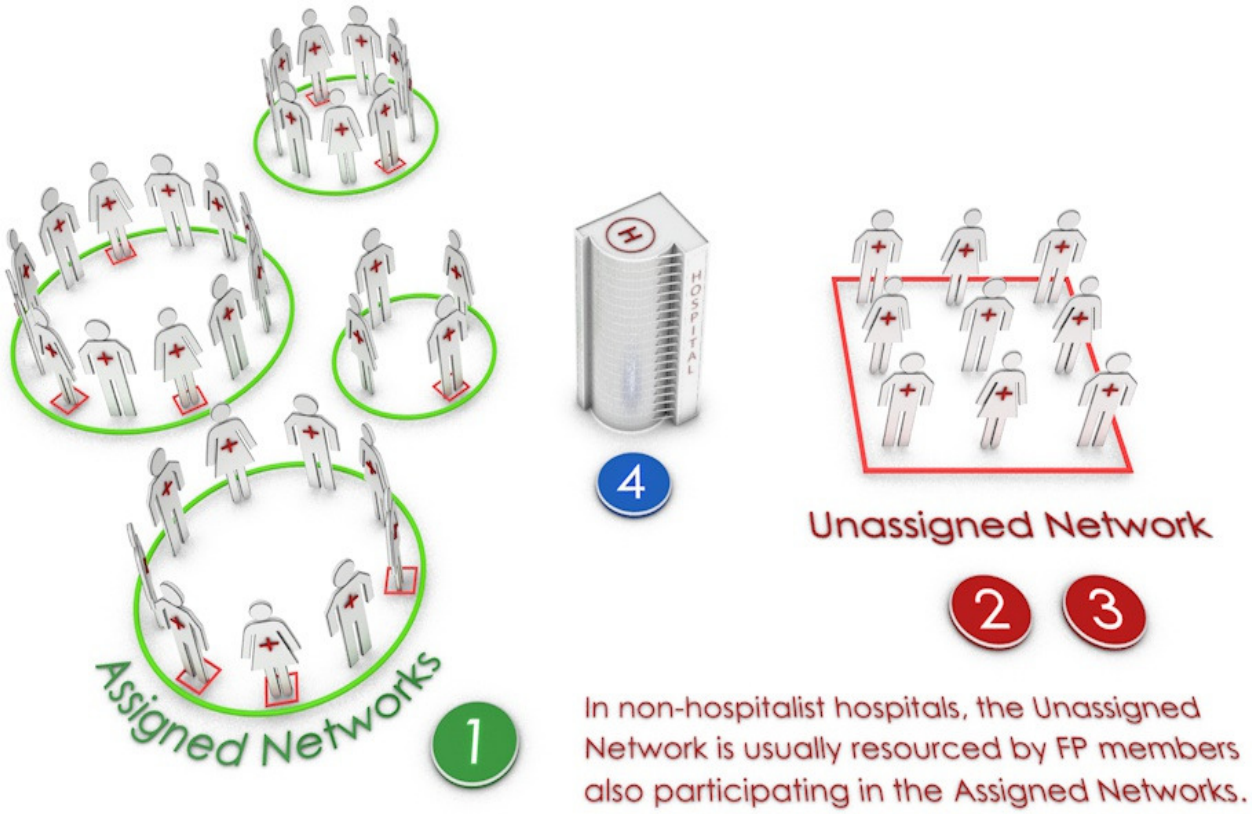
In-patient Care Incentive Implementation Scenarios

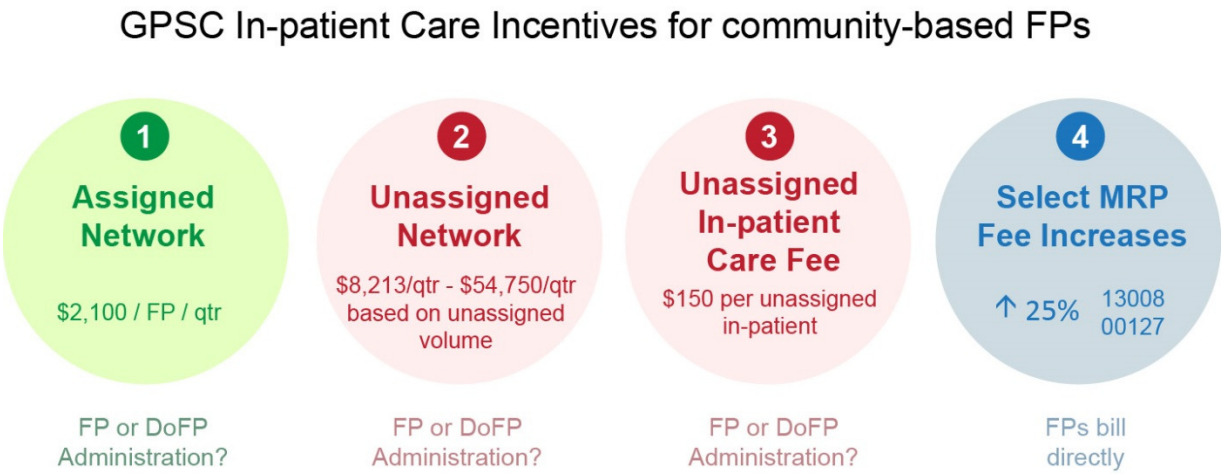
Overview:

