

GENERAL PRACTICE SERVICES COMMITTEE



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Mandate

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

This mandate was renewed under the 2004 MOH/BCMA Working Agreement, and most recently under the MOH/BCMA 2006 Agreement.

Organization Structure

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

All decisions of the GPSC are made by consensus.

In 2006/07, members of the B.C. Primary Health Care - Health Authority Leads Committee (Appendix B) participated in GPSC meetings on a rotating basis as meeting guests/observers.

Background

Whereas there are many points of patient contact with the health system and B.C. patients rely on various members of the health care system to identify and meet their changing health needs, the relationship between patients and their general practitioner (GP) remains unique. Specifically, the physician/patient relationship involves longitudinal, comprehensive medical care for an individual within the context of their family and community. As a result, this relationship provides the best opportunity to identify areas of health concern and appropriate intervention.

The important role GPs play in helping to ensure the sustainability of the B.C. health care system was recognized in the MOH/BCMA 2002 Working Agreement in which \$20 million was allocated to better support the care that occurs in the community by GPs. Through this Agreement, the GPSC was formed and tasked with the responsibility of working with B.C.'s GPs to develop financial incentives aimed at helping address the following challenges facing full service family practice (FSFP) in B.C.:

- Declining number of GPs choosing full service family practice;
- Declining number of medical students choosing to enter general practice;
- Declining number of GPs providing obstetric care to women in their community;
- Increasing number of patients requiring full service complex care over a long period of time (chronic disease, mental illness, frail elderly, end of life); and
- Regarding organization of the health system to episodic/acute episodes rather than longitudinal care.

In 2003/04, through the \$20 million targeted for FSFP in the 2001 Working Agreement, the GPSC established the Full Service Family Practice Incentive Program in which the following incentive payments were introduced to help address some of the challenges facing FSFP:

Full Service Family Practice Condition Based Payments were aimed at supporting high quality management of congestive heart failure and diabetes. Physicians were eligible to receive an annual \$75 incentive payment for each patient with diabetes and/or congestive heart failure whose clinical management was consistent with recommendations in the B.C. Clinical Practice Guidelines developed through the MOH/BCMA Guidelines and Protocols Committee.

Family Physician Obstetrical Premium was introduced to encourage and support low to moderate volume delivery practice. General practitioners were eligible to receive a 50 per cent bonus on the current value of the fee-for-service delivery payment (fee codes 14104 or 14109). The bonus payment is payable up to a maximum of 25 deliveries per calendar year.

Sessional Funding for Structured Collaborative Participation was introduced to enable GPs to attend chronic disease quality improvement structured collaboratives sessions without experiencing a loss in practice income (funding ended 2003/2004).

In 2004/05, the Full Service Family Practice Condition Based Payments and the Obstetrical Premium saw continued funding as a result of the 2004 MOH/BCMA Working Agreement in which \$37 million was allocated for FSFP. Under this Agreement, the GPSC also introduced the:

Maternity Care Network Payment that was initiated as a bridging program until the Maternity Care Enhancement Committee (created under the 2004 Working Agreement between the BC Medical Association and the Province of British Columbia) developed a long-term and sustainable maternity care strategy for B.C. Under this network payment eligible practitioners received a \$1,250 quarterly payment to support a group practice approach to GP provision of obstetrical care, whereby doctors forming their own shared care networks work as a team so that at least one physician is always available to deliver their patients.

Professional Quality Improvement Days (PQIDs) that were designed and delivered under the auspices of the GPSC as a province wide consultation with B.C. GPs on how best to renew the primary health care system for improved quality of patient care and GP professional satisfaction. The PQIDs engaged approximately 1000 GPs from across B.C. and resulted in the development of ideas and strategic direction for addressing challenges facing FSFP physicians.

