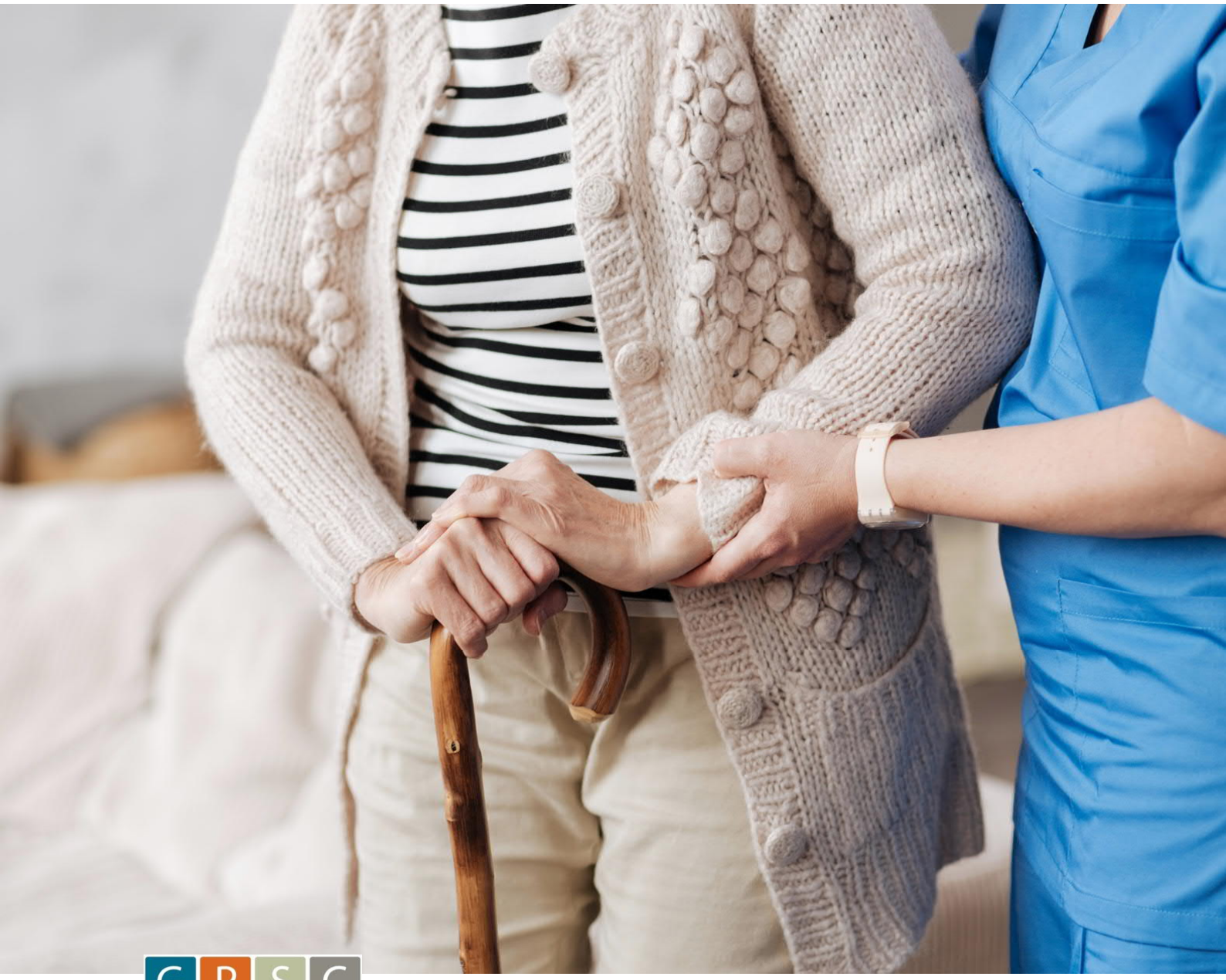


General Practice Services Committee

GPSC Long-term Care Initiative Service Review

January 19, 2021

Prepared by:

GPSC LTCI Working Group

Elayne McIvor, Catalyst Consulting Inc.

