

General Practice Services Committee



Annual Report 2007–2008

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General Practice Services Committee Annual Report 2007–2008

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Mandate

The General Practice Services Committee (GPSC) was originally established under the Ministry of Health (MoH)/BC Medical Association (BCMA) *Subsidiary Agreement for General Practitioners, November 2002* with the mandate of finding solutions to support and sustain full service family practice in B.C.

This mandate was renewed under both the 2004 MoH/BCMA Working Agreement, and the MoH/BCMA 2006 Agreement.

Under the 2006 Agreement, \$412 million over four years was allocated to address the following eight priority areas:

1. Chronic Disease Management
2. Maternity Care
3. Care of the frail elderly, and patients requiring end of life care
4. Patients with complex care needs
5. Prevention
6. Mental health
7. Recruitment and retention of full service family practitioners
8. Multidisciplinary care between general practitioners and health care providers.

Organizational Structure

The GPSC is a joint committee of the B.C. Ministry of Health Services (MoHS), the BC Medical Association (BCMA), and the Society of General Practitioners (SGP) of B.C. Both the MoH and the BCMA have four appointed members on the committee (Appendix A).

All decisions of the GPSC are made by consensus.

In 2007/08, all members of the *B.C. Primary Health Care Council* (Appendix B) participated in GPSC

meetings as guests in order to provide the health authority perspective to GPSC deliberations.

GPSC deliberations are also guided by feedback obtained from the province-wide consultation with B.C. general practitioners that took place under the auspices of the GPSC sponsored *2005 Professional Quality Improvement Days*. This consultation engaged approximately 1000 GPs from across the province, and identified key areas of focus for sustaining full service family practice in B.C.

The GPSC reviews all fee payments on a monthly basis and studies all recommendations received from the GP community on how the fees could be improved to better support and sustain full service family practice. Based on this information, GPSC has revised fees structures as required.

Full Service Family Practice Incentive Program

The *Full Service Family Practice Incentive Program* (FSFPIP) was launched in September 2003 with the introduction of:

- ▶ Annual bonus payments for the provision of diabetes and congestive heart failure care according to evidence-based clinical guidelines; and
- ▶ An obstetrical premium aimed at encouraging recruitment and retention of GPs providing maternity care to women in their community.

Since then additional incentives have been introduced to support and sustain full service family practice in the province (Table 1).

Table 1: Full Service Family Practice Incentive Program

Implementation Date	Incentive Payment
September 2003	- Annual condition based payment for diabetes and congestive heart failure (fee items 13050 initially then in 2006 renumbered 14050 & 14051) ¹ - General Practitioner Obstetrical Premium (fee items 14000 initially then renumbered in 2006 14004,14008,14009)
April 2006	- Condition Based Payment for Hypertension Management According to BC Clinical guideline recommendations (fee item 14052) - Maternity Care Network Payment ² (fee item 14010) - Community Patient Conferencing Fee (fee item(14016) - Facility Patient Conferencing Fee (fee item 14015) - Cardiovascular Risk Assessment Fee (fee item 14034)
April 2007	- Complex Care Payment: Options 1 and 2 (fee items 14030, 14031, 14032, 14033, 135/36/36/37/38)
June 2007	- Family Physicians for BC (FPs4BC) Program
January 2008	- Community Mental Health Initiative: GP Mental Health Planning Fee (fee item 14043; GP Mental Health Management Fee (fee item 14045/46/47/48) - revised Annual Complex Care Payment Management Fee(fee item 14033); Complex care Telephone/Email Follow-up Management Fee (fee item 14039) - Maternity Care for BC (MC4BC) Program

Footnotes:

¹ In 2006, the annual condition based payments for diabetes and congestive heart failure were increased from \$75 per patient to \$125 per patient.

² Effective December 31, 2006, the Maternity Care Network Payment was increased from \$1,250 to \$1,500 per quarter. As of December 31, 2007, the payment was further increased to \$1,850 per quarter.