The priorities identified during the PQIDs were used to set direction in the negotiation of the MOH/BCMA 2006 Agreement – *Article 7: Supporting Access and Improvement to Full Service Family Practice*, and in the development of the BC Ministry of Health’s, *Primary Health Care Charter* which sets out a strategic plan for increasing the capacity of the province’s primary health care system for improved patient health outcomes.

GPSC Report on 2006/07 Activities

As part of the MOH/BCMA 2006 Agreement – Article 7, \$382 million over four years was allocated for FSFP (Appendix C). Through this funding, the Full Service Family Practice Incentive Program was expanded to address the following priority areas for supporting and sustaining FSFP:

Chronic Disease Management

Over the past four years, B.C. has made in-roads in closing care gaps in the management of chronic disease, and has taken a leadership role in developing collaborative, evidence-based approaches to the management of diabetes and congestive heart failure.

In April 2006, the incentive payments for providing guidelines based diabetes (14050) and congestive heart failure (14051) care were increased from \$75 per patient/per year to \$125.

Hypertension is a major risk factor for heart attack and stroke, cardiovascular disease, and chronic kidney disease. As such, the GPSC introduced a \$50 hypertension care incentive (14052) to help ensure patients with hypertension are managed according to B.C. Clinical Guideline recommendations.

Table 1 shows the number of GPs who participated in the condition payments in 2006/07, and the number of patients who received care in accordance with the B.C. Clinical Guideline recommendations.

Table 1. Summary of Condition Based Payments for 2006/07 ¹

	GP Participation	Patients Receiving Evidence Based Care	Expenditures
Diabetes	2,783	109,079	\$13,652,250
Congestive Heart Failure	1,540	12,711	\$1,591,375
Hypertension	2,224	171,487	\$8,348,600

In recognition of their accomplishments in providing optimal diabetes care, in February 2007, letters of congratulations were sent to the 650 B.C. GPs who provided guidelines based diabetes care to 75 per cent or more of their diabetes patient caseload.

1. All statistics reported in the annual report reflects billings paid as of March 31, 2007.

Maternity care

B.C. GPs face challenges in providing maternity care such as increased complexity due to increasing maternal age at first birth, and limited surgical back-up and staffing support in rural and remote areas of the province. Whereas, there were 1,400 GPs delivering babies in B.C. in 1999/00, over the past five years the number of GPs providing maternity care has declined by 33 per cent. Over the past 4 years however, there appears to have been a levelling off in the drop in the numbers of deliveries involving GPs, with a slight increase in the most recent year. It is too early to tell yet whether this trend will continue.

In order to help ensure that women are able to receive obstetric care in their community, in April 2006, funding was allocated to continue the Obstetric Premium, and in January 2007, the premium was extended to fee item 14108 (elective c-section and post partum care).

In 2006/07, 805 GPs participated in the Obstetric Premium, providing maternity care to 13,050 women in their communities (2006/07 expenditure - \$3,400,888).

Per the recommendations of the Maternity Care Enhancement Committee report, funding was also continued for the Maternity Care Network Payment starting with the 3 month period ending June 30, 2006. Effective December 31, 2006, the Maternity Care Network Payment was increased to \$1,500 per quarter. As of March 31, 2007, 113 GP networks (total 700 GPs) were registered as eligible to receive the Maternity Network Payment (2006/07 expenditure as of April 30, 2007 - \$2,945,000).

In March 2007, the GPSC approved the expenditure of up to \$1 million to make a maternity training program available to B.C. GPs wanting to update their maternity skills. This training will include support for up to eight weeks of training for both urban and rural physicians, to meet the requirements for GP Obstetric privileges established by their local hospital.

The delivery model for the maternity training is based upon a sponsorship/mentorship model. Interested physicians will be funded to shadow a sponsoring physician with obstetrical credentials at their community hospital. Funding will be provided until they can meet the delivery requirements to be credentialed themselves. Eligibility will be offered to both rural and urban physicians. As such, GPSC funding has been allocated to the BCMA to administer the maternity care training program. This maternity training program will be available to GPs in Fall 2007.

