

General Practice Services Committee



Annual Report 2008–2009

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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 2007 Physician Master Agreement (formerly the 2006 Government/BCMA Agreement), \$382 million over four years was allocated to address the following eight priority areas:¹

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; and,
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 MoHS and the BCMA have four appointed members on the committee (Appendix A).

As in the previous year, in 2008/09, 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 their 2004/05 province wide consultation with B.C. General Practitioners (Professional Quality Improvement Days). This consultation engaged approximately 1,000 GPs from across the province, and identified key areas of focus for sustaining full service family practice in B.C.

In February 2009, the GPSC agreed to use the Institute for Healthcare Improvement's *Triple Aim Initiative* as a lens by which to assess existing and new initiatives. *Triple Aim* identifies the following health system-wide goals as key to achieving more coordinated, integrated and comprehensive patient care:

- ▶ The model/approach impacts positively the experience of the individual (i.e., the individual can receive the care that they exactly want and need, and how they exactly want and need it) and the healthcare professional providing those services;
- ▶ The model/approach impacts positively the health (physical and mental) of a defined population; and,
- ▶ The per capita cost of the model/approach has a positive effect on health care cost/spending.

All decisions of the GPSC are made by consensus.

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 fee structures as required (see Table 1).

¹ In total, \$452 million has been allocated to the GPSC since its inception in 2002.

External Evaluation of the Full Service Family Practice Incentive Program and the Practice Support 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 evaluation of the Practice Support Program was completed March 31, 2009.

The evaluation report on the Full Service Family Practice Incentive Program will be completed June 30, 2009.

Program Uptake and Expenditures – 2008/09

A summary of the incentive payments and their implementation date can be found in 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) -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 B.C. Clinical guideline recommendations (fee item 14052) -Maternity Care Network Payment (fee item 14010) -Community Patient Conferencing Fee (fee item 14016) -Facility Patient Conferencing Fee (fee item 14015)
April 2007	-Complex Care Payment: Introduced as Option 1 and 2 (fee items 14030, 14031, 14032, 14033, 135/36/37/38).
June 2007	-Family Physicians for B.C. (FPs4BC) Program
January 2008	- Revised: Complex Care Option 1 and 2 discontinued, and replaced with Complex Care Management Fee (G14033) and complex care e-mail/telephone follow up management fee (G14039) -Community Mental Health Initiative: GP Mental Health Planning Fee (fee item 14043; GP Mental Health Management Fee (fee item 14045/46/47/48) -Maternity Care for B.C. (MC4BC) Program -Cardiovascular Risk Assessment Fee (fee item 14034)

Chronic Disease Management²

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/

² Chronic Disease Management has been a focus of quality improvement efforts in primary health care for a number of years in B.C. and continues to be emphasized in the Primary Health Care Charter. According to the Canadian Institute of Health Information (CIHI) Health Indicators 2008, B.C. has the lowest hospitalization rate in Canada related to ambulatory chronic disease. http://secure.cihi.ca/cihiweb/products/HealthIndicators2008_hr_en.pdf

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 for those patients who do not also have diabetes or congestive heart failure.

Table 2 shows the number of GPs who participated in the condition based payments in 2008/09, and the number of patients who received care in accordance with the B.C. Clinical Guidelines recommendations.

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

	GP Participation	Patient Receiving Evidence Based Care	2007/08 Expenditures
Diabetes	3,027	154,596	\$19,332,625
Congestive Heart Failure	1,972	19,445	\$2,431,125
Hypertension	2,822	245,361	\$12,271,550

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. In 2008/09, 809 GPs participated in the *Obstetric Premium*, providing maternity care to 13,329 women in their communities (2008/09 expenditure: \$3,507,586).

The *Maternity Care Network Payment* helps cover the costs of group/network activities for

shared care of obstetric patients. The *Maternity Care Network Payment* provides \$1,850 per quarter to each GP participating in a formal group practice approach to maternity care provision.

