Family Practice Services Committee

FPSC Long Term Care Initiative (LTCI)
Frequently Asked Questions

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General

When did the initiative begin?

The initiative was based on prototype work done in some divisions working in partnership with the Health Authority (HA). It was supported to spread provincially through Ministry of Health funding beginning in 2011, and became an initiative of the Family Practice Services Committee (FPSC) in 2015. All divisions participate in the FPSC's Long-term Care Initiative (LTCI), covering over 30,000 long-term care beds (both public and private).

What is the purpose of the initiative?

The initiative supports divisions to deliver local, scalable, and sustainable solutions that deliver dedicated FP MRP services for patients in LTC facilities.

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 (BPE)?

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 attempt to encompass 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 facility in the community?

No. Each member is not individually expected to provide 24/7 availability to all local LTC facilities. However, collectively, the physicians participating in the initiative must determine how availability will be delivered so that every LTC facility does have 24/7 availability. The FPSC is providing on-call availability funding to support this BPE. Please see the funding section for more information.

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 DoFP participate in the initiative?

No. FPs are expected to be part of their local DoFP if they wish to participate in the local DoFP's LTCI solution and be eligible for LTCI QI or on-call/availability funding.

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

Individual physicians may participate in the LTCI of more than one DoFP.

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 DoFP.

Can multiple physician groups cover the same LTC facility?

Yes, however communities are asked to design and implement solutions that cover all facilities and all beds.

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

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 facility. Participating and eligible physicians will be compensated for on-call availability through the DoFP supporting the on-call program of that LTC facility.

What if a DoFP does not want to participate in the initiative?

Divisions are encouraged but not required to participate. For divisions no longer wishing to participate, please inform the FPSC at fpscltci@doctorsofbc.ca.

Funding

How is funding for LTCI for each DoFP determined?

LFP expansion into facility-based care in 2024 will enable physicians to be paid directly for LTC clinical work in a way that supports the best practice expectations. In July 2024, a reallocation of LTCI funding that currently supports physician compensation ($400/bed formula) will be directed to support LTC on-call/availability, MRP payments to FPs not eligible for the LFP payment model, and ongoing quality improvement (QI) and education, including project costs, program staff and administrative activities that support LTCI QI and physician leadership. Currently, some divisions provide on-call funding and payments to FPs through LTCI funding. The accessibility and amount of such on-call payments vary from community to community. Starting in July 2024, the FPSC will provide new On-call/Availability Funding to divisions for long-term care. This funding recognizes the necessity and challenge of having a physician be available to respond to the care needs of patients in LTC facilities after hours.

Four funding streams will be available to support physicians in providing LTC through the FPSC:

1. FPSC LTC On-Call/Availability Funding
2. FPSC LTC On-Call/Availability Administration Funding
3. FPSC LTCI QI/Administration Funding
4. FPSC LTCI Payment for FPs not eligible for LFP payment

FPSC LTC On-Call Availability	FPSC LTC On-Call Availability Administration	FPSC LTCI QI/Administration	FPSC LTCI Payment for FPs not eligible for LFP payment
•$130,000 + $80/LTCI bed • $: Physician compensation for after hours availability •Eligible: physicians working after hours on any payment model •Submit on-call plan in MOU •Administered by divisions	• up to 10% of LTC on-call availability funding • $: Administration costs of on-call program ie: scheduling software, on-call subscription and DoFP staff support to organize on-call •Submit budget proposal in MOU •Administered by divisions	•Amount based on divisions QI/Admin budget in FY 23/24 MOU •$: Costs to support LTCI QI ie: QI projects, evaluation consultants, DoFP staff support/project management; physician sessional for leadership & QI •Submit LTCI budget through MOU •Administered by divisions	•$290/LTCI MRP bed to maximum per physician •Eligible: FFS physicians who are not eligible to to enroll in LFP Payment Model •Physicians will submit application form to FPSC (details TBD) •Administered by FPSC directly to physicians

1. FPSC LTC On-Call / Availability Funding

The new FPSC LTC On-call/Availability funding will provide an amount of:

- $130,000 per year + $80 per long-term care initiative bed per Division of Family Practice for after-hours availability

