NPAA Nurse Practitioner Association of Alberta

NURSE PRACTITIONER PRIMARY CARE PROGRAM

General FAQ

Nurse Practitioner Association of Alberta
February 2026

NPAA Nurse Practitioner Association of Alberta

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FAQ

Expression of Interest (EOI)

Who's assessing the EOI and application within gov't?
Primary and Preventative Health Services (PPHS) will review EOIs and applications, and answer queries from NPs interested in applying to the program.
If you require further information contact health.npprogram@gov.ab.ca.

Should the Nurse Practitioner Association of Alberta (NPAA) review the application?
Applicants are strongly encouraged to seek the guidance of the NPAA to ensure all necessary information has been included in the application process.

How do NPs enroll in CII/CPAR?
Successful applicants for the Nurse Practitioner Primary Care Program will be guided through the registration and onboarding process by Primary and Preventative Health Services' Alternative Compensation Design Unit (ACDU) and the eHealth Services Team.

The process begins with the submission of a Confirmation of Participation (CoP) form which will be provided by the ACDU as part of the program welcome package. Once the CoP form has been submitted the eHealth team will support Nurse Practitioners through onboarding and implementation.

There are four key prerequisites for participation in CII/CPAR:

1. Clinic must be using the latest version of a conformed EMR
2. Clinic EMR PIA must be up to date
3. Clinic must be live on Alberta Netcare
4. Clinic must be panel ready (for clinics without panels this is not a prerequisite)

What does "panel ready" mean?
Being panel ready means the clinic has accurate patient data and the clinic has processes in place to confirm patient attachment and support CPAR requirements. Guidance and a checklist will be available, and clinics often review their panels during the onboarding process.

What will the process be to express interest? Will this information be sent out by the NPAA?
NPs can find information on the program and download the expression of interest (EOI) form at https://www.alberta.ca/nurse-practitioner-primary-care-program

What happens if there are not enough EOIs submitted?
Primary and Preventative Health Services will continue to accept and review EOIs and applications until the maximum program funding available has been reached.

What happens to my patient panel if I leave the NPPCP or close my practice?

- If you choose to leave the NPPCP, you must notify your assigned Primary and Preventative Health Services contact and submit the required forms to formally terminate your participation in the program, including your NPPCP panel.

- You are required to provide a minimum of 90 days' notice to Primary and Preventative Health Services, as well as to patients on your panel.
- Leaving the NPPCP does not necessarily mean you must close your practice. You may continue practising outside of the program, depending on your individual arrangements.
- If you are closing your practice entirely, you must follow the professional standards set by the College of Registered Nurses of Alberta (CRNA) regarding continuity of care and patient transition.
- In all cases, NPs may consult with the NPAA for guidance on panel transition, program exit, or practice closure.

Where do we find information on the Nurse Practitioner Primary Care Program, including the steps to submit my EOI or application?

Information on the Nurse Practitioner Primary Care Program, including the expression of interest form, can be found at https://www.alberta.ca/nurse-practitioner-primary-care-program

Do walk-in patients have to be unattached, or can an NP also see patients who have a GP but cannot get in to see GP?

NPs with a panel of fewer than 900 patients are required to provide walk-in availability to support any unattached patient until the minimum panel of 900 patients is reached. NPs may see patients who are paneled to another provider, provided this does not impede access to care for their own patients. They can report the time spent delivering those services; however, they cannot panel those patients.

Some GPs already use complex modifier billing codes in ARPs working in Edmonton at the "Radius". Members are hoping for details here.

NPs do not use the Schedule of Medical Benefits, used by family physicians, where modifiers can be used with the health services codes.

NPs will be using specific NP service codes found in the Schedule of Allied Benefits for their NP practice under the NPPCP and can utilize ICD-9 codes.

Can NPs work in 2 different locations with a single panel?

Requests to provide services at multiple locations will be considered on a case-by-case basis and should not impact patient access. Note: To maintain a single panel across two locations, both sites must use the same EMR. If each location uses a different EMR, two separate panels will be created. NPs should provide information on both locations in their application.

What is the expected timeline from submitting an EOI to approval?

Primary and Preventative Health Services will assess EOIs for NPPCP eligibility within approximately 3 business days. Submitted NP applications are assessed based on program eligibility and program elements with a decision on approval expected to take approximately four to six weeks from submission of the application. Once approval is granted, and required forms are accurately completed and submitted in a timely manner, there is typically a minimum three to four week timeline before the NP can begin service provision for funding under the NPPCP. Timelines may vary depending on onboarding volume and system backlogs.

Note: The EOI and Application review process are two separate processes.

Will it be quicker if the clinic I am joining is already live on CII/CPAR, and they are just adding me?
Yes, onboarding is typically quicker when joining a clinic that is already live on CII/CPAR. Certain steps may be abbreviated because the clinic is already live.

If joining a pre-existing clinic does an NP need a separate Privacy Impact Assessment (PIA). Does their name need to be added?

If an NP is joining an existing clinic, the clinic's PIA may need to be updated depending on the clinic's circumstances and PIA requirements. PPHS will confirm whether an existing PIA file number meets requirements for participation in CII/CPAR. Some clinics may choose to add individual custodians (including NPs), but this is not always required.

Will applications be first come first served?

Primary and Preventative Health Services will assess submitted NP applications based on program eligibility and program elements. These elements include, but are not limited to, patient panel, practice model, team-based approach, service provision and program location.

My EOI was denied because I do not have a Family/All Ages practice condition. Why?

Only EOIs that meet the mandatory eligibility criteria will be approved to move to the application stage. Eligibility criteria include being registered as an NP in good standing with the College of Registered Nurses of Alberta (CRNA) with a Family/All Ages practice condition.

What is CII/CPAR?

CII/CPAR will enable the NP to share patient information directly from community Electronic Medical Records (EMRs) to Alberta Netcare (a provincial health information system), allowing for a seamless exchange of patient information among care teams.

CII allows NPs to share essential patient information with Alberta Netcare, including consult letters and details of patient visits, which contribute to Community Encounter Digests (CEDs) between community EMRs and other care providers via Alberta Netcare. This enhances communication among health care providers across the province, promoting continuity of care between the Patient's Medical Home and Health Neighborhood.

CPAR is an enabler for continuity between patients and their providers in Alberta. It collects the confirmed panels of NPs and other providers to identify primary provider-patient relationships. Patient - provider relationships are shared to Alberta Netcare so other providers are aware of the relationship. CPAR can also send electronic notifications to providers when their patients undergo emergency department visits, hospital admissions, or day surgeries, ensuring that NPs stay informed about their patient's health care journey.

To get started with CII/CPAR an NP must be using one of these confirmed EMRs:

- Accuro
- AVA
- CHR (Collaborative Health Record)
- Connect Care (only for AHS-operated primary care clinics)
- Healthquest
- Med Access
- PS Suite
- QHR
- Juno (coming soon)

Will only direct patient encounters be shown, or will shadow billing also be included?

Only direct patient encounters are uploaded to CII/CPAR. Activities outside of direct encounters are not uploaded.

Note: CII is the patient encounters side, CPAR is the paneling side.

What are eNotifications?

