Nurse In Practice Program Application Guide

Ministry of Health February 2024

Primary Care Division, Ministry of Health

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Inquiries

The Ministry of Health (the Ministry) will determine eligibility for the Nurse in Practice (NinP) program based on the criteria set out in this document, which is subject to change at the discretion of the Ministry.

Inquiries regarding any aspects of the NinP program may be made in writing to the Ministry at: NurseInPractice@gov.bc.ca

Overview

Purpose

The Nurse in Practice program was first launched on a limited basis in 2017 and is now being expanded and improved to increase primary care capacity and access by integrating more nurses into primary care practices. Under this program, practices that deliver longitudinal primary care to one or more panels of patients, or that provide focused primary care to priority populations, may be eligible for funding to hire a registered nurse (RN) or licensed practical nurse (LPN) to work as part of their core clinical practice team.

Background

The Ministry of Health is committed to working with its partners to increase patient access to primary care and expand primary care capacity throughout British Columbia (BC) via the implementation of Patient Medical Homes (PMHs) linked together with one another and with other clinics and services in local Primary Care Networks (PCNs). A key element of this work is to increase team-based primary care throughout BC with a particular focus on team-based longitudinal primary care provided through family practice clinics.

In 2022, the Ministry worked with the provincial Family Practices Services Committee (FPSC) and PCN partners to learn about partner experiences after the first few years of

implementing PCNs. As a result of that process, in 2023, the Ministry committed to strengthening team-based care in family practices by enabling them to add more RNs and LPNs by hiring them directly to their practices, building on the current NinP contract model piloted in a number of practices in the BC Interior region.

Key lessons learned in the evaluation of the initial NinP pilot project included the importance of allowing clinics to hire nurses based on optimal fit for their own clinical team in order to support effective team functioning, scope optimization, and consistency for providers.

The updated and expanded program builds on the existing NinP initiative and addresses these recommendations by enabling longitudinal family practices and focused primary care practices serving priority populations to directly recruit and hire their own RNs and LPNs.

Objectives

The primary objective of the NinP program is to deliver more **timely access** to primary care services and follow-up care. RNs and LPNs funded through this program are expected to help increase a practice's capacity to serve patients, facilitate more timely access and reduce wait times for care, help FPs and NPs work to their full scope of practice and ultimately improve patient outcomes and satisfaction.

The secondary objective of the NinP program is to **increase attachment** in practice settings where this is possible. It is important to note that RNs and LPNs support attachment to FPs and NPs rather than attaching their own patients.

Eligibility Criteria

Type of Practice or Clinic

There are two types of practices or clinics invited to participate in the program, commencing February 2024:

1. FPs/NPs delivering care to a full panel of patients through a **longitudinal primary care practice.**
    - Longitudinal primary care clinics must be FP or NP owned and operated, or alternatively, operated by a not-for-profit society,
    - FPs and NPs working in longitudinal practices must meet specific panel size expectations to be considered for funding:
        - All eligible FPs and NPs must individually meet the minimum panel size criteria to be eligible.
    - Minimal panel size requirements are as follows:
        - Urban Practices:

            1 FTE FP panel = approx. 1250 patients of average complexity

            1 FTE NP panel = approx. 1000 patients of average complexity
        - Rural Practices:

            1 FTE FP panel = approx. 800 patients of average complexity

            1 FTE NP panel = approx. 800 patients of average complexity
        - For additional details on panel size expectations, see Appendix A.
2. FPs/NPs delivering primary care to priority populations through **focused primary care practices.**
    - Focused primary care clinics must be FP or NP owned and operated, or alternatively, operated by a not-for-profit society,
    - Focused primary care practices may include practices that deliver targeted care to Indigenous peoples, maternity patients, elderly/frail patients, complex care patients, patients seeking sexual health and/or gender affirming care, mental health and substance use patients. FPs and NPs delivering care to other priority populations may be considered for eligibility on a case-by-case basis at the discretion of the Ministry.
    - Focused primary practice clinics are not necessarily subject to the same panel size requirements as longitudinal primary care practices as they may have

alternate minimum panel size expectations as agreed to through other MoH funding arrangements (for panel size expectations, see Appendix A).

The Ministry may prioritize specific clinics, practices, or circumstances, using other criteria at their discretion.