Feedback From The Profession 2007/08

As part of the 2008 BCMA Members Survey (conducted by Ipsos Reid) B.C.'s general practitioners were asked for their views on the Full Service Family Practice Incentive Program. Survey results reported that

- ▶ 84 percent of the province's GPs had used the GPSC program and fees;
- ▶ 66 percent reported that the GPSC programs and fees improved their professional satisfaction; and
- ▶ 90 percent supported the overall approach to providing support and targeted financial incentives to family doctors.

PROGRAM UPTAKE AND EXPENDITURE

Chronic Disease Management

B.C.'s full service family practice physicians are eligible to receive an annual payment of \$125 for each of their patients with a confirmed diagnosis of diabetes mellitus and/or congestive heart failure who have received care in accordance with B.C. clinical guidelines recommendations. In addition, an annual \$50 payment is available to better support GPs for

the management of hypertension according to B.C. clinical guideline recommendations.

Table 2 shows the number of GPs who participated in the condition based payments in 2007/08, and the number of patients who received care in accordance with the B.C. Clinical Guidelines recommendations.

Uptake of the chronic condition management incentive payments increased dramatically over the previous year following province-wide billing tutorials undertaken by the GPSC during May and June 2007.

Table 2: Summary of Condition Based Payments for 2007/08³

	GP Participation	Patient Receiving Evidence Based Care	2007/08 Expenditures
Diabetes	3,021	142,454	17,821,750
Congestive Heart Failure	1,963	18,073	\$2,260,500
Hypertension	2,768	228,624	\$11,435,000

Footnotes

³ All statistics reported in the annual report reflect billings paid as of March 31, 2008.

Maternity Care

The GPSC introduced maternity care incentives to help ensure that B.C. women are able to obtain maternity care in their community, and better support GPs who provide this vital service in the community.

The *Obstetric Premium* provides a fifty percent bonus on delivery fee items 14104, 14108 and 14109. The *Maternity Care Network Payment* helps cover the costs of group/network activities for shared care of obstetric patients. Effective December 31, 2007, the *Maternity Care Network Payment* was increased to \$1,850 per quarter (formerly \$1,500 per quarter).

In 2007/08, 799 GPs participated in the *Obstetric Premium*, providing maternity care to 13,061 women in their communities (2007/08 expenditure - \$3,371,492). A change in payment policy now allows the *Obstetric Premium* to be billed more than once per day (for up to a maximum of 25 deliveries per year) thus making low volume delivery GPs eligible for the bonus on those occasional days when they deliver multiple births.

In 2007/08, 118 networks were registered to receive the *Maternity Care Network Payment*; 674 GPs participated in the network payment (2007/08 expenditure - \$3,942,100).

In attempt to reverse the level of attrition, in January 2008 the GPSC launched the *Maternity Care for BC (MC4BC) Program* which makes training available to B.C. GPs wanting to update their maternity skills, and graduating residents who want to include obstetrics in their practice (total funding allocated: \$1 million).

This training uses a sponsorship/mentorship model in which physicians are funded to shadow a sponsoring physician with obstetrical credentials in their community hospital. Both rural and urban physicians are eligible to receive this funding which will be provided until the doctor can meet the delivery requirements to be credentialed. As of March 31, 2008, ten GPs were participating in this program (2007/08 expenditure - \$46,705.60)

Improved Care of the Frail Elderly, Patients Requiring End of Life Care, and Increased Multidisciplinary Care between General Practitioners and Health Care Providers

In 2006 the following fees were introduced in order to support the care needs of the frail elderly, patients requiring palliative care or end-of-life care, patients with mental illness, or those with multiple medical needs or complex co-morbidity.

The *Community Patient Conferencing Fee* (14015) was developed to better support GPs create clinical action plans for the care of community based patients with complex care needs. The aim of the *Facility Patient Conferencing Fee* (14016) is to better support GPs in working with patients as partners, other health care providers, and patient family members in the review and management of patients, and to work with patients as partners, and other health care providers and patient family members in the review and on-going management of patients in a facility.

As of March 31, 2008, 1096 GPs have participated in the *Community Patient Conferencing fee*, developing clinical action plans for 8009 patients (2007/08 total expenditures: \$666,320). 1114 GPs have participated in the *Facility Patient Conferencing fee* providing collaborative planning for 7717 patients (2007/08 total expenditures: \$700,960).