CII/CPAR eNotifications are automated messages delivered directly into the care providers Electronic Medical Record (EMR), with information about key healthcare events for paneled patients such as emergency room visits and hospital admissions or discharges.

eNotifications contains the following key data:

- Patient PHN/ULI, patient name, and alternate identifiers (such as an out-of-province PHN)
- Type of event – emergency room discharge, change in patient class from emergency to inpatient, emergency department leave prior to admission, inpatient admission or discharge, day surgery discharge
- Date and time of the event
- Name of the facility where the patient was seen
- Attending physician's name
- Referring physician, if available
- Reason for admission, if available
- Who will receive eNotifications?

eNotifications will be sent to the physician or nurse practitioner to whom the patient is paneled in the Central Patient Attachment Registry (CPAR). If a patient is paneled to more than one provider, an eNotification will be sent to each provider and will list all providers notified, so that the receiving provider can coordinate care with the other provider(s) as needed.

Service Event Reporting (Claim Submission via H-Link)

How do Nurse Practitioners submit service event reporting (claims)?

Nurse Practitioners are required to submit service event reporting (claim submission) to Primary and Preventative Health Services (PPHS) through H-Link, Primary and Preventative Health Services' electronic submission application. Each NP must have:

- A business arrangement established with Primary and Preventative Health Services; and
- An accredited submitter assigned to that business arrangement.

An accredited submitter is an organization (e.g., the clinic) or an individual (e.g., clinic staff, biller, physician, or the NP) accredited by Primary and Preventative Health Services to transmit electronic claims and receive transaction results. Each accredited submitter is issued:

- A nine-digit submitter ULI; and
- A submitter prefix code (three alpha characters).

Every business arrangement must have an accredited submitter attached in order for claims to be submitted. NPs may:

- Use an existing accredited submitter (e.g., clinic or contracted biller); or
- Apply to Primary and Preventative Health Services to become their own accredited submitter.

NPs wishing to act as their own accredited submitter must apply through Primary and Preventative Health Services and obtain a submitter prefix code. Information is available at: https://www.alberta.ca/h-link-electronic-claims-system

NPs intending to become their own submitter should inform their assigned Primary and Preventative Health Services analyst following approval to participate in the NPPCP. The analyst will guide the NP through the registration process. Registration typically takes approximately two weeks once accurately completed forms are submitted and there are no EMR issues.

NPs are responsible for any financial compensation paid to billers or submitters acting on their behalf. For a list of accredited submitters or support, contact H-Link: Health.HLink@gov.ab.ca or 780-644-7643

What information is required for each claim submission?

Each service event report must include:

- **Who**: the provider submitting the claim
- **What**: the service performed
- **Where**: the location where the service was provided
- **When**: the date of the service event
- **Why**: the diagnosis or condition related to the service provided

What is the deadline for submitting claims?

Claims must be submitted within 90 days of the service event date. Outdated claims will be rejected and indicated on the Statement of Assessment with refusal code of 80G.

Exceptions for submission of outdated claims are limited to extraordinary circumstances such as significant IT system failures or natural disasters (e.g., fires or floods).

Who is responsible for ensuring claims are accurate and submitted?

While a biller, clinic manager, or other submitter may submit claims on behalf of the NP, the NP is ultimately responsible and accountable for:

- Accuracy of submitted claims; and
- Ensuring claims are successfully submitted.

What happens if a claim is rejected?

If a claim is rejected, it must be corrected and resubmitted.
It is the NP's responsibility to follow up on rejected claims and ensure appropriate resubmission.

How can NPs track payments and claim rejections?

NPs receive two statements from Primary and Preventative Health Services:

- **Statement of Account**
  - Details compensation received for the pay period.
- **Statement of Assessment**
  - Lists submitted claims;
  - Identifies rejected claims; and
  - Includes explanatory codes describing the reason for rejection.

Where can NPs find more information about claim refusals?

The Statement of Assessment includes explanatory codes for rejected claims. If clarification is required, NPs should contact:

- Their assigned PPHS analyst; or
- Their accredited submitter.

Can we submit the Confirmation of Participation (CoP) before signing the Letter of Participation (LOP)?

No. The Letter of Participation must be signed and submitted first. The Confirmation of Participation will not be processed without a signed letter.

> *Note: No other program forms will be processed without a signed letter of participation.*

Panel & Billing - Overview

What happens if an NP does not have the minimum panel size yet?
NPs have 24 months to reach the minimum panel size of 900 patients.

NPs will be compensated based on FTE and must accept walk-in patients until they reach the minimum 900 patient panel size. This provides NPs the opportunity to roster new patients and grow their panel from the start of their program.

How long do you have to grow the panel?
The minimum panel size for NPs at the start of their program is 900 patients. NPs who have a panel size of less than 900 after 24 months can provide a business case to Primary and Preventative Health Services for why they should remain eligible for the program.
The business case must provide a clear rationale of how the NP will meet the minimum panel size of 900 patients, outlining the minimum criteria below:

- Details of panel characteristics (e.g. age, gender, health profile and predicted healthcare needs of the paneled patients, etc.) including such considerations for possibly dealing with complex, higher acuity patients.
- Operating hours of the clinic, providing information on the NP's available hours, both in terms of specifics around regular business hours and after-hours.
- Metrics on access and workload.
- Population density and geographic challenges for NPs practicing in rural areas.

Generally, if a practitioner is having difficulties growing and sustaining a minimum panel size of 900 patients, the expectation is that the practitioner will work with Primary and Preventative Health Services, NPAA and/or their group practice to identify strategies to reach a minimum of 900 patients.

How much time do we have to reach a CPAR panel size of 900 patients?
24 months from when the NP starts participation in the program

What is the process to receive a higher level of compensation as your panel size increases?

- Compensation is based on 1.0 FTE (1,928 hours) according to the size of the panel, as determined by CPAR panel size data.
- Within the fiscal year there will be a bi-annual panel size review at the end of September and March. At that time, PPHS will reassess panel sizes and the associated compensation. If the reassessment indicates that the NP's panel size has increased to the next NP compensation range, the increase in compensation will be reflected prospectively within the bi-weekly payment. It may take a few pay periods for the increase in compensation to begin, however any discrepancy in payments will be resolved as part of the fiscal year end reconciliation.
- You must apply at the compensation level associated with your current panel size.

How and when will I be paid under the NPPCP?

- NPs are paid on a biweekly basis by Primary and Preventative Health Services throughout the year. This means you are not waiting until year-end to receive payment.
- At the end of each fiscal year, Primary and Preventative Health Services will conduct a reconciliation of payments against the Program Service Hours (PSH) you reported through

your monthly PSH submissions. This is to ensure alignment with your approved FTE (e.g., 1.0 FTE).
- If you have worked less than your approved FTE, compensation may be prorated to reflect the actual Program Service Hours (PSH) worked. This may result in adjustments to future payments or, if your agreement has ended, repayment of any overpaid amounts.
- If your reported Program Service Hours (PSH) align with your approved FTE, no adjustment will be required.

How do you "panel" patients?

CPAR is used to identify the primary provider-patient relationships and can send electronic notifications to providers when their patients undergo emergency department visits, hospital admissions, or day surgeries, ensuring that NPs stay informed about their patient's healthcare journey. A patient panel is a set of patients that have established relationships with a primary provider. There is an implicit agreement that the identified provider and team will provide comprehensive, longitudinal primary care.