In 2008/09, 118 networks were registered to receive the *Maternity Care Network Payment*; 660 GPs participated in the network payment (2008/09 expenditure: \$4,377,100).

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, 2009, 16 GPs have participated in this program; three graduated from the program and are providing maternity care in their community (2008/09 expenditure: \$226,874).

Although the number of general practitioners providing normal deliveries continues to decline, those general practitioner with obstetrical privileges are providing more services per practitioner.

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 comorbidity. 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.

As of March 31, 2009, 1,579 GPs have participated in the *Community Patient Conferencing fee*, developing clinical action plans for 13,255 patients (2008/09 total expenditures: \$995,660).

1,103 GPs have participated in the *Facility Patient Conferencing fee* providing collaborative planning for 8,434 patients (2008/09 total expenditures: \$764,860).

Patients with Complex Care Needs

Under the 2007 Physician Master 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).

Under the Annual Complex Care Management Fee (G14033), 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).

In 2008/09, 2,550 GPs billed the Annual Complex Care Fee (14033) for 108,145 patients (total expenditure for 2008/09: \$40,142,655).

In addition, a \$15 Complex Care E-mail/ Telephone Follow-up Management Fee 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 two-way telephone or e-mail communication for two way discussion of clinical issues.

As of March 31, 2009, 782 GPs used this fee for follow up on 6,582 patients (2008/09 expenditure: \$161,685).

Prevention

The 2007 Physician Master Agreement earmarked five per cent of the annual budget allocated for Full Service Family Practice for the development and implementation of evidence-based prevention activities.

In this regard, GPs can receive \$100 per patient for the cardiovascular risk reduction 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, 2009, 2,566 GPs participated in the cardiovascular risk reduction payments (47,900 patients received a personal action plan). Total expenditures for 2008/09: \$4,928,800.

Mental Health

The Community Mental Health Initiative 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 to warrant the development of a clinical action plan.

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;
- ▶ an assessment of the patient's current psychosocial symptoms/issues by means of psychiatric history, mental status examination, use of appropriate validated assessment tools, with confirmation of diagnosis through DSM IV diagnostic criteria;
- ▶ Develop a specific clinical plan for that patient including linkages with other healthcare professionals and their roles in care, and expected clinical outcomes; and,

- Communication of that plan to the patient and other involved professionals.

The fee requires a face-to-face visit with the patient, with or without the patient's medical representative.

As of March 31, 2009, 1,829 GPs participated in the Mental Health Planning Fee, developing a mental health plan for 49,697 patients (2008/09 total expenditure: \$5,552,900.

In addition, a Mental Health Telephone/E-mail Management Fee is payable for two-way clinical interaction provided between the GP or delegated practice staff (e.g., office registered nurse or medical office assistant) in follow-up of 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 four additional counselling equivalent "Mental Health Management Fees" for these patients over the balance of the calendar year.

The Mental Health Management Fee was billed by 371 GPs for 1,336 patients (2008/09 total expenditure: \$30,150).

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 Physician Master Agreement (Article 5.6) 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 -- \$4,000/biweekly (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.

In 2009, program eligibility policy was modified such that FPs4BC would accept applications from medical graduates coming from other provinces or countries on a temporary license.

Table 3, shows the number of spaces available per health authority, and filled, as of March 31, 2009. Total expenditures 2008/09: \$6,211,719.91.

Table 3: Summary of FPs4BC as of March 31, 2008/09

	Spaces Available	Spaces Filled
Interior Health Authority	16	14
Fraser Health Authority	32	29
Northern Health Authority	8	2
Vancouver Coastal Health Authority	23	15
Vancouver Island Health Authority	16	12

Physicians should be willing to accept new and orphan patients where feasible. The expectation will be determined by the needs of the particular community. Fifty-nine of the GPs funded through FPs4BC are providing obstetrical services.