Patients with Complex Care Needs

Under the 2006 Agreement, \$25 million was allocated for the development of a complex care fee to better support GPs for the care of their high risk patients with two or more of the following chronic illnesses:

- ▶ Diabetes mellitus (type 1 or 2);
- ▶ End stage kidney disease (GFR values less than 60);
- ▶ Vascular disease (limited to congestive heart failure, ischemic heart disease, cerebrovascular disease i.e., stroke); and
- ▶ Respiratory disease (limited to chronic obstructive pulmonary disorder and chronic asthma).

The Complex Care Management fees (G14030/14031/14032/14033) were introduced on April 1, 2007, whereby GPs could receive a maximum of \$315 per year/per high risk patient in the priority disease categories through the following two payment options:

- ▶ Option 1: three fees with different payment values for various face to face interactions which were all billed in addition to the office visit (e.g., initial chart review and care plan development (G14030) - \$100; care plan review (G14031) - \$75; four inter-sessional visits (G14032) - \$35 each); or
- ▶ Option 2: annual complex care management fee (G14033) plus an annual block payment

equivalent to 6 visits per year. Care under this option could be delivered face-to-face, provided by group visit, or by a nurse or other health professional, telephone, or email.

By December 2008, feedback from the GP community indicated that the two payment options were complicated and administratively burdensome. Specifically, feedback regarding Option One included:

- ▶ The fee option was difficult to track;
- ▶ Physicians were uncertain when to bill the minor care plan review (G14031) vs. the follow up fees (G14032); and
- ▶ While phone or e-mail management was an option included in the Option 2 block care payment, any phone or e-mail management under Option 1 was not billable.

Feedback regarding Option Two included:

- ▶ GPs found it confusing as to whether visits were or were not included in the pre-paid annual block visit fee if other matters were discussed;
- ▶ GPs expressed concern that care they provided to these patients that did not generate any billing would not be recognized in the calculation of “Majority Source of Care” patients, as there was no electronic indication that the care was actually provided; and
- ▶ GPs were uneasy about accepting a pre-paid amount equivalent to six office visits as full annual payment for the two qualifying conditions.

As such, effective January 1, 2008, the GPSC discontinued the two payment options and introduced a revised Complex Care Management Fee (G14033) whereby GPs are eligible to receive \$315 per patient/per year for developing and monitoring the patient’s care plan (at a maximum of five Complex Care Management Fees billable by a GP per calendar day).

1483 GPs participated in the Major Complex Care Plan fee 14030 (17,810) for a total 2007/08 expenditure of \$1,781,800. Between April 2007 and September 2007, 2053 GP billed the Annual Complex Care fee (14033) for 77,597 patients (total expenditure for 2007/08 – quarter 1-3: \$24,447,465). During the 4th quarter of 2007/08, 1730 GPs billed the 14033 Annual Complex Care fee (14033) for 15,071 patients for a total expenditure of \$4,747,365.

Effective January 1, 2008, a complex care e-mail/telephone follow up management fee (G14039) at a rate of \$15 that is payable up to a maximum of four times per year/per patient was made available. This fee enables the practice to follow-up with the patient or the patient’s medical representative using 2 way telephone or email communication. Between January and March 2008, 308 GPs used this fee for follow-up on 925 patients (2007/08 expenditure: \$17,250).

Uptake of the complex care fee surpassed initial projections resulting in a budget over-expenditure for 2007/08. In order to cover the potential budget over-run, unallocated funds from 2006/07 were set aside in April 2007.

Prevention

The 2006 Agreement has earmarked five percent of the annual budget allocated for Full Service Family Practice for the development and implementation of evidence-based prevention activities. Effective April 1, 2007, a cardiovascular risk reduction assessment payment for at-risk patients was made available to GPs (total budget allocation \$5 million).