The clinic must have a process in place to actively ask patients about their attachment:
- Patients are asked consistently to confirm that their Nurse Practitioner is their one and only provider for comprehensive, longitudinal primary care.
- Attachment information is recorded in the clinic EMR including the date of confirmation. Note: for inclusion in CII/CPAR panels patients MUST have a date of last visit and a confirmation date
- Confirmation rates are calculated regularly as a process check.
- The clinic EMR is used to produce lists of each provider's panelled patients.

Each conformed EMR has user guides to support the setup of CPAR panels specific to the EMR in use.

Will NPs be using billing codes via EMR as a means to track patient complexity and the number of patients seen?

Nurse Practitioners will be using the NP designated health service codes in the Schedule of Allied Benefits for their NP practice under the NPPCP. Although these health service codes do not track patient complexity, NPs can utilize the ICD-9 codes to document patient's diagnoses which can provide a representation of the patient's clinical complexity and health status.

What are the compatible Electronic Medical Records (EMRs) available to NPs for their practice?

NPs must enroll in Community Information Integration / Central Patient Attachment Registry (CII / CPAR). To get started with CII/CPAR an NP must be using one of these confirmed EMRs:
- Accuro
- AVA
- CHR (Collaborative Health Record)
- Connect Care (only for AHS-operated primary care clinics)
- Healthquest
- Med Access
- PS Suite
- Wolf (Being retired by TELUS soon)
- QHR
- TELUS

Do NPs in the NPPCP use the same health service (billing) codes as physicians?

- No. NPs participating in the NPPCP do not use physician billing codes from the Schedule of Medical Benefits (SOMB).

- Instead, NPs must use the NP-specific health service codes outlined in the Schedule of Allied Benefits for services provided under the NPPCP.
- These codes are also detailed in Appendix 3.0 of the Nurse Practitioner Primary Care Program Parameters (Ministerial Order).

  Note: This refers specifically to health service (billing) codes, not diagnostic codes (e.g., ICD codes), which may still be used as required for clinical documentation.

Can NPs use Alberta Health Diagnostic Codes with claims submissions (i.e. ICD-9 vs ICD-10)?
NPs can attach ICD-9 diagnostic codes to NP HSC codes when submitting claims to provide additional context regarding the disease, condition, or reason for the medical service. The selection of appropriate diagnostic codes is at the discretion of the Nurse Practitioner.

In Alberta, while ICD-10 may be used for clinical documentation and health reporting, ICD-9 remains the required standard for billing purposes.

What, if any, services is the NP allowed to bill the patient directly and can they retain the income?
Nurse Practitioners are responsible for verifying that the provision of medically required services to a patient are within the scope of the NPPCP for compensation under the program. The NP may bill the patient directly for services delivered outside the scope of the NPPCP.

The following, although the patient may be located in Alberta and received medically required services from the NP, are not compensable under the NPPCP:

- Third-party billings associated with Workers' Compensation Board (WCB);
- Members of the Canadian Armed Forces;
- Disability insured;
- Federal penitentiary inmates;
- Non-insured and insured medical services provided to out-of-province or out-of-country patients;
- Temporary residents, such as foreign workers, students and their dependents, who present an expired Alberta issued health care card; and
- Albertans who have opted out of the Alberta Health Care Insurance Plan
- Individuals who have entered Alberta and Canada as refugees

The time spent providing these services to these patients must not be included in the reported hours worked by the NP under the program if compensation has been secured through the patient or a third party provider.

Examples of services for which an NP ***may*** bill the patient directly include:

- Blue Cross forms
- Aviation medical
- Disabled parking placard
- Seniors Residence medical reports
- Child welfare forms
- General insurance eligibility forms
- Sick notes
- Return to work
- School requested forms and reports
- Certificate of fitness (e.g., summer camp, school, travel)
- Uninsured pre-employment/periodical health exams
- Employment insurance forms
- Pregnancy leave forms
- Alberta Income for the Severely Handicapped (AISH)
- Worker's Compensation Board

*If completion of a form is associated with a publicly funded clinical visit, an NP may report the time spent completing associated documentation in the reported hours worked under the program. If an NP reports this time towards hours worked under the program, they must not bill the patient. Examples where this applies includes completing sick notes associated with an insured clinical visit or completing pregnancy leave forms associated with an insured clinical visit.

Panel & Billing - Detailed Billing, Reporting & Reconciliation FAQs (PPHS – Feb 2026)

This section provides detailed operational guidance on billing codes, service event reporting, FTE tracking, reconciliation, and panel management for Nurse Practitioners participating in the Nurse Practitioner Primary Care Program (NPPCP). The information below has been reviewed and edited by Primary and Preventative Health Services (PPHS) and reflects the most current guidance as of Feb 2026.

Service Event Reporting

When should I use NPS006 vs. NPS007?

The NPS006 and NPS007 billing codes are used for documenting time spent reviewing patient(s) lab results, consultant or other care reports.

NPS006 is used when time spent in the identified activities is related to an individual patient, using the patient-specific ULI e.g., spending time reviewing lab results for Mr. Smith, use NPS006 with Mr. Smith's ULI.

NPS007 is for when these activities are done for multiple patients, in this case the non-patient specific ULI (NPSULI) is used. E.g., spending time reviewing lab reports for seven different patients, instead of billing a separate NPS006 code for each patient with the patient-specific ULI, a single NPS007 code can be billed with the NPSULI to capture the activity with the time spent doing the activity.

> *Note: Time spent providing both direct (NP001-NP0034) or indirect (NPS001-NPS007) patient care must be captured in the monthly PSH reporting.*

How do I submit NPS004 and NPS007 in EMRs that require a patient profile?

The non-patient specific ULI (NPSULI) is used in place of a patient's personal health number (PHN) and is established for each NPPCP NP Program. NPSULI allows for service event reporting to be submitted for service activity for indirect patient care that is not tie to a specific patient. Nurse Practitioners must use the NPSULI for the specific health service codes NPS004 and NPS007, where the code description clearly states the NPSULI is to be used.

NPs can create a "placeholder" patient record using the NPSULI. Create claims for this "patient" as usual.

Note: NPPCP health service codes do not have modifiers associated with the code (e.g., time or complexity indicators). Claims submitted with modifiers will be rejected or held for manual processing.

What do I need to submit every quarter?

NPs participating in the NPPCP must submit their Quarterly Performance Reports, which includes two mandatory metrics:

- Total patient visits
- Time to third next appointment

(NPs can discuss and identify with their Primary and Preventative Health Services assigned analyst any additional metrics to be added to the report that reflect the performance and impact of their practice).

Submission dates for quarterly performance reports:

- ➔ Quarter 1: April – June | July 31
- ➔ Quarter 2: July – September | October 31
- ➔ Quarter 3: October - December | January 31
- ➔ Quarter 4: January – March | April 30

Participating NPs must submit an Annual Performance Report on June 30 reflecting the performance of the previous fiscal year, which includes the following metrics:

- Total patient visits
- Time to third next appointment
- ASaP screening intervention
- Health Quality Alberta panel assessment

Note: The Health Quality Alberta panel assessment is retrospective. If you did not have an active panel in the previous fiscal year, a report will not be generated. If you had a panel prior to joining the NPPCP, the assessment will reflect that previously held panel.

