General Practice Services Committee

Annual Report 2010/11

BRITISH COLUMBIA

BCMA
BRITISH COLUMBIA MEDICAL ASSOCIATION

GENERAL PRACTICE SERVICES COMMITTEE ANNUAL REPORT 2010/11

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 BC.

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 4 years was allocated to address the following eight priority areas:

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

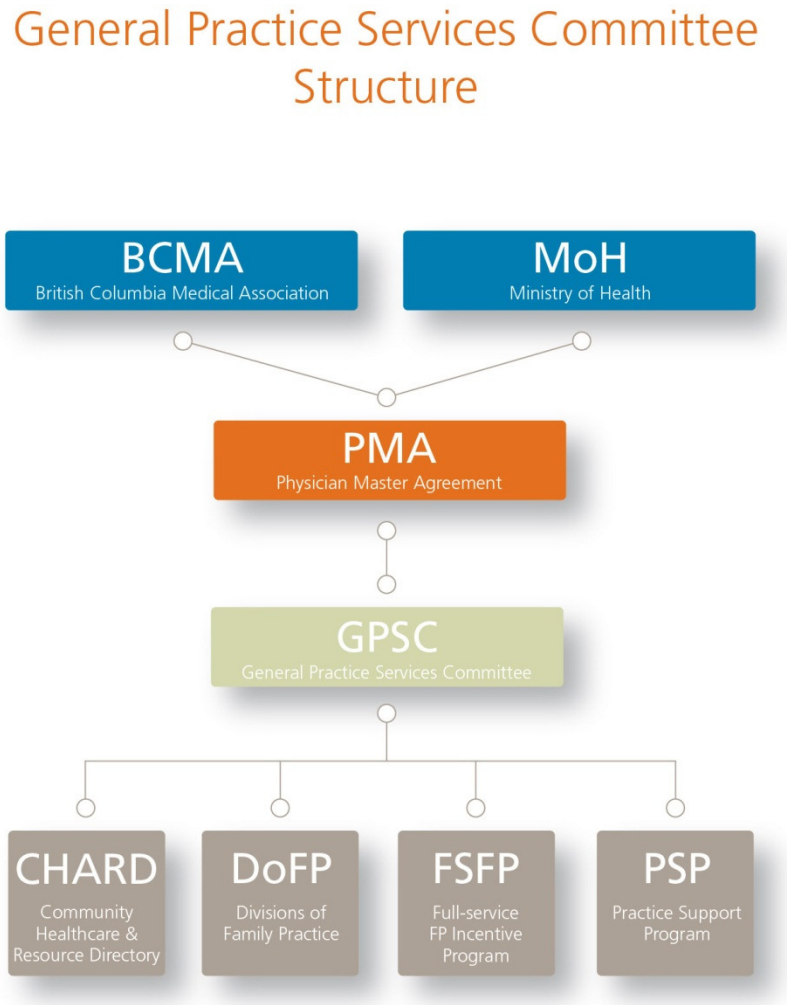
Under the April 2009 Memorandum of Agreement, GPSC funding was increased by an additional $64 million over 2 years for total funding of $799 million since the GPSC's establishment in 2004/05.[1]

