

GPSC Long Term Care Initiative (LTCI) Frequently Asked Questions

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General

When did the initiative begin?

The initiative was initially mobilized by the Ministry of Health in 2011 and became an initiative of the GPSC in April 2014. The GPSC's Long-term Care Initiative (LTCI) now covers 99.4% of the eligible 30,000 long-term care beds (both public and private).

What is the larger problem it is trying to resolve?

LTC patients make up less than 1% of BC's population and consume approximately 25% of the combined budgets for MSP, Pharmacare, acute care, and home and community care. At the same time, the number of family physicians who deliver LTC is steadily declining.

What is the purpose of the initiative?

The initiative supports divisions, or self-organizing groups of family physicians where no divisions exist, to design and implement local, scalable, and sustainable solutions that deliver dedicated FP MRP services for patients in LTC homes.

What is a dedicated FP MRP?

For the purposes of this initiative, a dedicated Family Physician (FP) Most Responsible physician (MRP) is a family physician who delivers care according to five best practice expectations and promotes three system level outcomes. The term most responsible physician refers to the physician who has overall responsibility for directing and coordinating the care and management of an individual patient.

What are the best practice expectations?

1. 24/7 availability and on-site attendance when required
2. Proactive visits to residents
3. Meaningful medication reviews
4. Completed documentation
5. Attendance at case conferences

What are the system level outcomes?

1. Reduced unnecessary or inappropriate hospital transfers
2. Improved patient-provider experience
3. Reduced cost/patient as a result of a higher quality of care

Can a community choose to only deliver some of the best practice expectations and system level outcomes?

No. Solutions must encompass all five best practice expectations and promote all three system level outcomes.

Can a community use a physician replacement service to meet the 24/7 requirement?

No, since a physician replacement service is generally not able to meet all five best practice expectations and promote all three system level outcomes.

Does participating in the LTCI require each member to provide 24/7 availability for every LTC home in the community?

No. Each member is not individually expected to provide 24/7 availability to all local LTC homes. However, collectively, the physicians participating in the initiative must determine how availability will be delivered so that every LTC home does have 24/7 availability.

How many family physician members can participate in the initiative?

There is no required number of family physicians that can or must participate. The expectation is that dedicated FP MRP LTC services will be delivered for the community, that the solution is sustainable, and that all community family physicians have an opportunity to participate. A local solution that involves a single family physician, or a very small number of family physicians relative to the number of LTC beds, would not be generally considered as sustainable.

Can a family physician who does not belong to a local division participate in the initiative?

No. FPs are expected to be part of their local division if they wish to participate in the local division's LTCI solution.

Can a family physician participate in the local solution of another division?

Divisions/self-organizing groups are free to determine who will participate in their local solutions.

What if some family physicians from a community do not want to participate in the initiative?

It is not mandatory that every family physician in a community participates in the local solution. Ideally, communities would consult and collaborate with all family physicians to encourage participation.

What if a family physician wishes to withdraw participation from a local solution?

Participation and local processes and procedures are up to the division/self-organizing group.

Can multiple physician groups cover the same LTC home?

Yes. However, communities are asked to design and implement solutions that cover all homes and all beds.

What happens if a LTC home is geographically in one division's catchment area and the majority of services are provided by physicians from a different division?

In some communities the Local Health Area (LHA) boundaries do not reflect how services are actually delivered. The two divisions can mutually determine the lead for a LTC home and the GPSC funding will be allocated accordingly. Participating physicians will then be compensated through the lead division regardless of their home division.

What if a division/self-organizing group does not want to participate in the initiative?

Divisions/self-organizing groups are encouraged but not required to participate. For divisions/self-organizing groups not wishing to participate, please inform the GPSC at gpsc@doctorsofbc.ca.

What if the division does not wish to undertake the LTCI but a self-organizing group is willing?

The intention is that divisions of family practice would lead the local implementation of the LTCI. If a division does not wish to lead the local implementation, but a self-organizing group does, please contact the GPSC (gpsc@doctorsofbc.ca) to discuss the local circumstances.

Funding

How much funding has GPSC earmarked for the LTCI?

The GPSC has committed up to \$12M annually for this initiative. This provincial budget was determined by allocating \$400 per approximately 30,000 LTC beds in BC.

Where does the money come from and how long will it be in place?

The initiative is funded through the Physician Master Agreement (PMA) negotiated between the Government of BC and Doctors of BC and is intended to be ongoing.

How was the incentive fee of \$400 per bed determined?

It was determined in consultation with several stakeholders including the Ministry of Health, Doctors of BC, health authorities, and some divisions.

What beds are in scope for the LTCI funding?

The funding formula considers both publicly and privately funded LTC beds. LTC beds are in scope for this initiative. Short term beds including convalescent, end-of-life, respite, and flex beds physically located within a LTC home are also included within the scope of the initiative. Assisted living beds are not included in the scope of this initiative.

