GPSC

General Practice Services Committee

ANNUAL REPORT

2011/2012

www.gpscbc.ca

BRITISH COLUMBIA

BCMA

BRITISH COLUMBIA MEDICAL ASSOCIATION

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MANDATE

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

This mandate was renewed under both the 2004 ministry/BCMA Working Agreement and the ministry/BCMA 2006 Agreement. Under the 2007 Physician Master Agreement (formerly the 2006 Government/BCMA Agreement), $402 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 (GPs) 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 $809 million since the GPSC's establishment in 2004/05.[1]

Identification of the GPSC's priorities was guided by feedback obtained from its 2004/05 province-wide consultations with BC GPs. These consultations (Professional Quality Improvement Days) engaged approximately 1,000 GPs from across the province and identified key areas of focus for sustaining full-service family practice in BC.

[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

ORGANIZATIONAL STRUCTURE

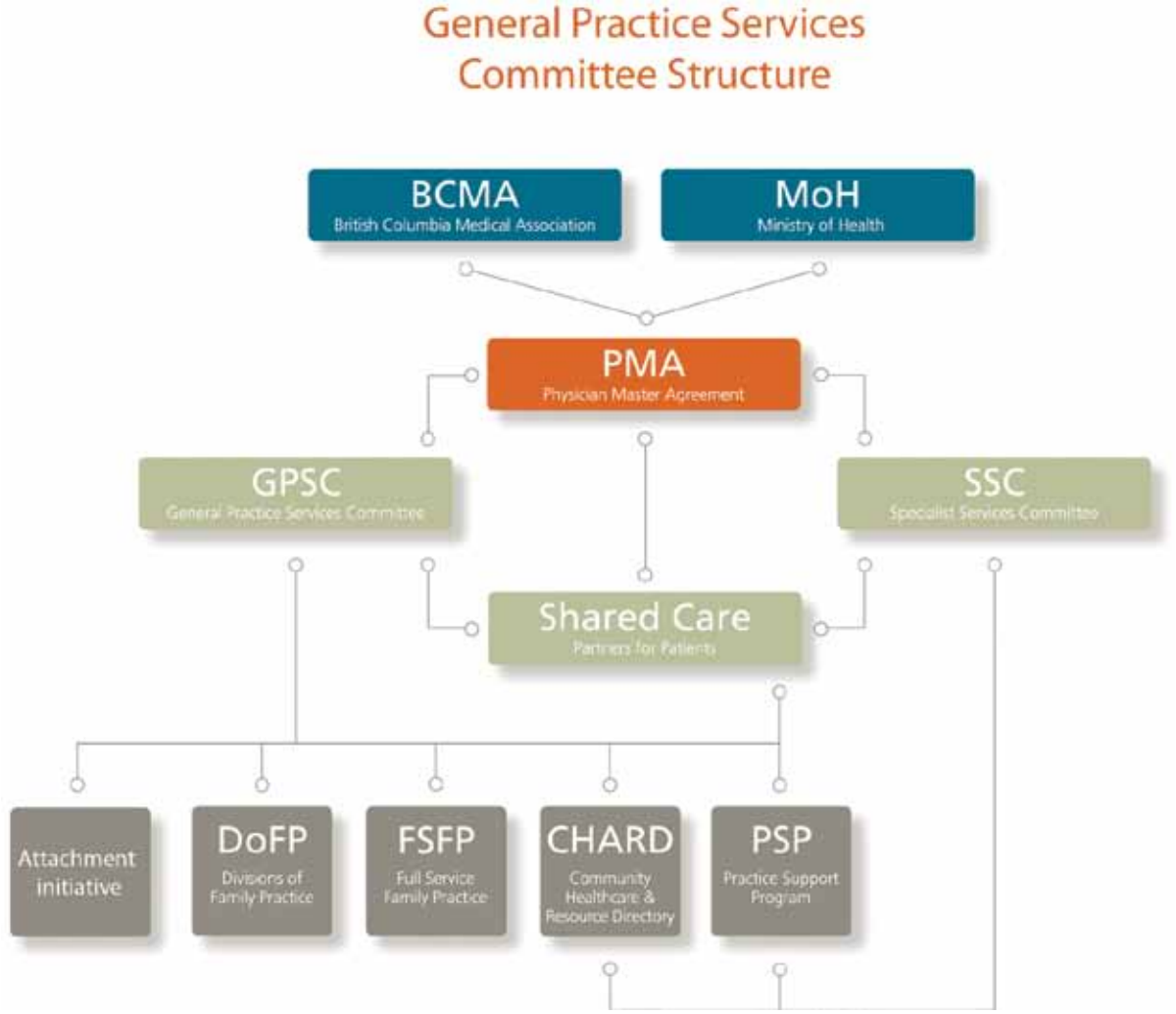
The GPSC is a joint committee of the ministry, the BCMA, and the Society of General Practitioners of BC (SGP).

