



General Practice Services Committee

General Practice Services Committee

...Improving primary care in British Columbia



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MANDATE

The General Practice Services Committee (GPSC) was originally established under the Ministry of Health Services (MoHS)/BC Medical Association (BCMA) subsidiary agreement for General Practitioners (GPs), November 2002 with the mandate of finding solutions to support and sustain full-service family practice in BC.

This mandate was renewed under both the 2004 MoHS/BCMA Working Agreement, and the MoHS/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. Under the April 2009 memorandum of agreement, GPSC funding was increased by an additional \$64 million over two years for total funding of \$799 million since the GPSC's establishment in 2004/05.¹

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.
8. Multidisciplinary care between general practitioners and health care providers.

Identification of GPSC priorities was guided by feedback obtained from its 2004/05 province-wide consultation with BC 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 BC.

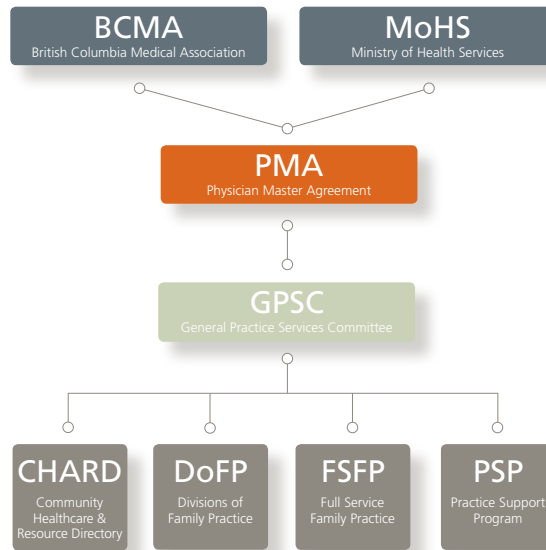
Organizational Structure

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

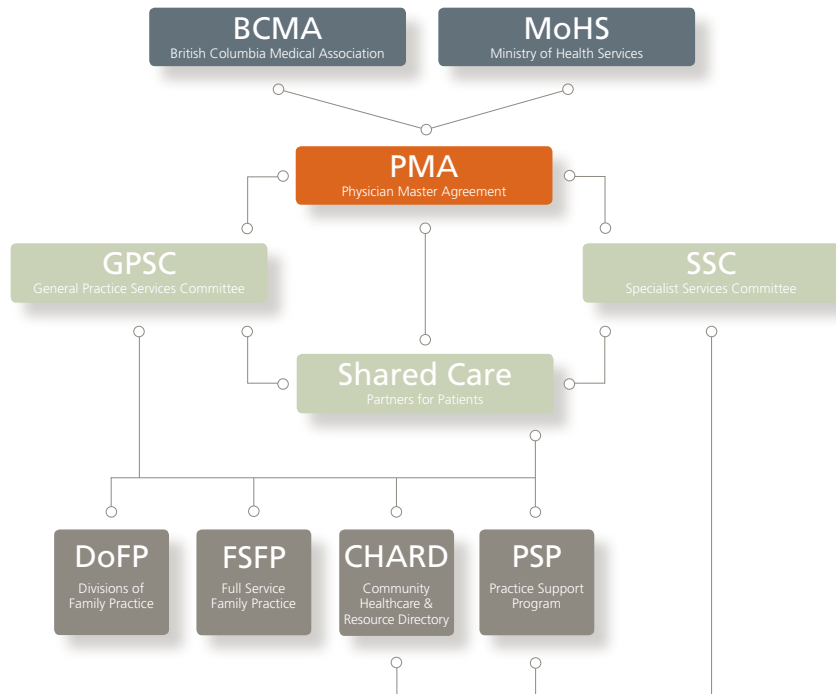
¹ The April 2009 memorandum of agreement, increased GPSC funding per the following two allocations:

- April 1, 2010: \$20 million per year
- April 1, 2011: an additional \$24 million per year

GENERAL PRACTICE SERVICES COMMITTEE



PHYSICIAN MASTER AGREEMENT



All decisions of the GPSC are made by consensus.