For a complete overview of the initiative, including the criteria for each of the four General Practice Services Committee (GPSC) In-patient Care Incentives available to community FPs, refer to the **Physician Overview of In-patient Care** document. In addition, there is a separate Q&A document entitled **Q&A GPSC In-patient Care Incentives** that answers many common questions related to the incentives. The purpose of this document is to present some scenarios for how local divisions of family practice, or FPs in communities without a division, might choose to go about implementing the incentives locally. The co-chairs of the GPSC In-patient Care Working Group are available to discuss options or answer questions. Please email Darcy Eyres (darcy.eyres@gov.bc.ca) and Dr Brian Winsby (winsby@shaw.ca).



Each division needs to decide which of the GPSC In-patient Care Incentives it wants to administer:

Where a division exists, it has the opportunity to decide which of the first three In-patient care incentives shown on the graphic on the next page that it wishes to administer through the division. The fourth incentive is anticipated to be billed directly by FPs since it is a 25% lift on the 13008 and 00127 fee items already directly billed by FPs. For communities with hospitalist models in place for unassigned In-patients, incentives #2 and #3 will generally not apply except in circumstances where special arrangements are made with the Health Authority and the GPSC In-patient Care Working Group.



Note: While division boards may have an initial conversation about how to best implement the incentives locally, it is important that divisions engage broadly with their members to try and build consensus on the best approach.

What should divisions consider when deciding whether to administer each incentive through the division, or whether to encourage local FPs to bill the incentives directly?

1. **Equity in allocation of funding:** There are many local circumstances for how In-patient care is delivered that cannot be easily anticipated at a provincial level. For example, FPs may work part-time or want to allocate different amounts of their time to delivering In-patient care. If funding is administered through a division, the local division has the ability to work with its local membership to tailor how the funding will flow to FPs in the community based on rules determined by the division in partnership with its FP membership.

2. **Flexibility in funding:** Although the GPSC In-patient Care Incentive Funding is made available in an equitable and consistent manner at a provincial level, divisions may wish to structure the funding differently at a local level. For example, some divisions pay an hourly rate to FP members to be on-site to deliver In-patient care services. Provided that divisions stay within the funding envelopes, pooling the incentives funding affords a greater degree of payment flexibility.

3. **Facilitating collaboration:** A comprehensive In-patient Care solution at a community level requires collaboration between many partners. Divisions of Family Practice, through their physician membership, may be able to more effectively set the vision and structures for In-patient care at a local level when they oversee the allocation of incentive funding that can be aligned to the community needs.

4. **Administrative burden:** While administering one or more of the incentives through the division does give it greater latitude on the specifics of the funding, it also results in a greater administrative responsibility for the division. If a particular incentive works well the way it is structured at a provincial level, the division may want to consider whether it is worth the extra administration of flowing the funding through the division. Where divisions will administer the In-patient care incentives, there is a small administrative funding envelope that will be provided to the division.

Guidelines for Divisions administration of incentive funding

The following guidelines for the GPSC In-patient Care Incentive administration are provided to ensure consistency and equity across the province. These guidelines will be expanded upon as ideas are identified by the partners:

- Keep it simple.
- The allocation process must be transparent and agreeable to the majority of local division members.
- Divisions are permitted to reallocate funding within the Assigned or Unassigned Incentive envelopes, but not across envelopes. The intention of not allowing reallocation across the envelopes is to avoid creating inequities across the province for delivering a similar service. As noted in the final bullet, exemptions will be considered if necessary.