Both the ministry and the BCMA have six appointed members on the committee (Appendix A). The GPSC has maintained a 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 ministry Patients as Partners portfolio is a member of the committee to support the GPSC's commitment to ensuring that the patient perspective is captured through the work of the Patient Voices Network. This network is a ministry, Patients as Partners initiative administered by ImpactBC. It is 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.**


General Practice Services Committee Structure
BCMA
British Columbia Medical Association
MoH
Ministry of Health
PMA
Physician Master Agreement
GPSC
General Practice Services Committee
SSC
Specialist Services Committee
Shared Care
Partners for Patients
Attachment initiative
DoFP
Divisions of Family Practice
FSFP
Full Service Family Practice
CHARD
Community Healthcare & Resource Directory
PSP
Practice Support Program

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., a Victoria-based national health services and policy research company. 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, 2013.

Evaluation reports are available at **www.gpscbc.ca/media/evaluations.**

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 item 13050 initially; renumbered 14050 and 14051 in 2006). • General practitioner obstetrical premium (fee item 14000 initially; renumbered 14004, 14008, 14009 in 2006).
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 fees (fee items 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 chronic obstructive pulmonary disease (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 $2,100 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 – initiated by a specialist or GP, urgent (less than 2-hour response time) (G14021). • GP with specialty training telephone advice – initiated by a specialist or GP, 1 week (G14022). • GP with specialty training telephone advice – initiated 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).
March 31, 2012	• FPs4BC program funding ended.

Program uptake and expenditures - 2011/12[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 in accordance with BC Clinical Practice Guidelines recommendations for patients who do not also have diabetes or congestive heart failure.

An incentive payment ($125 per year) is available to support enhanced management of COPD. This COPD 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 2011/12, the number of patients who received care in accordance with BC Clinical Practice Guidelines recommendations, and related expenditures in 2011/12.

Table 2. Summary of condition-based payments for 2011/12.

	GP participation	Number of patients	2011/12 expenditures
Diabetes	3,192	184,158	$23,021,200
Congestive heart failure	2,219	23,607	$ 2,951,375
Hypertension	3,090	273,244	$13,662,900
COPD	2,359	43,195	$5,399,500

[2] Data source: Divisional Strategic Implementation and Analysis, Medical Services Division, July 2012.

COPD telephone/ email follow-up	114	381	$ 7,545

Maternity care

The GPSC's maternity care incentives help ensure that BC women can obtain maternity care in their community and better support GPs who provide maternity care services in the community.

The obstetric premium provides a 50% bonus on delivery fee items 14104, 14105, 14108, and 14109. In 2011/12, 743 GPs participated in the obstetric premium, providing maternity care to 12,348 women in their communities **(2011/12 expenditures: $3,401,331)**.

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, 2012 there were 643 GPs registered in the maternity networks **(2011/12 expenditures: $4,926,600).**

The Maternity Care for BC (MC4BC) program makes training available to BC GPs wanting to update their maternity skills and to 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, 2012, 51 GPs have participated in the MC4BC program; 37 graduated from the program and are providing maternity care in their community **(2011/12 expenditures: $418,959).**

Improved care of the frail elderly, patients requiring end-of-life care, and increased multidisciplinary care between GPs 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 the 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 the Specialist Services Committee can best support and align with discharge planning work under way in BC's health system. A process mapping 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 problem areas and to determine what changes would best address gaps in care.

A palliative care planning fee (G14063) supports family physicians in taking the time needed to develop a care plan 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.

The general practice urgent telephone conference with a specialist (or GP with specialty training) fee (G14018) supports improved management of patients with acute needs and aims 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 the development and implementation of a care plan within the next 24 hours to keep the patient stable in his/her current environment.

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

Table 3 provides a summary of payment of the patient conferencing fees in 2011/12.

Table 3. Summary of patient conferencing payments for 2011/12.