Is there an NP dashboard or portal to submit reports?

Reports are submitted to Primary and Preventative Health Services as follows:

- Service Event Reporting (claims submission) are submitted through the EMR to PPHS via H-Link.
- PSH Reports – Monthly PSH reports are emailed directly to the Primary and Preventative Health Services assigned analyst by the 20th of the following month.
- Performance Reporting – Quarterly and Annual Performance Reports must be submitted to the Primary and Preventative Health Services assigned analyst (based on the provided schedule).

What's the difference between PSH and service event reporting?

PSH reporting and Service Event reporting serve different purposes:

- PSH reporting reflects the actual hours Nurse Practitioners (NPs) spend delivering Program Services under the NPPCP, reported monthly throughout the fiscal year. These hours contribute toward the annual maximum of 1,928 hours. The final PSH report (submitted in March) is used to reconcile total payments made against the actual hours reported for the year.

- Service Event Reporting captures the specific health services provided by NPs—both direct and indirect patient care—using designated NP service codes (NP0001–NP0034, NPS001–NPS007). These claims must be submitted under the NP's assigned business arrangement number. While these claims are submitted through the billing system, they are paid at $0, as they are used for tracking service delivery rather than compensation.

Where can I find the templates?
Ask your assigned analyst, email the NPPCP inbox at health.npprogram@gov.ab.ca, or download from the NPAA resource page:

- Quarterly Report Template
- Annual Report Template
- FTE Tracking Spreadsheet

Billing Codes & Practices

Can I use a "fake patient" to bill NPS005 or NPS007?
Create a patient record using the NPSULI, ideally with an identifiable name.

When can I use NPS002 (no-show)?
NPS002 is used to report time spent waiting for a patient who did not attend a scheduled appointment. It must not be used if any other program service was provided during that time (e.g., seeing another patient or completing indirect care such as lab reviews). In such cases, the appropriate health service code should be submitted instead.

- NPS002 must be submitted with the patient's Alberta Unique Lifetime Identifier (ULI).
    - A maximum of 15 minutes can be claimed per missed appointment. These minutes count toward the annual 1,928-hour service requirement and must be included in PSH reporting.
- Nurse Practitioners must retain documentation of the missed appointment (e.g., chart notes or appointment schedule) as supporting evidence.

See descriptions for all NP health service event codes in Appendix 3 of Ministerial Order 609/2024 – Schedule A: Nurse Practitioner Primary Care Program Parameters.

Will we be able to charge patients for missed appointments as part of the NP funding program?
NPs **must not** charge patients for missed appointments as per the Ministerial Order for the Program. NPs can count time spent waiting, up to 15 minutes, for a patient who did not attend a scheduled appointment towards their 1,928-hour commitment.

How long do I have to submit billing claims?
Claims must be submitted within 90 days of service event date. Outdated claims will be rejected and indicated on the Statement of Assessment with refusal code of 80G.

Clinical Billing Guidance

Can NP0002 be used for mental health visits (~60 mins)?
Yes. Use whichever code best reflects the service provided. Document time and care delivered.

Is NP0003 billable more than once annually?
No. This code is limited to one comprehensive assessment per patient per year.

What about NP0009 (90-minute geriatric assessment)?
The focus is on appropriate service delivery, not duration. A 60-minute visit is acceptable; however, the expectation is that the NP would take necessary time required to complete the assessment based on patient needs. ***The description and requirements for all the health service codes billable under the NPPCP can be found in Appendix 3 of Ministerial Order 609/2024 – Schedule A: Nurse Practitioner Primary Care Program Parameters.

PSH Tracking & Compensation

Program Service Hours (PSH) are used to report time worked. Compensation and reconciliation remain based on your approved Full-Time Equivalent (FTE), where 1.0 FTE equals 1,928 PSH annually.

Can I count time spent waiting for drop-in patients?

Only time spent waiting for a patient who did not attend a scheduled appointment or for drop-in patients can be counted towards the 1,928 Program Service Hours (PSH) (equivalent to 1.0 FTE).

How should I track time for PHS submissions?

Nurse Practitioners participating in the NPPCP are required to complete and submit monthly PSH reports by the 20th of the following month. Each submission must include PSH data for all preceding months in the fiscal year to date.

The March PSH report serves as the final submission for the fiscal year and must reflect the total actual Program Service Hours (PSH) worked across all months. This final report is used to reconcile total payments made throughout the year with the actual hours reported.

Compensation Reconciliation (FTE-based)

Will reconciliation reflect my actual start date if I joined mid-year?

Reconciliation under the NPPCP is conducted annually for the fiscal year period of April 1 to March 31. This process compares the actual hours worked, as reported through PSH submissions, against the payments issued throughout the fiscal year. Any discrepancies—whether overpayments or underpayments—are offset and resolved accordingly.

For Nurse Practitioners who onboard mid-year, compensation is prorated based on the start date through to March 31. Reconciliation for these NPs compares the payments made during that period against the actual Program Service Hours (PSH) worked, ensuring alignment between compensation and service provision.

Why was my reconciliation calculated from April–March, even though I started mid-year?

The reconciliation period always spans a full fiscal year (April 1 – March 31) and the process reconciles the compensation paid to the NP from the date service provision began within to the end of the fiscal year. Final reconciliation is based on the comparison of the total payments made against the actual Program Service Hours (PSH) reported in the March PSH Report. Compensation amounts are prorated for NPs who onboard mid-year.

Reconciliation Outcomes:

1. Underpayment:
    - If total bi-weekly payments made are less than what should have been paid based on reported PSHs: A reconciliation payment is issued to the NP to offset the difference.
2. Overpayment:
    - If total bi-weekly payments made are more than what should have been paid based on reported PSHs: A reconciliation recovery is required to recover the overpaid amount.
3. Exact Payment:
    - If total bi-weekly payments made equal the amount due based on reported PSHs: No payment or recovery is required.

Will my reconciliation be pro-rated if I joined mid-year?
Maximum compensation is pro-rated based on the NP's actual period of service provision within the fiscal year (i.e., from the NP's start date to March 31).

During the annual reconciliation process, the total Program Service Hours (PSH) reported for that period is compared against the pro-rated maximum compensation that was issued through bi-weekly payments. Any discrepancies identified—whether overpayment or underpayment—are adjusted to ensure alignment between actual Program Service Hours (PSH) of service provision and compensation received.

Will I still receive a reconciliation if I only worked one or two months in the fiscal year?
Reconciliation is a process. Payments made to every NP who participated in the NPPCP during a given fiscal year will be reconciled against the compensation that should have been paid, based on the number of Program Service Hours (PSH) reported in the March PSH report. Because the March PSH report is the basis for reconciliation, it is essential that NPs ensure all Program Service Hours (PSH) for the months in which they provided services are accurately recorded before submitting the report to their assigned Primary and Preventative Health Services contact. Once submitted, the March PSH report is considered final, and no changes will be accepted.