To be eligible, both longitudinal and focused primary care practices must also meet the following criteria:

- Eligible providers in the practice have uploaded their panels into the Panel Registry in the Provincial Attachment System (PAS) and are maintaining up to date panel information and identifying their availability for new attachment in the Registry,
- Clinics have uploaded information into the Clinic and Provider Registry in PAS and are maintaining up to date clinic information in the Registry,
- The practice has arrangements in place to provide after-hours care, and,
- The clinic has adequate space to accommodate an RN/LPN to provide services on-site.

As part of the eligibility assessment, FPs, NPs and clinics must demonstrate that they meet all NinP eligibility criteria by completing an Application Form available at https://www2.gov.bc.ca/assets/gov/health/forms/4699fil.pdf and submitting it to the Ministry of Health at: NurseInPractice@gov.bc.ca.

Applications may be submitted at any time. However, applications will only be assessed according to quarterly intakes. Deadlines for 2024/25 intakes are as follows: April 1, 2024; July 1, 2024; October 1, 2024; January 1, 2025. Future year intakes will be communicated at a later date.

Clinic and Provider Commitments

To receive funding, the clinic and participating providers must confirm their commitment and meet the following ongoing program requirements:

Service Commitments

- Hire no less than 0.2 RN/LPN full-time equivalent (FTE),
- Support the RN/LPN to meet service expectations, including ensuring the RN/LPN patient encounters are accurately reported to enable tracking of service volumes (anticipated to be approximately 4400 patient encounters per FTE). These encounters are inclusive of direct, virtual, and autonomous nursing care (see Patient Encounters section) and work to optimal scope of practice to meet patient needs (see Appendix B),
- Support the RN/LPN to deliver services predominantly in-person on site. This includes:
    - 70% or more direct in-person, RN/LPN clinical care (see Reporting Requirements section for more details),
    - A significant portion of encounters are nursing specific appointment types which do not require the patient to be also seen by an FP or NP and can be managed by a RN or LPN autonomously. There are prescribed scopes of practice for nurses of all designations including RNs (and RNs with certified practice designation(s) or RN(C)s), and LPNs. Certified practices are carried out autonomously using the decision support tools (DSTs) and are based on depth and breadth of knowledge that can be applied in clinical practice, clinical decision-making, and utilization of health research, and,
    - To support host clinics, practice supports will be coordinated to foster team and scope optimization. See Appendix B for more information to support optimized nursing scope of practice.
- Meet patient panel size and attachment expectations, where applicable:
    - Longitudinal primary care practices that **exceed** PCN panel size requirements are expected to maintain their existing panel size during their participation in the program. These practices will not be required to attach further patients,
    - Longitudinal primary care practices that **do not** exceed PCN panel size requirements are expected to increase patient attachment across eligible FPs/NPs. Increase in attachment per FTE RN/LPN is 300-500 patients in urban

settings or 200-400 patients in rural settings, above the minimum level set to qualify for the NinP Program (see Appendix A),

- The Ministry will monitor panel sizes to ensure that FPs and NPs are progressing to meet attachment expectations and to provide clinics with additional support where required.

- Participating providers are expected to provide after-hours care in compliance with their College practice standards or expectations.[1] This may be through a call group or the FPSC After-hours Care Program as it becomes available in PCNs across the province, and,
- RNs and LPNs are expected to increase access to the practice by providing or facilitating same-day urgent care during their regular hours at the participating clinic, as needed.

Operational Commitments

- Provide the RN/LPN with patient exam room/workspace, equipment, and necessary supplies to provide in-person clinic and outreach services as applicable,
- Meet employer requirements such as pre-employment/license checks, liability insurance or occupational health and safety expectations as per WorkSafe BC,
- FPs compensated under fee-for-service and Longitudinal Family Physician (LFP) Payment Model will not bill for delegated services delivered by a RN and/or LPN funded under the NinP program. An LFP physician may claim Indirect Patient Care for time spent with non-physicians (e.g., nurses, nurse practitioners, allied care providers, nonclinical staff) communicating, care planning, and conferencing about a specific patient or patients,
- Eligible FPs and NPs must upload their patient panel to the Panel Registry in the Provincial Attachment System (PAS) prior to applying,

[1] FPs and NPs have a duty to provide care. FPs and NPs should consult the practice standards of the College of Physicians and Surgeons of British Columbia and British Columbia College of Nurses and Midwives to determine their obligations for providing after-hours care.

