General Practice Services Committee
Improving primary care in British Columbia

www.gpscbc.ca
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MANDATE

The General Practice Services Committee (GPSC) was originally established under the Ministry of Health/BC Medical Association 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 has been renewed over the years with an emphasis placed on addressing 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.

The 2012 Government/BC Medical Association (BCMA) Physician Master Agreement increased the existing $190.5-million annual funding level for full-service family practitioners with an additional $10 million (effective April 1, 2012), and an additional $8 million (effective April 1, 2013).

ORGANIZATIONAL STRUCTURE

The GPSC is a joint committee of the BC Ministry of Health (MoH), the BC Medical Association, and the Society of General Practitioners of BC (SGP).

The MoH and the BCMA have each been allocated six appointed members on the committee (Appendix A).

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 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.

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.

<table>
<thead>
<tr>
<th>Implementation date</th>
<th>Incentive payment</th>
</tr>
</thead>
</table>
| 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) |
### Implementation dates and Incentive Payments

<table>
<thead>
<tr>
<th>Implementation date</th>
<th>Incentive payment</th>
</tr>
</thead>
</table>
| 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 14063) 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 $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)  |
| December 31, 2012   | • COPD telephone/email follow-up fee (fee item G14073) discontinued, and replaced with GP Telephone/email follow up fee (fee item 14079)  |
| April 1, 2013       | • A GP for Me/Attachment initiative  
|                     | • G14074 Unattached complex/high-needs patient attachment fee  
|                     | • G14076 Telephone visits  
|                     | • G14075 Attachment Complex Care management fee  
|                     | • G14077 Attachment Patient Conference fee  |
| April 1, 2013       | • In-patient Care program  
|                     | The following incentives are available to family physicians and participating local divisions of family practice:  
|                     | • G14086 GP Assigned In-patient Care Network Initiative  
|                     | • G14088 GP Unassigned In-patient Care Fee  |

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1 G14015 GP Facility Patient Conference fee, G14016 Community Patient Conference fee, or G14017 Acute Care Discharge Planning Conference fee have been discontinued as these fees are replaced by G14077 for those family physicians who have submitted the zero sum GP Attachment Participation code.
PROGRAM UPTAKE AND EXPENDITURES – 2012/13

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 COPD. This incentive payment requires the development of a COPD Action Plan to assist patients in managing their COPD exacerbations and includes a telephone/email follow-up management fee.

Table 2 shows the number of GPs who participated in the condition-based payments in 2012/13, and the number of patients who received care in accordance with BC Clinical Practice Guidelines recommendations.

Table 2. Summary of condition-based payments for 2012/13.

<table>
<thead>
<tr>
<th>Condition</th>
<th>GP participation</th>
<th>Number of patients</th>
<th>2012/13 expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>3,254</td>
<td>192,332</td>
<td>$24,045,525</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>2,293</td>
<td>24,842</td>
<td>$3,106,375</td>
</tr>
<tr>
<td>Hypertension</td>
<td>3,170</td>
<td>281,699</td>
<td>$14,085,950</td>
</tr>
<tr>
<td>COPD</td>
<td>2,482</td>
<td>47,318</td>
<td>$5,915,000</td>
</tr>
<tr>
<td>GP telephone/email follow-up</td>
<td>1,288</td>
<td>17,599</td>
<td>$465,120</td>
</tr>
</tbody>
</table>

Maternity care

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

The obstetric premium provides a 50 percent bonus on delivery fee items 14104, 14105, 14108 and 14109. In 2012/13, 720 GPs participated in the obstetric premium, providing maternity care to 11,825 women in their communities (2012/13 expenditure: $3,261,430).

The maternity care network payment helps support group/network activities for shared care of obstetric patients. It provides $2,100 per quarter to each GP participating in a formal group practice approach to maternity care provision. As of March 31, 2013 there were 643 GPs registered in a maternity network (2012/13 expenditure: $4,872,000).

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. 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, 2013, 74 GPs have participated in the MC4BC program (2012/13 expenditure: $737,690).  

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2 Data source: Divisional Strategic Implementation and Analysis, Medical Services Division, July 2013.
3 Data source: BCMA MC4BC office administrative records.
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, and those with multiple medical needs or complex co-morbidity.

The community patient conferencing fee (14016) was developed to better support GPs in creating 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 health care 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. It also supports the physician in reviewing patient 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 an 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 to develop a care plan that has worked through the various decisions and plans needed to ensure the best quality of life for dying patients and their families. A palliative care telephone/email follow-up fee (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) 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, three GP/specialist (or GPs with specialty training) telephone advice fees are available: for urgent advice, one-week follow-up, and patient management/follow-up.