The funding will be administered by local divisions and payable to all LTCI physicians participating in on-call, regardless of their payment model, in accordance with their designed on-call plan to be outlined in their MOU. All patient care services provided by FPs during their on-call time will be compensated by their payment model (eg: LFP Payment Model, fee-for-service, Alternate Payment arrangements).

a) Rates:

To allow some flexibility of daily payment amounts in response to community needs, daily payments can vary within the total weekly funding envelope, The maximum payable per participating physician is $150-750/day, within the funding envelope of $2500/week plus $210/statutory holiday/week. (Eg.: for the week of July 15-21, the maximum payment for the week is $2500. For the week of July 29 – August 4, the maximum payment is $2710, factoring $210 for the statutory holiday.) On-call payment rates are based on prorated MOCAP level 2 rates for call availability.

b) After Hours On-Call:

After hours availability can be compensated weekday evenings from 18:00-23:00, overnight 23:00-08:00 and 08:00-23:00 weekends and statutory holidays. Up to 6250 hours a year may be compensated for after hours call availability. Divisions may compensate more than one physician at a time for on-call availability, depending on their on-call program model.

c) Call Group Size:

A minimum number of 4 physicians must be a part of each call group in order to support sustainability of the group. In communities where there are less than 4 LTCI FPs, call group sizes may be less than 4. If <4 LTCI FPs are willing to participate in a communities' call group, the DoFP should connect with fpscltci@doctorsofbc.ca to discuss their circumstances.

d) On-Call Response Times

The BPE targets for on-call availability guide the on-call response time requirements. When providing on-call after hours, physicians must:

- Respond to urgent calls by telephone within 30 minutes;
- Provide or arrange urgent in-person on site services as clinically indicated.

e) On-Call for Multiple Services

A single physician may provide coverage simultaneously for more than one approved call group but can only receive payment on a daily basis for participating in one group. (Eg: If a FP is on-call for LTC and IPC, they may only be compensated for being on call for one program. If a FP is on-call for LTC and ER, they may only be compensated through the FPSC on-call availability funding or MOCAP).

As call groups are often composed of family physicians who work under a variety of payment models for clinic-based care as well as family physicians who do not provide clinic-based care, the new on-call/availability payments will be provided for family physicians working under a range of payment models. They will not be limited to those physicians paid under the LFP Payment Model for their clinic-based care.

Divisions will submit their on-call program plan as part of their MOU, following the MOU and FTA guidelines. Funds are prorated for FY 24-25.

Please note: while a physician is on-call, all patient services they provide will be compensated by the LFP Payment Model or any other payment model (e.g. fee-for-service or AP contract) that the physician is compensated by.

2. FPSC LTC On-Call / Availability Administration Funding

Divisions that have not previously utilized QI/Administration funds to support an on-call program in their community may apply for additional administration funding to support the development and implementation of their new on-call program. Examples of costs that may be funded include scheduling software, on-call subscription and administrative time for DoFP staff to support the coordination of the on-call program. On-call Administration Funding is not for physician compensation.

Divisions that have not previously administered an on-call LTC program utilizing their LTCI funds, may request an application for additional FPSC On-Call/Availability Administration funding from fpscltci@doctorsofbc.ca. The DoFP must outline their anticipated administration costs for the on-call program, provide details on each item (ie: scheduling software name) and the budget for each item. Divisions may be approved up to 10% in additional on-call administration funding based on their allocated on-call / availability funding and their on-call administration budget proposal. Funds are prorated for FY 24-25.

3. FPSC LTCI QI/Administration Funding

For fiscal year 2024/2025, each DoFP will have funding allocated to maintain LTCI QI activities based on their previous years' MOU budget. Emails will be sent to each DoFP confirming available funds to support their activities, as outlined in their 2023/2024 MOU.

Divisions must outline their LTCI QI/Administration budget in the FY 2024/25 MOU, based on the updated MOU and FTA guidelines. Funding will be prorated for July 1, 2024-March 31, 2024.

LTCI QI/Administration Funding may be used to support QI activities and education through:

- QI project funding
- DoFP administrative or project management staff for time spent supporting the LTCI
- Physician sessional time for leadership and/or participation in QI/education activities
- Costs supporting QI including catering, facility rental, evaluation consultant

Funds are not to be used to support the administration of the On-Call/Availability program. The On-Call/Availability Administration funding is used to administer the on-call program.