GPs can receive \$100 per patient for the assessment of up to 30 at risk patients over the calendar year, to a maximum payment of \$3,000 per GP. The assessment must include a personal action plan developed by the GP and patient, which includes the following elements:

- ▶ Patient’s goals related to diet, tobacco use and moderate exercise;

- ▶ Clinical elements determine by reference to specific MoHS/BCMA Guidelines and Protocols Committee guidelines (e.g., diabetes, hypertension, lipid), and the new cardiovascular disease primary prevention guideline which recognizes the importance of major individual disease specific guidelines and the critical importance of appropriate lifestyle modification for all patients; and
- ▶ Approaches to enable patients to understand and be active partners in defining and achieving their key clinical and personal goals to reduce the major risk factors.

As of March 31, 2008, 2532 GPs participated in the cardiovascular risk reduction payments (58,415 patients received a personal action plan). Total expenditures for 2007/08: \$6,077,700.

The GPSC Prevention Working Group will re-convene in Summer 2008 to further identify how prevention activities in full service family practice can best be supported for achieving optimal patient outcomes.

Mental Health

The Community Mental Health Initiative (effective January 1, 2008) supports GP provision of accurate diagnosis, a patient plan and longitudinal follow-up of patients in the community with: an Axis I diagnosis confirmed by DSM IV criteria and; and level of severity and acuity that causes sufficient interference in the activities of daily living.

Under this initiative, a Mental Health Planning Fee is available to GPs upon development and documentation of a patient's mental health plan. This fee requires the GP to:

- ▶ Conduct a comprehensive review of the patient's chart/history, assessment of the patient's current psychosocial symptoms;
 - ▶ Conduct an assessment of the patient's current psychosocial symptoms/issues by means of psychiatric history, mental status examination; and
- ▶ Use of appropriate validated assessment tools, with confirmation of diagnosis through DSM IV diagnostic criteria. It requires a face-to-face visit with the patient, with or without the patient's medical representative.

In addition, a mental health telephone/email management fee is payable for 2-way clinical interaction provided between the GP or delegated practice staff (e.g., office registered nurse or medical office assistant) in follow-up on the Mental Health Planning Fee. As well, GPs after creating and successfully billing for a mental health plan will be able to access up to 4 additional counselling equivalent "Mental Health Management Fees" for these patients over the balance of the calendar year.

As of March 31, 2008, 1122 GPs participated in the Mental Health Planning Fee, developing a mental health plan for 17,367 patients (2007/08 total expenditure: \$1,736,800.

The Mental Health Management fee was billed by 114 GPs for 189 patients (2007/08 total expenditure: \$3,600).

Attraction And Retention of Family Practitioners

The *Family Physicians for British Columbia* (FPs4BC) program was launched June 1, 2007, to encourage GPs who completed their residency training within the last 10 years to establish or join a group family practice in a community identified by the local Health Authority as being a community of need. FPs4BC received \$10 million in one-time funding through the 2006 Agreement (Article 7.8) allocation for attraction and retention of family practitioners.

The FPs4BC program provides up to a maximum of \$100,000 per GP to help them pay off student debt and set up/join their group practice as follows:

1. Student Debt repayment - up to \$40,000;
2. Funding to set up or join a group practice (e.g., leasehold improvements, a practice mentor, or

moving costs; consideration for solo for remote or rural areas) - up to \$40,000;

3. A New Practice Supplement for the first 26 weeks of practice -- \$2,000/week (maximum \$52,000); and
4. A bonus of \$1,500 (on top of \$100,000) will be provided if physician obtains full hospital privileges.

In return for the funding, the GP will provide three years return of service.

Each Health Authority was allocated a proportionate number of spaces. Table 4, shows the number of spaces available, and filled, as of March 31, 2008. Total expenditures 2007/08: \$3,329,500.

Table 4: Summary of FPs4BC for 2007/08

	Spaces Available	Spaces Filled
Interior Health Authority	15	6
Fraser Health Authority	31	23
Northern Health Authority	7	1
Vancouver Coastal Health Authority	22	9
Vancouver Island Health Authority	15	10

In March 2008 a Request for Proposals was issued to evaluate the design and implementation of the FPs4BC program. A \$25,000 contract was awarded to James Murtagh and Associates to undertake the evaluation, which is slated for completion Fall 2008.