### Table 3. Summary of patient conferencing payments for 2012/13.

<table>
<thead>
<tr>
<th>Fee</th>
<th>GP participation</th>
<th>Number of patients</th>
<th>2012/13 expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community patient conferencing fee</td>
<td>1,787</td>
<td>18,226</td>
<td>$1,274,240</td>
</tr>
<tr>
<td>Facility patient conferencing fee</td>
<td>1,132</td>
<td>9,839</td>
<td>$864,240</td>
</tr>
<tr>
<td>Acute care discharge planning fee</td>
<td>599</td>
<td>3,505</td>
<td>$257,600</td>
</tr>
<tr>
<td>Palliative care planning fee</td>
<td>1,282</td>
<td>3,341</td>
<td>$336,492</td>
</tr>
<tr>
<td>GP urgent telephone conferencing with specialist or specialty-trained GPs</td>
<td>1,825</td>
<td>17,743</td>
<td>$821,280</td>
</tr>
<tr>
<td>GP telephone patient follow-up with specialist or specialty-trained GPs (within one week of request)</td>
<td>36</td>
<td>77</td>
<td>$3,320</td>
</tr>
<tr>
<td>GP with specialty training telephone patient management follow-up (with patient)</td>
<td>50</td>
<td>703</td>
<td>$21,320</td>
</tr>
</tbody>
</table>
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). As of March 31, 2013, 2,863 GPs billed the complex care management fee, with 143,296 patients receiving a care plan (total 2012/13 expenditure: $51,841,125).

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, as well as 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, 2013, 2,532 GPs billed the mental health planning fee, developing a mental health plan for 89,295 patients (2012/13 total expenditure: $9,778,100).
Prevention

The GPSC personal health risk assessment initiative 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 MoH to encourage patients to take responsibility for their preventive health after completion of the personal health risk assessment visit.

As of March 31, 2013, 3,203 GPs billed the personal health risk assessment fee for 153,197 patients (2012/13 expenditure: $7,960,100).
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 GPs 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 Adult Mental Health module, was added next.

In 2012/13, 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 to physicians and their medical office assistant 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 redesign.
- Learning sessions facilitated by physician colleagues.
- MAINPRO-C credits.
- Reimbursement of provincial training event participation travel expenses.

As of March 31, 2013, more than 69 percent (2431) of BC’s active GPs, plus their medical office assistants, have participated in the PSP (Table 4).

Total additional funds allocated to the PSP in 2012/13 were $10.2 million.

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

Table 4. Number of physicians participating in PSP modules, by health authority, as of March 31, 2013.

<table>
<thead>
<tr>
<th>Module</th>
<th>FHA</th>
<th>IHA</th>
<th>NHA</th>
<th>VCHA</th>
<th>VIHA</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced Access and Office Efficiency</td>
<td>261</td>
<td>152</td>
<td>62</td>
<td>287</td>
<td>217</td>
<td>979</td>
</tr>
<tr>
<td>Chronic Disease Management</td>
<td>70</td>
<td>199</td>
<td>190</td>
<td>273</td>
<td>255</td>
<td>987</td>
</tr>
<tr>
<td>Group Medical Visits</td>
<td>121</td>
<td>93</td>
<td>85</td>
<td>118</td>
<td>57</td>
<td>474</td>
</tr>
<tr>
<td>Patient Self-management</td>
<td>65</td>
<td>73</td>
<td>25</td>
<td>132</td>
<td>29</td>
<td>324</td>
</tr>
<tr>
<td>Adult Mental Health</td>
<td>405</td>
<td>282</td>
<td>151</td>
<td>324</td>
<td>290</td>
<td>1,452</td>
</tr>
<tr>
<td>Child and Youth Mental Health</td>
<td>34</td>
<td>100</td>
<td>21</td>
<td>53</td>
<td>84</td>
<td>292</td>
</tr>
<tr>
<td>End of Life</td>
<td>263</td>
<td>216</td>
<td>52</td>
<td>146</td>
<td>202</td>
<td>879</td>
</tr>
<tr>
<td>Shared Care COPD and Heart Failure</td>
<td>204</td>
<td>96</td>
<td>20</td>
<td>3</td>
<td>54</td>
<td>377</td>
</tr>
<tr>
<td>Total number of physicians who have</td>
<td>1,423</td>
<td>1,211</td>
<td>606</td>
<td>1,336</td>
<td>1,188</td>
<td>5,764</td>
</tr>
<tr>
<td>participated in a module</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total discrete physicians participating</td>
<td>541</td>
<td>558</td>
<td>179</td>
<td>625</td>
<td>528</td>
<td>2431</td>
</tr>
<tr>
<td>Total number of practice self-assessment</td>
<td>405</td>
<td>389</td>
<td>198</td>
<td>437</td>
<td>524</td>
<td>1,953</td>
</tr>
</tbody>
</table>
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 and, 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 the Divisions of Family Practice initiative. This amount was increased to $9 million for 2010/11, $12 million in 2011/12, and $13.53 million in 2012/13.