To inform decision making:

- 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 needed (see Table 1).
- The BC Primary Health Care Council's primary health care leads participate in GPSC meetings as guests in order to provide the health authority perspective to GPSC deliberations.
- Starting in 2009, the director of the MoHS, Patients as Partners portfolio began attending GPSC meetings in order to support the GPSC's commitment to obtaining the patient perspective on various aspects of its work through the Patient Voices Network. The network is a new Impact BC initiative funded by MoHS and designed to create mechanisms to enable patients, their families, and members of the community to inform, and participate in, primary health and community care changes.
- The GPSC uses the Institute for Health 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:
 1. The model/approach positively impacts the experience of the individual (i.e., the individual can receive exactly the care he/she wants and needs exactly how he/she wants and needs it) and the health-care professional providing those services.
 2. The model/approach impacts positively the health (physical and mental) of a defined population.
 3. The per capita cost of the model/approach has a positive effect on health care cost/spending.

For more information on the GPSC, visit www.gpsc.bc.ca.

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 (Victoria, BC) was awarded a \$500,000 contract to evaluate the Full Service Family Practice Incentive Program and the Practice Support Program. The evaluation was completed on June 30, 2009.

Per the conditions of the original request for proposal for evaluation services, the evaluation contract was extended to March 31, 2011 in order to address specific evaluation questions in greater depth. The contract extension totalled \$500,000.

The key findings of the June 30, 2010 evaluation report for the Full Service Family Practice Incentive Program are as follows:

The Practice Support Program (PSP)

The PSP learning modules have been quite successful. For example:

- The time to get a regular appointment was reduced from 5.8 days to 2.4 days for GPs who completed the advanced access learning module.
- 89% of GPs who completed the chronic disease management learning module agreed that it had enabled them to take better care of their patients with chronic diseases.

- 93% of GPs who completed the patient self-management learning module agreed that they were comfortable helping patients to adopt self-managed care.
- 87% of GPs who completed the group medical visits learning module agreed that they were comfortable conducting group visits.

Incentive Payments

It appears that GPs who actively use incentive payments increase their proportion of majority source of care (MSOC) patients over time. A MSOC patient is one who receives at least three services in one year, and who receives at least 50% of their services from one GP. Thus, incentive payments may serve to increase the proportion of people who have a high attachment to practice, over time.

Data extrapolation for complex, high-need patients with diabetes and congestive heart failure (CHF) for fiscal year 2007/08 indicated that an overall increase in attachment of unattached patients to a GP of just 5% could potentially result in cost avoidance of approximately \$85 million.

As of 2007/08, the overall uptake of incentive payments for GPs with at least 50 MSOC patients was 92%. The uptake for chronic disease management incentives was 87.5%.

For diabetes, congestive heart failure, and hypertension patients with higher-care needs, annual costs, standardized by age and gender, were lower for patients who had received incentive-based care than those whose GP had not participated in the incentive payments.

For the obstetric bonuses, the evaluation indicated that even though the number of general practitioners providing normal deliveries continues to decline, those general practitioners with obstetrical privileges are providing more services per practitioner.

Key Findings from the Evaluation Interviews and Surveys

Interviews were conducted with key opinion leaders about their perceptions of the incentive payments. They indicated the following:

- The chronic disease management incentive payments have encouraged physicians to take on patients with complicated conditions and provide better and more proactive care.
- The complex care incentive payments have encouraged physicians to:
 - o Be more proactive.
 - o Pay more attention to how often they see patients with certain types of conditions.
 - o Pay more attention to why and how frequently they order various tests.
 - o Look at lab results more closely.
 - o Identify more patients who fit the billing criteria.
- The mental health incentive payments may have encouraged some physicians to take on mental health patients, and some physicians may be spending more time doing planned care.
- The maternity care incentive payments have encouraged many family physicians to stay in obstetrics. The payments may have more of an impact in urban settings than in rural or remote settings.

Surveys of GPs

GPs were divided into high, medium, and low billers of incentive payments. High billers generally responded that incentives had:

- Increased their income.
- Improved the quality of care they could provide.
- Increased their professional satisfaction.

Survey of Patients

Patients were generally satisfied with the care they received from their GP.

Barriers to access noted by patients included:

- Long wait times to see their GP.
- Travel distance (in rural areas).
- Out-of-pocket costs (for chronic disease management and complex care patients).

Mental health patients generally rated most aspects of their office visits lower than other patients.

Survey of Family Practice Residents

Seventy percent of residents indicated that they were planning to go into full-service family practice.

One-third of the surveyed residents indicated that they were not familiar with the work of the GPSC. However, residents were interested in learning more about GPSC.