More information on the Full Service Family Practice Incentive Program can be found at http://www.health.gov.bc.ca/phc/gpsc_incentive.html

Support for General Practitioners' Role in Hospital Care

Per Article 7.5 of the 2006 Agreement, the GPSC was given the mandate to review and recommend approaches that support GPs continued role in providing hospital care. The GPSC established a *Hospital Working Group* which reviewed the literature, and assessed cross-jurisdictional work

that piloted different models of re-engaging GPs in hospital work.

Moreover, through the 2005 Province-wide consultation with GPs (i.e., Professional Quality Improvement Days), concerns were voiced by the profession about decreasing morale among GPs providing continuous comprehensive care. GPs indicated feeling isolated and unsupported in their community practices, and were concerned about the erosion of communities of care in the province. Currently community infrastructure is not available

to support GPs who wish to work together to provide the best possible patient care and achieve improved professional satisfaction.

Following this review and community consultation, the GPSC recommended the province-wide establishment of GP infrastructure.

The creation and implementation of GP infrastructure would enable family physicians to develop and implement local solutions to local problems (of which re-engaging GPs in hospital care might be a priority), to assume greater involvement in the community by providing them with a global voice, and more potential sources of support across the health care system. Specifically, the GP infrastructure would enable:

- ▶ A shared responsibility for care;
- ▶ A GP voice in addressing systemic issues;
- ▶ Re-bundling of services;
- ▶ A legal entity for negotiating locum support and services contracts; and
- ▶ Organization of CME.

A model of GP infrastructure will be pilot tested in each of the province's health regions. GPSC has allocated \$6 million for the prototype project.

Multidisciplinary Care Between General Practitioners And Health Care Providers

Per the 2006 Agreement (regarding Section 7.5(d) – Health Authority Contracts with GPs), \$5.5 million will be made available to support GPs who, where directly, or through the health authorities, wish to contract with other health care providers to provide multidisciplinary care for targeted populations. A GPSC project group has been convened, and will develop recommendations that align with the implementation of GP infrastructure in 2008/09.

Shared Care and Scopes of Practice Committee

Per Article 8.1 of the 2006 Agreement, the *Shared Care and Scopes of Practice Committee* was established with equal representation of the GPSC and the *Specialist Services Committee* (SSC). The function of this committee is to develop recommendations, including the creation of new fees, to enable shared care and appropriate scopes of practice between general practitioners, specialist physicians, and other health care professionals.

The first meeting of this committee took place October 2007. In order to inform the work of the committee, focus groups were held with specialists and GPs in February and March 2008 to identify common barriers to shared care and their recommendations on overcoming the barriers for improve patient health outcomes and professional satisfaction.

Per the 2006 Agreement the *Shared Care and Scopes of Practice Committee* will be tabling its recommendations to the GPSC and SSC no later than March 21, 2009.

GP NON-COMPENSATION FUNDING

\$20 million in one-time funding was allocated under the 2006 Agreement to support primary health care renewal in the following specific priority areas:

- ▶ Improving clinical practice through e-health technology;
- ▶ Increasing group and multi-disciplinary practice;
- ▶ Retaining and upgrading physician skills to better meet the needs of priority patient groups; and
- ▶ Establishing cross-disciplinary quality improvement and provincial learning networks.

In determining the allocation of the non-compensation funds, the GPSC studied the recommendations from its 2005 *Professional*

Quality Improvement Days (PQIDS) province wide consultation with B.C. GPs. The consultation identified practice enhancement and system redesign as key GP priorities. To this end, the GPSC committed \$23.42 million (included in which is 2004 unallocated funding) to March 31, 2009, for the Practice Support Program; additional funding was subsequently provided by the MoHS to support the hiring and retention of Regional Support Team staff.

Practice Support Program (PSP)

The PSP was launched in May 2007 to provide professional development and support to help GPs redesign their practice and clinical change management in the following four key areas:

- ▶ Advance Access Scheduling;
- ▶ Group visits;
- ▶ Chronic Disease Management; and
- ▶ Patient Self Management.

Training modules were jointly developed by the MoHS, BCMA, Health Authorities and IMPACT BC-Healthy Heart Society and provide evidence-

based change management strategies and tools for clinical practice enhancement.