How is the quarterly lump sum funding calculated per community?

The quarterly lump sum incentive is calculated for equity at an annual \$400 per LTC bed. The formula considers both publicly and privately funded LTC beds.

What if the LTC home or bed counts are inaccurate or change over time?

The intention is to provide funding to communities based on a mutual understanding of the LTC homes and associated bed counts. If the bed counts change, the MOU can be revised with mutual consent to accurately reflect the current situation. In the event where the effective date of bed count changes is prior to the revision of the MOU, the GPSC may make retroactive payments (if bed count increased) for up to three months.

Are there any restrictions on how communities can allocate the lump sum funding?

No. It is anticipated that many divisions/self-organizing groups will elect to allocate the funding into several pots to enable multiple elements within their program.

How do divisions/self-organizing groups receive the quarterly lump sum funding?

The quarterly lump sum funding will be provided to divisions/self-organizing groups through the Doctors of BC on behalf of the GPSC.

What happens to the payment if a community does not deliver the best practice expectations?

The intention is that communities will not enter into a MOU unless they are prepared to deliver the best practice expectations. In the event that a community does not meet all of the best practice expectations, there would be a discussion between the GPSC, the health authority, and the division/self-organizing group about why the expectations are not being met. Depending on the results of those discussions, the GPSC may choose not to send the funding to the community for a quarter in which the expectations were not met.

Are there restrictions on how much funding can be allocated per provider?

The intent of the LTCI is to support a sustainable dedicated FP MRP solution for all communities in BC. To support a sustainable solution, a division/self-organizing group should not allocate more than \$45,000 of the LTCI incentive per provider. Where community circumstances dictate, a community can apply (via gpssc@doctorsofbc.ca) to the GPSC for consideration of an exemption to the maximum funding per provider.

Is there financial support for local divisions/ self-organizing groups to administer the LTCI?

Communities may allocate funding for administration from the lump sum community funding. It is anticipated that communities would have minimal administration.

Is there funding for health authorities to assist with local implementation?

No.

Does the GPSC LTCI replace Fee-for-Service?

No. The GPSC LTCI funding is intended to supplement fee-for-service payments for direct patient services provided by participating family physicians.

Can a physician continue a private contract with LTC homes in addition to the GPSC LTCI incentives?

Private arrangements may continue if that is part of the agreed upon local solution. However, where private arrangements continue, the beds in those LTC homes will not be included for the purposes of calculating the community lump sum funding.

Can some of the initiative funding be allocated for nurse practitioners or other providers?

While physicians may work collaboratively with other health care providers (such as nurse practitioners) to provide care in LTC homes, initiative funding is intended to support a dedicated FP MRP solution and is payable to physicians only.

Will rural retention premiums be applied to the LTCI?

No. Rural retention premiums do not apply to LTCI funding.

Does the LTCI contribute towards the dollars used to calculate FPs benefits?

No. LTCI funding do not contribute towards the calculation of FP benefits.

Are physicians working under an Alternative Payment/Funding Model eligible for initiative funding?

If services supported and paid through GPSC incentives are already included in an Alternative Payment/Funding Model contract, GPSC incentives (including LTCI funding) are not payable in addition. The GPSC defines an Alternative Payment/Funding Model as 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. 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.

Processes

Is a division/self-organizing group free to plan the local solution on their own?

It is intended that divisions/self-organizing groups will have the lead role in designing and implementing the local solution and will collaborate with their regional health authority on the local solution. The MOU, which is between the division and health authority, documents the stakeholders

shared principles for the initiative, their co-dependencies, and the commitments of each partner in contributing to the local solution.

What if some family physicians do not agree with the solution proposed locally?

Funding is provided as a lump sum to divisions/self-organizing groups for dedicated FP MRP services for all LTC homes and beds. Communities are encouraged to engage broadly with all family physicians to implement models which are agreeable to the *majority* of local family physicians. If local groups cannot reach a majority agreement on the model and/or funding allocations, contact the GPSC (gpsc@doctorsofbc.ca).

Is there a registration process/form required for establishing a local solution?

Once the division/self-organizing group has identified and agreed upon a local solution for dedicated FP MRP LTC services, the solution is articulated in a MOU between the division/self-organizing group and the regional health authority. This MOU is submitted to the GPSC (gpsc@doctorsofbc.ca) and will be used to develop a Funds Transfer Agreement (FTA) between the local division and Doctors of BC, on behalf of the GPSC.

How often will the MOU be reviewed/updated?

Each MOU will be reviewed annually at fiscal year-end. The existing MOU can continue through the mutual agreement of the MOU partners. However, The MOU can be updated at any time by mutual agreement of the MOU partners if key aspects of the local solution change (e.g., a new LTC home introduced into the community).

For local divisions with multiple communities in their mandate, can each community implement their program at their own pace?

Yes. For example, the Central Interior Rural Division contains both the 100 Mile House and Williams Lake communities. Each community can implement the solution at their own pace.

