Residential Care Initiative
Frequently Asked Questions

General Practice Services Committee

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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.

What is the larger problem it is trying to resolve?
The initiative aims to create a platform for work on broader topics, such as the linkages between residential care and home health, the sustainability of the service delivery models, or the anticipated 120% growth in the residential care population between 2011 and 2036.

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 solutions that deliver dedicated GP MRP services for patients in residential care facilities.

What is a dedicated GP MRP?
For the purposes of this initiative, a dedicated General Practitioner (GP) 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.

Which divisions were prototypes for this initiative?
Five local divisions of family practice were prototypes: Abbotsford, Chilliwack, Prince George, South Okanagan Similkameen, and White Rock-South Surrey.

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 residential care initiative require each member to provide 24/7 availability for every residential care facility in the community?

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

When can divisions/self-organizing groups begin work on the initiative?

Divisions/self-organizing groups can access the planning funding as of April 1, 2015 and it will be available until March 31, 2017. The lump sum implementation funding, allocated at $400 per bed for equity, can be accessed as early as July 1, 2015. Divisions/self-organizing groups are encouraged to plan and implement their local solution over the next 18 months.

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 GP MRP residential care 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 residential care beds, would not be generally considered as sustainable.

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

Yes. There is no requirement for a family physician to belong to a division to participate.

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 facility?

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

What happens if a residential care facility 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 facility 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 Residential Care Working Group at residentialcare@doctorsofbc.ca.

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

The intention is that divisions of family practice would lead the local implementation of the residential care initiative. If a division does not wish to lead the local implementation, but a self-organizing group does, please contact the GPSC Residential Care Working Group (residentialcare@doctorsofbc.ca) to discuss the local circumstances.

Funding

How much funding has GPSC earmarked for the residential care initiative?

The GPSC has committed up to $12M annually for this initiative. This provincial budget was determined by allocating $400 per approximately 30,000 residential care 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 much funding is available to support communities in planning a local solution that provides dedicated GP MRP residential care services?

Divisions/self-organizing groups interested in designing and implementing a local solution can access up to $7,000 per community within the division's geographic boundaries starting April 1, 2015. Through a Request for Planning Funding, the planning funding is available until March 31, 2017.

If a community needs more time to discuss the residential care initiative and to develop a local solution, will it lose any planning or initiative funding?

Divisions/self-organizing groups can access the planning funding as of April 1, 2015 and it will be available until March 31, 2017. The lump sum implementation funding, allocated at $400 per bed for equity, can be accessed as early as July 1, 2015. Communities that choose to enter into a Memorandum of Understanding (MOU) after July 1, 2015 will receive implementation funding starting on the date of the MOU. Retroactive implementation funding for services prior to the start date of the MOU will not be available.

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 residential care initiative funding?

The funding formula considers both publicly and privately funded residential care beds. Long term care (LTC) beds are in scope for this initiative. Short term beds including convalescent, end–of-life, respite, and flex beds physically located within a residential care facility 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 residential care bed. The formula considers both publicly and privately funded residential care beds. Information about the number of beds in each community is available on the GPSC website.

What if the 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 facilities and associated bed counts. Errors can be corrected. If the local circumstances change, the MOU can be revised with mutual consent to accurately reflect the current situation.

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 Residential Care Working Group, 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 initiative is to support a sustainable dedicated GP MRP solution for all communities in BC. In the spirit of supporting a sustainable solution, it is requested that no division/self-organizing group allocate more than $45,000 of the residential care incentive per provider. The intent of this request is to promote the allocation of funding in a way which supports a long term sustainable solution. Where community circumstances dictate, a community can apply (via residentialcare@doctorsofbc.ca) to the GPSC Residential Care Working Group for consideration of an exemption to the maximum funding per provider.

Is there financial support for local divisions/ self-organizing groups to administer the residential care initiative?
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 residential care initiative replace Fee-for-Service?
No. The GPSC residential care initiative 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 facilities in addition to the GPSC residential care incentives?
Private arrangements may continue if that is part of the agreed upon local solution. However, where private arrangements continue, the beds in those facilities will not be included for the purposes of calculating the community lump sum funding.