[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

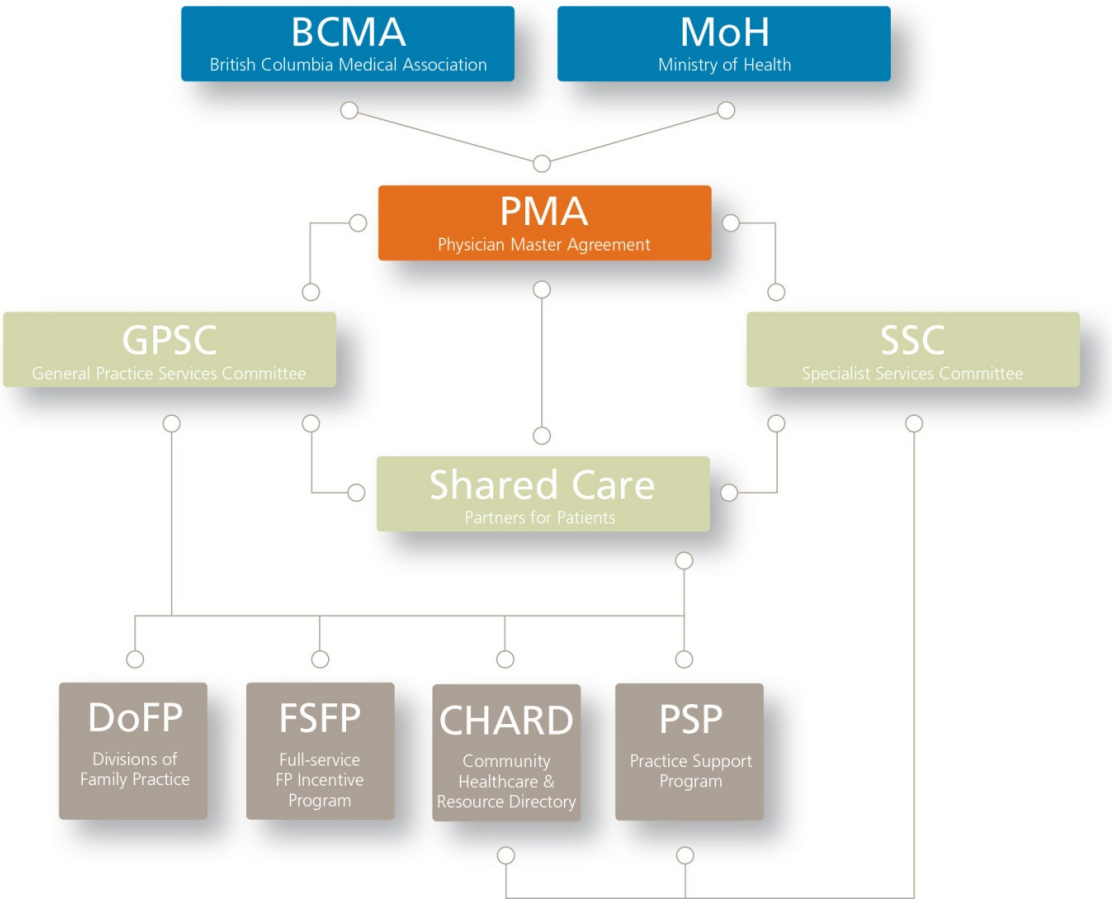
Identification of the GPSC's priorities was guided by feedback obtained from its 2004/05 province-wide consultations with BC general practitioners (GPs). These consultations (Professional Quality Improvement Days) engaged approximately 1,000 general practitioners from across the province and identified 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 (MoH), the BC Medical Association (BCMA), and the Society of General Practitioners of BC. (SGP).
Both the MoH and the BCMA will have six appointed members on the committee (Appendix A).



Physician Master Agreement Program Structure



The GPSC has maintained a very constructive working relationship with all decisions 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, the GPSC has revised fee structures as needed (see Table 1).

- The GPSC's initiatives have been reviewed by an external evaluator, and the committee reviews all evaluations findings with respect to identifying any changes to the initiatives that are needed.
- The primary health care leads from each of BC's health authorities participate in GPSC meetings as guests in order to provide the health authority perspective to GPSC deliberations.
- The director of the MoH Patients as Partners portfolio is a member of the committee to support the GPSC's commitment to ensuring that the patient perspective is captured on various aspects of its work through the Patient Voices Network. This network is an innovative joint MoH and Impact BC initiative 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 Healthcare Improvement's Triple Aim Initiative as a lens by which to assess existing and new initiatives. The 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 that 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 positively impacts 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.gpscbc.ca.

EXTERNAL EVALUATION OF THE FULL-SERVICE FAMILY PRACTICE INCENTIVE PROGRAM AND THE PRACTICE SUPPORT PROGRAM

An external evaluation is being conducted by Hollander Analytical Services Ltd. (Victoria). A contract for evaluation services was initially awarded through a request for proposal process. The original request for proposal provided notice that the GPSC reserved the right to extend the contract up to three times. The contract was subsequently extended to March 31, 2011 (contract extension expenditure $500,000).