Shared Care and Scopes of Practice Committee

Per Article 8.1 of the 2006 Agreement, the *Shared Care Committee* (SCC) 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 SCC tabled its recommendations to the GPSC and SSC on March 31, 2009. The SCC used the *Triple Aim* goals as a lens in assessing its recommendations for new models/approaches to shared care and scopes of practice.

Multidisciplinary Care between General Practitioners and Health Care Providers

Per the Physician Master Agreement (Section 5.3(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. The GPSC will be implementing this initiative in 2009/10.

Divisions of Family Practice

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. A GPSC working group conducted a literature review, assessed cross jurisdictional work, and community consultation on the issue – the results indicated that the engaging GPs in hospital work was a multifaceted issue that reflected the complex challenges faced by the many GPs in the province working in isolation of other physicians and community based resources.

Concerns were voiced by GPs during a Province-wide consultation with physicians in 2005 about decreasing professional morale and challenges associated with providing continuous comprehensive care. GPs indicate feeling isolated and unsupported in their community practices, and 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.

In response, the GPSC recommended the province-wide establishment of GP infrastructure in the form of Divisions of Family Practice -- of which re-engaging GPs in hospital care might be one of the Division's priorities based on the local population's health needs.

As well as offering their community extensive and comprehensive primary health care services, Divisions of Family Practice would provide additional services (e.g., in-hospital care in collaboration with the hospital Department of Family Practice; care for the elderly in a residential setting; and provision of clinic settings which care for the more vulnerable populations in their communities and provide services normally only found in emergency departments) through linkage to other community based services.

In 2008/09 three Divisions of Family Practice were implemented on a prototype basis. These Divisions of Family Practice are located in the Fraser Health Authority and the Northern Health Authority. As of March 2009, sixteen additional communities have indicated interest in forming a Division of Family Practice. Funding is available for up to a maximum of four Divisions of Family Practice in each B.C. health authority.

GPSC has allocated \$6 million for infrastructure costs associated with developing Divisions of

Family Practice, and hired an executive lead to oversee the initiative.

Additional funding from the Ministry of Health Services and other types of supports from the Health Authorities have been made available to help collectively address specific gaps in patient care at the community level.

Divisions of Family Practice are significant transformations in family practice. A prototyping process is identifying what works well and should be sustained and adopted, and what does not work and should be discontinued.

GP Non-Compensation Funding

In addition to \$5 million allocated under the 2004 Agreement, an additional \$20 million in one-time funding was allocated under the 2006 Agreement³ 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.

³ An additional \$5 million of unused funding originally allocated under the 2004 Agreement to fund Professional Quality Improvement Days (PQIDS) was used for the Practice Support Program in 2006.

Practice Support Program

The Practice Support Program (PSP) arose from the GPSC response to the 2004/2005 Professional Quality Improvement Days (PQIDs) — a provincial consultation with about 1,000 GPs in BC. The consultation indicated that two issues of great importance to B.C. general practitioners were practice enhancements and system redesign.

In response to these findings, the PSP offered the following modules: chronic disease management, patient self management, advanced access scheduling, and group patient visits.

The training modules (jointly developed by the Ministry of Health Services, B.C. Medical Association, & IMPACT BC) provide family physicians and their medical office assistants with a variety of practical, evidence-based

strategies and tools for managing practice enhancement change.

Since the initiatives implementation in May 2008, the modules have been delivered regionally by Practice Support Teams throughout the province in a series of Continuing Medical Education accredited interactive learning sessions, with in-practice support in the action periods between learning sessions.

As of March 31, 2009, more than 1,200 (approximately one third) of B.C.'s general practitioners, plus their medical office assistants (MOAs), have participated in the Practice Support Program (Table 4). \$15.4 million of the total \$20 million one time funding has been allocated to support the Practice Support Program.

Table 4: Number of Physicians Participating in Practice Support Program Modules, by HA, as of March 31, 2009.

