MODIFIED
PHYSICIAN RECRUITMENT AND RETENTION PROGRAM (PRRP) FOR RURAL AND SMALL URBAN COMMUNITIES

PROGRAM GUIDE

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BRITISH COLUMBIA
Ministry of Health and
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MODIFIED PHYSICIAN RECRUITMENT AND RETENTION PROGRAM FOR RURAL AND SMALL URBAN COMMUNITIES

Introduction

The *Modified Physician Recruitment and Retention Program* provides funding for recruitment, retention and on-call service in rural and small urban communities as per the recommendations of the Alan Hope QC Mediation Report, November 2000.

The program encompasses the existing funding for the Emergency Medical Coverage Program (EMCP), and $40 million in new funds which have been allocated to this program on an annualized basis. Premiums available under the *Modified Physician Recruitment and Retention Program* will be coordinated along with the benefits available under the *Subsidiary Program for Physicians in Rural Practice*.

The *Modified Physician Recruitment and Retention Program* draws upon many of the policies and procedures established under the EMCP and extends the provisions of EMCP to additional communities.

Physicians in Northern Isolation Allowance (NIA) communities will receive a retention premium in addition to their existing NIA payments from the Medical Services Plan.

Purpose

The purpose of the *Modified Physician Recruitment and Retention Program* is to offer a number of premium incentives to enhance the supply and stability of physician services in rural and small urban communities throughout the province listed in Appendix A.

The program allows Health Authorities to:

- provide retention premiums for general practitioners and specialists;
- offer $10,000 signing bonuses to new doctors recruited by health authorities;
- provide payments to general practitioners and specialists who provide on-call services;
- provide enhanced Continuing Medical Education (CME) funding; and
- support physician advanced practice and post graduate training.

Planning

Health Authorities, in consultation with their Medical Staff, must have, or be working towards the creation of a *Physician Supply Plan* (PSP) which addresses access issues over the immediate and long-term. The plan should be developed in the context of the following reference documents:

- *Strategic Directions for the British Columbia's Health Services System* http://www.hlth.gov.bc.ca/cpa/publications/strategic.pdf
- *Framework Memorandum* http://www.hlth.gov.bc.ca/msp/general/msc/framework.pdf
- *Framework for Physician Recruitment and Retention in Rural and Urban Centres (Appendix B);*
- *Subsidiary Agreement for Physicians in Rural Practice http://www.hlth.gov.bc.ca/rural/ruralagr.pdf and*
- *Emergency Medical Coverage program (EMCP) policy document http://www.hlth.gov.bc.ca/rural/emcpol.pdf*

Physician Supply Plans are to be developed for the health region, using Health Authority staff and Medical Staff knowledge of unique local and region wide needs, issues and opportunities. The plan must be reviewed by Regional Operations, Ministry of Health.

The Health Authority's plan for physician supply must:

- provide for the full continuum of services, including primary care, specialty care, acute care, home care and long term care in a coordinated, accountable and sustainable manner appropriate to the population served;
- make the best use of resources, recognizing the need to group and organize physicians to ensure viable practices and mutual professional support and coverage time-off;
- include the broad range of actions from continuing education to recruitment and retention;
- recognize the need of medical staff for reasonable periods away from work for such things as continuing education, vacation and health needs;
- identify which physician services can be provided within the region and those which must be referred out;
- identify the services which the health authority can provide as a referral centre for other regions;
- identify those services which can, and should, be available at all times (core services) and those which can only be available during restricted hours (non-core services);

- ensure the resources available for physician services are allocated to meet these identified needs, and particularly ensure out of office hours coverage; and
- enhance physician recruitment and retention in a coordinated fashion.

Physician Supply Plans should also be made available to the public.

Physician Eligibility

General practitioners and specialists with an established practice (includes hospital practice and service contracts) and medical staff privileges in the communities listed in Attachment A, and their locums, are eligible to receive premiums under this program.

Specialists eligible for on-call payments under both this program and the *Subsidiary Agreement for Physicians in Rural Practice*, may choose the greater of the two premiums, **but not both.**

Locum and temporary replacement physicians are eligible to receive the retention premium and on-call payments which apply to the community in which they are providing coverage.