Table of Contents

1. Executive Summary

Prior to the launch of the GPSC Long Term Care Initiative (LTCI) in early 2015/16, Divisions of Family Practice and Health Authorities reported several challenges related to delivering physician services in LTC homes. Examples of such challenges were: declining family physician participation; communities being unable to locate MRPs for all clients admitted; older physicians approaching retirement with large patient panels, but no succession plans; significant projected LTC client growth; and a lack of consistency in service standards for working in LTC homes. The GPSC's Long-term Care Initiative (LTCI) was designed to address these challenges by enabling divisions to develop local solutions to improve the care of clients receiving LTC services.

The GPSC initiative was built on the seniors care prototyping work done by five local divisions of family practice and their respective health authority partners from 2011. Those five local divisions were: Abbotsford, Chilliwack, Prince George, South Okanagan Similkameen, and White Rock-South Surrey. Learnings from these divisions and extensive consultation with other stakeholders helped establish five best practice expectations and three system-level outcomes for the provincial initiative.

With the current LTCI implementation across the province at approximately 96%, this report summarizes progress the initiative has made towards meeting its best practice expectations and system level outcomes and results from a review of local service, business and funding models implemented by funded communities. Overall, evaluation results demonstrate that the LTCI has made strong progress towards achieving its best practice expectations and system level outcomes at the provincial level since its implementation. In addition, findings from a recent survey demonstrate that family physicians/nurse practitioners have provided high quality care during the COVID-19 pandemic. LTC homes offered suggestions on how services can be improved in anticipation of a second wave.

All Divisions of Family Practice participating in LTCI completed: (i) an annual funding report; and (ii) a survey of local service, business and funding model questions. At a high-level, results from the annual funding report show that the majority of initiative funds are dedicated to different forms of physician compensation (roughly 75%), followed by administrative and project management costs, qualitive improvement, and educational activities. Most reported that they had funding surpluses in their last complete year of work, but identified why funds were unspent and how they planned to use them.

Findings from the service, business and funding model survey illustrate that Divisions of Family Practice have implemented similar, yet distinct mechanisms to achieve best practice expectations in service of the system level outcomes. Almost all communities reported that their physicians and/or nurse practitioners were given the opportunity to be consulted and engaged in the process of designing their local solutions. Clustering approaches where MRPs care for larger groups of clients who are cohorted to single facilities are implemented among two-thirds of communities. Some explained clustering approaches were expedited during COVID-19 given recommendations to limit providers working at multiple sites. These communities described positive, unintended consequences of implementing clustering models, to the extent that some continued on with these approaches once transmission of COVID declined in BC. The involvement of NPs in local solutions has increased over time, with half now engaging these providers in their solutions.

Divisions shared feedback on how LTCI articulates its best practice expectations, as well as recommendations for improvement of the initiative's funding model. Two-thirds of the communities believe that the best practice expectations can be more explicitly defined, particularly noting room for clarity with what is entailed for proactive visits. Communities most commonly indicated that the current funding model should not be changed, emphasizing the importance of local flexibility to use funds. However, half reported that current funding is insufficient for smaller communities, often noting that there is limited funding for quality

improvement, education, communication, and admin costs once the base cost to deliver the best practice expectations is accounted for.

Based on results from past evaluation work and the service review, a series of recommendations have been put forward for the GPSC to consider. According to Ministry of Health planning figures, we are aware the LTC clients are expected to double over the next few decades. We have an opportunity to prepare for this influx in volume now by learning about what is working well, and what needs to be improved in the future.

2. GPSC Strategic Context

The GPSC defines its vision as "To enable access to quality primary health care that effectively meets the needs of patients and populations in BC, using the patient medical home to form the foundation for care delivery within a broader, integrated system of primary and community care". The GPSC targets its programs and supports to family physicians providing full service longitudinal care to their patients. This is expressed through Patient Medical Homes (PMH) and Primary Care Networks (PCN) as key current strategic areas of focus and support. The Patient Medical Home represents an ideal team-based family practice and is supported through various incentives, tools, resources and coaching provided to individual physicians and practices. At a community level, the GPSC, through divisions, supports physicians to work collectively, and along with health authority and community partners, to form PCNs, focused on meeting the comprehensive care needs of a defined community population.

The GPSC's provincial Long-term Care Initiative (LTCI) has now been in place for more than five years and is a key example of community networking, and support of comprehensive primary care provision, predating but consistent with the current PCN strategy and direction.