Can I request a mid-year FTE payment adjustment?
Adjustments to scheduled bi-weekly payments can be made to better align with actual Program Service Hours (PSH) worked relative to the NP's approved FTE, helping to minimize the risk of underpayments or overpayments at fiscal year-end reconciliation. For:

- Planned PSH Reductions: If an NP plans to reduce their PSH for the upcoming fiscal year (e.g., from 1.0 to 0.8 FTE), they should notify their assigned Primary and Preventative Health Services analyst by the end of February. This allows for timely updates in the payment system so that bi-weekly payments are adjusted from the start of the new fiscal year.
- Mid-Year Adjustments: If, partway through the fiscal year, an NP is providing fewer Program Service Hours (PSH) than expected based on their FTE allocation, they may contact their Primary and Preventative Health Services analyst to discuss adjusting future payments. Likewise, if the analyst observes a discrepancy between Program Service Hours (PSH) and compensation, they may proactively recommend a payment adjustment.

To reduce the risk of administrative errors and misaligned payment periods—which could result in missed payments—multiple adjustments within a single fiscal year are discouraged.

What happens if I go over 1928 hours in a year? Do I get paid more?
Compensation will be provided for a maximum of 1,928 Program Service Hours (PSH) annually (equivalent to 1.0 FTE) (i.e., over the fiscal year). There is no additional compensation for hours worked beyond this limit.

Please ensure you track your Program Service Hours (PSH) carefully to stay within the maximum of 1,928 compensable service provision hours.

What if I had pre-booked vacation and wasn't full-time in my first year? Will I be penalized?
Under the NPPCP, NPs are compensated based on the actual Program Service Hours (PSH) of service provision during the fiscal year. As the NPPCP is an annualized program, the maximum compensation is distributed through scheduled, equal bi-weekly payments. NPs receive the same bi-weekly amount regardless of whether they work the full FTE during that period.

At the end of each fiscal year, Primary and Preventative Health Services will reconcile these payments against the actual Program Service Hours (PSH) reported in the monthly PSH reports. For example, if an NP received bi-weekly payments based on a 1.0 FTE (i.e., 1,928 PSH annually), but only reported 1,568 PSH worked due to time off, a recovery of the overpaid amount will be required. In this case, the NP should have only been compensated for the 1,568 PSH worked.

Important: Extended time off, including vacation, must be noted on your PSH report (in the comment column).

Does PPHS consider vacation time when reconciling hours?
Primary and Preventative Health Services compensates NPs only for actual Program Service Hours (PSH) worked, as reported in the final PSH report for the fiscal year. If vacation or other leave is taken, it must be clearly noted in the PSH report, including the type of leave, the month, and the duration. Note that leave time is not included in the maximum 1,928 compensable Program Service Hours (PSH).

As this is an independent contractor model, there is currently no provision for compensation during leaves in this initial phase of the program.

How do overpayments get recovered? Will I have to pay a lump sum?
If the fiscal year-end reconciliation results in an overpayment, Primary and Preventative Health Services will initiate recovery of the overpaid amount.

- **For NPs continuing in the NPPCP**: The overpayment will be recovered by reducing future bi-weekly payments by a pre-determined amount over a defined period, until the full amount is recovered.
- **For NPs who have exited the NPPCP**: The NP will be responsible for repaying any excess compensation received in the previous fiscal year directly to Primary and Preventative Health Services.

Reconciliation Reports

What should I do when I receive my reconciliation report?
Carefully review the reconciliation calculations and compare the payments and reported Program Service Hours (PSH) against your Statements of Account received throughout the fiscal year, as well as your own records of Program Service Hours (PSH).

Important: Ensure that your March PSH report accurately reflects your total Program Service Hours (PSH) worked over the fiscal year prior to submission. Once submitted, no adjustments are permitted.

If you identify any discrepancies, contact your assigned Primary and Preventative Health Services analyst as soon as possible and before the deadline specified in the reconciliation email. If no response is received by the deadline, Primary and Preventative Health Services will consider this as tacit approval of the reconciliation calculations and will proceed with finalizing the reconciliation, including issuing any payments or initiating recovery of overpaid amounts.

How long do I have to respond to my reconciliation report?
Your reconciliation email will include a deadline by which you must confirm or raise any concerns regarding the reconciliation results.

If no response is received by the specified deadline, Primary and Preventative Health Services will interpret this as tacit approval of the reconciliation and will proceed with finalizing it, including the issuance of any payment or the recovery of overpaid amounts.

Can I request an extension if I'm on vacation or need more time to review my reconciliation?
Extensions may be granted to allow additional time for reviewing and responding to reconciliation results. To request an extension, please contact your assigned Primary and Preventative Health Services analyst before the initial deadline specified in the reconciliation email.

> *Note: Only one extension will be permitted. Exceptions may be considered on a case-by-case basis.*

Who can help me review it?
Within the Ministry, contact your assigned analyst directly to assist with any NPPCP reconciliation issues or for support in reviewing the reconciliation calculations.

Paneling

How is my panel assigned?
NPs participating in the NPPCP must enroll in the CII (Community Information Integration) and CPAR (Central Patient Attachment Registry) systems. These systems enable NPs to share patient information directly from their Electronic Medical Record (EMR) to Alberta Netcare.

Enrollment begins with the submission of a completed NPPCP Confirmation of Participation form to the assigned Primary and Preventative Health Services analyst. This process is supported by an eHealth Services Implementation Consultant. Once enrollment is complete, the NP is assigned a CPAR panel ID number for their clinic location.

Patient attachment information—specifically for patients who have confirmed that the NP is their sole provider for comprehensive, longitudinal primary care—must be recorded in the EMR, including the date of confirmation.

> *Note: To be included in CII/CPAR panels, patients must have both a date of last visit and a confirmation date recorded in the EMR.*

The EMR can generate a list of the NP's paneled patients, which is uploaded to CPAR monthly, based on the specific EMR's upload schedule.

How do I get compensated if I will not have any panel to start with and it will take some time before I reach the target of 900 patients?
NPs have 24 months from the start of their participation in the NPPCP to reach a minimum panel size of 900 patients. During this period, NPs will be compensated based on their approved FTE and actual Program Service Hours (PSH) worked, and are expected to accept walk-in patients to support panel growth.

This approach provides NPs with the opportunity to build their patient panel from the outset of the program.

If, after 24 months, an NP's panel remains below 900 patients, they may submit a business case to Primary and Preventative Health Services explaining why they should remain eligible for the program despite not meeting the minimum panel size.

What if an NP is not able to meet panel size of 900 patients? Is there a penalty?
The minimum panel size for NPs at the start of their participation in the NPPCP is 900 patients. NPs have 24 months to reach this target. If an NP's panel remains below 900 patients after 24 months, they may submit a business case to Alberta Health outlining the rationale for continued eligibility in the program.

How are panel sizes calculated?
Panel size calculations will be based on data from the CPAR database, not from clinic's EMRs. Therefore, it is essential that NPs ensure their EMR panel uploads to CPAR accurately reflect their actual panel size.

Will panels be reviewed regularly?
CPAR panel reviews are conducted bi-annually, using a point-in-time snapshot on September 30 and March 31, to assess compensation levels based on changes in panel size. Compensation is based on 1.0 FTE (1,928 hours) and is determined using CPAR data.