2009 BC Medical Association Survey of General Practitioners

The BC Medical Association hired Ipsos Reid to conduct a survey on its overall performance and included questions about GPSC initiatives. Survey results indicated that:

- 95% of GP respondents support the activities of GPSC, with 71% strongly supportive.
- 79% of respondents used GPSC initiatives.
- 80% indicated that GPSC initiatives have improved their professional satisfaction; this improvement is up 14% from two years ago.
- 61% had participated in the Practice Support Program; 69% indicated their experience with the Practice Support Program was positive.
- 86% of respondents supported the continuation of the Practice Support Program.

PROGRAM UPTAKE AND EXPENDITURES – 2009/10² FULL SERVICE FAMILY PRACTICE INCENTIVE PROGRAM

A summary of the incentive payments, their implementation date, and fee modifications can be found in Table 1.

Table 1. Full Service Family Practice Incentive Program.

Implementation Date	Incentive Payment
September 2003	<ul style="list-style-type: none"> Annual condition-based payment for diabetes and congestive heart failure management informed by BC Clinical Guidelines recommendations (fee item 13050 initially then in 2006 renumbered 14050 & 14051). General practitioner obstetrical premium (fee item 14000 initially then renumbered in 2006, 14004, 14008, 14009).
April 2006	<ul style="list-style-type: none"> Annual condition-based payment for hypertension management informed by BC Clinical Guidelines 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	<ul style="list-style-type: none"> Complex care payment: Introduced as option 1 and 2 (fee items 14030, 14031, 14032, 14033, 135/36/37/38).
June 2007	<ul style="list-style-type: none"> Family Physicians for BC (FPs4BC) Program.
January 2008	<ul style="list-style-type: none"> Complex care option 1 and 2 discontinued and replaced with single complex care management fee (G14033) and complex care email/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 BC (MC4BC) Program. Cardiovascular risk assessment fee (fee item 14034).
June 1, 2009	<ul style="list-style-type: none"> Acute care discharge planning conference fee (G14017) introduced. Palliative care planning fee (fee item G14063) and palliative care telephone/email follow-up management fee (fee item G14069) introduced.
September 15, 2009	<ul style="list-style-type: none"> Chronic disease management fees expanded to include chronic obstructive pulmonary disease (fee item G14053) and chronic obstructive pulmonary disease telephone/email follow-up fee (fee item G14073).
December 31, 2009	<ul style="list-style-type: none"> Maternity care network incentive payment increased to \$2100 per quarter.
January 1, 2010	<ul style="list-style-type: none"> Complex care payment: Eligibility expanded to patients with chronic liver disease and neurodegenerative disorders. Chronic obstructive pulmonary disorder and chronic asthma combined with additional diagnoses into a single chronic respiratory conditions category.

² Data Source: MSP budget report-GPSC-as of July 15 2010, Divisional Strategic Implementation & Analysis, Medical Services Division.

Chronic Disease Management

Since April 1, 2006, BC'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 BC Clinical Guidelines recommendations. An annual \$50 payment is available to better support GPs for the management of hypertension according to BC Clinical Guidelines recommendations for those patients who do not also have diabetes or congestive heart failure.

In September 2009, a new condition-based payment valued at \$125 per year was introduced to support enhanced management of chronic obstructive pulmonary disease (COPD). This incentive payment requires the development of a COPD action plan to assist patients in managing their COPD exacerbations and includes a telephone/email following up management fee.

Table 2 shows the number of GPs who participated in the condition-based payments in 2009/10, and the number of patients who received care in accordance with the BC Clinical Guidelines recommendations.

Table 2. Summary of Condition-based Payments for 2009/10.

	GP Participation	Number of Patients	2009/10 Expenditures
Diabetes	3,041	160,548	\$20,072,275
Congestive Heart Failure	2,043	20,021	\$2,502,625
Hypertension	2,896	248,536	\$12,428,450
COPD*	1,817	27,678	\$3,459,875
COPD* Telephone/Email Follow-up	72	110	\$1,950

**The COPD management and COPD telephone/email follow-up fees were introduced in September 2009.*

The Patients Voices Network feedback provided recommendations on how the complex care plan and the hypertension flow sheet could be modified to provide the best information that is useful to patients in helping them manage their condition. The GPSC is studying these recommendations.

Maternity Care

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

The obstetric premium provides a 50% bonus on delivery fee items 14104, 14105, 14108 and 14109. In 2009/10, 585 GPs participated in the obstetric premium, providing maternity care to 13,125 women in their communities (2009/10 expenditure: \$3,580,876).