- Participate in PAS by maintaining up-to-date information in the Clinic and Provider Registry and the Panel Registry,
- Agree to submit a monthly invoice including financial data, and,
- Ensure nurses submit encounter coding.

Clinics Already Employing RNs and LPNs

FPs and NPs who already privately employ and fund their own RNs or LPNs (i.e., those not funded through a PCN, other Ministry source or other third parties) may apply under this program for funding to cover the cost of their existing RN/LPN (to a maximum of 1 FTE RN or LPN per FP or NP panel), subject to demonstration of eligibility and agreement to meeting ongoing service expectations and reporting set out in this document.

Clinics With PCN Funded/Health Authority Employed RNs and LPNs

Family practices that currently have a HA employed RN or LPN funded through the PCN (or otherwise) will continue with this status quo arrangement until the incumbent RN or LPN decides to leave the position or is re-deployed by mutual and prior agreement of the RN/LPN, practice, HA and Ministry of Health, in the form of a change request. Termination of the arrangement with HA employed RNs or LPNs for the purpose of hiring a clinic employed RN or LPN is not permissible.

Exclusion Criteria

In the following instances clinics are not eligible for the current phase of the NinP program:

- Clinics with HA employed RNs and LPNs. A mixed compensation model with both a HA employed RN or LPN working alongside a clinic employed NinP is not permissible in the current phase of the program,
- Primary Care Clinics that access RN or LPN funding through other alternative processes (e.g., the Ministry of Health, a PCN or other third-party such as the Federal Government),

- Episodic primary care clinics (e.g., walk-in clinics),
- Longitudinal Primary Care Clinics where no FPs or NPs have met the minimum panel size requirements described in Appendix A. To be eligible, each participating FP or NP must meet the minimum panel sizes, and,
- Longitudinal Primary Care Clinics where the FPs and NPs included in the application form have not uploaded and maintained an up-to-date panel list in the PAS Panel Registry and Clinic and Provider Registry.

Service Expectations

Nursing resources funded under this program are intended to be used only for services that are medically necessary (i.e., not for cosmetic or other non-insured services). RNs and LPNs are expected to work to their full scope of practice for clinically related services (i.e., are not to be used as a substitute for Medical Office Assistant or similar administrative role).

FTE Requirements

RNs and LPNs hired under the program are expected to provide a minimum of 0.2 FTE and a maximum of 1.0 FTE.

Eligible clinics may hire more than one RN or LPN to fulfill up to a maximum of 1.0 nursing FTE per eligible FP or NP FTE at the clinic (i.e., headcount > FTE). The service expectations for participating FPs, NPs, RNs and LPNs will be pro-rated based on the proportion of FTE funded. Practices will be supported over the course of the year to optimize team-based care to achieve the service expectations. To support multiple patient panels and improve clinical workflows, all eligible FPs and NPs in the clinic are encouraged to work as a team with RNs and LPNs hired under the Program.

Service Hours

A full FTE RN or LPN under this program will provide a minimum of 1628 service hours per year.

For a 7.5-hour shift, it is expected that up to one hour worked may be spent on clinical administration (see Appendix A).

Service Volumes

A full FTE RN/LPN is anticipated to provide a minimum of approximately 4400 encounters per year, inclusive of direct, virtual, and autonomous nursing care, based on an estimated average of 3.15 encounters per hour. The Ministry will monitor service volumes of participating RNs and LPNs to assess progress in meeting service volumes expectations and to provide additional support where required. Encounters may include a mix of in-person encounters and virtual encounters; however, the expectation is that services are predominantly provided in-person, at least 70% is direct, in-person clinical care time (see Reporting Requirements section for more details). It is also expected that a significant proportion of all nursing encounters do not require the patient to be seen by a FP or NP and can be managed by the RN or LPN autonomously.

The service volume expectations for RNs and LPNs will be pro-rated based on the proportion of FTE funded.

After-hours Care

Participating providers are expected to provide after-hours care in compliance with their College practice standards. This may be through a call group or the after-hours care program. If practices are not in compliance with this standard, they will not be eligible for this resource.

