

GENERAL PRACTICE SERVICES COMMITTEE INITIATED LISTINGS-PREAMBLE

The following incentive payments are available to B.C.'s eligible family physicians. The purpose of the incentive payments is to improve patient care. These fees were previously administered by the General Practice Services Committee (GPSC). Note that the GPSC Preamble governs the GPSC initiated listings in this section, however, the GPSC Preamble does not apply to the rest of the MSP fee listings.

Unless otherwise identified in the individual fee description, physicians are eligible to bill the following incentive payments if they are:

1. A Family Physician who has a valid BC MSP practitioner number;
2. Currently in family practice in BC as a community longitudinal family physician;
3. The most responsible physician/provider for the majority of their patients' longitudinal primary medical care.

Unless otherwise identified in the individual fee description, physicians are NOT eligible to bill GPSC Incentives if:

1. They are working under an Alternate Payment/Funding model as defined below and their duties would otherwise include provision of this care; and
2. They have billed any specialty consultation fee in the previous 12 months.

Additional detailed eligibility requirements are identified in each section.

Definitions in GPSC Initiated Listings:

(1) PHYSICIANS

Community Longitudinal Family Physician (CLFP):

For the purpose of GPSC incentives, a family physician is working as a "Community Longitudinal Family Physician" (CLFP) when they do all of the following:

- ✓ Assume the role of Most Responsible Physician/Provider (MRP) for a known panel of patients
- ✓ Confirm patient-physician relationship with their patients through a standardized conversation or "compact", as outlined in PG14070.
- ✓ Provide, or coordinate delivery of, longitudinal full scope family medicine primary care services to a patient panel that is inclusive of patients of diverse demographics and medical needs.
- ✓ Work in community settings such as physician offices or health care clinics where patients are seen in person. CLFP may also provide some virtual services to their patient panel via telephone, video or other virtual care modality. CLFP may also provide some services to patient panel in facility settings such as hospitals, long term care, hospices, assisted living, or group homes.
- ✓ Maintain the comprehensive longitudinal medical records of each patient on patient panel.

A family physician is not considered to be working as a CLFP while they are working solely in one or more of the following health care settings:

- × Episodic care settings such as (but not limited to) walk-in clinics, urgent care centres, and hospitals, where physician does not assume the role of MRP for patients.
- × Virtual care settings where patient care is delivered via telephone, video, or other virtual care modalities.
- × Focused practices serving a specific patient population or providing sub-specialty services such as (but not limited to) maternity care, palliative care, sports medicine, chronic pain, and addiction care.
- × Facility settings such as (but not limited to) hospitals, long term care, hospices, assisted living, or group homes.

Family Physician with Consultative Expertise

GPSC defines a Family Physician with Consultative Expertise as: “A family physician who has consultative expertise and provides consultative services or support to colleagues through a health authority supported or approved program. Examples of health authority supported programs include (but are not limited to) mental health, addictions, palliative, chronic pain, and emergency medicine.

Locum Tenens

For the purpose of its incentives, GPSC defines a locum tenens as a physician with appropriate accreditation who substitutes on a temporary basis for another physician who is away from practice.

Most Responsible Physician/Provider (MRP)

For the purpose of its incentives, the GPSC defines “Most Responsible Physician/Provider” (MRP) as a physician who takes responsibility for directing and coordinating the ongoing care and management of a patient. This includes coordinating clinical services delegated to other providers, ensuring cross coverage when MRP is unavailable, and coordinating referrals to specialty care when needed.

(2) ALLIED CARE PROVIDERS

Allied Care Provider

For the purposes of incentives, when referring to Allied Care Providers, GPSC includes trained professionals with a scope of practice that allows the provision of medical and medically related services to patients. Examples include but are not limited to: Nurses; Nurse Practitioners; Mental Health Workers; Midwives; Psychologists; Clinical Counsellors; School Counsellors; Social Workers; Registered Dietitians; Physiotherapists; Occupational Therapists; and Pharmacists etc.

Note: *Not all allied care providers are College-certified.*

College-certified Allied Care Provider

Allied Care Providers who are College-certified are governed by a provincial regulatory college or body. Specific GPSC incentives may require ACPs to be College-certified for the delegation of tasks, whereas other GPSC incentives may not require ACPs to be College-certified to undertake delegated tasks. Fee notes will clearly indicate whether the ACP must be College-certified to be delegated tasks.