Does the proposed solution have to cover all LTC homes in the community?

Yes. The MOU must include a solution for all homes and beds in the community, unless an exemption for a specific reason is requested (via gpsc@doctorsofbc.ca) of the GPSC. It is understood that there are a few very large divisions that may wish to implement in a few phases. For large communities with many homes, a request to implement the local solution in phases can be made to gpsc@doctorsofbc.ca.

Will baseline and ongoing data be available to divisions/self-organizing groups for planning and evaluation purposes?

Currently, quarterly reports are sent to divisions/self-organizing groups showing progress towards the five best practices expectations.

What annual fiscal reporting will be required by divisions/self-organizing groups?

The GPSC is currently developing a process to facilitate annual fiscal reporting for LTCI. More information will be shared with divisions/self-organizing groups in spring 2021.

Are there separate MOUs for each community or one per division capturing all communities?

The division and the regional health authority will decide if the local approaches will be documented in a single MOU or multiple MOUs. The purpose of the MOU is to capture the local approach for delivering dedicated FP MRP LTC services. If a division has multiple communities, the approach must be documented for each community.

Will there be any coordinated provincial efforts to support physician education?

The GPSC plans to explore opportunities to coordinate physician education. In the meantime, divisions/self-organizing groups are encouraged to collaborate and participate in the [Practice Support Program](#)'s learning modules.

Guiding Principles

The guiding principles are intended as a support to the five best practice expectations. Not all principles may be applicable at all times.

Align compensation to the service need

Compensation should be aligned to service need, rather than the compensation dictating what services can be delivered.

Comprehensive

The local solution should seek to be comprehensive.

Continuity

Solutions which enhance continuity of care are preferred.

Equity

Solutions should be equitable across communities, and between family physicians within a community. Equity does not mean equality as not every family physician will deliver LTC services. And, as the level of service should be the same everywhere, regardless of how it is provided, this equity principle also applies to patients and their families.

Ethically-based practice

Use of an ethics framework (as evidence informed) when difficult decisions are required is useful and important for an ethically-based practice.

Evaluation/Monitoring

Evaluation should be built into all solutions.

Evidence-informed

Solutions should be based on evidence of best practice, where available. Evidence should not just relate to the 'the elderly,' and instead should be relevant for the particular patient in the particular setting (e.g., 'fit elderly' population compared to 'frail elderly' population).

Function vs service location

In planning solutions, the function that is being delivered to meet patient needs is more important than the service location. For example, sometimes different supports are available depending on whether a site is classified under the Hospital Act or the Community Care and Assisted Living Act.

Generalization vs specialization

Where practical, the GPSC is trying to support family practice generalization, rather than specialization. Attracting more generalists to LTC would be seen as a success, although it is recognized that some communities may choose to have some degree of family physician specialization in LTC care.

Groups vs silos

Solutions that support collaboration between groups of family physicians as opposed to solo family physician efforts are preferable. It is difficult for a single family physician to provide LTC services in isolation. This links to the principle around an interdisciplinary approach.

Inclusivity

Solutions available to the majority of family physicians at a local level are preferable to those which limit support or with limited availability. Some communities may choose to have concentrated models that do not involve the majority of family physicians. However, it is expected that planning discussion will happen locally with the community of family physicians.

Integration

Solutions should seek to consolidate, coordinate, and streamline service delivery and transitions of care to avoid fragmentation. This includes teamwork and communication within the team. Integration also includes informing practice as well as sharing and knowledge translation within, amongst, and external to divisions.

Integrity

Solutions with few exceptions to the guidelines are desirable. Numerous exceptions may compromise consensus on the model or adherence in delivery.

Interdisciplinary

Models which promote a team-based approach are preferred.

Person/family-centered

Build local solutions around the needs of patients and their families. Physicians have an important role in developing relationship with families, providing information, and having conversations about prognosis and future decision-making. In this way, treatments are based on thoughtful consideration of the patient's wishes rather than a grief reaction to a stressful event.

Proactive

Solutions that promote proactive care are preferable, especially in the areas of chronic disease management, medication management, dementia care, advanced care planning, and end-of-life care planning.

Provincial consistency and local flexibility

While solutions need to be consistent and equitable at a provincial level, it is desirable to allow for local flexibility in implementation.

Scalable

Solutions must be scalable to all LTC homes in the province. This does not mean that every LTC home will utilize the same solutions, only that the range of solutions is equitable and can be available for all LTC patients in the province.

Simplicity

Solutions which are transparent and easily understood are preferred.

Sustainable

Solutions proposed should be sustainable from both a financial payer and family physician provider perspective.

Timely

Solutions which enable a timely response for patients are desired.

Triple Aim optimized

Solutions should seek to optimize the Triple Aim objectives of improved patient health outcomes, improved patient/family and provider experience, and optimized cost/patient.