

**RURAL RETENTION PROGRAM
(RRP)**

**POLICY FRAMEWORK
FOR
HEALTH AUTHORITIES**

Ministry of Health

Revised October 2005



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Section:	1 PREAMBLE	Effective:	01 JAN 2003

Description:

The Rural Retention Program (RRP) is a provincial program established by the Subsidiary Agreement for Physicians in Rural Practice. The RRP was implemented January 1, 2003.

Purpose:

The purpose of the RRP is to provide a provincial rural incentive program that enhances the supply and stability of physician services in eligible RSA communities (see RSA communities Appendix 1). Communities are assessed annually for RRP eligibility and community eligibility may change from one year to the next.

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Section:	2 GENERAL	Effective:	01 JAN 2003

Policy:

- 2.1 The RRP replaces all existing retention payment arrangements.
- 2.2 The initial total annual cost of the RRP was not to exceed the total expenditures for government funded retention programs for 2001/02. For 2004/05 to 2006/07. the total retention expenditures will net exceed the 2003/04 expenditures for the RRP.
- 2.3 Physicians *practicing* in eligible rural communities will receive a fee premium on claims paid by the Medical Services Plan; the maximum fee premium is 30 percent. A physician *living and practicing* in a qualifying rural community for at least 9 months of the year may also receive the flat sum premium allocated to the community.
- 2.4 A physician in an eligible community who is funded by an alternative payment arrangement will receive a retention payment, equivalent to the Fee-For-Service (FFS) premium. (see 5.2 and 6.1.3 for further details)
- 2.5 Rural Retention Premiums are based on the Medical Isolation Point Assessment (see Appendix 3) and are set annually by the JSC.

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Section:	3 DEFINITIONS	Effective:	01 JAN 2003

Term	Definition
<i>Alternative Payments</i>	<ul style="list-style-type: none"> Methods of payment, other than FFS, for physician services.
<i>APP</i>	<ul style="list-style-type: none"> Alternative Payments Program: A Ministry program, administered from within the Medical and Pharmaceutical Services (MPS) that promotes, provides funding for, and offers payment options to agencies employing or contracting physician services.
<i>BCMA</i>	<ul style="list-style-type: none"> British Columbia Medical Association.
<i>Designated Specialties:</i>	<ul style="list-style-type: none"> Designated specialties include General Surgery, Orthopaedics, Paediatrics, Internal Medicine, Obstetrics/Gynecology, Anaesthesia, Psychiatry, and Radiology.
<i>FTE (for medical isolation points calculation)</i>	<ul style="list-style-type: none"> The MSP FTE income figure is based on the 40th percentile of earnings for GPs and for <u>each specialty</u> in the previous calendar year as defined by MSP.
<i>Health Authority</i>	<ul style="list-style-type: none"> Governing bodies with responsibility for the planning, coordination and delivery of regional health services, including hospital, long term care and community services.
<i>Itinerant Physician</i>	<ul style="list-style-type: none"> A physician who travels from his/her home community to an eligible RSA community to provide outreach/direct patient services.
<i>Locum Tenens</i>	<ul style="list-style-type: none"> A physician with appropriate medical staff privileges (locum tenens) who substitutes on a temporary basis for another physician.
<i>MOH</i>	<ul style="list-style-type: none"> Ministry of Health
<i>Medical Services Commission</i>	<ul style="list-style-type: none"> The MSC is a 9 member statutory body responsible for the administration of MSP of BC.
<i>Northern Isolation Committee</i>	<ul style="list-style-type: none"> Joint Committee appointed by MSC, equal representation from BCMA and Medical Services Plan. NIC was responsible for policy direction for Northern Isolation Allowance (NIA), Northern and Isolation Travel Assistance Program (NITAOP) and the Northern and Rural Locum Program. NIC was replaced by the JSC in 2002.
<i>Resident Physicians</i>	<ul style="list-style-type: none"> For the purposes of this program, a physician who resides at least 9 months of every year in an RRP community is a resident physician.
<i>RRP Community</i>	<ul style="list-style-type: none"> An RSA community that meets all the criteria for the RRP.
<i>Service Clarification Code</i>	<ul style="list-style-type: none"> Code (Appendix A) for the community in which the service has been provided which must be indicated on all billings submitted by the physician in order to receive the fee premium.
<i>Subsidiary Agreement for Physicians in Rural Practice</i>	<ul style="list-style-type: none"> The Subsidiary Agreement for Physicians in Rural Practice (RSA) is administered by the JSC, as per the negotiated agreement between the BCMA and the Government.