Some key evaluation findings are as follows:

- The incentive payments have been well accepted and utilized by BC GPs as 92% of full-service family practice physicians billed at least one incentive payment in the 2009/10 fiscal year.
- The incentive payment increased patient attachment to a specific practice. In turn, attachment to practice was associated with reduced health care costs. This finding is consistent over time.
- In fiscal year 2009/10 the incentive payment for hypertension management, chronic obstructive pulmonary disease (COPD), and mental health planning resulted in an overall health system cost avoidance of $52.59 million, $10.06 million, and $16.10 million, respectively.
- It appears that receiving incentive-based care may have reduced the percentage of deaths among people with diabetes compared with people who did not receive incentive-based care.
- Over 80% of GPs reported that the Practice Support Program learning modules helped improve their clinical practice.
- 51% of GPs who participated in the Practice Support Program Advanced Access learning module reported decreasing their wait times for urgent appointments, and 70% reported decreasing their wait times for regular appointments. The average wait time for urgent appointments was reduced from 2.7 days to 0.03 days, while the average wait time for non-urgent appointments was reduced

from 7.1 days to 2.2 days. Sixty-seven percent of GPs reported that they were able to start and end their work day on time as a result of participating in this learning module.

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	- Annual condition-based payment for diabetes and congestive heart failure management informed by BC Clinical Practice Guidelines recommendations (fee items 13050 initially, then in 2006 renumbered 14050 and 14051) - General practitioner obstetrical premium (fee item 14000 initially, then in 2006 renumbered 14004, 14008, 14009)
April 2006	- Annual condition-based payment for hypertension management informed by BC Clinical Practice 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	- Complex care payment: Introduced as option 1 and 2 (fee items 14030, 14031, 14032, 14033, 135/36/37/38).
June 2007	- Family Physicians for BC (FPs4BC) program
January 2008	- *Revised:* 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	- 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)
September 15, 2009	- *Revised:* Chronic disease management fees expanded to include COPD (fee item G14053) and COPD telephone/email follow-up fee (fee item G14073)
December 31, 2009	- *Revised:* Maternity care network incentive payment increased to $2100 per quarter
January 1, 2010	- *Revised*: Complex care payment: Eligibility expanded to patients with chronic liver disease, and neurodegenerative disorders. COPD and chronic asthma combined with additional diagnoses into a single chronic respiratory conditions category.
September 1, 2010	- GP urgent telephone conference with a specialist (or GP with specialty training) fee (G14018) - GP with specialty training telephone advice – initiative by a specialist or GP, urgent (less than 2-hour response time) (G14021) - GP with specialty training telephone advice – initiative by a specialist or GP, 1 week (G14022)

	- GP with specialty training telephone advice – initiative by a specialist or GP, follow-up (G14023)
January 1, 2011	- *Discontinued:* Cardiac risk reduction fee (G14034)
January 1, 2011	- Personal health risk assessment fee (14066)

Program uptake and expenditures – 2010/11[2]

Chronic disease management

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 has received care in accordance with BC Clinical Practice Guidelines recommendations. An annual $50 payment is available to better support GPs for the management of hypertension according to BC Clinical Practice Guidelines recommendations for those patients who do not also have diabetes or congestive heart failure.

A COPD incentive payment ($125 per year) is available to support enhanced management of chronic obstructive pulmonary disease. This incentive payment requires the development of a COPD Action Plan to assist patients in managing their COPD exacerbations, and includes a telephone/email follow-up management fee.

Table 2 shows the number of GPs who participated in the condition-based payments in 2010/11, and the number of patients who received care in accordance with BC Clinical Practice Guidelines recommendations.

Table 2. Summary of condition-based payments for 2010/11.

[2] Data source: Divisional Strategic Implementation and Analysis, Medical Services Division, July 2011.