Funding Components

1. *Recruitment Premium*

   A premium of $10,000 per full-time* doctor is available to physicians recruited to fill vacancies, or pending vacancies that are part of the Physician Supply Plan for the region. The premium will not be available to doctors recruited from other communities listed in Attachment A, or to doctors practicing in a community where recruitment and retention initiatives funded by the provincial government are in place.

   Physicians must remain in active practice in the community for one full year after recruitment, or return the premium in full.

2. *Retention Premiums – General Practitioners*

   The annualized value of the general practitioner retention premium for each community is shown in Attachment A. It is payable to general practitioners who provide services in a community on a full-time basis (including their locums) consistent with the health authority's Physician Supply Plan. The

retention premium will be pro-rated for general practitioners who work less than full-time*.

3. *Retention Premiums – Specialists*

   The annualized value of the specialist retention premium for each community is shown in Appendix A. It is payable to specialists who provide services in a community on a full-time basis (including their locums) consistent with the health authority's Physician Supply Plan. The retention premium will be pro-rated for specialists who work less than full-time*.

4. *Emergency Coverage - EMCP*

   Existing emergency coverage provisions of the EMCP are extended to all communities listed in Attachment A, subject to a Health Authority plan for emergency coverage that is consistent with their Health Service Plan.

   Specifically:

   For communities, without hospitals, where emergency coverage is required under the health authority's plan, EMCP rates and policies apply*.

   For communities with hospitals, with less than 10 general practitioners, which are required to provide emergency coverage, EMCP rates and policies apply*.

   For communities with hospitals, with 10 or more general practitioners, and where fee-for-service billings for emergency room services are less than $80/hour averaged over the year ($720,000 annually), the options defined in the *Subsidiary Agreement for Physicians in Rural Practice*, apply.

5. *Enhanced Continuing Medical Education (CME)*

   The enhanced continuing medical education benefits under the EMCP are extended to physicians in communities listed in Attachment A. Existing EMCP policies apply. Physicians moving from one PRRP community to another can count their previous years of service toward entitlement toward receiving enhanced CME premiums.

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* For the purposes of this program, a full-time physician provides services throughout the year during normal office hours, except for vacation, sickness or CME time, and participates in on-call as required by the health authorities.

* EMCP policy document is available through the intranet at http://admin.moh.hnet.bc.ca/acpolicy/.

6. *On-Site Emergency Coverage*

   Where the Health Authority plan requires 24-hour on-site emergency room coverage, but fee-for-service billings averaged over the year are expected to be less than $100 per hour, there will be a maximum subsidy of $590 per 24-hour period. The hospital can apply the subsidy as appropriate, based upon planning and coordination.

7. *Specialist Coverage*

   GROUP A

   Where a Health Authority's Physician Supply Plan requires core service coverage 24 hours a day, 7 days a week, $75,000 per specialty, per year, is available, if both of the following conditions are met:

   1. The area of specialty is one of the following 8 'core' specialty areas: psychiatry, general surgery, anaesthesia, pediatrics, internal medicine, radiology, orthopedics, obstetrics/gynecology; and

   2. the specialists provide 24 hours a day, 7 days a week coverage.

   Where coverage is shared between a number of locations on a regional basis, the $75,000 will be shared between the locations participating in the coverage.

   The Health Authority may determine the manner in which on-call payments are made to participating physicians, based on regional and/or local planning and coordination.

   Group B

   Based on the Health Authority's Physician Supply Plan, when it is not required to provide on-call coverage 24 hours a day, 7 days a week, $12,000 per specialty as defined above, will be provided on an annual basis. The Health Authority can apply this funding as appropriate based on regional planning and coordination.

8. *Postgraduate Training*

   Physicians eligible for funding under the *Modified Physician Recruitment and Retention Program*, are also eligible to apply for support for further training to gain additional skills required under the Health Authority's approved Physician Supply Plan. An amount of $1 million annually will be made available to support and facilitate the training of physicians in rural practice.

This benefit will be administered in a manner consistent with the policies under clause 6 of the *Subsidiary Agreement for Physicians in Rural Practice*.