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Section:	4 JOINT STANDING COMMITTEE ON RURAL ISSUES (JSC)	Effective:	01 JAN 2003

Policy:

- 4.1 The JSC assumes the responsibilities of the NIC, including the application and administration of retention allowances (premiums) and reports to the MSC for those programs directly related to the Available Amount (AA). The JSC may periodically review and change the factors and their weighting.
- 4.2 The JSC is comprised of 5 members appointed by the BCMA and 5 members appointed by the Government, and up to 3 alternates for each party. The JSC meets a minimum of 6 times a year, and is co-chaired by a member chosen by the government and a member chosen by the BCMA.
- 4.3 Where a community has been recommended for inclusion in the RSA, the JSC must evaluate the community using the criteria for the determination of retention allowances. If the evaluation results in a rating for the community of at least the minimum number of points, as determined by the JSC, the community must be added to the eligible RRP list.
- 4.4 All case reviews/appeals concerning point allocations and eligibility must be submitted in writing to the JSC. The JSC may choose to hear this appeal in-person. If the JSC chooses not to alter its decision, the physician and/or Health Authority may request a review through the JSC, in writing, to the Medical Services Commission. At the MSC's discretion, it may review the issue/case and make recommendations to the JSC. Should you wish to request a review, mail or fax the request **within 30 days** from the date of the response from the JSC to:

Co-Chair's
Joint Standing Committee on Rural Issues
2-2, 1515 Blanshard St
Victoria BC V8W 3C8
Facsimile: 250 952-1391

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Section:	5 ELIGIBILITY: FEE PREMIUMS	Effective:	01 Jan 2003

Policy:**5.1 Fee Premium**

Those practitioners eligible for the fee premiums include resident physicians, itinerant physicians and locum tenens that provide medical services *directly in* eligible rural communities as outlined in the RSA (see Appendix A, RSA communities).

5.2 Alternative Payments Program (APP)

A physician in an eligible community who is funded by an alternative payment arrangement will receive a retention payment, equivalent to the FFS premium.

5.3 Service Clarification Code (SCC)

In order to receive the fee premium, the SCC for the community in which the service has been provided must be indicated on all billings submitted by the physician. No retroactive payments will be made. Any premiums paid in error on claims submitted with the incorrect SCC will be recovered.

5.4 Application of RRP for Diagnostic Services

A physician who practices in an eligible rural community and provides radiology or pathology services to an approved hospital or facility may be eligible to receive the RRP on the professional component of outpatient radiology and category I, II, and III laboratory medicine services. A listing of the professional component, provided by the BCMA, is used in the RRP calculation process.

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Section:	6 ELIGIBILITY: FLAT SUM PREMIUM	Effective:	01 JAN 2003

6.1 General application of flat sum premium:

6.1.1 Physicians who live and practice permanently (at least nine months per year) in an RRP community will receive the flat sum premium subject to meeting 6.1.3 below (Appendix A, RSA Communities).

6.1.2 If a physician lives and practices solely in a community that qualifies for a rural retention premium, the physician will receive the flat sum premium of the community in which he/she lives and practices.

6.1.3 If a physician lives and practices in an eligible RSA community for at least nine months of the year and bills \$50,000 or greater in MSP billings for the previous calendar year, s/he receives the full flat fee sum. If s/he bills <\$50,000, s/he receives no flat fee premium.

6.1.4 New physicians are entitled to the flat fee sum, retroactively, upon successful completion of the annual residency requirement in an eligible RSA community. HAs are required to submit notification of completion of the residency requirement to the Rural Practice Programs office. Reconciliation and payment of the retroactive flat sum fee will be done on a quarterly basis.

6.2 If a physician lives in an eligible RSA community but practices in a different eligible RSA community (for at least nine months of the year), s/he will receive the fee premium and flat sum premium for the community where s/he practices.

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Section:	7 MEDICAL ISOLATION POINTS AND RETENTION PREMIUMS	Effective:	01 Jan 2003

Policy:

- 7.1 The final medical isolation point allocation and the determination of the value of the retention payments resulting from those points shall be determined by the JSC.
- 7.2 In order for a new community to be assessed for a Rural Retention Premium and be considered for inclusion in Appendix A of the RSA (attached), a letter of application must be submitted by the health authority by mail or fax to the JSC, c/o the Ministry of Health.
- 7.3 The JSC may also recommend inclusion of communities for assessment as appropriate.
- 7.4 The total medical isolation points result must be at least 6.0 for a community to be eligible for a fee premium and/or flat fee allowance.