	GP participation	Number of patients	2011/12 expenditures
Community patient conferencing fee	1,721	17,327	$1,214,160
Facility patient conferencing fee	1,081	9,306	$830,640
Acute care discharge planning fee	547	2,871	$212,520
Palliative care planning fee	1,145	2,978	$300,600
Palliative care telephone/email management follow-up fee	396	621	$18,750
GP urgent telephone conferencing with specialist or specialty-trained general practitioners	1,586	13,534	$639,940
GP telephone patient follow-up with specialty-trained general practitioners (within 1 week of request)	26	40	$1,640
GP with specialty training telephone patient manage-ment follow-up (with patient)	58	635	$19,580

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.
- 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 addition, a $15 complex care email/telephone follow-up management fee (14039) 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.

Table 4 provides a summary of payment of the complex care fees in 2011/12.

Table 4. Summary of complex care payments for 2011/12.

	GP participation	Number of patients	2011/12 expenditures
Annual complex care management fee	2,819	138,714	$50,703,345
Complex care follow-up management fee	872	11,330	$271,365

Mental health

The community mental health initiative supports GP provision of accurate diagnosis, a patient plan, and 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, and 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 to other professionals involved.

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

As of March 31, 2012, 2,480 GPs billed the mental health planning fee, developing a mental health plan for 83,856 patients **(2011/12 total expenditures: $9,228,000).**

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 counseling-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 458 GPs for 2,523 patients **(2011/12 expenditures: $56,145)**.

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 ministry/BCMA Guidelines and Protocols Committee's obesity guideline.

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

As of March 31, 2012, 3,195 GPs billed the personal health risk assessment fee for 161,337 patients **(2011/12 expenditures: $8,374,800**).

Attraction and retention of family practitioners

The Family Physicians for British Columbia (FPs4BC) program launched in June 2007. Its goal was to encourage GPs who had completed their residency training within the last 10 years to establish or join a group family practice in a community of need identified by the local health authority. 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 ended on March 31, 2012.

The FPs4BC program provided physicians with up to $100,000 to help 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, GPs are required to provide 3 years return of service. The program allocated each regional health authority a proportionate number of spaces, based on population.

Table 5 shows the total number of spaces available and filled since inception, per health authority, as at March 31, 2012 **(total expenditures since inception: approximately $9,018,323)**.

Table 5. Summary of FPs4BC as at March 31, 2011.

	Spaces available	Spaces filled
Interior Health Authority (IHA)	17	16
Fraser Health Authority (FHA)	33	31.75
Northern Health Authority (NHA)	9	9
Vancouver Coastal Health Authority (VCHA)	24	23.84
Vancouver Island Health Authority (VIHA)	17	14.7
TOTAL	**100**	**95.29**

PRACTICE SUPPORT PROGRAM

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

In response, 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 in 2009.

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 heart failure, 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 enhancing their practices. 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 support.

Key features of the PSP include:

- MAINPRO-C credits.
- Locally provided learning sessions.
- A 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.
- Reimbursement for participation.

As of March 31, 2012, nearly 70% of all BC's practising family physicians, plus their medical office assistants, have participated in the PSP (**Table 6**).

The PSP receives additional direction, support, and funding from the Shared Care Committee and the Specialist Services Committee (also partnerships between the BCMA and the ministry).

More information on the PSP can be found at **www.pspbc.ca**.

2011/12 expenditures: $8,782,372.

Table 6. Number of physicians participating in PSP modules, by health authority, as of March 31, 2012.

Module	FHA	IHA	NHA	VCHA	VIHA	Total
Advanced Access	241	152	59	252	201	905
Chronic Disease Management	70	199	189	273	255	986
Group Medical Visits	109	91	76	91	51	418
Patient Self-management	65	73	25	132	29	324
Mental Health	336	282	150	304	259	1331
End of Life	108	141	42	66	117	474
Shared Care	76	24		0	31	131
Total number of physicians who have participated in a module	1005	962	541	1118	943	4569
Total discrete physicians participating	541	492	184	625	474	2316
Practice self-assessment questionnaires	**FHA**	**IHA**	**NHA**	**VCHA**	**VIHA**	**Total**
Practice self-assessment (short)	253	241	80	264	243	1081
Practice self-assessment (long)	107	116	108	134	205	670

SUCCESS STORY: Family doctor in small town provides discretion for patients with mental health issues

In a small town, everyone knows your business, so if a patient is dealing with mental health problems, there can be added stigma when seeking treatment. That's why many of Dr Tara Guthrie's patients are thrilled that she now has training and skills to help them with their mental health issues in her family practice.

Guthrie has a busy family practice in Creston in the Kootenays, population 5,000. In the past, when she had patients who needed mental health treatment, she would usually refer them to the mental health department at the local health authority, but now she can treat many of these patients herself, avoiding referrals and providing them a level of discretion and comfort that comes from seeing a family doctor with whom they are familiar.