The maternity care network payment helps support group/network activities for shared care of obstetric patients. The maternity care network payment provides \$2,100 per quarter to each GP participating in a formal group practice approach to maternity care provision.

In 2009/10, 118 networks were registered to receive the maternity care network payment; 656 GPs participated in the network payment (2009/10 expenditure: \$4,672,200).

In an 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 BC 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 a community/regional/referral 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, 2010, 23 GPs have participated in this program; 11 graduated from the program and are providing maternity care in their community (2009/10 expenditure: \$24,407.35).

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

The following fees are available 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 (14016) 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 (14015) is to better support GPs in working with patients as partners, other health care providers, and patients' family members in the review and management of patients in a facility.

In June 2009 an acute care discharge planning conferencing fee was introduced to support the community-based family physician in participating in a discharge planning conference regarding a patient with complex supportive care needs, for review of condition(s), and planning for safe transition to the community, to a different facility, another acute care facility, or a supportive care or long-term care facility. The discharge planning conference may be requested by the acute care facility or by the community family physician.

Also in June 2009, the GPSC made available a palliative care planning fee to support family physicians in taking the time needed to develop a care plan that has worked through the various decisions and plans needed to ensure the best quality of life for dying patients and their families. A palliative care telephone/email follow-up fee is also available for clinical follow-up management.

Table 3. Summary of Patient Conferencing Payments for 2009/10.

	GP Participation	Number of Patients	2009/10 Expenditures
Community Patient Conferencing Fee	1,581	14,071	\$1,046,480
Facility Patient Conferencing Fee	985	8,004	\$737,520
Acute Care Discharge Planning Fee*	290	1,006	\$72,160
Palliative Care Planning Fee	660	1,737	\$184,100
Palliative Care Telephone/Email management follow-up fee	272	410	\$12,330

*Acute care discharge planning fee and the palliative care fees were introduced in June 2009.

Patients with Complex Care Needs

A complex care fee is available to better support GPs for the care of their high-risk patients with two or more of the following eight (8) chronic illnesses/categories:

1. Diabetes mellitus (type 1 or 2).
2. Chronic renal failure with eGFR values less than 60.
3. Congestive heart failure.
4. Chronic respiratory condition (asthma, COPD, emphysema, chronic bronchitis, bronchiectasis, pulmonary fibrosis, fibrosing alveolitis, cystic fibrosis, etc.).
5. Cerebrovascular disease.
6. Ischemic heart disease, excluding the acute phase of myocardial infarct.
7. Chronic neurodegenerative diseases (multiple sclerosis, amyotrophic lateral sclerosis, Parkinson's disease, Alzheimer's disease, stroke or other brain injury with a permanent neurological deficit, paraplegia or quadriplegia, etc.).
8. Chronic liver disease with evidence of hepatic dysfunction.

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 2009/10, 2,599 GPs billed the annual complex care fee (14033) for 115,086 patients (total expenditure for 2009/10: \$41,529,638).

In addition, a \$15 complex care email/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 email communications for two-way discussion of clinical issues.

As of March 31, 2010, 754 GPs used this fee for follow up on 7,199 patients (2009/10 expenditure: \$172,228).

Prevention

The 2007 Physician Master Agreement earmarked 5% of the annual budget allocated for Full Service Family Practice for the development and implementation of evidence-based prevention activities.

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 determined 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.
- Approaches to enable the patient to understand and be an active partner in defining and achieving his/her key clinical and personal goals to reduce the major risk factors.

As of March 31, 2010, 2,707 GPs participated in the cardiovascular risk reduction payments (64,559 patients received a personal action plan). Total expenditures for 2009/10: \$6,455,912.

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 the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* criteria and with a 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.

And to:

- Develop a specific clinical plan for the patient that outlines linkages with other health care professionals and their roles in care, and expected clinical outcomes.
- Communicate 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, 2010, 2,081 GPs participated in the mental health planning fee, developing a mental health plan for 65,701 patients (2009/10 total expenditure: \$6,570,186).

In addition, a mental health telephone/email 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, after creating and successfully billing for a mental health plan, GPs are able to access up to 4 additional counselling equivalent mental health management fees for these patients over the balance of the calendar year.

The mental health telephone/email management fee was billed by 455 GPs for 3,011 patients (2009/10 total expenditure: \$45,171).