The PSP was introduced to the GP community through a number of regional meetings that took place in each of the province's five health regions during the months of May and June 2007. These meetings included a tutorial on how to bill the Full Service Family Practice Incentive Program incentive payments. The regional meetings were well received and attended by 3700 GPs and medical office assistants (1800 GPs).

The training modules have been delivered regionally by Practice Support Teams throughout the province in a series of CME accredited interactive learning sessions. As of March 31, 2008, approximately one quarter (1200) of B.C.'s GPs are participating in the PSP (Table 5):

- ▶ 310 practices have completed training modules; and
- ▶ 956 GPs are currently on wait lists to participate in a module.

More information on the Practice Support Program can be found at www.practicesupport.bc.ca

Table 5: GP Participation in PSP Modules 2007/08

Module	Number Of Participating Gps
Advance Access	653
Chronic Disease Management	664
Group Patient Visits	128
Patient Self Management	310
Discrete GPs	1150
Total Graduates	437

Evaluation of the Full Service Family Practice Incentive Program

Through a competitive Request for Proposals process, the external consulting company Hollander

Analytical Services Inc. (Victoria, B.C.) was awarded a \$500,000 contract to evaluate the *Full Service Family Practice Incentive Program* and the *Practice Support Program*. The term of the contract spans from July 30, 2007 to December 31, 2008.

LIST OF APPENDICES

Appendix A: GPSC Membership 2007/08

Appendix B: Primary Health Council Membership 2007/08

Appendix C: Ministry of Health/BC Medical Association 2006 Agreement; Article 7

Appendix A – GPSC Membership

Dr. William Cavers (BCMA) Co-Chair

Valerie Tregillus (MOH) Co-Chair

Dr. Jean Clarke (BCMA)

Judy Huska (MOH)

Dr. Garey Mazowita (MOH)

Nichola Manning (MOH)

Dr. George Watson (BCMA)

Dr. Brian Winsby (BCMA)

Staff Support

Dr. Dan MacCarthy (BCMA)

Dr. Cathy Clelland (SGP)

Angela Micco (MOH)

Committee Secretariat

Angela Micco (MOH)

Alternate: Greg Dines (BCMA)

Ex-Officio Members

Dr. Stephen Brown (MOH)

Dr. Mark Schonfeld, (BCMA)

Appendix B – Primary Health Care Council

Clay Barber, Director, Primary Health Care & Chronic Disease Management, Interior Health Authority

Laurie Gould, Executive Director, Health Planning & Systems Development - Primary Care & Chronic Disease Management, Fraser Health Authority

Judy Huska, Executive Director, Health Services Integration, Northern Health Authority

Dr. Heather Manson, Vice President, Population Continuums, Vancouver Coastal Health Authority

Victoria Power-Pollitt, Director, Primary Health Care and Chronic Disease Management, Vancouver Island Health Authority

Appendix C: MoHS/BCMA 2006 Agreement: Article 7

ARTICLE 7 - SUPPORTING ACCESS AND IMPROVEMENT TO FULL SERVICE FAMILY PRACTICE

7.1 General Practice Services Committee

- (a) Effective April 1, 2007, the membership of the GPSC will be reconstituted such that there is equal representation from the Government, the BCMA and the Health Authorities. The total number of members of the reconstituted GPSC will be nine.
- (b) All decisions of the GPSC will be consensus decisions. If the GPSC cannot reach a consensus decision on any matter that it is required to determine, the Government and/or the BCMA may make recommendations to the Commission regarding such matter and the Commission, or its successor, will determine the matter.

7.2 Costs of GPSC

7.3 The costs of:

- (a) administrative and clerical support required for the work of the GPSC; and
- (b) physician (other than employees of the parties) participation in the GPSC,

ARTICLE 7 - WILL BE PAID FROM THE FUNDS TO BE ALLOCATED BY THE GPSC PURSUANT TO THIS AGREEMENT.