Dr Guthrie gained valuable skills through the PSP Mental Health learning module. The PSP provides training and support for physicians and their MOAs designed to improve clinical and practice management and to support enhanced delivery of patient care.

The PSP Mental Health module enables GPs like Dr Guthrie to screen their patients more thoroughly for mental illness and diagnose conditions that were previously more difficult to detect. The program includes common screening scales, a diagnostic assessment interview tool, a tool for organizing patient issues, a cognitive-behavioural skills program, and a patient self-management workbook.

"Patients find it really useful, and I feel much more comfortable providing counseling using these tools," she says. "There has been a tendency to reach for medications in these situations before. Now, by the time we've done some counseling, the need for medications for most patients is reduced."

Gwen Benty and her family have been seeing Dr Guthrie for several years, so when Gwen's anxiety and depression needed treatment, she was really pleased to be able to see her family doctor, who already knew about her situation.

"It helps that I already have a relationship with my family doctor and that the trust is there," says Benty. "In small communities like ours, a referral to a specialist almost always means traveling, so it's beneficial for us to have her here."

Benty has worked with Guthrie through counseling and used the workbook provided by the Mental Health module. "She answered my questions, and saw me on an ongoing basis, and makes me feel like she's empathetic enough to understand," says Benty. "Sometimes you cry and cry and tear

yourself like an onion, but I gain strength from her approach. I think more GPs need to have training in this area."

Both Benty and Guthrie agree that some patients are reluctant to be seen even entering the mental health building in town. "It's much more comfortable entering the family physician's office, more discreet," says Guthrie.

DIVISIONS OF FAMILY PRACTICE

Feedback from the Professional Quality Improvement Days indicated that BC GPs were experiencing low morale and decreasing professional satisfaction. GPs wished to work together to provide the best possible patient care and improve professional satisfaction and felt they 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.

Initially, the GPSC allocated $6 million annually for infrastructure costs associated with developing local 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 and other types of support from BC health authorities have been made available to help collectively address specific gaps in patient care at the community level.

As of March 31, 2012, there were 29 divisions of family practice in BC encompassing 109 communities, and discussions were under way in up to another eight areas of the province. All BC family physicians are eligible to participate in the Divisions initiative. Currently more than 3,000 family physicians – or 88% of family doctors in the province – participate in their local division of family practice.

Each division works in partnership with its health authority and the GPSC in a Collaborative Services Committee. Together they identify issues of concern affecting patient care and determine priorities and solutions for their local communities. As of March 31, 2012, there are 24 Collaborative Services Committees across the province.

Working in collaboration offers divisions the opportunity to be deeply coordinated with health care partners and to achieve good results in areas such as residential care, hospital care, and coordinated community care. For example, various divisions are currently undertaking the advancement

of the ministry Integrated Primary and Community Care initiative through their local Collaborative Services Committees.

For more information on the Divisions of Family Practice initiative and for examples of projects and initiatives undertaken by local divisions, visit **www.divisionsbc.ca**.

Expenditures for 2011/12: $10,916,907.

SUCCESS STORY: Kootenay Boundary Collaborative Services Committee leads the way in methadone therapy for rural communities

When one of Castlegar's leading physicians in methadone therapy retired last year, the Kootenay Boundary Division of Family Practice recognized the large hole that would be left in methadone therapy in the community. The Division and its Collaborative Services Committee (CSC) partners from the Interior Health Authority established a strategy that would fill the gaps and strengthen care for those living with addictions.

Methadone is used medically as a maintenance drug in patient groups with an opioid dependency and for those patients managing severe chronic pain. Methadone acts on the same opioid receptors as drugs such as heroin and morphine. Typically, methadone is used to treat patients looking to overcome their addiction and better their health.

Previously, methadone therapy in the Kootenays had been provided by two physicians who serviced patients from all over the rural region, some traveling several hours just to receive treatment. Last year, one of the physicians retired, leaving a large portion of the population without therapy.

Zak Matieschyn, a nurse practitioner and board member of the Kootenay Boundary Division, offered his leadership in establishing a co-designed and collaborative regional strategy for methadone maintenance.

The Division strove for a strategy of not only physician delivery of methadone but also a collaborative process that included the provision of mental health and addictions services. Through the strategy, the need was identified to promptly fill the physician vacancy and to create a Kootenay Boundary CSC working/advisory group, which included the Division, Interior Health Authority, local mental health and substance abuse workers, and Ankors, a non-profit organization that supports education about HIV and Hepatitis C.