Additional funding from the MoH 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, 2013, 32 divisions of family practice encompassing 127 communities have been established in BC. Currently more than 3,000 family physicians, or 88 percent of family doctors in the province, are eligible to participate in their local division of family practice.

For more information on the Divisions of Family Practice initiative, visit www.divisionsbc.ca.
A GP FOR ME

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

• More appropriate preventive care.
• Fewer diagnostic tests.
• Fewer prescriptions.
• Fewer hospitalizations.
• Fewer visits to the emergency room.
• Lower costs of care.
• An enhanced experience of care.

They also 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 than those who are unattached.

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 improved care.

In 2011/12, the GPSC completed prototyping models of patient attachment in the communities of Cowichan, White Rock/South Surrey, and Prince George. During this prototyping phase, more than 9,400 individuals were matched with a family doctor.

Taking the lessons learned from the prototypes, on April 1, 2013, the GPSC launched the A GP for Me initiative. The goals are to:

• Confirm and strengthen the relationship between family physicians and patients.
• Better support the needs of vulnerable patients.
• Increase capacity within the system.
• Enable patients who want a family doctor to find one.

The initiative includes $60.5 million for two years for the following new family physician fees:

• Zero Sum Attachment Participation code.
• Telephone Management (Visit) fee.
• Expanded Complex Care Management fee.
• Patient Conference fee.
• Unattached Complex/High-needs Patient Attachment Referral fee.

The GPSC also allocated $40 million to Divisions of Family Practice over the next three years to:

• Conduct research to evaluate the number of people looking for doctors in their community, the needs of the local family physicians, and the strengths and gaps in local primary care resources.
• Develop a community plan for improving local primary care capacity, including a mechanism for finding doctors for patients who are looking for one.
IN-PATIENT CARE PROGRAM

The In-patient Care program recognizes the importance of continuous doctor-patient relationships. An important aspect of such continuous care is the coordination of patient transitions between hospitals and the offices of community family physicians.

This program will better support existing care provided by family physicians for patients in hospitals, and will replace any prior service agreements between local divisions of family practice and the MoH.

Effective April 1, 2013, the following in-patient care incentives will be available to family physicians and participating local divisions of family practice:

• Assigned In-patient Care Network incentive.
• Unassigned In-patient Care Network incentive.
• Unassigned In-patient Care fee.
• Enhanced clinical fees for select in-patient MRP services.

The GPSC has allocated $31.9 million to compensate family physicians who provide this important aspect of care.
LIST OF APPENDICES

Appendix A: GPSC membership 2012/13

Appendix B: Primary health care health authority representatives 2012/13

Appendix C: 2012 Physician Master Agreement – General Practitioners Subsidiary Agreement

Appendix A: GPSC membership 2012/13

Dr William Cavers (BCMA) Co-chair
Ms Nichola Manning (MoH) Co-chair
Mr Eric Bringsli (MoH)
Dr Jean Clarke (BCMA-SGP)
Dr John Hamilton (MoH)
Dr Jeff Harries (BCMA)
Dr Garey Mazowita (MoH)
Ms. Kelly McQuillen (MoH)
Ms Shana Ooms (MoH)
Dr George Watson (BCMA-SGP)
Dr Brian Winsby (BCMA)
Dr Joanne Young (BCMA)

Staff support

Dr Cathy Clelland (BCMA-SGP)
Dr Dan MacCarthy (BCMA)
Ms Angela Micco (MoH)

Committee secretariat

Ms Angela Micco (MoH)
Mr Greg Dines (BCMA)

Appendix B: Primary health care health authority representatives 2012/13

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: 2012 Physician Master Agreement – General Practitioners Subsidiary Agreement

2012 GENERAL PRACTITIONERS SUBSIDIARY AGREEMENT

THIS AGREEMENT made as of the 1st day of April, 2012,

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 have agreed to renew and replace the 2007 PMA, the 2007 General Practitioners Subsidiary Agreement, the 2007 Specialists Subsidiary Agreement, the 2007 Rural Practice Subsidiary Agreement, the 2007 Alternative Payments Subsidiary Agreement and the 2007 Benefits Subsidiary Agreement;

B. The parties have agreed that this Agreement will constitute the new General Practitioners Subsidiary Agreement, to take effect as of April 1, 2012; 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 2012 PHYSICIAN MASTER AGREEMENT

1.1 This Agreement is one of the Physician Master Subsidiary Agreements under the 2012 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 2012 Physician Master Agreement have the same meaning as in the 2012 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 ‘Attachment’ means the initiative aimed at ensuring that British Columbians have access to a family physician.
2.4 "Divisions of Family Practice" means the initiative created and supported by the General Practice Services Committee to organize physicians at the local or regional level in order to address common health care goals in their communities.