If a reassessment shows that an NP's panel size has moved into a different compensation range—either higher or lower—the change will be reflected in subsequent bi-weekly payments.

> *Note: It may take a few pay periods for the adjustment to appear.*

NPs are encouraged to review their CPAR panel size and reports on panel conflicts and demographic mismatches monthly to ensure accuracy and avoid delays or discrepancies in compensation.

What about panel conflicts?
A panel conflict occurs when a patient is listed on multiple practitioners' CPAR panels. NPs must ensure that their submitted panels are clean, and they are expected to resolve any panel conflicts.

The online CPAR portal provides access to key tools for panel management, including:

- CPAR Conflict Report
- CPAR Demographic Mismatch Report

These reports are updated monthly and allow NPs to view their estimated CPAR panel size and identify issues that may affect panel accuracy.

> *Note: Panel size calculations are based solely on CPAR data, not clinic EMRs. Patients with unresolved conflicts will not be counted toward the panel size until those conflicts are resolved. A formal paneling process, which will simplify panel management, is currently under development.*

What information does the CPAR conflict Reports provide?

The CPAR Conflict Report is generated monthly on a per-panel basis. It lists patients on the NP's CPAR panel who are also paneled to another participating primary care provider. A panel conflict is flagged when a patient appears on multiple CPAR panels.
Common causes of panel conflicts include:

- A patient switching primary care providers without notifying the previous provider
- A patient being inappropriately paneled after an episodic care visit
- A patient actively receiving care from more than one primary provider

Managing panel conflicts is an ongoing responsibility. Reducing conflicts improves continuity of care for patients and reduces administrative burden for providers. In many cases, resolving conflicts will have a neutral or positive impact on your panel size.

To help keep conflict rates manageable, providers should:

- Panel only patients for who they are the most responsible provider, not those seeking episodic care
- Respect requests from other clinics/providers to un-panel patients for who they are no longer the most responsible provider

The CPAR portal provides access to two key monthly reports for panel management:

- CPAR Conflict Report
- CPAR Demographic Mismatch Report

What information does the CPAR Demographic Mismatch Report provide?

The CPAR Demographic Mismatch Report is generated monthly on a per-panel basis. It identifies discrepancies between the demographic information in the NP's EMR and the Alberta Health Provincial Client Registry. The report also flags any deceased patients who have been included in the panel.

Important: Patients with demographic mismatches are not included in the CPAR panel size calculation. Therefore, resolving these mismatches can only have a neutral or positive impact on panel size estimates.

Regular review and resolution of demographic mismatches is essential to ensure accurate panel data.

How is panel-based incentive payment calculated?

An incentive payment of $75 will be provided for each new patient added to an NP's panel beyond the minimum 900 patient panel size, provided the patient is not currently attached to another primary care provider.

- This incentive is capped at $2 million for the fiscal year.
- It is available on a first-come, first-served basis.
- Payments will be reviewed and processed bi-annually.

What if I have paneling conflicts in CPAR?

NPs are responsible for reviewing and addressing CPAR panel conflicts on an ongoing basis. The CPAR Conflict Report helps identify patients who are paneled to multiple primary care providers, which can affect panel accuracy.

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Working Hours

Is there a specific time frame (e.g., after 1700H) that is considered after-hours?

- Regular hours are 0900H to 1700H
- After-hours services include but are not limited to:
    - Evening appointments (after 1700H); and/or
    - Weekends and Alberta statutory holidays

How many hours outside of regular business hours are we expected to do? Will it be per week or per month?

- NPs are required to offer patient appointments outside of regular business hours (i.e. evenings, weekends, and statutory holidays), termed 'alternate hours'. NPs can accrue up to 20 percent of their annual service hours (1,928 hours) commitment at a rate of 1.5 hours to provide clinical services at alternate hours.
- Alternate hours must focus on patient appointments and not on administrative tasks. NPs providing indirect patient care during alternate hours, but not seeing patients within this time, can accumulate those hours at the standard rate towards the 1,928 hours. This time cannot be accrued at the 1.5 hours as that time is limited to patient appointments i.e. direct patient care during alternate hours.
- NPs will not be compensated for "availability". However, eligible services NPs provide when called in during alternate hours fall within the scope of this program and are included in the NP's 1,928 hours.
- Alternate hours include but are not limited to:
    - Evening appointments (after 1700H); and/or
    - Weekends and Statutory holidays
- The Letter of Participation (LOP) that NPs must sign to participate in the NPPCP does not address the specifics of call requirements for patients within a group practice; this is a matter for the group practice to coordinate.

Will virtual care be accepted in the number of hours we need to work?

- This model is designed to provide comprehensive longitudinal care with the majority of services to be provided in-person.
- NPs will be able to provide some virtual care services. However, virtual care should be limited to a maximum of 10% of the total number of hours of service provision offered by the NP.

Will setting up a clinic count for NP hours as well?

No. The NPPCP compensates NP for the time spent providing medically necessary services. Time spent setting up a clinic is considered practice set up and readiness requirements and is not billable or compensable under the NPPCP does not count towards the annual 1,928 hours of service provision

Can a full-time position be split with 2 NPs?

- NPs can work in a group setting but are individually responsible for the 1,928 hours (1.0 FTE) and their own minimum 900 patient panel of distinct/unique patients.
- If an NP has not reached 1,928 hours, their compensation will be prorated based on the number of eligible hours reported to Primary and Preventative Health Services.

Can my hours be exclusive to evenings and weekends?

NPs are required to offer patient appointments during and outside of regular business hours (i.e. evenings, weekends, and statutory holidays), termed 'alternate hours.' This includes, but is not limited to:

- Evening appointments (after 1700 hours)
- Weekends and Statutory holidays

There is no minimum requirement on the number of after-hours work but only 20% of annual service hours (1,928 hours) can be accrued at a rate of 1.5 times to provide clinical services during after-hours beyond regular service hours; evenings (after 1700), weekends, and statutory holidays. The program requires NPs to work after hours irrespective of whether or not they have reached the minimum panel size of 900.

Is the alternate hours (evenings/weekends) requirement under the NPPCP?

NPs are required to offer patient appointments outside of regular business hours (i.e., evenings, weekends, and statutory holidays), termed 'alternate hours'. The Letter of Participation (LOP) that each NP signs confirms they commit to providing alternate hours.

Am I understanding that the 20% evening and weekend hours can be 385 total which then counts as 578 of your hours (385x1.5)?

NPs are required to offer patient appointments outside of regular business hours (i.e., after 1700H, weekends, and Alberta statutory holidays), termed 'alternate hours' and will be eligible for an incentive with some limitations:

- NPs can accrue up to 20 percent of their annual service hours (1,928 hours) commitment at a rate of 1.5 hours to provide clinical at alternate hours.
- Alternate hours should primarily target scheduled and walk-in visits, with limited virtual availability.
- Alternate hours must focus on direct patient care e.g. patient appointments and not on administrative tasks.
- The alternate hours incentive will be audited along with other regular audits of service delivery.
- Illustration of calculation:

  Total Annual Hours = 1,928
  Hours that can be accrued = 20% of 1,928 = 385
  Hours to be paid at straight times = 1,543
  Hours worked at 1.5 times to reach 385 = 256

This means that compensation for 1,543 hours will be paid for working during regular business hours. 256 hours can be accrued for working on evenings after 1700H, weekends and stat holidays which will be at 1.5 times and the total hours accrued will be 385.