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/bi-weekly (maximum \$52,000).
4. A bonus of \$1,500 (on top of \$100,000) will be provided if physician obtains full hospital privileges.
5. 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.

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 per health authority as of March 31, 2010. Total expenditures 2009/10: \$1,435,923.47.

Table 4. Summary of FPs4BC as of March 31, 2010.

	Spaces Available	Spaces Filled
Interior Health Authority	17	16
Fraser Health Authority	33	31
Northern Health Authority	9	3
Vancouver Coastal Health Authority	24	23
Vancouver Island Health Authority	17	15

Physicians should be willing to accept new patients where feasible. The expectation will be determined by the needs of the particular community. Seventy-five 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. 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.

In 2009/10, the Shared Care Committee made the following allocations:

1. \$500,000 for prototyping improved patient access to specialist knowledge/advice and care and more effective GP/specialist communication and referrals.
2. \$200,000 for specialist participation in the Practice Support Program (PSP) mental health module.
3. \$400,000 for specialist participation in the PSP chronic obstructive pulmonary disease shared care module (the GPSC allocated \$600,000 toward development and delivery of this module).
4. Up to \$250,000 to prototype through a Division (GPs and specialists) medication review for CDM/complex patients over 70 years of age.

The GPSC has earmarked \$2.5 million annually to support shared care initiatives, commencing 2010/11.

Divisions of Family Practice

BC's GPs have voiced concern 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. Community infrastructure is needed to support GPs who wish to work together to provide the best possible patient care and achieve improved professional satisfaction.

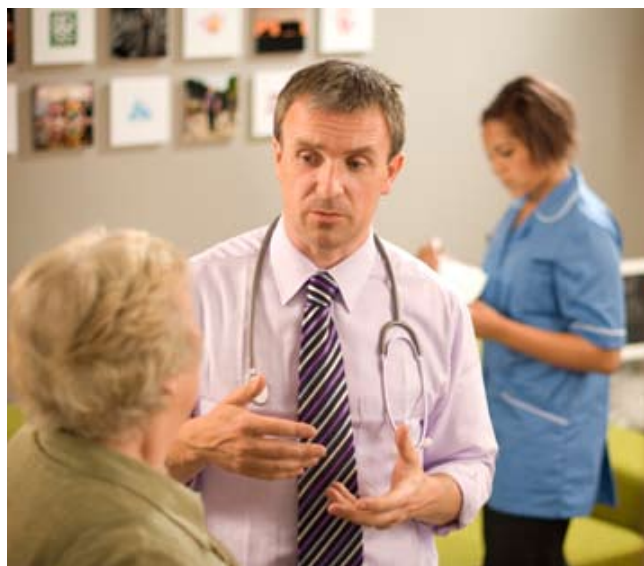
In response, the GPSC is leading the province-wide establishment of Divisions of Family Practice. As well as offering their community extensive and comprehensive primary health care services, Divisions of Family Practice may provide additional services (e.g., in-hospital care in collaboration

with the hospital department of family practice, care for the elderly in a residential setting, and provision of clinic settings that 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.

Initially, GPSC allocated \$6 million annually for infrastructure costs associated with developing Divisions of Family Practice. This amount was increased to \$9 million for 2010/11 and \$12 million in 2011/12. 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.

As of March 31, 2010, nine incorporated Divisions of Family Practice were fully underway (Prince George, Chilliwack, Abbotsford, Surrey/White Rock, Cowichan Valley, Mission, North Shore, Thompson Region, South Okanagan/Similkameen) and twenty more were at various stages of development.

For more information on Divisions of Family Practice, visit www.divisionsbc.ca



Attachment Initiative

The GPSC's external evaluation of its initiatives by Hollander Analytical Services found that British Columbians who are attached to a family doctor cost the health system considerably less than patients who do not have a regular family physician, especially those patients with several chronic diseases. Data extrapolation for high-need diabetes and congestive heart failure patients for fiscal year 2007/08 indicates that an overall increase in attachment of just 5% could potentially result in cost avoidance of approximately \$85 million.

The international literature indicates that patients who are attached to a particular family doctor receive:

- More appropriate preventive care.
- Fewer diagnostic tests.
- Fewer prescriptions.
- Fewer hospitalizations.
- Fewer visits to ER.
- Enhanced patient experience of care.
- Enhanced support from BC residents for the health care system.

And they:

- Are more likely to receive accurate diagnosis.
- Have lower costs of care.