9. Contingency Funding

In accordance with the recommendations of the Mediation Hope Report, November 2000, a contingency fund of $3,000,000 has been established "to offset circumstances where a community faces the loss of specialists seen as essential to the continued integrity of patient care" in that community. The fund is to be used specifically to respond to the immediate need to retain the services of core specialists in PRRP communities.

The contingency fund is to be administered by the Joint Standing Committee constituted under the Rural Agreement.

Terms

No additional funds are to be made available to physicians by the health authorities for clinical services covered by this program.

Retention and recruitment premiums are retroactive to June 12, 2000. Other premiums (EMCP and enhanced CME for new communities, on-site ER coverage, Specialist 0n-call) are retroactive to September 1, 2000.

This program runs until March 31, 2001 and will be modified and extended for future years, subject to negotiations between the Ministry of Health and the British Columbia Medical Association, and budget appropriations and ongoing program evaluation.

Physician Contracts

There is no requirement for physicians to sign contracts with their Health Authorities to receive these premiums. If a physician accepts these premiums they are deemed to have agreed to provide the services for which the premiums apply. Any activity which is intended to restrict access to medically required services or to refuse to provide related services or engage in a reduction or slow down will be considered job action and payments of these benefits discontinued. Payments are to be made to physicians for **services provided only**.

Reporting

Reporting requirements, including physician recruitment outcome, information on vacancies, and expenditure summaries will be provided at a later date by the Ministry of Health.

There will be a reconciliation of the funding at the end of the fiscal year. All health authorities are subject to audit.
This program will be subject to evaluation by the Ministry of Health.

Contact

Health authorities can contact their Regional Directors for further information about any aspect of the *Modified Physician Recruitment and Retention Program for Rural and Small Urban Communities*.

Appendix A

Attachment A

December 20,2000

Community	NIA	GP retention	Specialist retention
Elkford	18.2	$15,000	$0
Fernie	4.2	$18,000	$22,500
Sparwood	9.6	$18,000	$0
Cranbrook	0	$30,000	$37,500
Kimberley	0	$25,000	$0
Windermere (Invermere)	11.4	$15,000	$18,750
Creston	9.8	$15,000	$18,750
Kootenay Lake (Kaslo)	15.4	$15,000	$0
Kootenay Bay/Riondel	21.8	$15,000	$0
Nelson	0	$25,000	$31,250
Salmo	12	$15,000	$0
Winlaw	14.2	$15,000	$0
Castlegar	0	$25,000	$0
Nakusp	19.4	$15,000	$0
New Denver	21.2	$15,000	$0
Trail	0	$25,000	$31,250
Grand Forks (Boundary)	16	$15,000	$0
Kettle Valley	18.6	$15,000	$0
Oliver/Osoyoos	0	$15,000	$0
Keremeos	7.95	$18,000	$0
Princeton	10.95	$15,000	$0
Golden	13	$15,000	$18,750
Revelstoke	12.6	$15,000	$0
Sorrento	8	$15,000	$0
Salmon Arm	0	$10,000	$12,500
Sicamous	0	$20,000	$0
Armstrong - Spallumcheen	0	$10,000	$0
Barriere	11.2	$15,000	$0
Chase	0	$20,000	$0
Logan Lake	9.45	$20,000	$0
100 Mile House	12.2	$18,000	$0
Clearwater	18.6	$15,000	$0
Quesnel	0	$25,000	$31,250
Lillooet	9.15	$15,000	$0
Lytton	13.35	$15,000	$0
South Cariboo (Ashcroft)	13.05	$15,000	$0
Merritt	9.75	$15,000	$0
Hope	0	$20,000	$0
Bowen Island	6	$12,000	$0
Gibson's	0	$20,000	$0
Davis Bay	0	$20,000	$0
Sechelt	0	$20,000	$25,000