	GP participation	Number of patients	2010/11 expenditures
Diabetes	3,112	173,032	$21,629,900
Congestive heart failure	2,132	21,977	$2,747,125
Hypertension	3,005	260,937	$13,047,150
COPD	2,228	37,163	$4,645,375
COPD telephone/email follow-up	144	471	$9,180

Maternity care

The GPSC introduced maternity care incentives to help ensure that BC 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 50% bonus on delivery fee items 14104, 14105, 14108 and 14109. In 2010/11, 781 GPs participated in the obstetric premium, providing maternity care to 12,690 women in their communities (2010/11 expenditure: $3,478,605 million).

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. As of March 31, 2011 there were 808 practitioners registered in 119 maternity networks (2010/11 expenditure: $4,956,000 million).

The Maternity Care for BC (MC4BC) program 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, 2011, 32 GPs have participated in the MC4BC program; 24 graduated from the program and are providing maternity care in their community (2010/11 expenditure: $2.49 million).

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 to 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 patient family members in the review and management of patients in a facility.

An acute care discharge planning conferencing fee (G14017) is available 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 acute care facility or by the community family physician. The GPSC has established a working group to review this fee. The working group studied BC health authority and hospital goals and current initiatives aimed at improving discharge planning in order to determine how the GPSC and Specialist Services Committee can best support and align with discharge planning work underway in BC's health system. A process mapping of the patient's pathway from the point of admission to patient follow-up in the community after being discharged from hospital is being undertaken in order to identify the problem areas, and determine what changes would best address gaps in care.

A palliative care planning fee (G14063) supports family physicians in taking the time needed 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 (G14069) is also available to GPs for clinical follow-up management.

Effective September 1, 2010, the general practice urgent telephone conference with a specialist (or GP with specialty training) fee (G14018) was introduced in order to support improved management of patients with acute needs, and to reduce unnecessary ER or hospital admissions/transfers. This fee is billable when the patient's condition requires urgent conferencing with a specialist or GP with speciality training, and requires the development and implementation of a care plan within the next 24 hours to keep the patient stable in his/her current environment.

Also effective September 1, 2010, three GP/specialist (or GPs with specialty training) telephone advice fees were introduced: for urgent advice, 1-week follow-up, and patient management/follow-up.

Table 3. Summary of patient conferencing payments for 2010/11.

	GP participation	Number of patients	2010/11 expenditures
Community patient conferencing fee	1,672	16,762	$1,194,280
Facility patient conferencing fee	1,093	9,084	$817,520
Acute care discharge planning fee	486	2,218	$178,600
Palliative care planning fee	952	2,488	$251,100
Palliative care telephone/email management follow-up fee	419	700	$22,035
GP urgent telephone conferencing with specialist or specialty-trained general practitioners	952	5251	$243,220
GP telephone patient follow-up with specialist or specialty-trained general practitioners (within 1-week of request)	19	23	$920

GP with specialty training telephone patient management follow-up (with patient)	41	216	$6,120

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 chronic illnesses/categories:

- Diabetes mellitus (type 1 or 2).
- Chronic kidney disease (GFR values less than 60).
- Congestive heart failure (CHF).
- Cerebrovascular disease.
- Coronary artery disease.
- Chronic respiratory disease (e.g., COPD, asthma, cystic fibrosis, pulmonary fibrosis).
- Chronic liver disease.
- Neurodegenerative disease.

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 2010/11, 2,750 GPs billed the annual complex care fee (14033) for 128,691 patients (total expenditure for 2010/11: $47,209,365).

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 is available to GPs. 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, 2011, 958 GPs used this fee for follow-up on 11,073 patients (2010/11 expenditure: $280,935).

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. In November 2010, the GPSC expanded its investment in prevention by approving an increase in the prevention budget to 10% of the total GPSC budget.

On January 1, 2011 the GPSC introduced the personal health risk assessment initiative, which focuses on targeted patient populations with the following risk factors:

- Smoking
- Unhealthy eating
- Physical inactivity
- Medical obesity

GPs can bill the personal health risk assessment fee in addition to an office visit when undertaking a personal health risk assessment visit with their at-risk patients as part of proactive care, or in response to a patient request for preventive care. The $50 fee is billable for up to 100 patients per calendar year per physician.

To be eligible for the payment, the GP must develop a plan that recommends age- and sex-specific targeted clinical preventive actions of proven benefit that are consistent

with the Lifetime Prevention Schedule and the joint MoH/BCMA Guidelines and Protocols Committee's obesity guideline.