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

Yes. However, if the services provided by a nurse practitioner are covered by another source (e.g., NP4BC), utilization of the GPSC residential care initiative funding is not allowable. The intent of the initiative is to support a sustainable dedicated GP MRP solution for all facilities in BC. In the spirit of supporting a sustainable solution, it is requested that no division/self-organizing group allocate more than $45,000 of the residential care incentive to any one provider.

Will rural retention premiums be applied to the residential care initiative?

No, because the residential care incentive is not physician specific.

Does the residential care initiative contribute towards the dollars used to calculate GPs benefits?

No, as the residential care incentive is not physician specific.

Can practices funded under a blended funding model participate in the initiative?

Yes. However, if services supported and paid through GPSC incentives are already included in the sessional, salary or service contract portion of the blended funding model, those providers are not eligible for the GPSC residential care initiative.

Are physicians on Alternate Payment Program (APP) contracts eligible for initiative funding?

Communities which are funded through APP contracts are not eligible for the GPSC residential care initiative incentive funding. Some health authorities contract with physicians to deliver site medical director functions, which are separate from the GPSC residential care initiative. If the services delivered are different, a physician may receive funding through the GPSC residential care incentive. If the services supported and paid through the GPSC incentives are already included in the APP contract, those providers are not eligible for the residential care initiative in addition.

Processes

When can local divisions/self-organizing groups start to plan local solutions?

Divisions/self-organizing groups interested in designing a local solution for dedicated GP MRP services for residential care can access planning funding as of April 1, 2015 through a Request for Planning Funding.

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.

After receiving planning funding and engaging in planning activities, what if a division/self-organizing group cannot come to agreement or does not wish to participate in a local program?

There is no obligation to enter into the MOU for the residential care initiative if a division/self-organizing group decides not to proceed.

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 GP MRP services for all residential care facilities 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 Residential Care Working Group (residentialcare@doctorsofbc.ca).

When will implementation of local solutions start?

Divisions/self-organizing with completed MOUs can start the implementation as early as July 1, 2015. There is no deadline to implement a local solution.

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 GP MRP residential care 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 (residentialcare@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 facility introduced into the community).

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

Yes. To support each community's solution, the GPSC website has information on about 104 locations in the province with residential care facilities. 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 residential care 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 residentialcare@doctorsofbc.ca) of the GPSC. It is understood that there are a few very large divisions that may wish to implement their facilities in a few phases. For example, the Vancouver Division has over three dozen facilities, which may be challenging to transition all at once. For large communities with many facilities, a request to implement the local solution in phases can be made to residentialcare@doctorsofbc.ca.

Will divisions/self-organizing groups be required to report on activities and evaluate their local solution?

In consultation with divisions/self-organizing groups, the GPSC is currently developing an evaluation framework for the residential care initiative based on the five best practices and three system level outcomes. The GPSC will conduct the provincial evaluation process and provide a short monitoring report for all communities to collect, review, and discuss the data/findings. It is anticipated that divisions/self-organizing groups will use this information in the spirit of continuous quality improvement for their local solutions. For example, based on the monitoring report's learnings about the amount of local proactive visiting, the division/self-organizing group may decide to modify the level of proactive visits. The division/self-organizing group will need to allocate some of the local lump sum funding to plan and implement the change. It is not intended that divisions/self-organizing groups hire their own evaluator, unless they wish to augment the provincial evaluation framework. As the provincial evaluation framework is currently in development, more details are forthcoming.

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

Based on the evaluation framework for the residential care initiative, there will be standardized information available for all communities on a quarterly basis. The intention is to have baseline information available by July 1, 2015.

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

There is currently no quarterly or annual reporting requirement; however, once the evaluation framework is complete, this will be revisited.

It is expected that divisions/self-organizing groups will regularly monitor and quarterly review the evaluation information to assess the functionality of their local program. Divisions/self-organizing groups are encouraged to refine their local solution when opportunities arise, in addition to at least annually when reviewing/updating the MOU.

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 GP MRP residential care 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 Residential Care Working Group 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 residential care 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 residential care would be seen as a success, although it is recognized that some communities may choose to have some degree of family physician specialization in residential 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 residential care 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 residential care facilities in the province. This does not mean that every facility will utilize the same solutions, only that the range of solutions is equitable and can be available for all residential care 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.