Timely Access

As the primary objective of the NinP program is to deliver more timely access to primary care services and follow-up care, the addition of RNs and LPNs to a practice is expected to help increase a practice's capacity to serve its patients in general. It is also expected that the addition of RNs and LPNs will facilitate same-day urgent access to the practice during their regular hours at the participating clinic. This could be accomplished, for example, by setting

aside one to two nursing appointments per day for same-day urgent care. RNs or LPNs may triage or provide preliminary patient assessment that could facilitate patient care by an FP or NP. In other cases, they may provide the assessment and treat appropriately within their scope, within a timeframe based on clinical need.

Attachment

Expectations for attachment will vary by clinical setting and circumstances. Generally, FPs and NPs that integrate an RN or LPN into their longitudinal primary care practice are expected to provide longitudinal care to larger than average patient panels (see Table 2, Appendix A).

Consistent with other primary care initiatives (e.g., PCN funding parameters), it is assumed that an average panel size (i.e., prior to the integration of an RN or LPN) would be:

- Urban
  - 1 FTE FP panel = approx. 1250 patients of average complexity
  - 1 FTE NP panel = approx. 1000 patients of average complexity
- Rural
  - 1 FTE FP panel = approx. 800 patients of average complexity
  - 1 FTE NP panel = approx. 800 patients of average complexity

The addition of an RN or LPN FTE is expected to result in a net increase to average panel sizes in the clinic of between 300 to 500 (urban) or 200 to 400 (rural) within one year of hiring. For example, an urban clinic with one FP and one RN that hires one RN FTE, would need 1550 - 1750 patients attached in total to meet the attachment service expectation.

To support FPs and NPs in meeting attachment expectations, the Ministry, PCN Managers and PCN Attachment Coordinators will facilitate patient-provider attachment using the Health Connect Registry. Attachment expectations will be pro-rated based on the proportion of Nursing FTE funded.

Eligible FPs and NPs are expected to maintain attachment levels, recognizing that there are circumstances that could slow the attachment process (see Table 2). Attachment expectations will be reviewed intermittently to ensure practices are moving towards expectations. If a clinic's eligible FPs and NPs do not meet attachment expectations, the Ministry will engage the clinic and providers to understand the situation and arrange attachment assistance for the providers through the PCN. Should the providers continue to not meet the attachment requirement, the clinic's RN/LPN FTE funding may be removed at the discretion of the Ministry.

Attachment Requirement Exceptions

A clinic whose eligible FPs and NPs have already exceeded the expected panel size by 300 to 500 (urban) or 200 to 400 (rural) will not be expected to attach additional patients. Such practices may focus on improving access and quality of care for the existing panel of patients by enhancing urgent and timely access to the practice and/or provision of after-hours care.

Longitudinal primary care clinics whose FPs and NPs wish to seek an exception to the minimum panel sizes required for eligibility due to perceived complexity of their panels should be prepared to have their panels assessed by the Ministry using a complexity scoring methodology currently under development to support PAS.

Focused primary care clinics serving priority populations are expected to maintain minimum panel size expectations (where those exist based on an approved funding arrangement with the Ministry or Health Authority) while increasing access through additional hours and encounters (see Appendix A). These practices will be required to meet Ministry reporting requirements and timelines.

Reporting Requirements

Reporting requirements are in place to support program oversight and ensure practices

continue to meet service expectations. Failure to meet Ministry reporting requirements and timelines may affect availability of ongoing funding.

- To demonstrate service expectations are being met, practices must provide encounter reporting through MSP/Teleplan for all RN and LPN services,
- To demonstrate panel size and complexity pre-and post-addition of an RN or LPN, practices must actively participate in PAS, which includes upload and regular maintenance of patient panel information,
- To demonstrate service expectations are being met, practices must provide regular monthly reporting as part of the invoicing process, including financial data & hours reporting, and,
- To assess and evaluate the impact of the program on quality of services provided provincially, practices receiving funding must participate in any such provincial measurement and evaluation. This may include administration of a patient or provider satisfaction survey.

RN/LPN Encounter Reporting

Encounter codes for RNs and LPNs in primary care practices are outlined in the PCN Toolkit. Encounter codes are matched to the Medical Service Plan diagnostic codes outlined in the ICD9 index prior to submission. The Health Sector Information, Analysis and Reporting Division (HSIAR) of the Ministry uses the data from encounter coding to look at population health trends in conjunction with the services provided.

Provincial Attachment System (PAS) Reporting

PAS is designed to provide a coordinated approach to connecting patients to FPs and NPs who are taking on new patients. PAS applies to any FP or NP providing longitudinal care in BC regardless of payment model.