The GPSC is working in partnership with the Ministry of Health to encourage patients to take responsibility for their preventive health after completion of the personal health risk assessment visit.

As of March 31, 2011, 2,552 GPs billed the personal health risk assessment fee for 56,006 patients (2010/11 expenditure: $2,800,300).

As a result of the new realigned prevention initiative and following the review of the cardiovascular risk assessment fee using the Triple Aim lens, the GPSC decided to discontinue the cardiovascular risk assessment fee, effective January 1, 2011.

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 *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 and an assessment of the patient's current psychosocial symptoms.
- Conduct an assessment of the patient's current psychosocial symptoms/issues by means of psychiatric history, mental status examination, 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 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, 2011, 2,353 GPs billed the mental health planning fee, developing a mental health plan for 74,883 patients (2010/11 total expenditure: $8,193,700 million).

In addition, a mental health telephone/email management fee is payable for two-way clinical interaction between the GP or delegated practice staff (e.g., office registered nurse or medical office assistant) and the patient or patient's medical representative in follow-up to the mental health planning fee. As well, after creating and successfully billing for a mental health plan, GPs are 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 telephone/email management fee was billed by 531 GPs for 2,822 patients (2010/11 total expenditure: $65,475).

Attraction and retention of family practitioners

The goal of the Family Physicians for British Columbia (FPs4BC) program is 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 a 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 licence.

In return for the funding, the GP will provide 3 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, 2011. Total expenditures 2010/11: $8.5 million.

Table 4. Summary of FPs4BC as of March 31, 2011.

	Spaces available	Spaces filled
Interior Health Authority (IHA)	17	16
Fraser Health Authority	33	30.75

(FHA)		
Northern Health Authority (NHA)	9	5
Vancouver Coastal Health Authority (VCHA)	24	22.84
Vancouver Island Health Authority (VIHA)	17	15
TOTAL	100	89.59

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

PRACTICE SUPPORT PROGRAM

The Practice Support Program (PSP) arose from the GPSC response to the 2004/05 Professional Quality Improvement Days. The consultations indicated that two issues of great importance to BC general practitioners were practice enhancements and system redesign.

As a result, in 2007 the GPSC introduced the PSP to provide family physicians and their staff with specific learning modules and in-practice learning sessions to improve office efficiency and address clinical gaps in patient care. The PSP started with four learning modules: advanced access and office efficiency, chronic disease management, patient self-management, and group medical visits. One of the PSP's most popular offerings, the mental health module, was added next.

In 2010/11, the PSP began development of additional modules in the areas of end-of-life care, shared care with a focus on COPD and CHF, and child and youth mental health. The end-of-life module is now being delivered across the province.

The learning modules provide family physicians and their medical office assistants with a variety of practical, evidence-based strategies and tools for managing practice enhancement change. The first step in engaging physicians in the PSP involves the practice self-assessment questionnaire, which provides insight into the needs of the practice for specific changes and supports.

Key features of the PSP include:

- Payment for participation.
- Locally provided learning sessions.
- Process of in-office follow-up and support to help tailor and embed new skills into clinical practice and office re-design.
- Learning sessions facilitated by peer physician colleagues.

As of March 31, 2011, more than 50% (1941) of BC's active general practitioners, plus their medical office assistants (MOAs), have participated in the PSP (Table 5).

In 2010/11, the GPSC approved a one-time allocation of $1 million for the PSP to design and test a module addressing how musculoskeletal pain and related problems can be diagnosed and managed by GPs in real-time primary health care practice.

Total additional funds allocated to the PSP in 2010/11 were $9.4 million.

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

Table 5. Number of physicians participating in PSP modules, by health authority, as of March 31, 2011.