Improved care of the frail elderly, patients requiring end of life care, and increased multidisciplinary care between general practitioners and health care providers:

In April 2006, a Facility Patient Conference Fee (14015) and a Community Patient Conference Fee (14016) were made available to better support GPs in working with patients as partners, other health care providers and patient family members in the review and ongoing management of patients in a facility, and for creation of a coordinated clinical action plan for the care of community-based patients with more complex needs, respectively.

These new fees are aimed at supporting 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.

In 2006/07, 798 GPs participated in the Facility Patient Conference Fee, providing collaborative planning for 3,784 patients (2006/07 expenditures - \$312,627). Moreover, clinical action plans were developed for 7,920 patients under the Community Patient Conference Fee (billed by 1,073 GPs in 2006/07). 2006/07 expenditures for this fee were \$666,785.

Incentive Payments - Effective April 1, 2007

Complex Care Fee

As patients grow older it is not uncommon that they experience a combination of chronic diseases. This complexity requires thoughtful planning and care coordination by the GP, medical specialists and other health care professionals. It also requires the full involvement of the patients, and often involves their families.

The 2006 Agreement allocated \$25 million for the development of a chronic care fee that is payable in addition to an office visit, which enables GPs to take the time out of the rapid episodic care system and spend the time necessary to develop and implement a personal care plan for each patient.

Effective April 1, 2007, GPs are able to access complex care payment for the care of their high-risk patients with two or more of the following conditions:

- Diabetes Mellitus
- End stage kidney disease
- Vascular Disease, limited to:
 - Congestive Heart Failure
 - Ischemic Heart Disease
 - Cerebrovascular Disease (stroke)
- Respiratory Disease, limited to:
 - Chronic Obstructive Pulmonary Disease
 - Chronic Asthma

GPs will be paid a maximum of \$315 per year/ per high risk patient in the priority disease categories, and for each qualifying patient the GP can choose to be paid in one of the two following ways:

Option 1: Consists of 6 fees for the following face to face interactions: initial review of chart and development of personal care plan at \$100, review of care plan later in the year at \$75, and 4 inter-sessional visits at \$35 per visit. All are billed in addition to the office visit.

Option 2: Annual payment of \$315 plus a block payment equivalent to 6 visits per year for each high risk complex patient for the care for those co-morbid conditions. Care under this option can be face-to-face, could be provided by group visit or by a nurse or other health professional, telephone or e-mail.

Conferencing with other health professionals and family is covered by GPSC's Community Patient Conferencing Fee (14016).

Prevention

Effective April 1, 2007, per the 2006 Agreement, 5 per cent of the annual budget allocated for FSFP under the 2006 Agreement will be used to develop and implement evidence based prevention activities delivered in GP offices to high risk patients.

The GPSC has developed an incentive payment for GPs undertaking a cardiovascular risk reduction assessment with their at-risk patients (effective April 1, 2007). If major risk factors are present, a personal action plan will be developed by the GP and patient that includes the following elements:

- Patient's goals related to diet, tobacco use and moderate exercise;
- Clinical elements determined by reference to specific GPAC guidelines (e.g. diabetes, hypertension, lipid) and the new cardiovascular disease primary prevention guideline (which recognizes the importance of major individual disease specific guidelines and the critical importance of appropriate lifestyle modifications for all patients); and
- Approaches to enable patients to understand and be an active partner in defining and achieving their key clinical and personal goals to reduce the major risk factors.

A \$3000 payment will be made for the assessment of a minimum of 30 patients over the calendar year; billing will be done on an individual patient basis for a maximum of 30 such patients. The budget for this prevention incentive is capped at \$5 million for 2007/08.

