

Transforming family practice in British Columbia

The General Practice Services Committee

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ABSTRACT

OBJECTIVE To describe a new approach to primary care reform developed in British Columbia (BC) under the leadership of the General Practice Services Committee (GPSC).

COMPOSITION OF THE COMMITTEE The GPSC is a joint committee of the BC Ministry of Health Services, the BC Medical Association, and the Society of General Practitioners of BC. Representatives of BC's health authorities also attend as guests.

METHOD This paper is based on the 2008-2009 annual report of the GPSC. It summarizes the history and main activities of the GPSC.

REPORT The GPSC is currently supporting a number of key activities to transform primary care in BC. These activities include the Full Service Family Practice Incentive Program, which provides incentive payments to promote enhanced primary care; the Practice Support Program, which provides family physicians and their medical office assistants with various practical evidence-based strategies and tools for managing practice enhancement; the Family Physicians for BC Program to develop family practices in areas of identified need; the Shared Care Committee, which supports and enables the determination of appropriate scopes of practice among GPs, specialists, and other health care professionals; the Divisions of Family Practice, which are designed to facilitate interactions among family doctors and between doctors and their respective health authorities; and the Community Healthcare and Resource Directory, a Web-based resource to help health care providers find appropriate mental health resources.

CONCLUSION Early results indicate that the GPSC's initiatives are enhancing the delivery of primary care services in BC.

RÉSUMÉ

OBJECTIF Décrire une nouvelle façon d'envisager la réforme des soins primaires instaurée en Colombie-Britannique (CB) sous la direction du General Practice Services Committee (GPSC).

COMPOSITION DU COMITÉ Le GPSC est un comité conjoint qui réunit le BC Ministry of Health, la BC Medical Association et la Society of General Practitioners of BC. Des représentants des services de santé publique assistent aussi aux réunions.

MÉTHODE Cet article est basé sur le rapport annuel de 2008-2009 du GPSC. Il résume l'histoire et les principales activités du GPSC.

LE RAPPORT Le GPSC supporte présentement un certain nombre d'activités-clés visant à transformer les soins primaires en CB. Ces activités comprennent le Full Service Family Practice Incentive Program, qui propose aux MF et aux intervenants de leurs bureaux diverses stratégies pratiques fondées sur des données probantes et des outils pour améliorer leur pratique; le Family Physicians for BC Program, qui cherche à développer la médecine familiale dans des régions qui en ont besoin; le Share Care Committee, qui soutient et rend possible l'identification de champs de pratique appropriés pour les MF, les spécialistes et les autres professionnels de la santé; les Divisions of Family Practice, qui ont été créées pour faciliter l'interaction entre les MF ainsi qu'entre les médecins et les responsables des services de santé publique; et le Community Healthcare and Resource Directory, un site Web qui aide les intervenants de la santé à trouver les ressources appropriées en santé mentale.

CONCLUSION Les premiers résultats suggèrent que les initiatives du GPSC améliorent la distribution des services de santé primaires en Colombie-Britannique.

Through the British Columbia (BC) Ministry of Health Services (MoHS) and the BC Medical Association (BCMA) 2002 Subsidiary Agreement for General Practitioners, government and the BCMA worked together to establish the General Practice Services Committee (GPSC) to support and foster family practice in BC. The GPSC is a joint committee of the BC MoHS and the BCMA, including the Society of General Practitioners of BC. Representatives of BC's health authorities also attend as guests. The GPSC engages in numerous activities to support GPs. Its operational funding and mandate are based on a formal working agreement between the BC government and the BCMA. The GPSC has the mandate of finding solutions to support and sustain full-service family practice in BC. Unlike other jurisdictions, which have opted for structural changes in how primary care services are delivered (eg, the adoption of community health clinics with salaried physicians), the BC approach has been to address an operational problem (ie, the decline in family practice) with an operational response, by improving the existing system rather than changing the system by adopting new structural changes.