Module	**FHA**	**IHA**	**NHA**	**VCHA**	**VIHA**	**Total**
Advanced access	241	134	57	218	201	851
Chronic disease management	70	193	180	273	252	968
Group medical visits	76	79	66	68	46	335
Patient self-management	64	72	23	132	29	320
Mental health	278	239	146	250	210	1123
Total number of physicians who have participated in a module	729	717	475	941	739	3601
Total discrete physicians participating	433	390	189	512	417	1941
Practice self-assessment questionnaires	**FHA**	**IHA**	**NHA**	**VCHA**	**VIHA**	**Total**
Practice self-assessment (short)	250	238	80	264	243	1075
Practice self-assessment (long)	99	84	61	120	189	553

DIVISIONS OF FAMILY PRACTICE

Feedback from the Professional Quality Improvement Days held in 2004/05 indicated that BC GPs were experiencing low morale and decreasing professional satisfaction. They felt isolated: As a result of the erosion of hospital-based communities of practice, they did not have support in their communities. GPs who wished to work together to provide the best possible patient care and improve professional satisfaction needed community infrastructure to support them.

In response, the GPSC established the Divisions of Family Practice initiative. Divisions of Family Practice are groups of physicians who work collaboratively with regional health

authorities and other community partners to achieve common health care goals in a defined geographical area. Divisions are designed to improve patient care, increase family physicians' influence on health care delivery and policy, and provide professional satisfaction for physicians. The work is founded in the belief that our communities are best served when we seek to improve the health of all residents in the region.

The benefits associated with being a member of a division include:

- Shared efforts to provide full-spectrum primary care.
- Greater impact on the organization of local and regional health services around a Division practice area.
- Improved access to health authority and specialist services.
- Enhanced professional collegiality and access to physician health and wellness programs.
- Shared efforts for recruitment, retention, and locums.
- Support from colleagues in caring for complex or unattached patients.
- Reliable assistance with duties historically falling to call groups, such as scheduling and meeting organization.

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 and other types of support 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, 2011, 22 incorporated Divisions of Family Practice were fully under way, and 15 were at various stages of development. More than 2,800 family physicians – or 80% of family doctors in the province – are eligible to participate in their local Division of Family Practice.

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

ATTACHMENT INITIATIVE

The GPSC external evaluation of its initiatives by Hollander Analytical Services found that British Columbians who are attached to a particular 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 have:

- More appropriate preventive care.
- Fewer diagnostic tests.
- Fewer prescriptions.
- Fewer hospitalizations.
- Fewer visits to the ER.
- Lower costs of care.
- An enhanced experience of care.

And are:

- More likely to receive an accurate diagnosis.
- More likely to support the health care system.

In general, patients who are attached to a family physician are healthier and cost the overall system less.

Physicians in several Divisions of Family Practice have also identified the issue of unattached patients as something they would like to address in collaboration with their health authority, the GPSC, and community partners. Many physicians have also identified how better supporting family doctors and integrating them into the overall primary health care environment will enable more patients to receive better care.

In response to input from both the Ministry and the BCMA, the GPSC has developed an attachment initiative that will provide per-person funding to a Division of Family Practice and reward individual physicians for maintaining the role of most responsible physician for patients, including those from vulnerable or marginalized populations (e.g., people with mental health and substance use problems, those in home and community care.) In 2009/10, $8 million (plus $1 million in both 2010/11 and 2011/12) was allocated to this initiative.

In order to help build GP practice capacity for patient attachment, the GPSC has requested that Section 5.3(d) of the Physician Master Agreement (Multidisciplinary care between GPs and health care providers) be amended such that the annual $5.5 million budget will be allocated to the Attachment initiative for provision of multidisciplinary care.

The 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. As of March 31, 2011 the following communities were prototyping the Attachment initiative: Prince George, White Rock/South Surrey, and Cowichan. Additional communities will join the prototyping in late fall/winter 2011.

The goal of the Attachment initiative is to ensure that by 2015, every British Columbian who wants a family physician will have one.

COMMUNITY HEALTHCARE RESOURCE DIRECTORY (CHARD)

The GPSC has worked with HealthLinkBC to establish the web-based Community Healthcare Resource Directory (CHARD), the goal of which is to enable health care providers to more efficiently find an appropriate specialist/service in their community. In 2010/11 CHARD was made available to GPs across the province. The CHARD database contains information on specialist services and mental health, COPD, end-of-life, and musculoskeletal resources available within a specific geographic region. Expenditures for 2010/11: $1.65 million.