Allied Care Provider “Employed by” a Physician Practice:

For the purposes of its incentives, GPSC defines Allied Care Providers (ACPs) “employed by” a physician practice as ACPs who are employed by a physician practice and paid out of practice earnings to work directly within the practice team, with no cost recovery either directly or indirectly from a third party (e.g.: Health Authority, Division of Family Practice, Ministry of Health, etc.), unless otherwise specified.

Allied Care Provider “Working within” a Physician Practice Team:

For the purpose of its incentives, GPSC defines Allied Care Providers (ACPs) “working within” a physician practice team as ACPs who work as part of an FP practice’s team to support the ongoing care of its patients. The costs of an ACP “working within” the practice team may be paid either by the physician practice or by a third party (directly or indirectly). ACPs employed by a Health Authority are considered to be “working within” the practice team if they are assigned to work with an FP practice to support the longitudinal care of its patients. By contrast, ACPs not assigned to work with an FP practice and who provide episodic services to patients on a referral basis such as through Specialized Health Authority Programs or in stand-alone chronic disease clinics are not considered to be “working within” the physician practice team.

(3) PAYMENT MODELS

Alternative Payment/Funding Model:

For the purposes of these fees Alternative Payment/Funding Model means an Alternative Payment Arrangement or Alternative Funding contract between an entity (e.g. Ministry of Health, Health Authority or other organization) and an individual physician or physician clinic. An Alternative Payment Arrangement or Alternative Funding contract may or may not be governed by the Physician Master Agreement. If services supported and paid through GPSC incentives are already included in an Alternative Payment/Funding Model contract, GPSC incentives are not billable in addition. Private agreements between physicians to pool FFS billings and pay out physicians in a mutually acceptable way (e.g. per day, per shift, per hour, etc.) are not considered as an Alternative Payment/Funding Model.

(4) MISCELLANEOUS

Assisted Living:

For the purpose of its incentives when referring to assisted living, GPSC utilizes the ministry definition as found at: <https://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/care-options-and-cost/assisted-living>

Care Plan

For the purpose of its incentives, when referring to a care plan, GPSC requires documentation of the following core elements in the patient’s chart, as follows:

1. There has been a detailed review of the case/chart and of current therapies;
2. Name and contact information for substitute decision maker;
3. Documentation of eligible condition(s);
4. There has been a face-to-face planning visit with the patient, or the patient’s medical representative if appropriate, on the same calendar day that Care Planning Incentive code is billed;
5. Specifies a clinical plan for the patient’s care;

6. Documentation of patient’s current health status including the use of validated assessment tools when available and appropriate to the condition(s) covered by the care planning incentive;
7. Incorporates the patient’s values, beliefs and personal health goals in the creation of the care plan;
8. Outlines expected outcomes as a result of this plan, including advance care planning when clinically appropriate;
9. Outlines linkages with other allied care providers who would be involved in the patient’s care, and their expected roles;
10. Identifies an appropriate time frame for re-evaluation of the plan;
11. Provides confirmation that the care plan has been created jointly and shared with the patient and/or the patient’s medical representative and has been communicated verbally or in writing to other involved allied care providers as appropriate. The patient and/or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.

Face to Face:

For the purpose of its incentives, GPSC defines “face to face” to mean in in-person.

Living in Community:

For the purpose of its incentives, GPSC considers patients living in group homes to be living in community.

Patient’s Medical Representative:

For the purpose of its incentives, GPSC defines Patient’s Medical Representative as outlined in the “Health Care (Consent) and Care Facility (Admission) Act” Representative means a person authorized by a representation agreement to make or help in making decisions on behalf of another and includes an alternate representative. Temporary Substitute decision makers (Alternate Representative) in listed order, of the following who is available and qualifies under subsection 16(2):

- (a) the adult’s spouse
- (b) the adult’s child
- (c) the adult’s parent
- (d) the adult’s brother or sister
- (d.1) the adult’s grandparent
- (d.2) the adult’s grandchild
- (e) anyone else related by birth or adoption to the adult
- (f) a close friend of the adult
- (g) a person immediately related to the adult by marriage

Patient self-management

Patient self-management can be defined as the decisions and behaviours that patients with chronic illness engage in that affect their health. Self-management support is the help given to patients with chronic conditions that enables them to manage their health on a day to day basis. There are a variety of publicly available tools that FPs can provide to patients, to help build the patients’ skills and confidence to manage their chronic conditions.

Patient Panel

For the purpose of its incentives, the GPSC defines a “patient panel” as the group of patients for which a family physician has assumed the role of MRP, and has confirmed their ongoing patient-physician relationship.