Attraction and Retention of Family Practitioners

As per the 2006 Agreement, the GPSC approved the expenditure of \$10 million in one-time funding to attract and retain recently qualified physicians in full service family practice in those areas of the province where the GPSC identified in collaboration with regional health authorities that there is a demonstrated need for additional FSFP physicians.

GPs who have been in practice from 0 – 10 years may be eligible to receive the following one-time funding to a maximum of \$100,000 as follows:

Up to:

- \$40,000 for student debt forgiveness,
- \$52,000 as a New Practice Supplement,
- \$40,000 to set up or join a group practice, and
- \$1,500 as an additional bonus for obtaining full hospital privileges.

To be eligible for this funding, GPs must agree to a three year return of service, and it is expected that they participate in chronic disease management, and take on orphan patients. This incentive program became effective June 2007, but in the first year, payment will be available for practices started since April 1, 2006.

GP Non-Compensation Funding

Per the 2006 Agreement, \$20 million in one-time funding was allocated to support primary care renewal in the following specific priority areas:

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

During the 2005/06 PQID consultation, B.C. GPs identified practice enhancement and system-redesign as two issues of importance in supporting and sustaining full service family practice. In response, the GPSC allocated \$6.4 million for 2006/07 fiscal year to support the Practice Support Program (PSP). This program will provide GPs with the resources and support to identify and make the changes to their clinical practice for improved patient health outcomes and physician professional satisfaction.

The PSP will offer a menu of practice enhancement training modules spanning three domains: clinical, practice management, and information technology that includes:

- Developing Patient Registers,
- Managing Planned Care,
- Enabling Patient Self-Management,
- Introducing Group Visits,
- Expanding the Medical Office Assistant's (MOA) Role, and
- Adopting the CDM Toolkit.

The training modules (jointly developed by the MoH, BCMA, Health Authorities & IMPACT BC-Healthy Heart Society) will provide to GPs practical, evidence-based strategies and tools for managing practice enhancement change. The PSP is being delivered regionally, and each of BC's five health authorities received \$1 million of the \$6.4 allocation for the establishment of regional change management teams. The regional change-management teams will provide expertise for clinical, practice and information management/technology transformation using a collaborative approach and engaging with family physicians and other health professionals to introduce and embed evidence-based changes into clinical practice.

On April 11-13, 2007, the PSP held a three-day regional support team orientation workshop that trained the regional support teams on how to effectively mentor and support physicians and MOAs in managing changes to their practice.

In May 2007, B.C. GPs were invited to attend a one day PSP workshop where they were given an overview of the PSP and of the new culture for HA/GP engagement; at this time GPs were also introduced to the practice enhancement training modules and mentorship support available to them. A billing seminar on the application of the GPSC incentives was also included. Additional funding was made available from the \$20 million allocation for this activity.

One-time Allocation

Per the 2006 Agreement, GPs who as of April 1, 2006, billed the chronic care incentive payment for at least 10 patients with diabetes or congestive heart failure by completing the patient flow sheets since the inception of the program in 2003, and/or performed at least five deliveries (fee codes 14104 or 14109) in the preceding 12 months, were eligible to receive a one time payment of \$2,500. In addition, GPs who as of June 30, 2006, provided the care mentioned above in the last 12 months were eligible to receive a one time payment of \$7,500.

In total, 2,879 GPs received payments under this program. Total expenditures for these 2 one-time payments were \$28,175,000.

Upcoming 2007/08 GPSC Activities

In March 2007 a Request for Proposals to evaluate the impact of the Full Service Family Practice Incentive Program and the Practice Support Program was publicly tendered. A contract with the successful proponent is expected to be negotiated by August 2007.

Per the 2006 Agreement, in 2006/07, the GPSC formed a project group that undertook the review and formulation of recommended approaches that support the continued roles of GPs in providing hospital care. Recommendations will be issued in 2007.

In 2007, the GPSC will participate on a trilateral Shared Care and Scope of Practice committee to develop recommendations to better enable shared care among GPs and specialists and appropriate scopes of practice. This committee will issue its report no later than March 31, 2009.