The difference will be 129 hours, which will be counted towards working alternate hours.

How will we be reporting and tracking hours? Will we need to have time sheets?

NPs must report to Primary and Preventative Health Services the number of hours worked on a monthly basis.

Does covering for a physician count towards the annual hour requirement?
NPs may see the patients of other NPs or physicians within their team on a short-term basis to cover leaves and absences. The time spent in service provision may be counted towards the annual 1,928 hours requirement and the NP still has to submit claims to reflect the services provided. As the NP is not the most responsible provider, these patients should not be paneled to the NP. As these patients are not on the NP's panel there is no associated increase in compensation due to an increase in the panel size range. Such coverage should be short in duration and the NP must ensure it does not impact their own paneled patient's access to them.

If we have no intention from the start to work the full 1928 hours, can we prorate from the start?.
NPs who know they will work less than 1.0 FTE may advise Primary and Preventative Health Services in their application of the anticipated number of Program Service Hours (PSH) they will work so that their Letter of Offer reflects this. Payments for these NPs will be prorated accordingly.

NPAA Nurse Practitioner Association of Alberta

Practice Setup and Structure

How does this model differ from working for a health authority?
This is not an employment model. NPs in the program are independent contractors providing services to Albertans through a direct arrangement with Primary and Preventative Health Services.

Who am I managed by or accountable to?
NPs will be accountable to Primary and Preventative Health Services as per the Ministerial Order and a Letter of Participation (LOP) which outlines the service delivery conditions and compensation rates under the model.

NPs are accountable to College of Registered Nurses of Alberta (CRNA) for professional standards of practice.

What is the Practitioner ID (PRAC ID), and why is it important?
The Practitioner ID (PRAC ID) is an identifying number assigned to each practitioner registered with Primary and Preventative Health Services. It is required for claims submissions, referrals, and payments.

Do Facility IDs stay the same if the clinic has multiple buildings?
Facility IDs are location-specific. Each physical building requires its own Facility ID.

What is the process if I need to use a new EMR but my Facility ID stays the same?
The Facility ID is tied to the clinic's address. Changing EMRs does not change the Facility ID, but changing the clinic's address will. You must contact your assigned analyst to inform them of a clinic move or EMR transition at minimum 30 days before the transition (a 60-day notice is preferred) to allow the time for the changes to your Business arrangement, if needed, and CII/CPAR updates.

Will there be restrictions in terms of having other side practices such as consulting jobs in addition to this funded NP practice? For example, a medical director for a separate clinic that is not affiliated or working for AHS.
If NPs are meeting the program criteria and delivering the required clinical services for 1,928 hours per year, it is up to each individual NP to pursue additional possibilities. However, NPs should ensure that these opportunities do not create a conflict of interest, impact access or the care of their patients or create a risk to patient safety.

Can you join up with an already existing clinic, rent an office and examination area, and share the running cost? Or do we have to share only with NPs?
NPs can partner with other NPs or physicians and are responsible for all business arrangements with their clinic partners.

How is compensation for the Rural, Remote and Northern Program (RRNP) determined?
Compensation for NPs under the RRNP program is based on the eligibility of the community, in which the NP will be practicing, with regard to the extent of rural isolation.

The Rural Remote Northern Program Community Rate Table lists eligible communities and the corresponding benefits https://open.alberta.ca/publications/rrnp-community-rate-table.

If we have a BA currently, should we transfer it or submit a new one?

NPs are assigned a new Business Arrangement to participate under the NPPCP. Only one NPPCP BA is assigned.

If there are any changes to the BA, will I have two BAs, with one inactive?

Only one NPPCP BA is assigned to the NP. If the NP changes clinics or EMRs, the NP must ensure the transition is timed appropriately to allow for update to their BA and CPAR panel to minimize the risk of payment, claims submission or panel issues. PPHS must be notified at least 30 days (60 days preferred) prior to the transition to allow sufficient time for processing and completion of these updates. Note: Because CPAR panels are tied to a facility ID, moving clinics results in the creation of a new panel at the new site and the termination of the previous panel.

Regulations and Licensing

Is there a minimum amount of time/years of being licensed necessary to apply to the program?

- There is no minimum number of years of experience.
- NPs may apply for one-time funding of $10,000 for mentorship to support new to practice NPs during their first 18 months of practice with the goal to provide direct support, business support, guidance and/ or clinical mentorship specifically tailored to the needs of individual NPs.

Can NPs join Primary Care Networks (PCNs) as members?

- NPs may seek to join a PCN. PCNs can offer increased access to team-based services and potential infrastructure support.
- The decision to attach an NP to a PCN is made at the discretion of the individual PCN board. Primary and Preventative Health Services (PPHS) is not involved in this decision.
- NPs are responsible for exploring and establishing relationships with their local PCN based on their community context.
- NPs interested in joining a PCN should reach out directly to their local PCN to explore options. Additional guidance may be available through the NPAA members website.

Business Development and Support

What happens if an NP needs to take extended time off (e.g., sick leave, maternity leave)?

- As the primary provider responsible for their panel, NPs must ensure that the health care needs of their patients are met.
- This is an independent contractor model. There is no provision for compensation for NPs taking leaves.
- NPs are responsible for making appropriate arrangements for another provider to provide services for their panel during any absences and must ensure continuity of care to their panel.

How long will the program be operational?

The Ministerial Order for the program is in place for a minimum of 5 years.

How is quality improvement monitored?

NPs must report on performance measures quarterly and/or annually to demonstrate program outcomes to include but not limited to:

- number of patient visits;
- third-to-next appointment availability;
- ASAP Screening intervention; and
- HQA panel assessment (NPs must share their panel with the Health Quality of Alberta (HQA) for quality improvement (i.e., Panel Reports).

Additional measures to report on an individual NP practice can be facilitated by contacting your assigned program analyst. Due dates for performance reporting are outlined in the reporting template that will be provided to the NP.

Who is evaluating the application process?

Primary and Preventative Health Services will review and assess applications based on the following criteria:

- Demonstrated autonomous practice to full scope of practice.
- Support of the patient's medical home model for community primary health care delivery by addressing how to develop a panel of patients, continuity of care and supporting after hours coverage.
- Completion and comprehensiveness of the application form.
- Program requirements are met.
- Business viability established.
- Demonstrated team-based/collaborative care.
- Target patient population (more weight for service provision to underserviced populations).

How does this program work with the Blended Capitation Model (BCM) Clinical Alternative Relationship Plan (ARP)?

- The Nurse Practitioner Primary Care Program (NPPCP) directly compensates NPs for providing primary care services.
- The Blended Capitation Model (BCM) is a physician funding model where clinic funding is provided based on the clinic's patient roster and physician FFS billings.

- NPs compensated through the NPPCP, who also work within a BCM Clinical ARP, must provide primary care services to the patients on their panel and must conduct panel management activities on an ongoing basis to confirm patient attachment.

Do PCNs have to change their structure?