The fee premium is 70 percent of the total isolation points to a maximum of 30 percent for communities with a minimum of one resident physician or a vacant position, as per health authority Physician Supply Plans. The flat fee allocation is based on the remaining 30 percent of the total isolation points multiplied by a per point dollar figure determined annually by the JSC. The maximum fee premium for any eligible community is 30 per cent. For communities without a resident physician or vacancy, the total isolation points will be applied as a fee premium, to a maximum 30 percent.

- 7.5 The JSC reviews the medical isolation point assessments on an annual basis and amends the points assigned as necessary.
- 7.6 If the annual review results in a community falling below the minimum isolation points required to qualify, the community will be deleted from the RRP list. Eligible physicians in that community are entitled to receive 50 percent of the previous year's retention allowance (fee and flat fee premiums – if received previously) for a one-year period.



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Section:	8 MONITORING, REPORTING, EVALUATION	Effective:	01 Jan 2003

Policy:

- 8.1 The Ministry will monitor RRP expenditures on a regular basis and perform an annual reconciliation of program expenditures.
- 8.2 For the purpose of determining isolation points, Health Authorities (HAs) will report physician numbers and vacancies on an annual basis, as per the Ministry request. That information will be integral to the development of the HAs' regional Physician Supply Plans.



Appendix A	RURAL RETENTION PROGRAM	Page:	10 of 15
	Appendix A - Communities Covered by RSA	Effective:	01 Jan 2003
	Subject to Meeting the Minimum Point Requirement		

Community		
100 Mile House	Halfway River	Port McNeill
Agassiz/Harrison	Hartley Bay	Powell River
Ahousat	Hazelton	Prince George
Alert Bay	Holberg	Prince Rupert
Armstrong-Spallumcheen.	Hope	Princeton
Ashcroft	Hornby Island	Quadra Island
Atlin	Hot Springs Cove	Qualicum/Parksville
Barriere	Houston	Queen Charlotte
Bella Coola	Hudson's Hope	Quesnel
Big White	Invermere	Revelstoke
Blue River	Kaslo	Rivers Inlet
Blueberry River	Keremeos	Salmo
Bowen Island	Kimberley	Salmon Arm/Sicamous
Bridge Lake	Kincolith	Saltspring Island
Burns Lake	Kingcome	Saturna Island
Campbell River	Kitimat	Sayward
Canal Flats	Kitkatla	Sechelt/Gibsons
Castlegar	Kitsault	Seton Portage
Chase	Kitwanga	Smithers
Chetwynd	Kootenay Bay/Riondel	Sointula
Christina Lk/Grand Forks	Kyuquot	Sooke
Clearwater	Ladysmith/Chemainus	Sorrento
Clinton	Lake Cowichan	Sparwood
Cortes Island	Lillooet	Squamish
Courtenay/Comox/Cumberland	Logan Lake	Stewart
Cranbrook	Lower Post	Tahsis
Creston	Lumby	Takla Landing
Dawson Creek	Lytton	Takla Lake
Dease Lake	Mackenzie	Telegraph Creek
Denman Island	Madeira Park	Tepella
Doig Rivery	Masset	Terrace
Duncan/N. Cowichan	Mayne Island	Texada Island
Edgewood	McBride	Tofino
Elkford	Merritt	Trail/Rossland/Fruitvale
Enderby	Miocene	Tsay Key Dene
Fernie	Nakusp	Tumbler Ridge
Fort Nelson	Nelson	Ucluelet
Fort St. James	New Aiyansh	Valemount
Fort St. John	New Denver	Vanderhoof
Fort Ware	Ocean Falls	Waglisia
Fraser Lake	Osoyoos/Oliver	Wardner
Gabriola	Pemberton	Whistler
Galiano Island	Pender Island	Williams Lake
Gold River	Port Alberni	Winlaw/Slocan Park
Golden	Port Alice	Woss
Granisle	Port Clements	Zeballos
Greenwood/Midway/Rock Cr	Port Hardy	

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Section:	APPENDIX 1: Service Clarification Codes for RSA Communities	Effective:	01 Jan 2003