Per the 2006 Agreement (re: Section 7.5 (d) – Health Authority Contracts with GPs), \$5.5 million will be available to support GPs who, where directly, or through health authorities, wish to contract with other health care providers to provide multidisciplinary care for targeted populations. A GPSC project group will present its recommendations to the GPSC in 2007.

GPSC members are participating on a joint Tariff Committee working group to develop recommendations on potential ways of re-profiling the 0120 counselling fee series to better meet patient and practitioner needs. Recommendations were tabled at GPSC early 2007.

Appendix A: GPSC Membership 2006/07

Dr. William Cavers (BCMA) Co-Chair
Valerie Tregillus (MOH) Co-Chair
Phyllis Chuly (MOH)
Dr. Steven Goodchild (SGP)
Judy Huska (MOH)
Dr. Art Macgregor (MOH)
Dr. George Watson (SGP)
Dr. Brian Winsby (BCMA)

Staff Support

Dr. Dan MacCarthy (BCMA)
Dr. Cathy Clelland (SGP)
Angela Micco (MOH)

Committee Secretariat

Angela Micco (MOH)
Alternate: Greg Dines (BCMA)

Ex-Officio Members

Dr. Stephen Brown (MOH)
Dr. Mark Schonfeld (BCMA)

Appendix B: Primary Health Care - Health Authority Leads Committee Membership 2006/07

Laurie Gould

Executive Director
Health Planning & Systems Development
Primary Care & Chronic Disease Management
Fraser Health Authority

Judy Huska

Regional Manager
Health Services Integration
Northern Health Authority

Victoria Power-Pollitt

Director
Primary Health Care and Chronic Disease Management
Vancouver Island Health Authority

Robert Turnbull

Director
Primary Health Care & Chronic Disease Management
Interior Health Authority

Nancy Rigg

Executive Director
Community Care Network
Vancouver Coastal Health Authority

Appendix C: Ministry of Health/BC Medical Association 2006 Agreement, Article 7

ARTICLE 7 - SUPPORTING ACCESS AND IMPROVEMENT TO FULL SERVICE FAMILY PRACTICE

7.1 General Practice Services Committee

- (a) Effective April 1, 2007, the membership of the GPSC will be reconstituted such that there is equal representation from the Government, the BCMA and the Health Authorities. The total number of members of the reconstituted GPSC will be nine.
- (b) All decisions of the GPSC will be consensus decisions. If the GPSC cannot reach a consensus decision on any matter that it is required to determine, the Government and/or the BCMA may make recommendations to the Commission regarding such matter and the Commission, or its successor, will determine the matter.

7.2 Costs of GPSC

7.3 The costs of:

- (a) administrative and clerical support required for the work of the GPSC; and
- (b) physician (other than employees of the parties) participation in the GPSC,

ARTICLE 7 - WILL BE PAID FROM THE FUNDS TO BE ALLOCATED BY THE GPSC PURSUANT TO THIS AGREEMENT

7.1 Full Service Family Practice Funding

- (a) The vehicle of the re-constituted GPSC 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:
 - (i) effective April 1, 2006, \$60 million (inclusive of \$5 million for a Maternity Care Network Initiative Payment);
 - (ii) effective April 1, 2007, an additional \$20 million;
 - (iii) effective April 1, 2008, an additional \$25.5 million; and
 - (iv) effective April 1, 2009, an additional \$31 million;
- (b) such increases to be allocated by the GPSC to the areas identified in sections 7.2(a) and 7.3, or to any other areas that may be determined by the GPSC.
- (c) The parties agree that no further funds will be available or provided pursuant to Article 6.6 of the 2004 Subsidiary Agreement for General Practitioners.