Examples of Quality Improvement Activities include:

Review LTC data; HA/DoFP meeting to improve LTC; peer to peer coaching/mentorship; LTC Medical Advisory Committee; Project Evaluation; CME; topic-specific projects to improve LTC (ie: streamline admissions; increase completion rate of MOST; standardize MRP forms; streamline SBAR usage; develop geriatric outreach team); Educational materials for physicians/interdisciplinary teams; collaboration with Shared Care/Facilities Engagement; create toolkit for physicians/interdisciplinary team.

4. FPSC LTCI Payment for FPs not eligible for LFP payment model

The FPSC will be providing a new payment for family physicians that provide long term care and are not eligible for the LFP Payment Model. Through this new payment, intended to recognize and value services provided by these physicians in support of the BPE, the FPSC aims to help sustain long term care services when the LFP Payment Model for facility-based care is introduced. Family physicians participating in the Long-Term Care Initiative who are not eligible for the LFP Payment Model can claim an amount of $290 per LTCI bed per year for which they are the MRP, up to a maximum amount per physician per year. This payment is intended to help family physicians who aren't eligible for the LFP Payment Model to maintain their long-term care services.

This funding will be centrally administered through the FPSC directly to FPs.

Please note: More details, including how physicians can claim the payment, will be publicly communicated in the coming months.

How much funding has FPSC earmarked for the LTCI?

The FPSC's LTC budget has increased to $14M to cover the on-call availability payment, payment to physicians that are not eligible for the LFP model, and to ensure continued funding for divisions to support the LTCI in their communities through administration and quality improvement initiatives.

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.

What beds are in scope to calculate the On-Call/Availability funding?

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

What if the LTC facility 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 facilities and associated bed counts. Bed counts will be based on yearly MOU submissions. If bed counts change during the year after the MOU submission, the DoFP will request an addendum from fpscltci@doctorsofbc.ca and update the bed count in the provided addendum LTC bed chart.

Are there any restrictions on how communities can allocate LTC On-Call/Availability, On-Call/Availability Administration and LTCI QI/Administration funding?

1. FPSC LTC On-Call/Availability Funding

Yes, On-Call/Availability funding is to be used for physician compensation for providing after hours availability for LTC. Additional details are listed above.

2. FPSC LTC On-Call/Availability Administration Funding
   Yes, On-Call/Availability Administration funding is to be used for administrative items to support the on-call program. Examples include scheduling software and divisions staff support to administer the on-call program. Funds are not to be used for physician compensation for being on-call. For consideration of administration funding approval, divisions must submit a budget proposal via the MOU, to a maximum of 10% of their on-call/availability funding. Additional details are listed above.

3. FPSC LTCI QI/Administration Funding
   Yes, LTCI QI/Administration funds are to be used for activities supporting QI initiatives for the divisions' LTCI. This can include DoFP support staff to support QI project design and implementation, consultant fees for project evaluation and physician sessional for QI project participation. Physician leadership in the LTCI, such as attending a LTCI Steering Committee can also be funded through the QI/Administration funding.
   Physician clinical work cannot be funded. Additional details are listed above.

Physicians must participate in the LTCI in order to receive LTC funding payments (i.e. On-Call/Availability, QI/Administration, FP payment if not eligible for LFP Payment Model($290/bed)). This is to ensure coordination of services between all FPs in a community and to ensure coverage for all MRP beds in a community that meets the needs of all patients in their community.

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

The intention is that communities enter into an MOU 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 FPSC, the health authority, and the DoFP about why the expectations are not being met.

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

No.

Can a physician continue a private contract with LTC facilities in addition to the FPSC 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 facilities will not be included for the purposes of calculating the current LTCI funding formula ($400/LTCI bed) or the future on-call availability 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 (NPs) to provide care in LTC facilities, initiative funding is intended to support a dedicated FP MRP solution. The exemption to allow NPs to receive LTCI funding in FY 2023/24 has been extended to FY 2024/25, provided the DoFP submit and have approved the NP exemption form.