- Divisions must allocate 100% of GPSC In-patient Care Incentive Funding to local FPs for delivering services related to the incentives. A small, separate envelope will be provided to the division for administration where required.
- 100% of the incentive funding must be paid out within three months past the end of each fiscal year.
- In the event that a FP or a division wishes to appeal how any of the GPSC In-patient Care Incentives are applied locally, they can do so by raising the specific appeal to the GPSC In-patient Care Working Group. If a satisfactory solution cannot be found through the working group, appeals can be sent directly to the GPSC co-chairs.

Note: These guidelines are established to help FPs and divisions consistently and equitably administer the GPSC In-patient Care Incentives. If there are ideas missing or not valid from your perspective, please email the Working Group co-chairs identified in the overview.

The following scenarios are provided to illustrate the pros and cons of different funding alternatives for divisions. The final decision for what works best will be made by each division.

Scenario #1 – A community with hospitalists that only intends to claim the Assigned In-patient Care Network Incentive

In communities with a hospitalist model for unassigned In-patients, it is only incentive #1 for the Assigned In-patient Care Network shown in the graphic on the top of page 2 that will be generally available to the community. For communities with hospitalist models in place for unassigned In-patients, incentives #2 and #3 will generally not apply except in circumstances where special arrangements are made with the Health Authority and the GPSC In-patient Care Working Group. If the division feels that $2,100 per FP for participating in the Assigned In-patient Care Network seems appropriate, regardless of differing workload related to the Assigned In-patient Care service delivery, then allowing FPs to directly claim the Assigned In-patient Care Network Incentive creates the least administrative burden for the division.

The other option for a community with a hospitalist model for unassigned In-patients is to administer the Assigned In-patient Care Network Incentive through the division. For example, the Thompson Region Division implemented an Assigned In-patient Care Network Incentive for FPs that was based on participation levels. Its model is included here to provide an example of the type of

reallocation that is possible where the Assigned In-patient Care Network Incentive is administered through the division:

- Full incentive for: FPs who round on their own patients Monday through Friday + do their share of call on the weekends.
- ¾ incentive for: FPs who do their own call during the week but half the weekend call.
- ½ incentive for: FPs who split weekday and weekend call.
- ¼ incentive for: FPs who do some call.

Where a division wants to flow the Assigned In-patient Care Network Incentive through the division, the following extra steps are required (compared to FPs claiming the incentive directly):

- The division will need to establish a MSP Billing Number with Health Insurance BC (HiBC). This is a simple one page form that only has to be set up once.
- The division will need to link its banking information to that MSP Billing Number so that Teleplan can make payments for the incentives claimed. This is a simple one page form that only has to be set up once.
- The division will need to establish Teleplan software to submit the incentives. The division will then need to complete an application for Teleplan service which is a simple one page form that only has to be set up once.
- On a quarterly basis the division will need to bill the Assigned In-patient Care Network Incentive on behalf of each FP member participating in the incentive. Note: If the division decides that FPs will administer the Assigned In-patient Care Network Incentive, then each FP will need to complete this billing quarterly.
- The division will need to work with its FP membership to determine a set of rules for the amount of funding that each FP will receive for the Assigned In-patient Care Network service. One scenario for the Thompson Region was provided above; other options are possible and would need to be determined by the community of FPs.
- The division will need to establish a process to make the Assigned In-patient care Network Incentive payments to their FP members.

Regardless of whether the Assigned In-patient Care Network Incentive is administered through the division or not, the following forms also need to be completed:

- Each Assigned In-patient Care Network will submit a completed Assigned In-patient Care Network Registration Form; there can be multiple Assigned In-patient Care Networks for a community. In many cases the Assigned In-patient Care Networks will closely resemble the

already existing call groups that are in place for the community. The purpose of this form is for the Assigned In-patient Care Network to get set up administratively with Teleplan so the Assigned In-patient Care Network Incentives can be claimed, either directly or through the division.

Scenario #2 – A community claiming both the Assigned and Unassigned Incentives

In this scenario, community-based FPs are delivering In-patient care for both their own patients (Assigned), and for Unassigned In-patients. The division, where it exists, can choose to administer any of the first three incentives shown in the graphic on the top of page 2:

1. **Assigned Network (Incentive #1):** Using the incentive criteria and by reviewing scenario #1 above, the division can decide how it will administer the Assigned In-patient Care Network Incentive funding.
2. **Unassigned Network (Incentive #2):** The Unassigned In-patient Care Network Incentive is based on the volume of unassigned In-patients for the hospital. The specific level of Unassigned In-patient Care Network Incentive funding for a particular hospital can be found in the Q&A document for the In-patient care incentives.
3. **Unassigned In-patient Care Fee (Incentive #3):** An incentive of $150 per unassigned In-patient.