METHODS

The GPSC works by consensus. Minutes of meetings are kept and consensus decisions are recorded. This paper is based on the fiscal 2008-2009 year annual report of the GPSC. The Annual Report is prepared by the Secretariat to the GPSC. The minutes of meetings, records of decisions, and administrative data are reviewed by the Secretariat, as are existing descriptions of the GPSC, evaluation results, and other relevant materials. The Secretariat prepares a draft Annual Report, which summarizes the history and main activities of the GPSC. The draft Annual Report is reviewed by the GPSC. Edits are made based on input provided by the committee, and the final document is approved by the GPSC.

Full Service Family Practice Incentive Program

Chronic disease management. Since 2003, BC's full-service family practice physicians have been eligible to receive an annual payment of \$125 for each of their patients with a confirmed diagnosis of diabetes mellitus or congestive heart failure who have received care in accordance with BC clinical guideline recommendations. In addition, as of 2006, an annual \$50 payment is available to better support GPs in the management of hypertension according to BC clinical guideline recommendations for those patients who do not also have diabetes or congestive heart failure.

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Maternity care. The Obstetric Premium, implemented in 2003, provides a 50% bonus on delivery fee items. The Maternity Care Network Payment, implemented in 2006, helps cover the costs of group or network activities for shared care of obstetric patients. The Maternity Care Network Payment provides \$1850 per quarter to each GP participating in a formal group practice approach to maternity care provision. In an attempt to reverse the level of attrition, in January 2008 the GPSC launched the Maternity Care for BC program, which makes training available to BC GPs who want to update their maternity skills and to graduating residents who want to include obstetrics in their practices.

Conferencing fees. In 2006, fees were introduced in order to support the care needs of frail elderly patients requiring palliative care or end-of-life care, patients with mental illness, or those with complex comorbidities. The Community Patient Conferencing Fee was developed to better support GPs in developing clinical action plans for the care of community-based patients with complex care needs in these 3 areas. The aim of the Facility Patient Conferencing Fee is to better support GPs as they work with patients, other health care providers, and patients' family members as partners in the review and ongoing management of patients in facilities.

Complex care. Under the 2007 Physician Master Agreement, \$25 million was allocated for the development of a complex care fee to better support GPs for the care of their high-risk patients with 2 or more of the following chronic illnesses:

- diabetes mellitus (type 1 or 2),
- end-stage kidney disease (glomerular filtration rate less than 60 mL/min),
- vascular disease (limited to congestive heart failure, ischemic heart disease, and cerebrovascular disease), and
- respiratory disease (limited to chronic obstructive pulmonary disease and chronic asthma).

Under the Annual Complex Care Management Fee, GPs are eligible to receive \$315 per patient each year for developing and monitoring the patient's care plan. In addition, a \$15 complex care e-mail or telephone follow-up management fee is payable up to 4 times per year for each patient. This fee enables the practice to follow-up with the patient or the patient's medical representative using telephone or e-mail communication for 2-way discussions of clinical issues.

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 this regard, GPs can receive \$100 per patient for cardiovascular risk-reduction assessments for up to 30 at-risk patients over

the calendar year, to a maximum payment of \$3000 per GP. The assessment must include a personal action plan developed by the GP and patient.

Mental health. The Community Mental Health Initiative, implemented in January 2008, supports GPs' provision of accurate diagnoses, patient plans, and longitudinal follow-up of patients in the community with an Axis I diagnosis confirmed by DSM-IV criteria and 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 the development and documentation of a patient's mental health plan. The fee requires a face-to-face visit with the patient, with or without the patient's medical representative.

In addition, a mental health telephone or e-mail management fee is payable for 2-way clinical interaction provided between the GP or delegated practice staff (eg, office registered nurse or medical office assistant) in follow-up of the plan developed under the Mental Health Planning Fee. As well, after creating and successfully billing for a mental health plan, GPs are able to access up to 4 mental health counseling visits for these patients over the balance of the calendar year (this is in addition to up to 4 counseling visits per year that can be billed for any patient, as appropriate).