NP exemption funding criteria:

- NPs are members of a DoFP and/or participate in a PCN;

- NPs who are hired directly by Health Authorities will **not be** eligible for LTCI funding, unless the LTCI services provided fall outside of the current terms of their HA contract;
- Majority of LTCI FP MRPs must agree to compensate the NP(s) utilizing the funds allocated to the Division of Family Practice (DoFP);

Will rural retention premiums be applied to the LTCI?

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

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

LTC On-Call/Availability Funding:
Yes, physicians are eligible for on-call availability funding no matter which payment they are working under.

LTCI QI/Administration Funding:
If physicians are not already compensated through their contract for LTC QI initiatives or leadership, physicians may be compensated through the LTCI QI/Administration funding. However, if activities supported and paid through FPSC incentives are already included in an Alternative Payment/Funding Model contract, LTCI QI/Administration funds are not payable in addition. The FPSC 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.

Processes

Is a DoFP free to plan the local solution on their own?

It is intended that divisions 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 DoFP 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?

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 FPSC at fpscltci@doctorsofbc.ca

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

Once the DoFP has identified and agreed upon a local solution for dedicated FP MRP LTC services, the solution is articulated in a MOU between the DoFP and the regional health authority. This MOU is submitted to the FPSC and will be used to develop a Funds Transfer Agreement (FTA) between the local DoFP and Doctors of BC, on behalf of the FPSC.

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 should 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 facility introduced into the community).

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

Yes. A number of divisions submit one MOU with multiple appendices that reflect unique solutions for their communities.

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

Yes. The MOU must include a solution for all facilities and beds in the community, unless an exemption for a specific reason is requested (via fpscltci@doctorsofbc.ca) of the FPSC.

What annual fiscal reporting will be required by divisions?

The FPSC requires a fiscal year end reporting for LTCI for ongoing funding. The reporting template will be issued each year to divisions.

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

The purpose of the MOU is to develop the local approach for delivering dedicated FP MRP LTC services. If a DoFP has multiple communities, the approach must be documented for each community, and if there are different solutions, can be documented on different appendices within the same MOU. Where one DoFP spans multiple health authorities or different health authority signatories for different communities, they may decide if the local approaches will be documented in a single MOU or multiple MOUs.

SDM= Substitute Decision Maker/Family/Contact

MRP = MD or NP

Best Practice Expectations Matrix

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Initial community reporting and sharing for the purposes of QI

	24/7 Availability	Proactive Visits	Medication Reviews	Care Conferences	Completed Documentation
General Standard	MRP belongs to a group or is supported to ensure there is a backup plan if unavailable. MRP or alternate available 24-hours a day, 7-days a week for urgent calls	MRP available to see in-person individuals in care once every 3 months			All LTCI document terminology updated to use the term Resident / Patient / Individual in care
Pre-Admission					
Admission	MRP (or on call) review admission with RN and pharmacy including the medication order and the MOST on day of admission.	MRP available to provide In-person assessment and complete the admission package within 14 days of admission		MRP attend in person or virtual at a time pre-scheduled and suitable for care team, individual in care and SDM within the first 8 weeks of moving in and then annually or as needed	
Acute Medical Event	MRP (or on call) response times: emergent availability to call SDM urgent availability to respond to SBAR within 30 minutes non-urgent respond to SBAR with in 1 business day				Documentation completed with a record in facility's EMR or individual in care's chart at LTC
Proactive Care		MRP on site as scheduled and agreed upon with the LTC DOC at a time that is convenient for individuals in care, SDM and Nursing Team	Semi-annual medication review with the pharmacist and Nurse (who knows the individual in care) and SDM or an agreed upon process for communicating with the individuals in care and/or SDM		
Actively Dying	MRP (or on call) response times: urgent availability to respond to SBAR within 30 minutes non-urgent respond to SBAR within 1 business day			MRP discuss with SDM (in person/phone) and get their consent to start palliative when notifying them that their loved one may be in actively dying stage	MRP (or on call) document discussion with the MRP and update MOST (if required) in the facilities EMR or individuals in care's chart at LTC
Death	Report and Certify Death if needed (non-urgent response times)				