Code	Community	Code	Community	Code	Community	Code	Community
MH	100 Mile House	E1	Elkford	L4	Ladysmith/ Chemainus L5	SA	Salmon Arm
A6	Agassiz/ Harrison	E3	Enderby		Lake Cowichan	SS	Saltspring Island S7
A4	Ahousat	F1	Fernie	L1	Lillooet		Saturna Island
A1	Alert Bay	F2	Fort Nelson	L3	Logan Lake	S1	Sayward
A5	Anahim Lake	F3	Fort St. James	L7	Lower Post	SG	Sechelt/ Gibsons
A7	Armstrong/ Spallumcheen	F4	Fort St. John	L6	Lumby	S8	Slocan Park
A3	Ashcroft	F6	Fort Ware	L2	Lytton	S2	Smithers
A2	Atlin	F5	Fraser Lake	M1	Mackenzie	S6	Sointula
B8	Bamfield	G7	Gabriola Island	M5	Madeira Park	SK	Sooke
B4	Barriere	G5	Galiano Island	M3	Masset	M7	Mayne Island
B3	Bella Coola	G6	Gold Bridge/ Bralorne	M2	McBride	M2	McBride
B7	Big White	G2	Gold River	M4	Merritt	M6	Miocene
B5	Blue River	G1	Golden	N1	Nakusp	N1	Nakusp
B9	Blueberry River	G4	Granisle	N5	Nelson	N5	Nelson
B6	Bowen Island	G3	Greenwood	N2	New Aiyansh	N2	New Aiyansh
B1	Bridge Lake		Midway/ Rock Creek	N3	New Denver	N3	New Denver
B2	Burns Lake	H9	Halfway River	N4	Nitinat	N4	Nitinat
CR	Campbell River	H6	Hartley Bay	CF	Ocean Falls	CF	Ocean Falls
C5	Canal Flats	H1	Hazelton	LS	Oliver/ Osoyoos	LS	Oliver/ Osoyoos
CA	Castlegar	H2	Holberg	PQ	Parksville/ Qualicum	PQ	Parksville/ Qualicum
CH	Chase	H8	Hope	P1	Pemberton	P1	Pemberton
C2	Chetwynd	H5	Hornby Island	P8	Pender Island	P8	Pender Island
C7	Christina Lake/ Grand Forks	H7	Hot Springs Cove	PA	Port Alberni	PA	Port Alberni
C8	Clearwater	H4	Houston	P2	Port Alice	P2	Port Alice
C3	Clinton	H3	Hudson's Hope	P6	Port Clements	P6	Port Clements
C4	Cortes Island	VM	Invermere	P3	Port Hardy	P3	Port Hardy
CC	Courtenay/ Comox/ Cumberland	K1	Kaslo	P4	Port McNeill	P4	Port McNeill
CB	Cranbrook	K8	Keremeos	P9	Port Simpson	P9	Port Simpson
C6	Creston	KM	Kimberley	PR	Powell River	PR	Powell River
D1	Dawson Creek	KK	Kincolith	PG	Prince George	PG	Prince George
D3	Dease Lake	K6	Kingcome	P5	Prince Rupert	P5	Prince Rupert
D2	Denman Island	K2	Kitimat	P7	Princeton	P7	Princeton
D5	Doig River	K9	Kitkatla	Q1	Quadra Island	Q1	Quadra Island
D4	Duncan/North Cowichan	K3	Kitsault	Q2	Queen Charlotte Lake	Q2	Queen Charlotte Lake
E2	Edgewood	K4	Kitwanga	Q3	Quesnel	Q3	Quesnel
		K5	Kootenay Bay/ Riondel	R1	Revelstoke	R1	Revelstoke
		K7	Kyuquot	R3	Rivers Inlet	R3	Rivers Inlet
				S5	Salmo	S5	Salmo
						W3	Winlaw
						W1	Woss
						Z1	Zeballos

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Section:	APPENDIX 2: Medical Isolation Point Rating System	Effective:	01 Jan 2003

RRP Medical Isolation Point Rating System		
Factor	Points	Max Pts
Number of Designated Specialties within 70 km		
0 Specialties within 70 km	60	
1 Specialty within 70 km	50	
2 Specialties within 70 km	40	
3 Specialties within 70 km	20	
4+ Specialties within 70 km	0	60
Number of General Practitioners within 35 km		
over 20 Practitioners	0	
11-20 Practitioners	20	
4 to 10 Practitioners	40	
0 to 3 Practitioners	60	60
Community Size (If larger community within 35 km then larger pop is considered)		
30,000 +	0	
10,000 to 30,000	10	
Between 5,000 and 9,999	15	
Up to 5,000	25	25
Distance from Major Medical Community (provided by Davenport Maps) (Kamloops, Kelowna, Nanaimo, Vancouver, Victoria, Abbotsford, Prince George)		
first 70 km road distance (70km-104km)	4	
for each 35 km over 70 km	2	
to a maximum of	30	30
Degree of Latitude		
Communities between 52 to 53 degrees latitude	20	
Communities above 53 degrees latitude	30	30
Location Arc	%	
- communities in Arc A (within 100 km air distance from Vancouver)	0.10	
- communities in Arc B (btwn 100 and 300 km air distance from Vancouver)	0.15	
- communities in Arc C (btwn 300 and 750 km air distance from Vancouver)	0.20	
- communities in Arc D (over 750 km air distance from Vancouver)	0.25	
RSA Specialist Centre		
- 3 or 4 designated specialties in physician supply plan	30	
- 5 to 7 designated specialties in physician supply plan	50	
- 8 designated specialties and more than one specialist in each specialty as set out in the physician supply plan	60	60