Questions about PAS can be directed to the Provincial Health Services Authority (PHSA) at

HealthBcSupport@phsa.ca and to Doctors of BC's central intake practice support at psp@doctorsofbc.ca.

PAS Participation Process:

1. **Create a OneHealth ID:** OneHealth ID is used to access PAS. DoBC created an infographic for the steps involved in creating a OneHealth ID.
2. **Panel Registry:** FPs and NPs providing longitudinal care must log into the Panel Registry to verify clinic information and identify any capacity for new patients if it exists. To complete the panel registry step, providers must submit their current patient panel to MSP using their EMR or Dr. Bill's patient panel uploader tool.
3. **Clinic and Provider Registry:** Medical directors must log into the Clinic and Provider Registry to provide basic information about their clinic, including address, operating hours, and physician and clinical staff. The registry will be pre-populated with clinic information, where possible.

Funding Parameters

The Ministry will provide clinics with 'block' funding for all RN/LPN positions to cover costs arising from the employment of a nurse in practice who is providing primary care services, including salary and benefits, and other costs such as overhead. Block funding rates as of February 2024 will be $133,000 per RN 1.0 FTE and $96,000 per LPN 1.0 FTE, which are considered all-inclusive amounts (i.e., salary, benefits, overhead, etc.). Funding will be prorated based on FTE. Additional funding for relief of the RN/LPN position (e.g., for short-term leave coverage) will not be provided. It is the responsibility of the practice to manage all short- and long-term absences (e.g., seeking a temporary replacement to cover an extended period of leave for the RN/LPN).

Application Process and Administrative Information

Application Form

Applications may be submitted at any time starting in February 2024. However, applications will only be assessed according to quarterly intakes. Deadlines for 2024/25 intakes are as follows: April 1, 2024; July 1, 2024; October 1, 2024; January 1, 2025. Future year intakes will be communicated at a later date.

The estimated period from application to Ministry **approval** for the funding of NinP is four to six weeks. Approval indicates the clinic will be proceeding to next steps to receive funding. It does not include the time to complete the Electronic Funds Transfer (EFT) process, execute a contract or recruit a nurse.

Clinics will be required to submit an application form available online at https://www2.gov.bc.ca/assets/gov/health/forms/4699fil.pdf and e-mail it to NurseInPractice@gov.bc.ca prior to the intake deadline.

Applications received after the quarterly intake deadline will be assessed during the next quarterly intake. Once an application has been reviewed and approved by the Ministry, clinics will need to provide an electronic funds transfer (EFT) form and sign a contract (see below). The ongoing clinic payment will be through EFTs.

Contract

Requirements for the RNs/LPNs and Hosting Clinics

Once an eligible clinic has been approved to participate in this program, a contract template will be shared with the clinic for their review. FPs/NPs must agree to the Clinic and Provider commitments as well as all terms and conditions laid out in the contract including that they will not bill for services provided by the RN/LPN via the Medical Services Plan (MSP). Expectations

for encounter volume will be tracked using encounter reporting and attachment will be tracked for all eligible FPs and NPs listed in the application using PAS.

Note that the contract is a standard template, and the Ministry will not permit amendments to the template.

RN/LPNs must hold a valid license to practice in BC and be in good standing with their professional College under the *Health Professions Act*. They must hold the degree of skill and experience appropriate to providing primary care services as assigned to them by the clinic. Signatories to the contract will be required validate RN/LPN licensure with the College as part of pre-employment checks and assume liability for this pre-check.

The contract will outline the expectations for services provided, reporting requirements, and payment provisions.

- The contract term will be a two-year period and will begin on the first day of any month and may be renewed,
- The clinic must submit an invoice for nursing hours worked to the Ministry on the schedule and format set by the Ministry. Payments will be made monthly (once onboarded) by EFT to the clinic and a year-end reconciliation process will take place after the end of each contract year to reconcile hours worked against hours required under the contract, and,
- Funding will be provided via block funding method which is all inclusive covering the costs arising from the employment of a nurse in practice who is providing primary care services, including salary and benefits, and other costs outlined in the contract such as overhead.

