to determine eligibility for approval of the change. Endorsement from the PCN and health authority contract management regarding this change will also be required to grant approval.

Third Party Billing

The NP service contract allows the NP to bill third parties for services not covered in the contract, such as:

- Services for WorkSafe BC, ICBC, the Canadian Armed Forces or corrections;
- Non-insured services other than medical/legal services; and
- Services to patients not covered by B.C.'s Medical Services Plan.

Time spent delivering those services does not count towards the 1,680 hours required in the contract.

Contract Model Versus Employed Model

The NP service contract is intended to attach a relatively large number of patients from the general population in a primary care setting that is separate from health authority service delivery (i.e., a PCN). In contrast, the health authority-employed model can be more appropriate in situations in which an NP serves specialized, acute, vulnerable or complex populations, and requires a stronger link to the health authority system. The ministry prefers PCN NPs to be on contract rather than employed by health authorities.

In some situations, the ministry may consider allowing a PCN NP to be employed rather than contracted or may support the conversion of existing contracted PCN NPs to an employed model. The criteria for approving these exceptions are the subject of broader policy work that is currently ongoing.

Implementation

Principles for Implementation of NPs in PCNs

- NPs will have equitable access to shared resources with other primary care providers within practice settings and within the PCN. This includes team-based support from RNs and allied health care providers, where relevant, as well as equitable support from MOAs and administrative assistants.
- Regions considering NPs as part of their service plan or that have NPs working in PCN community settings should include NPs in their PCN steering committee membership.
- The NNPBC NP regional leads are mandated to support implementation and integration of contract NPs into PCN settings. Engagement with this team by PCN steering committees, PCN managers and health authority contract teams will facilitate successful recruitment and implementation of NPs in PCNs.
- Successful implementation is facilitated by NP participation in practice support programming (including but not limited to continuing professional development, PSP quality improvement initiatives, quality assurance, leadership and team building and PCN education opportunities).
- A practice readiness assessment of interested PMHs should be completed prior to onboarding a contract NP. (NNPBC NP regional leads are available to support assessment.)

Please refer to the NNPBC Integration Guidebook (https://www.nnpbc.com/np-content/index.php/resource/np-integration-guidebook/) for a fulsome overview of NP implementation in a PCN setting.

PCN NP Student Preceptorship

PCN NPs on service contracts may act as preceptors for NP students, with priority given to NP students from B.C. post secondary institution (PSI) NP programs (University of British Columbia (UBC), University of Northern British Columbia (UNBC) and the University of Victoria (UVic)). All placements go through the practicum coordinators from the three PSIs, who will contact NPs directly to make arrangements. The three B.C. PSIs typically provide a student affiliation agreement to be signed prior to the placement. It is at the discretion of the NP and their clinic to decide who should sign the agreement (e.g., the NP themselves, the clinic director, etc.); the ministry does not have a prescriptive view on this.

UBC, UVic and UNBC may have some flexibility with the affiliation agreements and may be open to amendments as per the NP/clinic director's preference. NPs should work with the practicum coordinator directly on this matter.

NPs Switching Clinics While Under Contract

Individual NP service contracts offered through PCNs contain rate increases which are tied directly to the year of the service contract term and indirectly to attachment targets which increase year-over year. The following principles and scenario matrix for switching (appendix B) outline policies with respect to contracted NPs moving from one clinic to another, which is a common occurrence for both NPs and FPs with established patient panels.

In terms of whether a service contract (and its associated compensation structure) should continue or restart as part of a NP's decision to move clinics, a principles-based approach should guide decision making. These principles are based primarily on the nature of the move, the geographic distance involved and whether the NP is retaining some or all of their patient panel:

1. Generally, the compensation structure follows from the year of the service contract term and the progress towards attachment targets.
2. Any position the NP moves to must be part of an approved PCN service plan. Health authorities should consider PCN-level implications (i.e., whether the move is within a single PCN or across PCNs).
3. If the NP does not intend to retain their current patient panel, the compensation structure restarts at year 1. If the NP does intend to retain their current patient panel, and it is feasible to do so, the compensation structure follows the year of the service contract term.
4. If the NP moves to a clinic in a different health authority, a new service contract is required. The compensation structure restarts at year 1.
5. If the NP moves to a clinic in the same health authority but in a different PCN, a new service contract is required. The compensation structure depends on:
    a. The year of the current service contract term, and
    b. Whether the NP intends to retain their patient panel.
6. If the NP moves to a clinic in the same PCN, the service contract may be amended, but a new PA is required. The compensation structure depends on:
    a. The year of the current service contract term, and
    b. Whether the NP intends to retain their patient panel.

Review and quality improvement

1. This guideline will be refreshed as needed and reviewed annually from September 28, 2021 and following completion of the PCN evaluation.
2. This guideline may also be reviewed as determined through consultation between the Ministry of Health and external partners (e.g., NNPBC, health authorities, etc.).

Appendix A

Practice Agreement Exception Eligibility Questions

1. Can you confirm and provide detail of how the FPs are contracted to your clinic (e.g., service contract, salaried or are some fee-for-service with a particular agreement in place)? Does your practice have the authority to direct practitioners' practice specifically in terms of things like scheduling, covering other practitioners' vacations/leaves and distributing/assigning patients and ensuring balanced patient panels and access to timely care for patients?

2. In other words, does your clinic have the authority over the other practitioners at the site to ensure the practice operates in a way that supports the NP in meeting their service contract deliverables specifically in terms of attachment and minimum hours/days target as well as maintaining an appropriately balanced panel?

Appendix B
Scenarios Matrix for Switching

Clinic Location	PCN	Health authority	Patient Panel	Contract	Compensation Structure	Comments
Different	Same	Same	Follows NP	Amend contract	Initial start date	• All or most patients follow NP. • Attachment target continues to step-up.
Different	Same	Same	New panel	New contract	New start date	• NP to build a new patient panel – few or no patients follow NP. • Restarts with lower attachment targets.
Different	Different	Same	Follows NP	New contract	Initial start date	• Initial start date only if feasible for majority of patients to follow the NP. • NP re-attaches retained and new patients. • PCN funding implications (within one health authority).
Different	Different	Same	New panel	New contract	New start date	• NP to build a new patient panel – few or no patients follow NP. • Restarts with lower attachment targets.
Different	Different	Different	Follows NP	New contract	Initial start date	• Initial start date only if feasible for majority of patients to follow the NP. • NP re-attaches retained and new patients. • PCN funding implications (two health authorities).
Different	Different	Different	New panel	New contract	New start date	• NP to build a new patient panel – few or no patients follow NP. • Restarts with lower attachment targets.

Notes

- Any movement between clinics by contracted NPs, whether in the same PCN or a different PCN, requires a vacant FTE which is part of an approved PCN service plan.

- Any movement between clinics will, at minimum, require a new PA between the NP and the clinic they are joining.
- Health authorities should consider PCN funding implications as part of decision making.