Community	NIA	GP retention	Specialist retention
Powell River	0	$20,000	$25,000
Texada Island	10.95	$12,000	$0
Pemberton	12.45	$12,000	$0
Squamish	0	$10,000	$12,500
Whistler	0	$10,000	$0
Bella Coola Valley	29	$15,000	$0
Masset, Queen Charlotte	30	$12,000	$0
Stewart	30	$12,000	$0
Prince Rupert	17.5	$18,000	$22,500
Hazelton	27.25	$15,000	$0
Houston	25.6	$15,000	$0
Smithers	15	$18,000	$22,500
Burns Lake	21	$18,000	$0
Fort St. James	21.4	$15,000	$0
Fraser Lake	22.8	$15,000	$0
Vanderhoof	14.8	$18,000	$22,500
Mackenzie	19.4	$18,000	$0
McBride	21.8	$18,000	$0
Valemount	22.6	$18,000	$0
Chetwynd	24.2	$18,000	$0
Dawson Creek	15.5	$24,000	$30,000
Tumbler Ridge	29.4	$15,000	$0
Hudson's Hope	30	$12,000	$0
Fort St. John	16.5	$24,000	$30,000
Sooke	0	$10,000	$0
Galiano Island	9.8	$12,000	$0
Saltspring Island	0	$10,000	$12,500
Mayne Island	9.6	$12,000	$0
Pender Island	9.6	$12,000	$0
Saturna Island	9.6	$12,000	$0
Lake Cowichan	0	$10,000	$0
Chemainus	0	$10,000	$0
Ladysmith	0	$10,000	$0
Gabriola	0	$20,000	$0
Parksville/Qualicum	0	$10,000	$0
Alberni	0	$20,000	$25,000
Tofino	13.95	$15,000	$0
Ucluelet	13.8	$15,000	$0
Comox/Courtenay	0	$10,000	$12,500
Denman Island	9	$12,000	$0

Community	NIA	GP retention	Specialist retention
Hornby Island	13.8	$12,000	$0
Campbell River	0	$10,000	$12,500
Cortes Island	15.3	$12,000	$0
Quadra Island	9.3	$12,000	$0
Sayward	10.5	$15,000	$0
Agassiz - Harrison	0	$15,000	$0
Summerland	0	$10,000	$12,500
Enderby	0	$10,000	$0
Kitimat	19	$18,000	$22,500
Fort Nelson	30	$12,000	$15,000
Tahsis	16.65	$24,000	$0
Gold River	15	$24,000	$0
Alert Bay	21	$18,000	$0
Port Alice	23	$15,000	$0
Port Hardy	17.8	$18,000	$0
Port McNeill	17.8	$18,000	$0
Waglisla	29	$15,000	$0
Stikine	30	$12,000	$0
Terrace	14	$21,000	$26,250
Nisga'a (Kincolith)	30	$12,000	$0
New Aiyansh, Greenville	30	$12,000	$0

Appendix B

FRAMEWORK
FOR PHYSICIAN RECRUITMENT AND RETENTION
IN RURAL AND SMALL URBAN CENTRES

JULY 2000

Ministry of Health and
Ministry Responsible for Seniors

The B.C. government is committed to supporting and sustaining an effective and efficient publicly-funded health care system that provides equitable access to appropriate services to all British Columbians. This commitment is clearly defined in *Strategic Directions for the Health Services System*[1] which was released in the summer of 1999.

Since the release of this paper, work has progressed towards implementing the Strategic Directions within the existing agreements between the government and the British Columbia Medical Association[2] and concurrently within the negotiation of new agreements for April 2001. This work includes the development of a physician supply plan; the initiation of a compensation review; and an evaluation of the Emergency Medical Coverage Program, which is almost complete. However, recent actions by doctors in some centres have pre-empted the planned actions and required immediate resolution.

The provincial government is committed to providing the resources health authorities will need to fulfill their responsibilities for the immediate future, and eventually bringing all the initiatives into alignment with an integrated provincial policy for physician services.

PREAMBLE:

In recognition of pressures which health authorities must deal with in carrying out their health-care delivery responsibilities, the Ministry of Health will make funding available to health authorities in a manner equitable with that provided to the Northern Interior Health Region for Prince George and appropriate to the specific context of each authority, to ensure appropriate access to medically required care for their residents.

Stabilization of the supply of physicians has been more of an issue in some communities than in others. Various strategies have been tried, but none have been consistently effective in ensuring the stable medical resource base that is needed to provide specialty services and equitable access to services for all communities. Additional funding would appear to be part of the solution, but there are no guarantees that providing more money in the present system will resolve supply and stability issues.