Termination of RNs/LPNs

If the clinic terminates the RN/LPN, or the RN/LPN chooses to leave the clinic or is otherwise

unable to provide primary care services, the clinic will notify the Ministry in writing to NurseInPractice@gov.bc.ca and use its best efforts to replace the RN/LPN as soon as possible. The Ministry will not be responsible for further payments until such a time as a replacement RN/LPN is employed and the Ministry is notified.

Leave of Absence

If the RN/LPN requires an extended leave of absence, the clinic may enter into a temporary agreement with another RN/LPN to provide continuity of services during the absence. At the point where hours are not being invoiced, payments will stop.

Appendix A: Service and Panel Size Expectations

Improved access will be facilitated by primary care teams. RNs and LPNs are expected to deliver approximately 4400 nursing encounters per year (consisting of 1628 annual service hours) with at least 70% of those direct in-person RN/LPN clinical care time. Participating providers are expected to provide after-hours care in compliance with their College practice standards or expectations. This may be through a call group or the FPSC after-hours care program. RNs and LPNs are expected to increase access by providing and facilitating same-day urgent care during their regular hours at the participating clinic. Expectations for service volume, direct in-person care, clinic hours including after-hours care, same-day urgent care and attachment will be monitored by the Ministry.

Eligible FPs and NPs delivering longitudinal primary care must meet or exceed PCN panel size parameters to qualify for NinP funding. Once qualified, it is expected that such practices will increase the total number of attached patients across the clinic's participating FPs and NPs (see Table 2 below for more detail). In urban settings the anticipated increased panel size is **300-500 patients** above the minimum levels set for the FPs and NPs to qualify for the NinP program. In rural settings the anticipated increased attachment is **200-400 patients** above the minimum levels set for the FPs and NPs to qualify for the NinP Program.

Longitudinal primary care practices that exceed PCN panel size requirements are expected to maintain panel size during their participation in the program and will not be required to attach further patients. Attachment expectations will be tracked through PAS.

FPs and NPs with focused primary care practices, delivering care to priority populations, are not necessarily subject to the same panel requirements as longitudinal primary care practices, but are expected to increase patient access as described above. Focused primary care practices serving priority populations are expected to maintain minimum panel size expectations, where those exist based on approved funding arrangements. Attachment expectations, where applicable, will be tracked through PAS.

Table 1: Service Expectations per RN/LPN FTE

SERVICE REQUIREMENT - ACCESS			
	URBAN/METRO Family Practice	**RURAL Family Practice**	**FOCUSED Primary Care Practice (Priority Populations)**
SERVICE EXPECTATIONS	**1628 hours per year** **4400 nursing encounters per year,** which is all inclusive of direct, virtual, and autonomous nursing care with: - Services **predominantly in-person,** ≥70% direct clinical care time by the nurse (see Reporting Requirements section for more details), and - Significant proportion of nursing encounters **autonomously managed** by a RN or LPN. - Participating providers are expected to provide after-hours care in compliance with their College practice standards or expectations. This may be through a call group or the after-hours care program. - RNs and LPNs are expected to increase access by providing same-day urgent care during their regular hours at the participating clinic, as needed.		

* Assumes nurse works 7.5 hours/day, with 6.5 hours/day of clinical time.
** Assumes 3.15 encounters per hour on average

Table 2: Attachment eligibility / expectations

Eligibility Requirement – Minimum Panel Size			Clinic Panel Size Expectations Within 1 Year		
Urban/Metro Primary Care Practice	**Rural Primary Care Practice**	**Focused Primary Care Practice**	**Urban/Metro Primary Care Practice**	**Rural Primary Care Practice**	**Focused Primary Care Practice**
FP - 1250 attached NP - 1000 attached	FP - 800 attached NP - 800 attached	Minimum panel size based on funding arrangement.[1]	+ 300-500 per RN/LPN FTE[2]	+ 200-400 per RN/LPN FTE[2]	Minimum panel size based on funding arrangement.[1]

Note 1: Focused Primary Care Practices serving priority populations are expected to maintain minimum panel size expectations, where those exist based on approved funding arrangements. Some practices do not have panel expectations, e.g. maternity clinics or mental health and substance use focussed practices. Other practices such as Indigenous focused practices have panel expectations set at 650.

Note 2: As patient panel sizes can fluctuate over the course of the year, a 10% temporary reduction in panel size at the clinic-level is an allowable variance. The allowable variance is only applicable for unanticipated circumstances, such as practitioner leave and will require actions to mitigate the negative impact on panel sizes.