Practice Support Program

In order to better understand the perceived decline in family practice, the GPSC held consultations in fiscal year 2004-2005 called Professional Quality Improvement Days (PQIDs) with 1000 GPs in BC. In response to the PQID consultations, the GPSC established the Practice Support Program (PSP). The PSP was designed to address the training and support components of GPs' needs identified through the PQID consultations.¹

The PSP offers the following learning modules: chronic disease management, patient self-management, advanced access scheduling, group medical visits, and mental health. The learning modules (jointly developed by the MoHS, the BCMA, and Impact BC) provide family physicians and their medical office assistants with a variety of practical, evidence-based strategies and tools for managing practice enhancement.²

Since the implementation of the learning modules in May 2007, the modules have been delivered regionally by Practice Support Teams throughout the province in a series of interactive, accredited continuing medical education learning sessions, with in-practice support in the action periods that occur between learning sessions.

As of March 31, 2009, more than 1200 (approximately one-third) of BC's GPs, plus their medical office assistants, had participated in the PSP. Some \$15.4 million of the total \$20 million one-time funding has been allocated to support the PSP.

Other initiatives

Attraction and retention of family practitioners. The Family Physicians for British Columbia (FPS4BC) program was launched on June 1, 2007, to encourage GPs who had completed their residency training within the past 10 years to establish or join group family practices in communities identified by local health authorities as being communities of need. The FPS4BC program provides up to a maximum of \$100000 per GP to help them pay off student debt and set up or join their group practices. In return for the FPS4BC funding, GPs are required to provide 3 years return of service.

Shared Care and Scopes of Practice Committee. This committee was established with equal representation from the GPSC and the Specialist Services Committee. The function of this committee is to develop recommendations, including the creation of new fees, to enable shared care and appropriate scopes of practice among GPs, specialist physicians, and other health care professionals.

Multidisciplinary care between GPs and health care providers. Through the Physician Master Agreement, \$5.5 million was made available in fiscal year 2009-2010 to support GPs who directly, or through the health authorities, wished to contract with other health care providers to provide multidisciplinary care for targeted populations.

Divisions of Family Practice. In fiscal year 2008-2009, 3 prototype Divisions of Family Practice, designed to facilitate interactions between family physicians and their respective health authorities, were implemented. As of March 2009, 16 additional communities had indicated interest in forming Divisions of Family Practice. Funding is available for up to 4 Divisions of Family Practice in each BC health authority. The GPSC has allocated \$6 million for infrastructure costs associated with developing Divisions of Family Practice and has hired an executive lead to oversee the initiative.

Community Health and Resource Directory. In fiscal year 2008-2009, the GPSC worked with the provincial HealthLinkBC to build a Web-based Community Healthcare and Resource Directory (CHARD). The goal of the CHARD is to enable health care providers to more efficiently find appropriate specialists or services within particular geographic locations. The CHARD program was fully implemented by April 2010.

FINDINGS

The GPSC activities are being evaluated. To date GPSC initiatives have generally been well received by physicians. However, work is ongoing in regard to electronic medical

records and the additional paperwork generated by the incentive payments. The overall uptake of the payment incentives has been quite high. Once one focuses on family physicians and excludes GPs who do not appear to have active full- or part-time practices, such as hospitalists, emergency department GPs, and GPs working in walk-in clinics, it was found, for example, that the uptake for billing a diabetes incentive went from 45.3% in fiscal 2003-2004 to 85.9% in fiscal year 2007-2008. The comparable percentages for all GPs were 33.4% and 62.5%, respectively. The uptake for all incentives for family physicians in fiscal 2007-2008 was 92.2%. It was 71.7% for all GPs.³

The PSP learning modules have been well received and well attended, and have had an effect. For example, the waiting time for a regular appointment to see a GP was reduced, on average, from 5.8 days to 2.5 days for GPs who completed the advanced access learning module. In addition, some 91% of GPs who completed the chronic disease management learning module agreed that attending the module had prompted them to develop a chronic disease management patient register.¹

Finally, it was found that patients with higher care needs who received most of their care from a single primary care practice cost the health care system less than patients who did not. Most of the cost differential was attributable to lower hospital costs for patients who received most of their care from a single practice.⁴ In fact, an extrapolation of the data from the paper indicated that even a 5% overall increase in attachment of patients with higher care needs to individual practices could potentially result in annual cost avoidance of \$85 million.⁵ This finding demonstrates the benefits of good primary care and supports the efforts of the GPSC to enhance the delivery of primary care services in BC. It is anticipated that additional papers will be published based on the evaluation of GPSC activities. 🌿