The Ministry of Health is committed to finding long-term solutions. It believes that any new resources must address residents' fundamental medical care requirements. Residents should know which services they can depend upon in their communities, and which will require travel to larger centres.

THE COMMITMENT:

To begin the process of finding long-term solutions to these specific health care issues, the provincial government, through the Ministry of Health, is making a new strategic investment to improve patient services for the period ending March 31, 2002.

Funding will be made available to health authorities in a manner equitable with, but not necessarily the same as, that made available to the Northern Interior Health Region, in order that authorities can fulfill their responsibilities to provide medically required services consistent with a regional plan. The indicators of need for additional support in small urban centres are:

- high turnover of physicians over time;
- persistent physician vacancies;
- inability to recruit to approved plans for physician staffing levels;
- difficulty in providing necessary emergency coverage for the community.

Funding for each eligible community will be specifically determined to correspond to the need and will be capped for the period of this arrangement.

The funding must be used to ensure continuing coverage on a consistent basis for the critical health care needs of the population ranging from primary care to tertiary care where appropriate. With these resources, the health authorities must also deal with issues such as wait lists, recruitment and retention of physicians.

At the end of February 2002, an evaluation of the use of the funds will be made, based on a process acceptable to both of the parties and to the provincial government. It is expected that adjustments will be required to bring all the initiatives into alignment with possible revisions to the Emergency Medical Coverage Program, the Northern Isolation Allowance, physician supply plan and other elements of an integrated province wide policy for physician services.

THE PROCESS

For their part, the health authorities will be required to develop a detailed plan, which is both immediate and long-term in focus, to address these key health resource and access issues. It is essential for this plan to be developed by the health authority, using the particular knowledge of the board and staff about unique local conditions, needs, issues and opportunities.

The health authority's plan for physicians must

- make the best use of resources in a coordinated way recognizing the need to group and organize physicians into critical masses to ensure viable practices and mutual professional support and coverage of time off;
- provide the broad range of actions from continuing education to recruitment and retention;

- recognize the need of their medical staff for reasonable periods away from work for such things as continuing education, vacation and health needs;
- preclude withdrawal of services by physicians;
- identify the range of physician services which are medically required for the population, and identify which can be provided within the region and those which must be referred out;
- identify the services which the region can provide as a referral centre for other regions;
- identify those services which can, and should, be available at all times (core services) and those which can only be available during restricted hours (non-core services);
- ensure that the resources available for physician services are allocated to meet these identified needs, and particularly ensure out of office hours coverage;
- recognize that physician earnings are an important factor in recruitment and retention, that previous billing levels may in some cases have been inadequate for this purpose, and that some of the new funds will be used to ensure an increase to physicians' incomes;
- provide for the full continuum of services, including primary care, specialty care, acute care, home care and long term care in a coordinated, accountable and sustainable manner appropriate to the population served;
- enhance recruitment in a coordinated fashion;

The plan and measures put in place under this framework must be made available and explained to the public.

It is expected that, in order to achieve these requirements, the health authority may consider:

- where the supply plan calls for recruitment of physicians, a recruitment payment of $10,000 for physicians obtaining active privileges at the hospital and establishing a

practice in the community. The payment will not be available to physicians recruited from other communities eligible for recruitment or retention payments;

- a proportion of Emergency Medical Coverage Program and Continuing Medical Education payments reflecting travel costs to Vancouver compared with costs from Prince George;
- in communities where retention of physicians is an issue, some form of retention payment;
- in smaller communities where emergency coverage of the community is difficult to maintain because of low emergency room volumes, subsidy payments for out of hours coverage or subsidized locum support equitable with the *subsidiary agreement for physicians in rural practice*;
- in communities where specialty care provides inadequate income to maintain out of hours services, specialist call payments or subsidized locum support appropriate to the demand for services;
- other initiatives where appropriate, such as in-house emergency coverage payments or subsidies for doctor of the day services.

Health authorities will be required to enter into contractual arrangements with their physicians to ensure accountability for the additional payments.

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[1] http://www.hlth.gov.bc.ca/cpa/publications/strategic.pdf

[2] http://www.hlth.gov.bc.ca/msp/general/msc/mscagree.html