- There is no requirement for NPs working in PCNs to apply to the Nurse Practitioner Primary Care Program or vice versa.
- NPs already providing primary care services within a PCN may continue to do so. There is no requirement for NPs working in PCNs to apply to the Nurse Practitioner Primary Care Program.
- NPs cannot simultaneously enroll in both the PCN NPSP and NPPCP. NPs can only be registered in one program at a time.

General

Who is eligible to participate in the NPPCP?

To be eligible for the NPPCP, Nurse Practitioners (NPs) must meet the following requirements:

- Be registered in good standing with the College of Registered Nurses of Alberta (CRNA), with no sanctions or conditions on their licence.
- Hold a valid Nurse Practitioner permit with a Family/All-Ages (FAA) condition.

NPs who hold additional specialist training (e.g., focused practice areas such as women's health, geriatrics, etc.) are eligible to participate, provided they also hold an FAA permit and are able to deliver comprehensive, longitudinal primary care services to patients across the lifespan.

NPs who hold only Child, Adult, or Neonatal practice conditions are not eligible for the program. This applies even in situations where the NP is working within a team or clinic that includes other providers (NPs or physicians) with a full-family scope—the eligibility requirement is tied to the individual NP's licence, not the team composition.

Graduate Nurse Practitioners (GNPs) are also not eligible to participate. While GNPs have completed their education, they hold a provisional permit and must practise under supervision until they have successfully passed the NP exam. As participation in the NPPCP requires autonomous, independent practice to full scope, this supervision requirement makes GNPs ineligible.

All NPs participating in the NPPCP are expected to provide comprehensive primary care in alignment with program requirements.

How does one find out more about funding for the Indigenous stream?

- Under the Nurse Practitioner Primary Care Program, there are allocated spots held for NPs those working on First Nations Reserves or Metis settlements, equivalent to three to five NPs, depending on panel size. If more than three to five NPs who are working in these areas apply, and meet eligibility criteria they would be approved, pending budget availability.
- NPs working within urban or rural areas that are Indigenous or who may support Indigenous patients are eligible to apply within the broader program and if they meet the eligibility criteria, will be approved, pending budget availability.
- Under the recommended model parameters, First Nations or Metis communities, Indigenous clinics and other Indigenous organizations would be able to submit joint applications alongside the NP to support them increasing panel sizes, with administrative costs, and provide wrap-around services to ensure the NP is successful.
- Program requirements for Indigenous stream applicants are the same as for all other NP applicants.

Are insured services provided to refugees compensated under the NPPCP?

Refugees are classified in 3 categories:

- Refugees sponsored by the government, family or organization
    - Health service provision is compensated under the NPPCP if the patient has a signed Confirmation of Permanent Resident document, or a Permanent Resident Card issued by Immigration, Refugee and Citizenship Canada (IRCC) and an Alberta Health Services Card.

- Convention refugees who hold a Notice of Decision from the Government of Canada indicating that their refugee claim was approved.
    - Health service provision is compensated under the NPPCP if the patient has a Primary and Preventative Health Services Card.
- Refugee Claimants and Failed Refugee Claimants
    - The NPPCP does not compensate NPs for medically required services provided to Refugee Claimants and Failed Refugee Claimants who are living in Alberta and waiting for a decision from IRCC. These patients would be provided coverage through the Interim Federal Health Program (IFHP).

What about locuming for those that may not be approved by the government?
In this phase, there is no provision for locum programs within NPPCP. NPs are responsible for making appropriate arrangements for another provider to provide services for their panel during any absences.

What level of insurance am I required to have?
NPs must hold adequate professional liability protection with the Canadian Nurses Protective Society according to the scope of her/his services, or other adequate insurance against acts of negligence and malpractice. In addition to professional liability insurance, where the NP owns or rents the premises where the services are provided, the NP must maintain comprehensive or commercial general liability insurance.

Who is determining the complexity of my patients?
At the 18-month review built into this program, patient complexity will be reviewed to determine if the panel size requires a complexity modifier. Further details on this process will be available closer to that date.

What is the schedule for compensation payments?
Compensation will be paid biweekly and will be reconciled at the end of the fiscal year based on actual Program Service Hours (PSH) worked relative to the NP's approved FTE. Payments will be prorated for any partial FTE and panel size.

What is your rationale for providing 80% of what physicians are compensated when we are providing equal work?
Typically, NPs can provide about 80% of the medical services a family physician provides. Compensation under the Nurse Practitioner Primary Care Program is calculated as 80% of the fee-for-service (FFS) compensation received by family physicians with similar patient panels who work 90% of their time providing comprehensive primary care and determined based on their comprehensive care billings only.

I currently am a salaried NP at a PCN and the PCN gets funding for my FTE. Will the PCN be able to apply for more funding for the NPs since I work at a clinic that does not have the capability of having a patient panel (i.e., I work at the after-hours clinic)?
The annual funding for NP FTE in the PCN Nurse Practitioner Support Program (NPSP) was increased to $145,000 effective April 1st, 2024.

PCNs are responsible for budgeting for costs above the funding allocation of $145,000 and can supplement this funding through their per-capita operating revenue.

Applications to the NPPCP must be submitted by individual NPs. However, clinics, communities or PCNs may partner with NPs and express a formal interest in applying for one-time funding of $10,000 to support new to practice NPs during their first 18 months of practice with the goal to provide direct support, business support, guidance and/ or clinical mentorship specifically tailored to the needs of individual NP practicing in the NPPCP model.

Can an attached patient decide to leave their MD/NP and come to you, and you can then panel them?
Adding a patient to your panel means you are identifying yourself as the most responsible provider (MRP) for that patient.

NPs may panel patients who were previously attached to other primary care providers. However, the one-time incentive of $75 for each new patient added to the panel after 900 patients is only applicable to patients who are not currently attached to a primary care provider (i.e. unattached patients).

Is there a required commitment to participate in the NPPCP? What happens if I decide to leave the program?

- Participation in the NPPCP is voluntary, and NPs may choose to leave the program at any time.
- If withdrawing, NPs must provide a Letter of Termination to Primary and Preventative Health Services at least 90 days prior to their intended withdrawal date. NPs must also provide at least 90 days' notice to patients on their panel.
- Leaving the NPPCP does not mean you must close your practice. NPs may continue practicing outside of the program (e.g., in other clinic models or funding arrangements).
- NPs remain accountable to the College of Registered Nurses of Alberta (CRNA) for professional standards related to closing or transitioning a practice.
- NPs may also consult with the NPAA for guidance when leaving the program or transitioning their practice.

If there is room at our clinic, can a PCN nurse come to our clinic once a week like they do at doctor's clinics?
It is the responsibility of the NP to make arrangements with other health professionals they wish to collaborate with at their clinic. It will be the responsibility of the NP to provide or arrange compensation to staff hired by them individually or through a group practice.

Will we be able to charge patients for missed appointments as part of the NP funding program?
NPs **must not** charge patients for missed appointments as mandated in the NPPCP Ministerial Order. NPs can count time spent waiting, up to 15 minutes, for a patient who did not attend a scheduled appointment towards their 1,928 hours commitment. However, if another program service is provided during that time, the health service code that reflects that service should be billed instead and the time spent captured on the Program Service Hour Report.