As the GSPC is currently starting work planning for the next fiscal year, leading into the last year of the current Physician Master Agreement, the committee is reviewing its current programs and initiatives in light of current strategic directions, in addition to taking into account the impact of the COVID-19 pandemic. The GPSC is also considering how to support comprehensive care provision through Primary Care Networks in a more holistic fashion. At this crossroads, it is an ideal time to review the outcomes of the LTCI, along with the associated resourcing and community developed service delivery and business models, to define potential areas for improvement and evolution of this initiative.

3. Overview of the Long-term Care Initiative

3.1. Summary of the initiative

Overview

Between 2003/04 and 2012/13, BC experienced an increase of approximately 10% in the number of community-based family physicians. Over this same time period, the number of family physicians delivering LTC services dropped by about 13%. GPSC's LTCI is designed to address this challenge by enabling divisions to develop local solutions that improve the care of clients receiving LTC services.

Dedicated GP MRP Services

The initiative supports Divisions of Family Practice to design and implement local solutions that deliver dedicated GP MRP services for clients in long term care facilities. For the purposes of this initiative, a dedicated GP MRP is defined as one who delivers care according to five best practice expectations and promotes three system level outcomes (see box below).

Best practice expectations	System level outcomes
• 24/7 availability & on-site attendance, when required • Proactive visits to clients • Meaningful medication reviews • Completed documentation • Attendance at case conferences	• Reduced unnecessary or inappropriate hospital transfers • Improved client-provider experience • Reduced cost/client as a result of a higher quality of care

Through this collaborative work, it is also anticipated that divisions will be positioned to explore broader topics, such as the linkages between LTC and home health, the sustainability of the service delivery models, or the anticipated 120% growth in the LTC population between 2011 and 2036.

Process for Getting Started

1. *Intent:* From April 2015 to March 31, 2017, divisions interested in designing and implementing a local solution accessed up to $7,000 for planning per community within the division's geographic boundaries through the submission of a Request for Planning Funding.
2. *Engagement:* For an equitable process, divisions were encouraged to invite all local family physicians to participate in discussions about the proposed local solution and funding allocations.
3. *Planning:* With the planning funding, the local divisions were to convene at least once to discuss how to best locally achieve the dedicated GP MRP services. The local model and funding allocation details were determined by the local division, and were required to meet the initiative's best practice expectations and system level outcomes. Divisions allocated funding into several pots to enable various elements of their programs. For example: (i) a division/community coordinator for long term care; (ii) the network structure itself including on-call; (iii) support of enhanced client care; (iv) quality improvement, evaluation, mentoring, or education sessions, and/or (v) other functions as determined locally.
4. *Memorandum of Understanding:* Once the division planned a local solution for dedicated GP MRP long term care services, the solutions were articulated in a Memorandum of Understanding (MOU) between the division and the regional health authority.
5. *Funding:* Funding is provided to divisions through a Funds Transfer Agreement (FTA) between the local division and Doctors of BC, on behalf of the GPSC. The MOU forms part of the FTA. Starting July 1, 2015, divisions with a completed MOU and FTA accessed monthly lump sum incentives, calculated for equity at an annual $400 per long term care bed, to implement their local solutions. The formula considers both publicly and privately funded long term care beds. The lump sum incentive is not available retroactively. There was no deadline to complete an MOU and launch the local solution.
6. *Payment:* Based on the FTA, divisions receive monthly payments, through the Doctors of BC on behalf of GPSC, approximately two weeks after each month. Divisions determine the specific payment processes to individual family physicians based on their local solution.
7. *Monitoring/Learning:* Working with divisions and health authorities, the GPSC has implemented ongoing quality improvement and evaluative processes that measure local and provincial expectations and outcomes, as well as a process to share learnings with all stakeholders.

3.2. Why was a GPSC LTCI needed?

Prior to the launch of the GPSC LTCI in early 2015/16, Divisions of Family Practice (DoFPs) and Health Authorities (HAs) were reporting several challenges related to delivering physician services in LTC homes. Some examples of the issues reported included:

- **Declining FP participation:** Between 2003/04 and 2012/13, BC experienced an increase of approximately 10% in the number of community-based family physicians (FPs). Over this same time period the number of FPs delivering long term care services dropped by approximately 13%. This was resulting in family physician LTC capacity issues in some communities.