7.1 Full Service Family Practice Funding

- (a) The vehicle of the re-constituted GPSC will be used to further collaborate with General Practitioners to encourage and enhance full service family practice and benefit patients through increases to the existing \$10 million annual funding level for full service family practitioners, as follows:
 - (i) effective April 1, 2006, \$60 million (inclusive of \$5 million for a Maternity Care Network Initiative Payment);

- (ii) effective April 1, 2007, an additional \$20 million;
- (iii) effective April 1, 2008, an additional \$25.5 million; and
- (iv) effective April 1, 2009, an additional \$31 million;
- (b) such increases to be allocated by the GPSC to the areas identified in sections 7.2(a) and 7.3, or to any other areas that may be determined by the GPSC.
- (c) The parties agree that no further funds will be available or provided pursuant to Article 6.6 of the 2004 Subsidiary Agreement for General Practitioners.

7.2 Allocation of Full Service Family Practice Funding to March 31, 2007

- (a) The priorities for the allocation of the funds referred to in section 7.1(a)(i) up to March 31, 2007, will be as follows:
 - (i) General Practitioners who:
 - (A) as of April 1, 2006, have provided care and billed the 13050 CDM Incentive Payment for at least ten patients with diabetes or congestive heart failure; or
 - (B) in the 12 months preceding April 1, 2006, have performed at least five deliveries;
 - (ii) will receive a one time payment of \$2500. This payment will be funded first from the unexpended portion of the full service family practice fund referred to in Article 6.1 of the 2002 Subsidiary Agreement for General Practitioners (approximately \$4.7 million) and the balance from the funds referred to in section Article 7 - 7.1(a)(i);
 - (iii) General Practitioners who:
 - (A) as of June 30, 2006, have provided care and billed the 13050 CDM Incentive Payment or the new incentive payment referred to in section Article 7 - 7.2(a)(v) for at least ten patients with diabetes, congestive heart failure or hypertension; or
 - (B) in the 12 months preceding June 30, 2006, have performed at least five deliveries;
 - (iv) will receive a one time payment of \$7500 (approximately \$25 million expenditure);
 - (v) effective April 1, 2006, the 13050 CDM Incentive Payment will be increased to an annual amount of \$125 per patient. In addition, a new incentive payment will be implemented effective April 1, 2006, in the annual amount of \$50 per patient, for the guideline based chronic care of hypertension where this is not covered in treating diabetes or congestive heart failure, which will be paid in accordance with guidelines and criteria set out by the GPSC;
 - (vi) effective April 1, 2006, a patient case management conference fee and a complex patient clinical action plan fee will be implemented, in accordance with guidelines and criteria set out by the GPSC, for General Practitioners providing longitudinal care to their patients. These fees will not be available to physicians who are compensated through a Service Contract, Sessional Contract or Salary Agreement;

- (vii) \$5 million will be available in each year to reinstate and support the Maternity Care Network Initiative Payment; and
- (viii) any of the funds referred to in section Article 7 - 7.1(a)(i) that remain unexpended for services rendered on or before March 31, 2007, will be paid as a one time payment to those General Practitioners who:
 - (A) have provided care and billed the 13050 CDM Initiative Payment or the new incentive payment referred to in section Article 7 - 7.2(a)(v) for at least ten patients with diabetes, congestive heart failure or hypertension; or
 - (B) in the 12 months preceding April 1, 2007, have performed at least five deliveries.
- (b) Physicians who are compensated through a Service Contract, Sessional Contract or Salary Agreement, and who have provided the services identified in sections Article 7 - 7.2(a)(i), 7.2(a)(iii) and/or 7.2(a)(viii), will be eligible to receive the one time payments identified in those sections in addition to their service, sessional or salary payments.

7.3 Allocation of Full Service Family Practice Funding Commencing April 1, 2007

Commencing April 1, 2007, the GPSC will use the funds then available to it pursuant to section 7.1(a) as follows:

- (a) the payments referred to in sections Article 7 - 7.2(a)(v), 7.2(a)(vi) and 7.2(a)(vii) will continue;
- (b) five percent (5%) of the funds will be allocated by the GPSC to improved disease prevention;
- (c) a complex care fee (which will be billable no more than six times per year, per patient) will be developed and implemented by the GPSC on April 1, 2007, which, provided its billing includes the diagnostic codes for each chronic disease with which the patient presents, will be payable in addition to an office visit (fee items 12100, 00100, 16100, 17100 and 18100 in the MSP payment schedule) for patients with two or more chronic diseases, including:
 - (i) asthma or chronic obstructive pulmonary disease;
 - (ii) diabetes;
 - (iii) hepatitis;
 - (iv) hypertension;
 - (v) chronic kidney disease; and
 - (vi) congestive heart failure;
- (d) \$5.5 million will be made available to provide funding to Health Authorities for contracts with General Practitioners for targeted populations and to support General Practitioners who, whether directly or through Health Authorities, wish to contract with other health care providers for multidisciplinary care; and
- (e) the GPSC will set patient centred measurable goals and will place priority on the following areas:
 - (i) improved chronic disease identification and management for:

- (A) depression/anxiety;
 - (B) arthritis;
 - (C) asthma and chronic obstructive pulmonary disease;
 - (D) gastro esophageal reflux disease; and
 - (E) two or more chronic conditions;
- (ii) improved care for the frail elderly, including those in Long Term Care and Assisted Living facilities;
 - (iii) increased support to patients requiring end-of-life care; and
 - (iv) increased multi-disciplinary care between General Practitioners and other health care providers.

7.4 Carry Forward of Funding

Any funds identified in sections 7.1(a)(ii), 7.1(a)(iii) and 7.1(a)(iv) that remain unexpended for services rendered in a Fiscal Year will be available to the GPSC in the subsequent Fiscal Year for use as one time allocations in that subsequent Fiscal Year.

7.5 Support for General Practitioners' Role in Hospital Care

The GPSC will review and recommend approaches that support General Practitioners' continued role in providing hospital care, including the relationship between that role and the role of hospitalists. The GPSC will determine the key elements or models of care with indicators that demonstrate and support optimum patient outcomes. The recommendations will propose how best to utilize existing allocations for primary care support of hospitalized patients.

7.6 One Time Funding to Attract and Retain Full Service Family Practitioners

In addition to the funds referred to in section 7.1(a), the Government will provide new one time funding of \$10 million to be used by the GPSC to attract and retain additional recently qualified physicians in full service family practice in those areas of the province where the GPSC determines that there is a demonstrated need for additional full service family practice practitioners. Physicians will be eligible to receive support from such funds only if they commit to full service family practice to meet patient needs in the area and are recently qualified General Practitioners (i.e. those within five years of licensure to practice). In exceptional circumstances where an insufficient number of recently qualified physicians is willing to commit to providing full service family practice in areas of the province where the GPSC determines that there is a demonstrated need for additional full service family practitioners, the GPSC will have discretion to provide funds to General Practitioners with more than five years of practice since licensure if the GPSC believes doing so will attract and retain full service family practitioners on a long term basis in such areas of the province. The GPSC may use these funds to provide:

- (a) repayment of student loan debt of up to \$40,000 under a return of service agreement scheme that requires five years of service for the full amount;

- (b) support for the costs of establishing a new full service family practice group to a maximum of \$40,000 (support for solo practices may be considered for remote rural areas); and/or
- (c) alternative payment arrangements for these full service family practice recruitments for a limited time while they build up a patient base to provide patients with access to full service family practice.

ARTICLE 7 - A FORMAL APPLICATION AND APPROVAL PROCESS AND GUIDELINES WILL BE ESTABLISHED BY THE GPSC TO IMPLEMENT THIS INITIATIVE.

7.1 Non-Compensation Funding

One time non-compensation support for full service family practice will be provided using the \$20 million fund for primary care renewal referred to on page 8 in Article 5(b)(ii) of the Letter of Agreement (Related Matters). This funding will be used to support the achievement of the GPSC priorities referred to in section Article 7 - 7.3(e) and to provide change management support through regional full service family practice patient access and clinical improvement initiatives in the following specific priority areas:

- (a) improving clinical practice through e-Health technology;
- (b) increasing group and multi-disciplinary practices;
- (c) retraining and upgrading physician skills to better meet the needs of priority patient groups; and
- (d) establishing cross-disciplinary quality improvement and provincial learning networks.

7.2 GPSC Work Plans

On an annual basis, the GPSC will develop a work plan, ensure that evaluations to measure outcomes are an integral part of the plan, and report annually on progress and outcomes to the Government, the BCMA and the Health Authorities.



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