Module	FHA	IHA	NHA	VCHA	VIHA	Total
Practice Self-Assessment (short)	235	216	71	250	224	996
Practice Self-Assessment (long)	84	54	71	108	155	434
Advanced Access	231	99	29	178	150	687
Chronic Disease Management <i>(includes Chronic Disease Management+, a 2008 revision to merge Chronic Disease Management, Patient Self Management and Group Clinical Visits into a single larger module)</i>	34	162	120	253	254	823
Group Medical Visits	43	37	42	68	41	231
Patient Self Management	67	58	9	139	29	302
Mental Health <i>(interest to date)</i>						~800*
Total	375	356	187	570	474	1962**
Total Discrete Physicians	259	252	139	322	311	1283**

Evaluation of Practice Support Program

An external evaluation of the Practice Support Program found that it is already starting to show positive results, for example:

- ▶ For GPs who completed the Advanced Access Learning Module:
 - The average wait time for access for urgent appointments decreased from 1.3 days to 0.4 days;
 - For regular appointments, wait times dropped from an average of 5.8 days to 2.5 days; and,
 - 64% of GPs reported a reduction in their backload of patients.
- ▶ For GPs who completed the Chronic Disease Management (CDM) Learning Module:
 - 89% indicated that the learning module had enabled them to take better care of their patients;
 - 83% indicated that they were better able to identify which patients require CDM; and,
 - 91% had developed a CDM patient registry.
- ▶ For GPs who completed the Self-Management Learning Module:
 - 93% were comfortable helping patients to adopt self-managed care;
 - 93% indicated that they would make self-management an ongoing part of their practice; and,
 - 80% felt that their patients liked self-managed care.
- ▶ For GPs who completed the Group Medical Visits Learning Module:
 - 91% felt that group visits increased patient satisfaction;
 - 87% indicated that they were comfortable conducting group visits; and,
 - 83% felt that satisfaction with their work load had increased.

In 2008/09 a Mental Health Assessment training module was developed under the Practice Support Program to support family GPs in the accurate assessment and diagnosis of patients with mental illness. This module was developed in partnership by a GP Services Committee working group that included psychiatrists, psychologists, family physicians, and the Canadian Mental Health Association.

Train-the-trainer sessions were conducted in March and April 2009, with province-wide roll out of the mental health module slated for June 2009.

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

Community Health Resource Directory (CHARD)

During the GP Services Committee's 2005 PQID consultation with B.C. GPs, the profession identified the need for an up-to-date directory to facilitate patient referral to both specialists and other community-based services.

In 2008/09, the GPSC worked with the Provincial HealthLink BC to build a web-

based *Community Healthcare Resource Directory* (CHARD). The goal of CHARD is to enable health care providers to more efficiently find an appropriate specialist/service, and find specialists/services within a particular geographic location.

CHARD will initially focus on mental health resources; a three month pilot project (ending June 2009) in the Vancouver Island Health Authority is being conducted to inform decision making as to whether CHARD access will be expanded province-wide.

In 2008/09, the GPSC allocated \$1,174,800 funding support for the incremental cost of building and operating CHARD within the mental health and addictions pilot project.

New Initiatives in 2009

The GPSC is developing the following new incentive payments which will become available to GPs in Summer/Fall 2009:

- ▶ The GPSC will be expanding the chronic disease bonus incentive payments to include care plan development for people living with Chronic Obstructive Pulmonary

Disorder (COPD). COPD is a leading driver of emergency room and hospital room admissions in B.C. A chronic disease self management approach directed by health professionals can significantly improve health status and reduce hospital admissions and exacerbation;

- ▶ An End of Life Planning Fee and an End of Life Telephone/E-mail Management Fee will be available to better support GPs in ensuring the best quality of life for dying patients and their families;
- ▶ An Acute Care Discharge Planning Conference Fee will be made available for community GP participation in a discharge planning session at an acute care facility regarding a patient with complex supportive care needs, for review of condition and planning for safe return to the community or transition to a different acute care, supportive care, or long term care facility; and,
- ▶ An initiative supporting multidisciplinary care practice is also slated for implementation in 2009/10.