Appendix B:

Nursing Scope of Practice/Summary of Therapeutic Interventions in Primary Care

In a primary care setting, nurses may fulfil several key clinical functions including triage and assessment, health promotion, disease/injury prevention, and care coordination. In a longitudinal family practice, it is expected that FPs/NPs and RNs/LPNs will work autonomously within their optimal scopes of practice to improve patient access to primary care services.

The Ministry of Health sets scopes of practice for nurses of all designations including RNs (including RNs with certified practice designation(s)-RN(C)s), and LPNs. Although RNs and LPNs work autonomously within their scope of practice and level of competence, their education differs in the knowledge covered, competencies developed, and expectations within clinical practice. RNs receive more comprehensive education, resulting in greater depth and breadth of knowledge that can be applied in clinical practice, clinical decision-making, and utilization of health research. Refer to PCN Toolkit: RN, LPN, RN(C), RPN Scope of Practice resource and the BC College of Nurses and Midwives for more information about nursing scope of practice.

Registered Nurses (RNs)

RNs work in partnership with FPs, NPs, and other members of the healthcare team to provide care to the entire patient population, including those with complex, unstable, or unpredictable conditions.

- RNs focus on providing assessment, screening, healthy lifestyle support, education, and chronic disease management with a goal of improving health outcomes and facilitating access to services.
- RNs have a scope of practice that enables them to work autonomously to perform activities which they are educated and competent to perform (and accountable and responsible for) without a client-specific order.
- RNs with certified practice (RN(C)s) have completed additional BC College of Nurses

and Midwives approved education, have specialized knowledge and skills, and are registered to practice in one or more certified practice areas, (i.e., Remote Certified Practice, Reproductive Health: Sexually Transmitted Infections, Certified Practice Reproductive Health: Contraceptive Management Certified Practice, RN First Call Certified Practice; and Opioid Use Disorder Certified Practice (RN & RPN (Registered Psychiatric Nurse)).

RN key duties focus on:

- In person/virtual triage and screening (e.g., routine preventative cancer screening, mental health screening (PHQ-9, GAD-7, MOCA, etc.)),
- A comprehensive assessment of the presenting problem as well as a complete assessment of the health status, risks and opportunities that can affect long-term health (e.g., health history and assessment of psychosocial, physiological, psychological, emotional, spiritual, ethnic and socio-cultural needs; physical examination; medication review, lab review; etc.),
- Health care management and therapeutic interventions (e.g., initiation, contribution, monitoring, evaluation of the health care plan in collaboration with the primary care team, provision/discussion of treatment options within scope of practice or diagnose/prescribe (see Registered nurses (certified) standards for prescribing medications)/treat certain diseases/disorders/conditions if RN has obtained applicable certified practice designation),
- Development and delivery of a variety of educational approaches to address health topics/health education needs, including individual and group sessions (e.g., well baby, chronic disease management, problematic alcohol and substance use, etc.) delivered via clinic, telephone or home/outreach visits,
- Coordination of services and follow up care with the patient, interdisciplinary team, and community services (as applicable), and,
- Research, and use of, evidence-informed practice to guide the delivery of services.

Licensed Practical Nurses (LPNs)

LPNs work in partnership with FPs, NPs, RNs, and other members of the health care team to provide primary care nursing services primarily to patients with stable and predictable health needs. LPNs can work autonomously to support more complex care with additional education, training, and/or supervision.

LPN key duties focus on:

- Screening/assessment to inform the development of the health care plan,
- Provision of therapeutic interventions in accordance with the health care plan in collaboration with the interdisciplinary team,
- Conducting individual and established group education to address health topics and support chronic disease prevention and self-management (e.g., smoking cessation, problematic alcohol and substance use, physical activity, and healthy eating),
- Monitoring/evaluation of the health care plan, and,
- Supporting coordination of services internal and external to the health care team.

Summary of RN/RN(C)/LPN Therapeutic Interventions in Primary Care

- Health education and care coordination to support chronic disease management (e.g., diabetes, COPD, asthma, hypertension),
- Health maintenance and rehabilitation strategies, as well as risk factors and lifestyle changes (e.g., smoking counseling/cessation, diet review, coaching, education),
- Point of care testing and results review (e.g., glucose, urine drug screen),
- Sexually Transmitted Infection testing/management,
- Medication administration (e.g., injectables),
- Contraception management,
- Pregnancy testing/prenatal follow-up,
- Well baby and well childcare (growth monitoring, health education),

- Immunization (infant, child, adult),
- Well woman care,
- Sexual health,
- Wound care, suture/staple removal,
- Wart treatment (cryotherapy),
- Management of acute minor illnesses (e.g., lower UTI, acute otitis media, conjunctivitis),
- Ear syringing,
- Catheter care,
- Footcare.