For each of the two unassigned In-patient care incentives (#2, #3), the division can choose to administer one or both incentives.

Exploring the Unassigned In-patient Care Network (Incentive #2):

The Unassigned In-patient Care Network Incentive is an amount paid quarterly based on the volume of unassigned In-patient cases annually. The incentive varies from $8,213/qtr where the unassigned In-patient care volume is low, to $54,750/qtr where the volume is high. In the communities that have a division, it will likely work best if the division receives this funding and determines a mechanism for equitably distributing it to its FP members.

Where a division wants to administer the Unassigned In-patient Care Network Incentive, the following steps are required:

- The division will need to establish a MSP Billing Number with Health Insurance BC (HiBC). This is a simple one page form which only has to be set up once. The division may have already completed this form if it plans to administer the Assigned In-patient Care Network Incentive.
- The division will need to link its banking information to that MSP Billing Number to enable Teleplan to make payments for incentives claimed. This is a simple one page form which only has to be set up once. The division may have already completed this form if it plans to administer the Assigned In-patient Care Network Incentive.
- The division will need to establish Teleplan software to submit the incentives. The division will then need to complete an application for Teleplan service which is a simple one page form that only has to be set up once. The Teleplan software is the same as for the Assigned In-patient Care Network Incentive if being administered through the division.
- The division will determine the membership for the Unassigned In-patient Care Network and submit a single completed Unassigned In-patient Care Network Registration Form. In most cases this Network will already be established in practice but there may be changes in light of the new incentives. The purpose of this form is for the Network to get set up administratively with Teleplan so that the Unassigned In-patient Care Incentives can be claimed.
- The division will need to work with its FP membership to determine a set of rules for what each FP will receive for participating in the Unassigned In-patient Care Network Service. Some ideas for allocation are:
  - Unassigned Network Incentive / # FPs on the rota = payment to each FP.
  - Unassigned Network Incentive / # days in quarter = amount each FP gets paid for the day there are delivering the Unassigned In-patient Care Service on behalf of the Unassigned Network.
  - The funding formula that will work best will vary depending on how the Network is set up operationally and is up to the division to decide.
- The division will need a process to make the Unassigned In-patient Care Network Incentive payments to its FP members based on a mechanism and schedule to be determined by them.

On a quarterly basis, at the start of each quarter, the Teleplan system will send to the division MSP Billing Number the Unassigned In-patient Care Network Incentive.

Exploring the $150 Unassigned In-patient Care Fee (Incentive #3):

The volume of unassigned In-patients being admitted across B.C.'s hospitals varies from less than one per day to just over two dozen. This provides a bit of guide on how many Teleplan submissions will be required daily into order to claim this fee. There are a couple of approaches for how to administer the $150 per Unassigned In-patient Care Fee:

1) FPs participating in the Unassigned In-patient Care Network bill the $150 Fee directly:
   Depending on how the Unassigned In-patient Care Model works for the community, the local FPs might agree that whoever assumes MRP for the In-patient on the first day will bill the $150/per unassigned In-patient care fee. Because In-patients across the province - including Alternate Level of Care (ALC) – spend, on average, 7.4 days in hospital, this might not be seen as fair because the Unassigned In-patient Care Network FP changes each day in some communities. Over time who assumes the MRP does average out so divisions may find it easiest to go with the 'first day of MRP' approach for billing the fee. As long as the $150 per Unassigned In-patient Care Fee is only billed once for the patient during their hospital stay, other approaches can be worked out by the local community as they see fit. For divisions wishing to minimize their administration of the In-patient care incentives, direct FP billing of the $150 Unassigned In-patient Care Fee is best.

2) The division bills the $150 per Unassigned In-patient Fee in order to pool funding:

   An alternate approach to the FPs individually billing the $150 per Unassigned In-patient Care Fee would be for the fee to be billed through the division and then an alternate method could be determined for how to divide the money amongst the Unassigned In-patient Care Network members who delivered the service. While this approach offers the division increased flexibility to allocate funding, it also means extra administration around the billing of incentives and figuring out an equitable payment to FP members. Communities that want to maintain models where FPs will be paid for being on-site during certain times of the day may wish to use this approach to pool money to support that model.

   The division will need to have each FP from the community that participates in the delivery of In-patient care sign an assignment of payment form. This allows the division to claim the incentives on behalf of the FP. This is a simple one page form per FP that only needs to be set up once every several years.