List of Appendices

Appendix A: GPSC Membership 2008/09

Appendix B: Primary Health Council Membership 2008/09

Appendix C: 2007 Physician Master Agreement – General Practitioners Subsidiary Agreement

Appendix A – GPSC Membership

Dr. William Cavers (BCMA) Co-Chair

Valerie Tregillus (MoHS) Co-Chair

Dr. Jean Clarke (SGP)

Judy Huska (MoHS)

Dr. Garey Mazowita (MoHS)

Nichola Manning (MoHS)

Dr. George Watson (SGP)

Dr. Brian Winsby (BCMA)

Staff Support

Dr. Dan MacCarthy (BCMA)

Dr. Cathy Clelland (SGP)

Angela Micco (MoHS)

Committee Secretariat

Angela Micco (MoHS)

Alternate: Greg Dines (BCMA)

Appendix B: Primary Health Council Committee Guests 2008/09

Carol Gillam, Vancouver Coastal Health Authority

Colleen Hart, Fraser Health Authority

Dr. Dan Horvat, Northern Health Authority

Betty Jeffers, Interior Health Authority

Victoria Power-Pollitt, Vancouver Island Health Authority

Appendix C: 2007 Physician Master Agreement – General Practitioners Subsidiary Agreement

ARTICLE 1 GENERAL PRACTITIONERS SUBSIDIARY AGREEMENT

THIS AGREEMENT made as of the 1st day of November, 2007,
BETWEEN:

**HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE
OF BRITISH COLUMBIA**, as represented by the Minister of Health
(the “**Government**”)

AND:

BRITISH COLUMBIA MEDICAL ASSOCIATION
(the “**BCMA**”)

AND:

MEDICAL SERVICES COMMISSION
(the “**MSC**”)

ARTICLE 2 WITNESSES THAT WHEREAS:

- A. The BCMA, the MSC and the Government entered into the LOA and the ASMA with the intention of negotiating a new agreement structure to consist of a new master agreement to be known as the Physician Master Agreement; and five subsidiary agreements to be known as the General Practitioners Subsidiary Agreement, the Specialists Subsidiary Agreement, the Rural Practice Subsidiary Agreement, the Alternative Payments Subsidiary Agreement, and the Benefits Subsidiary Agreement;
- B. The parties have agreed that this Agreement will constitute the General Practitioners Subsidiary Agreement; and
- C. The parties intend this Agreement to address those matters of unique interest and applicability to General Practitioners.

NOW THEREFORE in consideration of the premises and the agreements of the parties as set out herein, the parties agree as follows:

ARTICLE 3 - RELATIONSHIP TO THE PHYSICIAN MASTER AGREEMENT

- 3.1 This Agreement is one of the Physician Master Subsidiary Agreements under the Physician Master Agreement and is subject to its terms and conditions.

ARTICLE 4 – DEFINITIONS AND INTERPRETATION

- 4.1 Words used in this Agreement that are defined in the Physician Master Agreement have the same meaning as in the Physician Master Agreement unless otherwise defined in this Agreement.
- 4.2 “**this Agreement**” means this document, as amended from time to time as provided herein.
- 4.3 “**Maternity Care Network Initiative Payment**” means the payment that was available between December 3, 2004 and June 30, 2005, through the General Practice Services Committee, to General Practitioners who formed shared care maternity networks in accordance with eligibility criteria established by the General Practice Services Committee.
- 4.4 “**Physician Master Agreement**” means the agreement titled “Physician Master Agreement” between the Government, the BCMA and the MSC, dated November 1, 2007.
- 4.5 “**13050 CDM Incentive Payment**” means the payment available, in accordance with guidelines and criteria set out by the General Practice Services Committee, for the provision of guideline based chronic care for patients with diabetes or congestive heart failure.
- 4.6 The provisions of sections 1.2 to 1.8 inclusive of the Physician Master Agreement are hereby incorporated into this Agreement and shall have effect as if expressly set out in this Agreement, except those references in such sections to “this Agreement” shall herein be construed to mean this Agreement.