- **No available MRP:** For a client to be admitted into an LTC care home, they need to have an MRP assigned to them. Many communities were not able to locate MRPs for all the clients being admitted to their local LTC care homes. As a result, some clients would remain in non LTC settings such as Alternate Level of Care (ALC) beds in hospitals.
- **Unsustainable MRP concentration:** It was common for communities to report that some physicians were carrying panels of hundreds of LTC clients. The challenge reported was that many of these physicians were older male physicians near retirement without a cohort of younger physicians coming up behind them. As a result, when the physician retired, or if they were no longer able to deliver LTC services for other reasons such as their own health, then it would leave large panels of LTC clients with no Most Responsible Physician (MRP).
- **Significant LTC client growth projected:** Based on statistics reported by the Ministry of Health Planning Division, it was anticipated that there would be 120% growth in the LTC population between 2011 and 2036.
- **Community Networking:** Many communities have multiple care homes providing services for hundreds of clients across dozens of FPs. Prior to the GPSC LTCI there was no mechanism or resources to systematically plan FP services for all LTC beds across the community.
- **Increased provincial consistency:** Prior to the GPSC LTCI, not all communities were consistently delivering the five best practices expectations, nor were these expectations clearly defined. Over the last five years of the initiative, DoFPs and HAs have been able to proactively work on minimizing many of these historical issues.

3.3. The GPSC LTCI networking approach

Historically family physicians have delivered LTC services as individual practices. Sometimes practices would collaborate to deliver functions such as on-call for their client panels. However, no individual practice has responsibility for all local LTC homes, which meant that there was no way to systematically and proactively address community level LTC issues. For example, five years ago it was common in some communities that no MRP could be found for an LTC client who was not attached to a longitudinal FP. As a result, the client could remain in an Alternate Level of Care (ALC) bed in a hospital for weeks until an MRP could be located. This issue is largely addressed now as communities have implemented processes for locating MRPs for all clients.

In order to support community level approaches to solving local issues, the funding for the LTCI was allocated at a community level. That allows the local DoFP to determine for themselves how to best solve their local issues, often through various FP networking approaches.

Community Spotlight:
Shuswap North Okanagan

With LTCI funding, the Division has implemented a system to ensure all long-term care clients have an MRP, through which orphaned clients from the community or alternate level of care beds are assigned an MRP to facilitate their transition to long-term care beds.

This work has resulted in an average 23% drop in emergency transfer rates from facilities between 2016/17 and 2018/19. These systems and processes have also made the transfer of orphaned clients much easier and efficient.

4. What has the LTCI accomplished so far?

The LTCI is supported by an ongoing quality improvement (QI) and evaluation strategy with the central purpose of assessing progress towards the initiative's best practice expectations and system level outcomes. On a quarterly basis, communities are provided with QI reports assessing progress towards best practice expectations and system level outcomes (see Appendix A). The purpose of these reports is to stimulate local dialogue about what is working and what can be improved. Data included in these reports is presented at the facility, community, regional and provincial levels. The quarterly QI reports are informed by two main data sources: (i) a quarterly survey assessing the quality of physician services completed by LTC staff; and (ii) administrative data from the BC Ministry of Health and individual health authorities. In the spirit of learning for improvement, the initiative Co-Chairs reach out to communities to explore reasons for shifts or negative results in quarterly data, as well as how communities aim to address the issues moving forward. Discrete evaluation activities have also been completed to gather information from relevant stakeholders about LTCI successes, challenges and areas for improvement.

Using QI and evaluation results, this remainder of this report section summarizes LTCI accomplishments, including progress towards LTCI best practice expectations and system level outcomes.

4.1. Widespread Implementation

LTCI has been widely implemented with 96% uptake across the ~31,000 LTC beds in BC.[1] There are approximately 340 LTC sites in BC, 35 Divisions of Family Practice and 97 communities.

~96%
LTCI uptake across the ~31,000 beds in BC

4.2. Satisfaction with LTCI Overall

Interviews with Physician Leads and Health Authority representatives demonstrated that stakeholders are highly satisfied with LTCI overall, largely because of the improvement of care relative to the 5 best practice expectations. There have been reported improvements in facilities' satisfaction with their working relationships with physicians over time at the provincial level.