Scenario #3 – There is no division associated with the local acute hospital, or the division does not want to administer the incentives

There are many benefits to having a division; these incentives might be a reason for considering the set-up of a division. More information about establishing a division can be found at www.divisionsbc.ca. If the local FPs do not wish to proceed with setting up a division, the incentives can still be claimed using the steps below. The incentive numbers below are referring to the graphic shown at the top of page 2.

Set up for the Assigned In-patient Care Network (Incentive #1):

The following steps are required in order to get set up to claim the Assigned In-patient Care Network Incentive where the community FPs will directly claim the incentive:

- There can be multiple Assigned In-patient Care Networks for a community and each Assigned In-patient Care Network will submit an Assigned In-patient Care Network Registration Form. In many cases the Assigned In-patient Care Networks will closely resemble the already existing call groups that are in place for the community. The purpose of this form is for the Assigned In-patient Care Network to get set up administratively with Teleplan so that the Assigned In-patient Care Network Incentive can be claimed.
- On a quarterly basis each FP will need to bill the Assigned In-patient Care Network Incentive.

Set up for the two Unassigned In-patient Care (Incentives #2, #3):

The following steps are required in order to prepare to claim the Unassigned In-patient Care Incentives, where they are applicable for the community. Communities with a hospitalist model for Unassigned In-patient Care will generally not be able to claim the Unassigned In-patient Care Incentives:

- FPs would need to establish a shared MSP Billing Number or agree that one of the FPs would receive the Unassigned In-patient Care Incentive on behalf of the other FPs. The MSP Billing Number included on the Unassigned In-patient Care Network Registration form is where the Unassigned In-patient Care Network Incentive would be sent to on a quarterly basis. The local FPs will need to agree upon how they will divide the Unassigned In-patient Care Network Incentive between themselves; a few ideas are presented in scenario #2.
- The local FPs will determine the membership for the Unassigned In-patient Care Network and submit a single completed Unassigned In-patient Care Network Registration Form. In most

cases this Network will already be established but there may be changes due to the new incentives. The purpose of this form is for the Network to get set up administratively with Teleplan so the Unassigned In-patient Care Network Incentives can be claimed.

- On a quarterly basis, at the start of each quarter, the Teleplan system will send to the Network's MSP Billing Number the Unassigned In-patient Care Network Incentive.
- FPs would bill the $150 per Unassigned In-patient Care Fee either directly or through the shared MSP Billing Number, depending on what they decide works best.

Scenario #4 – Divisions with an existing MoH Service Agreement or a MOCAP Doctor of the Day (DOD) Agreement

In communities which have existing Ministry of Health (MoH) In-patient Care Service Agreements, or MOCAP DOD agreements, the GPSC In-patient Care Working Group, MoH, and the Health Authority will help divisions transition to the new incentives. In some cases that may take beyond April 1, 2013 to accomplish and in those cases the agreements will be extended to allow the transition to occur. With the exception of the Thompson Region Division, all MoH Service Agreements focus only on Unassigned In-patient Care Service Delivery. The choice of which of the three incentives to administer through the division is up to the division: the scenarios included in this document are intend to help with those decisions.

Some divisions have implemented customized solutions to pay their members for the Unassigned In-patient Care Service Delivery. For example, some facilities have FPs on-site during certain times of the day. During those on-site times, they are paid an hourly rate. In some hospitals the hourly rate changes depending on when the service is delivered. If divisions want flexibility to implement creative funding mechanisms for their members, then they will need to administer both the Unassigned In-patient Care Network Incentive and the $150 per Unassigned In-patient Care Fees. The division, in turn, is free to allocate the funding as it sees fit within their funding envelope.

As the funding through the GPSC In-patient Care Incentives is different from the MoH Service Agreements in some cases, divisions may wish to change how their Unassigned In-patient Care service delivery model works moving forward. In these cases it is requested that the division work closely with the Regional Health Authority on any transitions to ensure consistency in the In-patient care service delivery.

Scenario #5 – Division/FPs want the least amount of administration possible

Some communities may desire that the administration of the In-patient Care Incentives is set up in a way that results in the least amount of administrative work possible.

In a community with hospitalists, FP administration of the Assigned In-patient Care Incentives would result in the least administration for the division. See scenario #1 for an overview of the two possible options.

In a community where both the Assigned and Unassigned In-patient Care services are delivered by community-based FPs, scenario #3 has the least administration.