Dr Cavers is a family physician in Victoria, BC, a member of the board of the BC Medical Association, and Co-Chair of the General Practice Services Committee (GPSC). **Ms Tregillus** is the Executive Director of Primary Health Care for the Ministry of Health Services in Victoria, BC, and Co-Chair of the GPSC. **Dr Micco** is the Secretariat to the GPSC for the BC Ministry of Health Services in Victoria. **Dr Hollander** is the President of Hollander Analytical Services Ltd, a national health services and policy research firm headquartered in Victoria.

Acknowledgment

In the 2008-2009 fiscal year, the General Practice Service Committee comprised the following members: **Dr William Cavers** (BC Medical Association [BCMA]), Co-Chair; **Valerie Tregillus** (Ministry of Health Services [MoHS]), Co-Chair; **Dr Jean Clarke** (Society of General Practitioners [SGP]); **Judy Huska** (MoHS); **Dr Garey Mazowita** (MoHS); **Nichola Manning** (MoHS); **Dr George Watson** (SGP); and **Dr Brian Winsby** (BCMA). The following were invited guests from the regional health authorities in fiscal year 2008-2009: **Carol Gillam**, Vancouver Coastal Health Authority; **Colleen Hart**, Fraser Health Authority; **Dr Dan Horvat**, Northern Health Authority; **Betty Jeffers**, Interior Health Authority; and **Victoria Power**, Vancouver Island Health Authority. Staff support was provided by **Dr Dan MacCarthy** (BCMA), **Dr Cathy Clelland** (SGP), and **Dr Angela Micco** (MoHS). **Dr Angela Micco** is the Committee Secretariat, and **Greg Dines** (BCMA) is the alternate Secretariat.

Contributors

All 4 authors had an active involvement in writing or editing the article. In addition, the Co-Chairs were instrumental in developing the General Practice Services Committee initiatives described.

Competing interests

Dr Cavers can bill sessional fees for his participation in General Practice Services Committee (GPSC) activities. **Ms Tregillus** and **Dr Micco** are staff of the BC Ministry of Health Services and work on GPSC activities as part

of their duties at the Ministry of Health Services. **Dr Hollander** has a contract to evaluate GPSC activities, and his firm receives funds for conducting the evaluations.

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EDITOR'S KEY POINTS

- The General Practice Services Committee (GPSC) seeks to find solutions to support and sustain full-service family practice in British Columbia by improving the existing system rather than changing the system by adopting structural changes.
- The GPSC has implemented numerous services that are being evaluated. Initiatives have generally been well received by physicians, participation is quite high, and effects are already being seen. For example, the waiting time for a regular appointment to see a GP was reduced, on average, from 5.8 days to 2.5 days for GPs who completed the advanced access learning module. It was also found that patients with higher care needs who received most of their care from a single primary care practice cost the health care system less than patients who did not, demonstrating the benefits of good primary care and supporting the efforts of the GPSC to enhance the delivery of primary care services in British Columbia.

POINTS DE REPÈRE DU RÉDACTEUR

- Le General Practice Services Committee (GPSC) recherche des solutions pour supporter et maintenir des services complets de médecine familiale en Colombie-Britannique en améliorant le système plutôt qu'en le changeant par l'adoption de modifications structurelles.
- Le GPSC a instauré plusieurs services qui sont en voie d'évaluation. Ces initiatives ont été généralement bien acceptées par les médecins: la participation est relativement élevée et les effets commencent à se faire sentir. Ainsi, le temps d'attente pour un rendez-vous ordinaire avec un MF a diminué, passant de 5,8 à 2,5 jours en moyenne pour les MF qui ont complété le module d'apprentissage «accès plus rapide». On a également observé que les patients nécessitant des soins plus importants coûtaient moins cher au système lorsqu'ils étaient suivis dans un seul établissement de médecine primaire, démontrant ainsi les avantages des soins primaires de bonne qualité, tout en appuyant les efforts du GPSC pour promouvoir les services de soins primaires en Colombie-Britannique.