ARTICLE 5 - TERM

- 5.1 This Agreement comes into force on November 1, 2007.
- 5.2 This Agreement shall be for the same term as the Physician Master Agreement and will be subject to renegotiation and/or termination pursuant to Articles 27 and 28 of the Physician Master Agreement.

ARTICLE 6 - GENERAL PRACTICE SERVICES COMMITTEE

- 6.1 The parties agree that full service family practice must be encouraged and supported.
- 6.2 The General Practice Services Committee shall continue under this Agreement as a vehicle for representatives of the Government, the BCMA and the Society of General Practitioners to work together on matters affecting the provision of services by General Practitioners in British Columbia, including ways of providing incentives for General Practitioners to provide full service family practice.

- 6.3 The General Practice Services Committee shall be composed of four members appointed by the Government and four members appointed by the BCMA.
- 6.4 The General Practice Services Committee shall be co-chaired by a member chosen by the Government members and a member chosen by the BCMA members.
- 6.5 Decisions of the General Practice Services Committee shall be by consensus decision.
- 6.6 If the General Practice Services Committee cannot reach a consensus decision on any matter it is required to determine, the Government and/or the BCMA may make recommendations to the MSC and the MSC, or its successor, will determine the matter.
- 6.7 On an annual basis, the General Practice Services Committee 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 Physician Services Committee.
- 6.8 The costs of administrative and clerical support required for the work of the General Practice Services Committee and physician (other than employees of the Government, BCMA and Health Authorities) participation in the General Practice Services Committee, will be paid from the funds to be allocated by the General Practice Services Committee pursuant to this Agreement.

ARTICLE 7 - FULL SERVICE FAMILY PRACTICE FUNDING

- 7.1 The General Practice Services Committee 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:
 - (a) \$55 million made available effective April 1, 2006;
 - (b) an additional \$20 million made available effective April 1, 2007;
 - (c) an additional \$25.5 million to be made available effective April 1, 2008; and
 - (d) an additional \$31 million to be made available effective April 1, 2009,

such increases to be allocated by the General Practice Services Committee to the areas identified in sections 5.2(a), 5.3 and 5.4 or to any other areas that may be determined by the General Practice Services Committee.

7.2 The priorities for the allocation of the funds referred to in section 5.1(a) 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;have received a one time payment of \$2500. This payment was to 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 5.1(a);
- (ii) 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 5.2(a)(iii) 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;have received a one time payment of \$7500 (approximately \$25 million expenditure);
- (iii) effective April 1, 2006, the 13050 CDM Incentive Payment was increased to an annual amount of \$125 per patient. In addition, a new incentive payment was 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 General Practice Services Committee;
- (iv) effective April 1, 2006, a facility patient conference fee and a community patient conference fee have been implemented, in accordance with guidelines and criteria set out by the General Practice Services Committee, 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;

- (v) any of the funds referred to in section 5.1(a) 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 5.2(a)(iii) 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.
- (a) Physicians who are compensated through a Service Contract, Sessional Contract or Salary Agreement, and who have provided the services identified in sections 5.2(a)(i), 5.2(a)(ii) and/or 5.2(a)(v), will be eligible to receive the one time payments identified in those sections in addition to their service, sessional or salary payments.