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Section:	APPENDIX 3: Medical Isolation Point Assessment	Effective:	01 Jan 2003

MEDICAL ISOLATION POINT ASSESSMENT

Medical Isolation Factors

1. Number of Designated Specialties within 70 km

All designated specialties within 70 km (by road or ferry) of the community where the specialist(s) meet the FTE income figure as defined below are counted.

2. Number of General Practitioners within 35 km

General Practitioners practicing within 35 km (by road) of the community and who meet the FTE income figure as defined below are counted. General Practitioners practicing in a community within 35 km of the community by ferry are not counted.

3. Distance from a Major Medical Community

Major Medical Communities are designated as Kamloops, Kelowna, Nanaimo, Vancouver, Victoria, Abbotsford and Prince George. Major Medical Community is defined as those communities with at least 3 specialists in each of the Designated Specialties.

Maximum points are awarded for communities with no road or ferry access.

4. RSA Specialist Centre

Points will be assigned to a community where the regional Physician Supply Plan requires designated specialists to provide services for a community. A community must be included in Appendix A of the RSA in order to be considered an RSA Specialist Centre.

An RSA community located within 35 km (by road) of an RSA Specialist Centre will receive the same points as the RSA Specialist Centre for this factor.

Living Factors

5. Community Size

Where a community is within 35 km by road of a larger community, the points are based on the population of the larger community. Where a community is within 35 km of a larger community by ferry, the population of the larger community is not counted. When two communities are combined in this Agreement, the populations will be amalgamated.

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Section:	APPENDIX 3: Medical Isolation Point Assessment (cont)	Effective:	01 Jan 2003

Community populations are established annually using the most recent National Census-based estimate for the preceding calendar year, which is supplied by BC STATS, Ministry of Finance and Corporate Relations. They are based on regional districts defined by the Ministry of Community, Aboriginal and Women's Services. In case of changes to regional districts from one year to the next, population assignment is determined by the ministry, based on all available information (available on request).

6. Degree of Latitude

Points are allocated for those communities in British Columbia located at and above the 52° of latitude.

7. Location Arc

Four differential multipliers have been established for the purpose of determining the final point total for determination of retention allowances. Arcs are based on air distance from Vancouver and multiplied by the applicable factor to determine the community's final point total.

DESIGNATED SPECIALTIES:

1. Designated specialties include General Surgery, Orthopaedics, Paediatrics, Internal Medicine, Obstetrics/Gynecology, Anaesthesia, Psychiatry, and Radiology.
2. Physician FTE count: At the beginning of each calendar year, the number of physicians practicing in each community is verified through written confirmation by the responsible Health Authority. This is done in collaboration with the local and/or regional Medical Advisory Committee.
3. A confirmation form must be submitted for all communities.
4. Physicians are counted as one physician if their total income (including fee-for-service, salary, sessional and subsidy income) exceeds the FTE income figure established by the ministry for that year for their specialty. For those physicians who did not practice in the community for the full year, income will be extrapolated to produce an estimated annual income figure. For physicians whose total income (or estimated annual income) is below the FTE income figure, the incomes of all such physicians will be added and divided by the FTE income figure.

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Section:	APPENDIX 3: Medical Isolation Point Assessment (continued)	Effective:	01 Jan 2003

The resulting number is rounded down to the nearest whole number, which is counted in the number of physicians in the community. If there is more than one specialist in the same specialty meeting the FTE income figure, only one specialist is counted; if there is more than one specialist in the same specialty who do not meet the FTE income figure, the incomes of those specialists are combined to determine if their combined income equals an FTE. General Practitioners practicing more than 75 percent in a specialty (based upon fee for service billings) will be counted as specialists; all specialists practicing more than 75 percent as a general practitioner (based upon fee for service billings) will be counted as a General Practitioner. The FTE income figure is based on the 40th percentile of earnings for each specialty in the previous calendar year as defined by the ministry.

ROAD DISTANCES:

In all cases where reference is made to road distances, these distances are determined by Davenport Maps:

- road distances are converted to travel time using an assumed average speed of 70 kilometres per hour;
- for communities accessible only by ferry, a multiplier is applied to the ferry distance, based on data from the BC Ferry Corporation and the Ministry of Transportation;
- where communities are combined in this Agreement, the distance from the furthest community is used.