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[3] 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.

SHARED CARE COMMITTEE

Per article 8.1 of the 2006 Agreement, the Shared Care Committee 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

[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.

enable shared care and appropriate scopes of practice between general practitioners, specialist physicians, and other health care professionals.

In 2010/11, the Shared Care Committee allocated the following funding:

1. $350,000 for prototyping specialist participation in the Practice Support Program (PSP) module for adult mental health.
2. $350,000 for specialist participation in the PSP mental health module.
3. $250,000 for rapid access to psychiatry prototypes.
4. $500,000 (i.e., $83,000 per six health authorities) for GP participation in Process Re-design.
5. $400,000 for specialist participation in the Practice Support Program COPD shared care module (the GPSC allocated $600,000 toward development and delivery of this module).
6. $250,000 to prototype, through a Division of Family Practice (GPs and specialists), medication review for chronic disease management/complex patients over 70 years of age.
7. $3.25 million for the Partners in Care initiative, which aims to strengthen the relationship between GPs and specialists.

PATIENTS AS PARTNERS

Patients and families are partners in primary health care when they are supported and encouraged to:

- Participate in their own health care.
- Participate in decision making about that care.
- Participate at the level they choose.

- Participate in quality improvement and health care redesign in ongoing and sustainable ways.

Patients as Partners is a key component of the primary health care system 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' engagement in their own health and health care as a societal norm.
- People living with chronic disease and complex conditions spend on average only 8 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, skills, and confidence to self-manage and be partners in their own health and health care.
- 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 in care, practice redesign, and quality improvement, the GPSC allocated $900,000 ($450,000 annually in 2009/10 and 2010/2011) to support Patients as Partners initiatives.

In 2010/11, the GPSC concluded its pilot test of How's Your Health, a web-based survey for patients and practice redesign, in which a patient receives a summary of findings plus a list of resources for further information about his or her own health information after answering a number of basic health questions. The pilot test confirmed the

efficiency and effectiveness of this resource on improving patient/physician communication during the office visit. The tools ensured a new quality of health care that embraced patient-centredness.

The pilot emphasized the active partnering of patients and their families in both their own care and how that care is delivered instead of guessing their needs. This approach also acknowledges that professionals are intermittent guests in the patient's health journey, and that physician practices can activate patients to be true partners in care, redesign, and improvement.

The pilot showed how Patients as Partners can assist in family practice redesign by leveraging relevant ideas and information and by focusing on issues critical to the patient.

LIST OF APPENDICES

Appendix A: GPSC membership 2010/11

Dr William Cavers (BCMA) co-chair

Ms Valerie Tregillus (MoH) co-chair

Dr Jean Clarke (BCMA-SGP)

Ms Judy Huska (MoH)

Ms Nichola Manning (MoH)

Dr Garey Mazowita (MoH)

Ms Kelly McQuillen (MoH)

Dr George Watson (BCMA-SGP)

Dr Brian Winsby (BCMA)

Staff support

Dr Cathy Clelland (SGP)

Dr Dan MacCarthy (BCMA)

Ms Angela Micco (MoH)

Committee secretariat

Ms Angela Micco (MoH)

Alternate: Mr Greg Dines (BCMA)

Appendix B: Primary health care health authority participation 2010/11

Primary Health Council committee guests 2010/11

Ms Gayle Anton, Northern Health Authority

Ms Darlene Arsenault, Interior Health Authority

Ms Carole Gillam, Vancouver Coastal Health Authority

Ms Diane Miller, Fraser Health Authority

Ms Victoria Power, Vancouver Island Health Authority

Appendix C: Divisions of Family Practice, Attachment initiative, Practice Support Program, and communications guests (2010/11)

Mr Brian Evoy (executive lead, Divisions of Family Practice)

Mr Kyle Pearce (executive lead, Attachment initiative)

Dr Brenda Hefford (Attachment initiative)

Dr John Hamilton (Attachment initiative)

Mr Andy Basi (executive lead, Practice Support Program)

Ms Dianne Warnick (executive lead, Communications)

Appendix D: 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 (glomular 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 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 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.