Note: This list is not exhaustive and may differ depending on the nursing designation, but can be helpful in determining the nursing role required to meet patient needs in team-based primary care. For more detailed information, refer to:

Ministry of Health. (2023). Licensed Practical Nurse (LPN), Registered Nurse (RN), Registered Nurses with Certified Practice (RN(C)), and Registered Psychiatric Nurse (RPN); Scope of Practice in Primary Care

UBC ISU Primary Care Capacity Estimator (ongoing work, 2023). See https://isu.familymed.ubc.ca/our-work/evaluation/primary-care-capacity-estimator-capes/

Appendix C: Program 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.

Encounter - An occurrence of a patient being seen by a practitioner (e.g., FP, NP, nurse, allied health). More than one clinical service could be provided within one encounter. An encounter is a measure of practitioners seen within a patient visit.

Encounter Code - An encounter code is a unique five-digit number which corresponds to a service/activity or group of services/activities and is a mandatory field within each encounter record. These are called “fee items” under fee-for-service (FFS).

Encounter Record - Encounter records are the principal mechanism for contracted physicians and health professionals to report on the services they provide under contract arrangements. Encounter records are collected by the ministry through Teleplan, a process similar to fee-for-service (FFS) claim submission. An encounter record is a claim submitted to Teleplan for a distinct clinical service or activity provided by a practitioner to a patient or group of patients. Encounter records are similar to FFS claims and contain many of the same mandatory fields. Unlike FFS claims, however, encounter records pay $0.

Encounter Reporting – Encounter reporting involves submitting information through the Teleplan system for the services a practitioner (e.g., physician, RN, Nurse Practitioner, LPN) provides. It does not mirror the Medical Services Commission Payment Schedule and has no associated dollar value. Encounter reporting involves the submission of information about services provided, but not for the purpose of reimbursement. (Encounter Reporting for Primary Care Networks: Frequently Asked Questions, General Practice Services Committee, 2022).

Optimal Scope(s) of Practice - An approach to team design where the most effective

complement of professional roles is determined by the relative competencies of all health care providers on the team. This means that the scope of each team member is maximized to effectively deliver care through service provision that is based on respective strengths/skills of team members, for example, the physician or nurse practitioner focus on complex diagnostics and establishing a longitudinal relationship over time with patients across health care settings. This approach facilitates the maximal contribution of all team members, supports continuity of care and optimizes health outcomes. (Team-based Care policy, MOH, 2020).

Patient Visit – An occurrence of a patient visiting a clinic. There may be one or more encounters and services during a single visit. A visit is a measure of patient volumes.

Primary Care - A person's first point of contact with the health care system where the majority of health problems are treated by a generalist and coordinated continuing care occurs with specialists as needed. (Primary and Community Care in BC: A Strategic Policy Framework, MOH, 2015).

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. (Standard Messaging, MOH, 2020).

Primary Care Provider - Primary care providers are family physicians or nurse practitioners, who attach patients and provide longitudinal care in team-based settings that can include nurses, clinical pharmacists, social workers, physiotherapists, occupational therapists, registered dietitians, traditional wellness healers, midwives, and other allied health

professionals. Benefits of having a continuous relationship with a primary care provider include relational continuity, improved disease management, positive health outcomes and improved experiences of care. (Primary Care Division, Ministry of Health, 2021).

Priority Populations - Those who would benefit most from public health program and services, and in which public interventions may have a significant impact at the population level. These individuals are at a higher risk of adverse health outcomes, may experience an increased burden of disease, or face ongoing health inequalities and access barriers to public health services. For the purpose of the NinP program, these populations may include: Indigenous People, maternity care, elderly/frail, complex care, sexual health and/or gender affirming care, mental health and substance use. Other priority populations may be considered for eligibility on a case-by-case basis at the discretion of the Ministry.

Service – A clinical service provided in a patient encounter.

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). (Team-based Care policy, MOH, 2020).