# Physician Overview of In-patient Care Initiative

## Introduction

Research has proven that a continuous relationship with a family physician (FP) can improve patient health outcomes and ease the burden on hospitals by reducing repeat hospitalizations and emergency room visits. In B.C., Hollander Analytical Services determined that higher levels of attachment between a patient and a family physician leads to better outcomes and significant cost savings for higher-needs patients. The study projected that an increase of five per cent in attachment for these patients would results in a cost savings of about $85 million annually.

An important aspect of such continuous care is the coordination of patient transitions between hospital and community FP offices. Yet in recent years, British Columbia has experienced a gradual loss of community-based family physicians providing care to patients in hospitals. It is estimated that the rate of attrition is approximately three per cent per year over the last decade.

To address this issue, the GPSC has approved a set of incentives aimed at better supporting and compensating FPs who provide this important aspect of care.

This funding will support family physicians who:

- Provide care to their own patients when they are in hospitals;
- Provide care for patients admitted to hospital without an FP, whose FP does not have hospital privileges, or who are from out-of-town; and
- Provide hospital or terminal facility care to patients, through increased incentives.

## Goals

The goals of the In-patient Care Initiative are to:

- Retain a critical mass of family physicians delivering in-patient care services;
- Enhance collaboration between FPs, and between FPs and Health Authorities;
- Better compensate and support family physicians practising in the community as a means of encouraging them to care for their own patients and those patients without FPs, when they are admitted to the hospital; and thereby
- Ensure patients' care is well-coordinated and comprehensive when they are transitioning between hospital and FP offices in the community.

## Funding

As part of a more comprehensive set of recommendations related to in-patient care, the General Practice Services Committee (GPSC) is providing $31.9 million in funding for four incentives to recognize and support community-based family physicians that provide in-patient care services.

The incentives will be available starting on April 1, 2013 with the funding being provided to participating divisions of family practice. Where there is no local division or the division decides not to provide the oversight, funding will be provided to the FP Network groups. These new incentives will replace existing in-hospital care programs such as Doctor of the Day (DoD) and Ministry of Health In-patient Care Service Agreements. Hospitalist programs, which typically provide FP coverage in large urban hospitals and are funded by Health Authorities, will remain in place as is.

## Summary of Incentives

### 1. Assigned In-patient Care Network Incentive (G14086)

The term 'Assigned In-patient' is used in this context to denote those patients whose family physician has:

- Accepted Most Responsible Physician (MRP) status for their care while resident in the community, and
- Admitting privileges at the acute care facility in which the patient has been admitted.

A quarterly networking fee of $2,100 per FP is available for those delivering Assigned In-patient Care and who meet a minimum set of criteria defined below.

Eligibility for the Assigned In-patient Care Network Incentive:

- Be a family physician in active practice in B.C.;
- Have active hospital privileges;
- Be associated and registered with a minimum of three other network members (special consideration will be given in those hospital communities with fewer than four FPs providing inpatient care);
- Submit a completed Assigned In-patient Care Network Registration Form;
- Co-operate with other members of the network so that one member is always available to care for patients of the Assigned In-patient Care Network; and
- Provide MRP care to at least 24 admitted patients over the course of a year (networks may average out this number across the number of members).

Exemptions can be made through the GPSC In-patient Care Incentive Working Group.

### Unassigned In-patient Care Incentives

The term 'Unassigned In-patient' is used in this context to denote those patients whose family physician does not have admitting privileges in the acute care facility in which the patient has been admitted. Two incentives are available for unassigned in-patients: 3

### 2. Unassigned In-patient Care Network Incentive

This incentive is based on the annual volume of unassigned in-patients and is available for most hospitals with a community FP-run unassigned in-patient care model. The incentive for Unassigned In-patient Care Network is not available for hospitals that employ a Hospitalist model. This payment will be made to participating divisions of family practice, or where there is no local division or the division decides not to provide the oversight, to the Network group. The funding level for each hospital will be published in a separate Q&A document.

Eligibility for claiming the Unassigned In-patient Care Network Incentive:

- Be a family physician in active practice in B.C.;
- Have active hospital privileges;
- Submit a completed Unassigned In-patient Care Network Registration Form;
- Also be a member of the Assigned In-patient Care Network unless an exemption is granted by the DoFP or the GPSC In-patient Care Incentive Working Group; and
- Co-operate with other members of the network so that one member is always available to care for patients of the unassigned in-patient network.

Exemptions can be made through the GPSC In-patient Care Incentive Working Group.

**3. Unassigned In-patient Care Fee (G14088)**
A fee of $150/per unassigned in-patient is available to community-based FPs assuming MRP or delivering the majority of care for a non-admitting diagnosis when a Medical or Surgical Specialist is MRP. This $150/per unassigned in-patient fee is in addition to the Unassigned In-patient Care Network Incentive.

Eligibility for claiming the Unassigned In-patient Care Fee:

- Must be a part of an Unassigned In-patient Care Network and/or a Maternity Network;
- Payable once per unassigned in-patient per in-hospital admission;
- Payable only to the FP who is the Most Responsible Physician (MRP) for the patient during the in-hospital admission or is providing shared MRP responsibilities with a specialist due to a significant medical issue unrelated to the purpose of admission; and
- Payable in addition to hospital visit fee on same day.

The Unassigned In-patient Care fee is ***not available*** to physicians who are:

- employed by or who are under contract to a facility and whose duties would otherwise include provision of this care; and
- working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.

Exemptions can be made through the GPSC Inpatient Care Incentive Working Group.

**4. Enhanced clinical fees for select in-patient MRP services**
The General Practice Services Committee is providing funding to increase the 13008 and 00127 fee items by an additional 25 per cent through a bonus that will be applied directly to the fees, bringing their value to $51.30. Where applicable for the community, Rural Retention Premiums will be applied to the fee increases.

For local divisions that will be administering incentives #1, #2, or #3 through the local division of family practice, a small administrative funding envelope will be provided during the first year of implementation and possibly beyond, depending on demonstrated need.

Specific details about the incentives and how to claim them will be available in late March on the GPSC website at www.gpscbc.ca.