7.2 Allocation of Full Service Family Practice Funding to March 31, 2007

- (a) The priorities for the allocation of the funds referred to in section 7.1(a)(i) 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;
 - (ii) will receive a one time payment of \$2500. This payment will 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 Article 7 - 7.1(a)(i);
 - (iii) 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 Article 7 - 7.2(a)(v) 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;
 - (iv) will receive a one time payment of \$7500 (approximately \$25 million expenditure);
 - (v) effective April 1, 2006, the 13050 CDM Incentive Payment will be increased to an annual amount of \$125 per patient. In addition, a new incentive payment will be 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 GPSC;
 - (vi) effective April 1, 2006, a patient case management conference fee and a complex patient clinical action plan fee will be implemented, in accordance with guidelines and criteria set out by the GPSC, 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;
 - (vii) \$5 million will be available in each year to reinstate and support the Maternity Care Network Initiative Payment; and
 - (viii) any of the funds referred to in section Article 7 - 7.1(a)(i) 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 Article 7 - 7.2(a)(v) 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 Article 7 - 7.2(a)(i), 7.2(a)(iii) and/or 7.2(a)(viii), will be eligible to receive the one time payments identified in those sections in addition to their service, sessional or salary payments.

7.3 Allocation of Full Service Family Practice Funding Commencing April 1, 2007

Commencing April 1, 2007, the GPSC will use the funds then available to it pursuant to section 7.1(a) as follows:

- (a) the payments referred to in sections Article 7 - 7.2(a)(v), 7.2(a)(vi) and 7.2(a)(vii) will continue;
- (b) five percent (5%) of the funds will be allocated by the GPSC 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 GPSC 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 MSP payment schedule) for patients with two or more chronic diseases, including:
 - (i) asthma or chronic obstructive pulmonary disease;
 - (ii) diabetes;
 - (iii) hepatitis;
 - (iv) hypertension;
 - (v) chronic kidney disease; and
 - (vi) 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; and
- (e) the GPSC 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.

7.4 Carry Forward of Funding

Any funds identified in sections 7.1(a)(ii), 7.1(a)(iii) and 7.1(a)(iv) that remain unexpended for services rendered in a Fiscal Year will be available to the GPSC in the subsequent Fiscal Year for use as one time allocations in that subsequent Fiscal Year.

7.5 Support for General Practitioners' Role in Hospital Care

The GPSC 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 GPSC 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.

7.6 One Time Funding to Attract and Retain Full Service Family Practitioners

In addition to the funds referred to in section 7.1(a), the Government will provide new one time funding of \$10 million to be used by the GPSC to attract and retain additional recently qualified physicians in full service family practice in those areas of the province where the GPSC 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 five 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 GPSC determines that there is a demonstrated need for additional full service family practitioners, the GPSC will have discretion to provide funds to General Practitioners with more than five years of practice since licensure if the GPSC believes doing so will attract and retain full service family practitioners on a long term basis in such areas of the province. The GPSC may use these funds to provide:

- (a) repayment of student loan debt of up to \$40,000 under a return of service agreement scheme that requires five years of service for the full amount;
- (b) support for the costs of establishing a new full service family practice group to a maximum of \$40,000 (support for solo practices may be considered for remote rural areas); and/or
- (c) alternative payment arrangements for these full service family practice recruitments for a limited time while they build up a patient base to provide patients with access to full service family practice.

ARTICLE 7 - A FORMAL APPLICATION AND APPROVAL PROCESS AND GUIDELINES WILL BE ESTABLISHED BY THE GPSC TO IMPLEMENT THIS INITIATIVE.

7.1 Non-Compensation Funding

One time non-compensation support for full service family practice will be provided using the \$20 million fund for primary care renewal referred to on page 8 in Article 5(b)(ii) of the Letter of Agreement (Related Matters). This funding will be used to support the achievement of the GPSC priorities referred to in section Article 7 - 7.3(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.

7.2 GPSC Work Plans

On an annual basis, the GPSC 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 Government, the BCMA and the Health Authorities.



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