2.5 "2012 Physician Master Agreement" means the agreement titled "2012 Physician Master Agreement" between the Government, the BCMA and the MSC, dated April 1, 2012.

2.6 The provisions of sections 1.2 to 1.8 inclusive of the 2012 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 April 1, 2012.

3.2 This Agreement shall be for the same term as the 2012 Physician Master Agreement and will be subject to renegotiation and/or termination pursuant to Articles 27 and 28 of the 2012 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 and benefit patients. In addition to the core mandate outlined in section 8.2 of the 2012 Physician Master Agreement, the General Practice Services Committee will fulfill the specific mandate set out in this Agreement.

4.3 The General Practice Services Committee shall be composed of six members appointed by the Government and six 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 and shall appoint two of its members as vice chairs, one who shall be chosen by the Government from among the Government members and one who shall be chosen by the BCMA from among 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 to the Physician Services Committee in the manner outlined in section 6.3(a) of the 2012 Physician Master Agreement.

4.8 The General Practice Services Committee must follow any communication protocol developed by the Physician Services Committee, and in any event must ensure that the co-chairs of the General Practice Services Committee pre-approve any communication about the business and/or decisions of the General Practice Services Committee.
4.9 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 $190.5 million annual funding level for full service family practitioners, as follows:

(a) $10 million made available effective April 1, 2012;
(b) an additional $8 million made available effective April 1, 2013.

The funds identified in this section 5.1 are to be allocated by the General Practice Services Committee to support its work in maintaining, enhancing and expanding the programs that support the delivery of primary care services to British Columbians by, among other things, supporting integrated and collaborative initiatives including change management, identifying and treating patients and communities with unmet needs, providing incentives for General Practitioners to provide full service family practice, enhancing risk assessment and reduction, improving capacity in primary care, enhancing comprehensive and continuous care and improving coordination and quality of care to family practice patients in British Columbia, with allocations to include, but not be limited to, the areas identified in section 5.2.

5.2 The General Practice Services Committee will use the funds available to it pursuant to section 5.1 for the following purposes, among others:

(a) to fund financial incentive programs for the support of full service family practice, including:
   (i) improved identification and management of:
      (A) mental health conditions;
      (B) chronic disease;
      (C) complex co-morbidities;
      (D) maternity care;
      (E) the frail elderly;
      (F) the co-ordination of care of patients in hospital or residential care; and
      (G) patients requiring end of life care; and
   (ii) increased multi-disciplinary care between General Practitioners and other healthcare providers;
(b) to fund, in whole or in part, full service family practice support programs such as Divisions of Family Practice and the Practice Support Program; and
(c) to improve disease prevention.

5.4 Any funds identified in sections 5.1 that remain unexpended at the end of any Fiscal Year will be available to the General Practice Services Committee for use as one time allocations to improve the quality of care.

5.5 The General Practice Services Committee will continue to 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.
ARTICLE 6 – ATTACHMENT

6.1 If the General Practice Services Committee agrees, the Government may, at its discretion, make funds available to the General Practice Services Committee to be used to support non-physician related costs of Attachment. Any such additional funds will be identified specifically for this purpose and any such funds not so expended by the General Practice Services Committee will be returned to the Government.

6.2 Funds previously approved by the General Practice Services Committee to support Attachment will be available for the direct physician compensation associated with Attachment unless otherwise decided by the General Practice Services Committee.

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.

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 20, 21 and 22 of the 2012 Physician Master Agreement applicable to Provincial Disputes.

IN WITNESS WHEREOF the parties have executed this Agreement by or in the presence of their respective duly authorized signatories as of the 1st day of April, 2012. SIGNED, SEALED & DELIVERED on behalf of HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, by the Minister of Health or his/her duly authorized representative, in the presence of:

______________________________
Signature of Witness

______________________________
Name

______________________________
Address
THE CORPORATE SEAL of the BRITISH COLUMBIA MEDICAL ASSOCIATION was hereunto affixed in the presence of:

__________________________________________________________
Signature of Authorized Signatory

__________________________________________________________
Name

__________________________________________________________
Position

MEDICAL SERVICES COMMISSION

Per:

__________________________________________________________
Authorized Signatory

__________________________________________________________
Name

__________________________________________________________
Position