"The Division thought it was crucial to collaborate with local groups that had their finger on the pulse in the community. That collaboration was able to provide key insights on patient needs and how things should be structured to achieve success," said Matieschyn.

The Kootenay Boundary CSC working group established a designated methadone clinic that was based on the "hub and spoke" model. The hub would be the physical clinic in Castlegar, and the spokes would be mental health and substance abuse departments in the smaller communities that would provide counseling and ongoing support to patients.

"Intake for these patients is through their respective communities, where they can have face-to-face contact with someone who specializes in mental health and addictions," said Maggie Haley, Interior Health's Community Integrated Health Services Manager. The patient would then receive methadone therapy in the clinic in Castlegar.

"This area of the province is known for its progressive thinking in health care. The Divisions concept of grassroots, front-line stakeholders influencing health care is unique. We aligned our methadone delivery problem with that concept and created a best practice through the Division," added Matieschyn.

ATTACHMENT INITIATIVE

The external evaluation of GPSC initiatives by Hollander Analytical Services found that British Columbians who are attached to a family doctor cost the health system considerably less than comparable patients who are not. This is particularly so for those patients with several chronic diseases 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 the Attachment Initiative.

In order to help build the capacity of family physicians' practices to take on unattached patients, the GPSC received an amendment to Section 5.3(d) of the Physician Master Agreement (multidisciplinary care between GPs and health care providers) such that the annual $5.5 million budget was 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 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 Valley.

The goal of the Attachment Initiative is to increase the number of British Columbians who have access to a family physician.

Expenditures for 2011/12: $5,146,552.

COMMUNITY HEALTHCARE AND RESOURCE DIRECTORY (CHARD)

The GPSC worked with HealthLink BC to establish the web-based Community Healthcare and Resource Directory (CHARD), which enables health care providers to more efficiently find appropriate and available specialists/services for their patients.

In 2010/11, CHARD was made available to GPs across the province, providing them with access to information on mental health and addictions resources. In 2011/12, all remaining medical topics were added to the directory; CHARD now contains listings for more than 50,000 practitioners and services across the province.

Expenditures for 2011/12: $3,240,358.

LIST OF APPENDICES

Appendix A: General Practice Services Committee membership (2011/12)

Dr William Cavers, co-chair (BC Medical Association)
Ms Valerie Tregillus, co-chair (Ministry of Health) [3]
Ms Nichola Manning, co-chair (Ministry of Health) [4]
Dr Jean Clarke (BC Medical Association - Society of General Practitioners of BC)
Judy Huska (Ministry of Health) [5]
Dr Garey Mazowita (Ministry of Health)
Ms Kelly McQuillen (Ministry of Health)
Dr George Watson (BC Medical Association - Society of General Practitioners of BC)
Dr Brian Winsby (BC Medical Association)

Staff support

Dr Cathy Clelland (Society of General Practitioners of BC)
Dr Dan MacCarthy (BC Medical Association)
Ms Angela Micco (Ministry of Health)

Committee secretariat

Ms Angela Micco (Ministry of Health)
Alternate: Mr Greg Dines (BC Medical Association)

Appendix B: Primary health care, health authority participation (2011/12)

Ms Gayle Anton (Northern Health Authority)
Ms Darlene Arsenault (Interior Health Authority)
Ms Carole Gillam (Vancouver Coastal Health Authority)

[3] Until August 2011.
[4] Effective August 2011.
[5] Until August 2011.

Ms Diane Miller (Fraser Health Authority)
Ms Victoria Power (Vancouver Island Health Authority)

Appendix C: Divisions of Family Practice, Practice Support Program, Attachment Initiative, Ministry of Health Primary and Community Care Integration, and Communications guests (2011/12)

Mr Brian Evoy (Executive Lead, Divisions of Family Practice)

Mr Andy Basi (Executive Lead, Practice Support Program)

Mr Kyle Pearce (Executive Lead, Attachment Initiative)
Dr Brenda Hefford (Attachment Initiative)
Dr John Hamilton (Attachment Initiative)

Ms Shana Ooms (Director, Ministry of Health, Primary Health Care and Specialist Services Branch – Integration, Medical Services and Health Human Resources Division)
Ms Leigh Ann Seller (Executive Director, Ministry of Health, Home, Community and Integrated Care, Health Authority Division)

Ms Dianne Warnick (Communications Lead, General Practice Services Committee)

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.