7.3 Commencing April 1, 2007, the General Practice Services Committee will use the funds then available to it pursuant to section 5.1 as follows:

- (a) the payments referred to in section 5.2(a)(iii) and 5.2(a)(iv) will continue;
- (b) five percent (5%) of the funds will be allocated by the General Practice Services Committee 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 General Practice Services Committee 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 Payment Schedule) for patients with two or more chronic diseases, including:
 - (i) asthma;
 - (ii) chronic obstructive pulmonary disease (emphysema and chronic bronchitis);
 - (iii) diabetes mellitus (type 1 or 2);
 - (iv) cerebral vascular disease;
 - (v) ischemic heart disease (excluding acute phase of myocardio infarct);

- (vi) chronic renal failure with GFR (glomerular filtration rate) less than 60; and
- (vii) 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 healthcare providers for multidisciplinary care;
- (e) the General Practice Services Committee 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 healthcare providers.

7.4 Any funds identified in sections 5.1(b), 5.1(c) and 5.1(d) that remain unexpended for services rendered in a Fiscal Year will be available to the General Practice Services Committee in the subsequent Fiscal Year for use as one time allocations in that subsequent Fiscal Year.

7.5 The General Practice Services Committee 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 General Practice Services Committee 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 In addition to the funds referred to in section 5.1, the Government has provided one time funding of \$10 million to be used by the General Practice Services Committee to attract and retain additional recently qualified physicians in full service family practice in those areas

of the province where the General Practice Services Committee 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 ten 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 General Practice Services Committee determines that there is a demonstrated need for additional full service family practitioners, the General Practice Services Committee will have discretion to provide funds to General Practitioners with more than ten years of practice since licensure if the General Practice Services Committee believes doing so will attract and retain full service family practitioners on a long term basis in such areas of the province.

- (a) The General Practice Services Committee may use the funds referred to in section 5.6(a), in accordance with specific guidelines and policies established by the General Practice Services Committee, to provide to eligible physicians:
 - (i) repayment of the physician's student loan debt of up to \$40,000 per physician, upon provision of proof of student loan debt acceptable to the General Practice Services Committee;
 - (ii) support of up to \$40,000 per physician toward the costs of establishing a new, or joining an existing, full service family practice group, upon provision of receipts acceptable to the General Practice Services Committee (support for solo practices may be considered for remote rural areas);
 - (iii) a supplement of up to \$2000 per week per physician for up to the first 26 weeks of practice, while the physician builds up a patient base in their full service family practice, and/or
 - (iv) a signing bonus of \$1500 per physician, if the physician obtains full hospital privileges;

provided that:

- (v) the total financial support to be made available to any individual physician pursuant to subsections (i) to (iii) inclusive may not exceed \$100,000; and
- (vi) eligibility for the support referred to in subsections (i) to (iv) inclusive is subject to the signing of an agreement between the eligible physician and the Government that requires the physician to, among other things

as required by the General Practice Services Committee, provide three years of full service family practice in the community in issue or repay a proportional amount of any support received.

7.7 One time non-compensation support for full service family practice, in the amount of \$20 million, has been provided by the Government for primary care renewal. This funding will be used to support the achievement of the General Practice Services Committee priorities referred to in section 5.3(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.

ARTICLE 8 - SUPPORT FOR MATERNITY CARE BY GENERAL PRACTITIONERS

8.1 In addition to the funding set out in section 5.1, effective April 1, 2006, the Government will provide \$5 million annually to be used to reinstate and support the Maternity Care Network Initiative Payment.

ARTICLE 9 - DOCTOR OF THE DAY

- 9.1 The need for a Doctor of the Day will be determined by the Health Authorities.
- 9.2 A Doctor of the Day will be compensated at the rate of \$400 per twenty-four hours of coverage.
- 9.3 Where there is a requirement for less than twenty-four hours of coverage, an appropriate rate based upon the twenty-four hour rate shall be determined at the local level.
- 9.4 Funding for Doctor of the Day will be allocated from the annual MOCAP budget of \$126.4 million over the term of this Agreement.

ARTICLE 10 - DISPUTE RESOLUTION

10.1 Disputes as to the interpretation, application, operation or alleged breach of this Agreement are Provincial Disputes and will be resolved in accordance with the provisions of Articles 21, 22 and 23 of the Physician Master Agreement applicable to Provincial Disputes.