In response, the GPSC is developing an attachment initiative that will work to ensure that every British Columbian who wants one will have access to his/her own family physician. GPSC will provide per patient funding to a Division of Family Practice to support access to full-service family practice, with particular focus in the initial stages on attachment of people with mental health and substance use problems, those in home and community care, First Nations and other populations who live in remote communities. In 2009/10, \$8 million (plus an additional \$1 million in both the 2010/11 and 2011/12 fiscal years) was allocated to this initiative by GPSC.

In order to help build GP practice capacity for patient attachment, GPSC has requested a change to the Physician Master Agreement Section 5.3(d), as follows:

(Multidisciplinary care between GPs and health care providers) to be amended such that the annual \$5.5 million budget will be allocated to the attachment initiative for provision of multidisciplinary care.

GPSC has also allocated additional one-time funding of \$18.5 million for a total available fund for the attachment initiative of \$44 million to March 31, 2012.

On March 25, 2010, GPSC hosted a one-day meeting to introduce the initiative concepts and invite feedback. Participants included GPs from BC Divisions of Family Practice, health authorities, MoHS, non-governmental organizations, and patient representatives.

Feedback from the participants indicated considerable excitement and enthusiasm for this initiative. The GPSC has hired an executive lead and began prototyping the attachment initiative in 2009/10.

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 Agreement to support primary health care renewal in the following specific priority areas:

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

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 BC general practitioners were practice enhancements and system redesign.

In response to these findings, the PSP offered the following modules beginning in June 2007: chronic disease management, patient self-management, advanced access scheduling, and group medical visits. Participation of many MOAs in selected parts of the mental health module has led to a better understanding and awareness of mental health issues. Consequently, MOA interactions with this patient group are more proactive.

In June 2009, an additional module on adult mental health was launched. GPSC has also approved the development of additional modules on end-of-life care, shared care with a focus on COPD, and child and youth mental health.

The training modules 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 initiative's implementation, the modules have been delivered regionally by regional support teams throughout the province in a series of accredited interactive learning sessions, with in-practice support in the action periods between learning sessions.

As of March 31, 2010, 1,549 (approximately half) of BC's active general practitioners, plus their medical office assistants (MOAs), have participated in the Practice Support Program (Table 5).

In 2009/10 the GPSC approved a one-time allocation of \$1 million for an eighteen-month initiative to design and test, through the PSP, how musculoskeletal pain and problems can be diagnosed and managed by GPs in real-time primary health care practice.

Total additional funds allocated to PSP in 2009/10 were \$9.4 million.

More information on the Practice Support Program can be found at www.gpsc.bc.ca/psp/practice-support-program.

Table 5. Summary of FPs4BC as of March 31, 2010.

Module	FHA	IHA	NHA	VCHA	VIHA	Total
Advanced Access	241	116	50	170	179	756
Chronic Disease Management	70	193	173	245	250	931
Group Medical Visits	43	74	66	68	41	292
Patient Self-management	64	70	24	132	29	319
Mental Health	148	132	115	158	132	685
Total number of physicians who have participated in a module	566	585	428	773	631	2983
Total discrete physicians participating	283	326	185	393	371	1549
Practice Self-Assessment Questionnaires	FHA	IHA	NHA	VCHA	VIHA	Total
Practice Self-Assessment (short)	246	225	76	252	229	1028
Practice Self-Assessment (long)	93	66	36	112	164	471

Community Healthcare and Resource Directory (CHARD)

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

The GPSC worked with the provincial HealthLink BC to build a web-based Community Healthcare and Resource Directory (CHARD). The goal of the CHARD is to enable health care providers to more efficiently find an appropriate specialist/service, and find specialists/services within a particular geographic location.

In 2009/10 the CHARD focused on mental health and addictions resources. A three-month pilot project (ending June 2009) in the Vancouver Island Health Authority found it to be highly useful, leading to the expanded access to the CHARD by GP practices province-wide.

Next steps for the CHARD are to expand its database to include information on chronic obstructive pulmonary disease and end-of-life, as well as specialists' information within a specific geographic region.

Patients as Partners

The BC Primary Health Care Charter sets the direction, targets, and outcomes to support a strong, sustainable, accessible, and effective primary health care system. Ensuring patients are full participants in their care is the central premise of the Charter, and Patients as Partners is the basic philosophy because:

- Personal decisions and behaviours account for approximately 40% of health status. Therefore, preventing lifestyle-related diseases not only requires effective policies and programs but also citizens accepting and engaging with them as societal norms of behaviours.
- People living with chronic disease and complex conditions spend on average only eight hours a year with health professionals; the remaining time they are alone in making decisions that directly impact their health. Individuals require support to develop the knowledge and skills to self-manage their health care and become partners in their own health.
- Informal family care represents over 75% of the total care effort; this care is often dependent on the voluntary and community sector to meet care needs.
- The costs of potential technical advances and increased demand for health and social care are likely to surpass available resources, making it an important policy principle to involve and empower citizens to achieve the highest possible level of health and to help shape health priorities and policies.

In recognition of the importance of supporting patient voice, choice, and representation, the GPSC allocated \$900,000 (\$450,000 annual in 2009/10 and 2010/2011) to support Patients as Partners initiatives.

In 2009/10, the GPSC pilot tested How's Your Health, a web-based survey for patients in which a patient receives a summary of findings plus a list of sources for further information about his or her own health information after answering a number of basic health questions.

The pilot test is assessing the impact of this resource on improving office visit communication, efficiency, and effectiveness.

LIST OF APPENDICES

Appendix A: GPSC Membership 2009/10

Appendix B: Primary Health Council Membership 2009/10

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

Appendix A: GPSC Membership

Dr. William Cavers (BCMA) Co-Chair

Ms. Valerie Tregillus (MoHS) Co-Chair

Dr. Jean Clarke (BCMA-SGP)

Ms. Judy Huska (MoHS)

Dr. Garey Mazowita (MoHS)

Ms. Nichola Manning (MoHS)

Dr. George Watson (BCMA-SGP)

Dr. Brian Winsby (BCMA)

Staff Support

Dr. Dan MacCarthy (BCMA)

Dr. Cathy Clelland (SGP)

Ms. Angela Micco (MoHS)

Committee Secretariat

Ms. Angela Micco (MoHS)

Alternate: Mr. Greg Dines (BCMA)

Appendix B: Primary Health Council Membership 2009/10

Primary Health Council Committee Guests 2009/10

Ms. Carole Gillam, Vancouver Coastal Health Authority

Ms. Dianne Miller, Fraser Health Authority

Ms. Gayle Anton, Northern Health Authority

Ms. Betty Jeffers, Interior Health Authority

Ms. Victoria Power, Vancouver Island Health Authority

Patients As Partners Committee Guest 2009/10

Ms. Kelly McQuillen, Director, Patients as Partners, B.C. Ministry of Health Services

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

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”)

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 1 – RELATIONSHIP TO THE PHYSICIAN MASTER AGREEMENT

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

ARTICLE 2 – DEFINITIONS AND INTERPRETATION

- 2.1 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.
- 2.2 “**this Agreement**” means this document, as amended from time to time as provided herein.

- 2.3 “**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.
- 2.4 “**Physician Master Agreement**” means the agreement titled “Physician Master Agreement” between the Government, the BCMA and the MSC, dated November 1, 2007.
- 2.5 “**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.
- 2.6 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 3 – TERM

- 3.1 This Agreement comes into force on November 1, 2007.
- 3.2 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 4 – GENERAL PRACTICE SERVICES COMMITTEE

- 4.1 The parties agree that full service family practice must be encouraged and supported.
- 4.2 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.
- 4.3 The General Practice Services Committee shall be composed of four members appointed by the Government and four members appointed by the BCMA.
- 4.4 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.
- 4.5 Decisions of the General Practice Services Committee shall be by consensus decision.
- 4.6 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.
- 4.7 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.
- 4.8 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 5 – FULL SERVICE FAMILY PRACTICE FUNDING

- 5.1 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.
- 5.2 (a) 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.
 - (b) 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.
- 5.3 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.
- 5.4 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.
- 5.5 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.
- 5.6 (a) 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.
- (b) 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.
- 5.7 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 multidisciplinary 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 6 – SUPPORT FOR MATERNITY CARE BY GENERAL PRACTITIONERS

- 6.1 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 7 – DOCTOR OF THE DAY

- 7.1 The need for a Doctor of the Day will be determined by the Health Authorities.
- 7.2 A Doctor of the Day will be compensated at the rate of \$400 per twenty-four hours of coverage.
- 7.3 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.
- 7.4 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 8 – DISPUTE RESOLUTION

- 8.1 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.