4.3. Increased Client Attachment

With initiative funding, communities developed mechanisms for client attachment to the extent that all clients now have a dedicated MRP. This is a substantial improvement from five years ago when it was common in some communities that no MRP could be found for an LTC client who was not attached to a longitudinal FP. Client attachment is associated with widespread benefits, ranging from enhanced client care to health system improvements given reduced pressure on already stretched hospitals.

Communities have developed mechanisms for client attachment to the extent that all LTC clients now have a dedicated MRP.

[1] As of September 2018, the LTCI uptake was 96% (initiative covered 30,286 of the 31,590 LTCI beds in the province).

4.4. Increased Accountability

The LTCI's best practice expectations hold physicians accountable to provide a standard of care. Physician Leads and Health Authority representatives noted improved consistency of care in comparison to prior experience, with the commitment from physicians to the best practice expectations. Some also noted that the LTCI sets expectations for the LTC sites to provide support to help the expectations be realized. Interviewees commonly reflected on the inadequacy of care in facilities before the initiative was implemented, where physicians were not held accountable to provide a standard of care. For instance, some clients had not been visited by their MRPs in years, medication reviews were not always completed, and the provision of timely 24/7 coverage was rare. They explained that the LTCI successfully addresses such shortcomings by creating clear and standardized expectations and a community of practice for physicians who choose to work in LTC. Through the LTCI, physicians contribute to a suite of services in support of longitudinal care.

4.5. Progress Towards Best Practice Expectations

24/7 availability and on-site attendance, when required

Figures 1 and 2 illustrate how often facility staff report being able to reach physicians in a timely manner during office and non-office hours over time. Since the LTCI was implemented in 2015 there has been a positive increase in the frequency at which facilities can reach physicians/NPs during both office and non-office hours at the provincial level. The most substantial improvements were observed in the 2016/17 fiscal year. These positive results are consistent when viewing findings at the health authority level.

Figure 1. Proportion of time facilities can reach physicians in a timely manner during office hours in BC (2015/16 to 2020/21) (Source: Facility Survey)

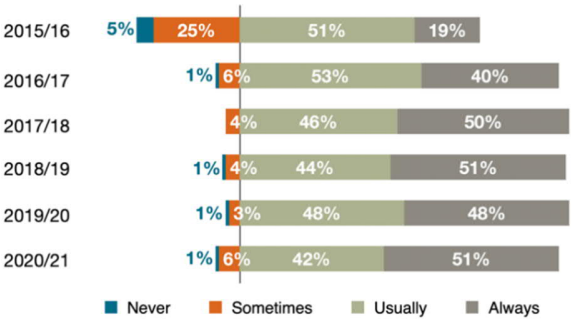


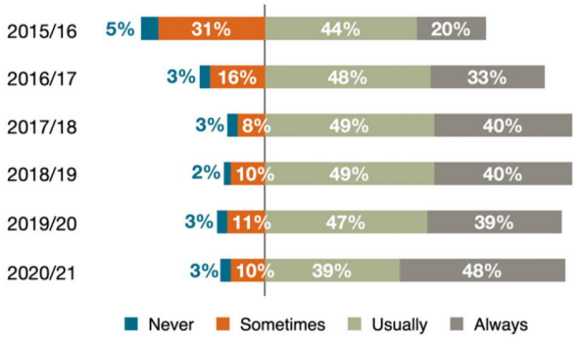
Figure 2. Proportion of time facilities can reach physicians in a timely manner during non-office hours in BC (2015/16 to 2020/21) (Source: Facility Survey)

Community Spotlight: Victoria and South Island

The Victoria LTC After-Hours Call Group launched in April 2017 with 26 physicians who helped build a coordinated, responsive system of long-term care coverage in the community. The group provide after-hours coverage for all clients in 28 Victoria facilities. Coverage is provided between 5pm and 7am on weekdays and all hours on Saturdays, Sundays, and holidays.

Key Features & Results

There is one phone number for facilities to call. All calls are managed by a dispatch service that connects the physician on call directly to facility staff. The majority of calls are patched to a physician in less than one minute. Call volume continues to decline over time.

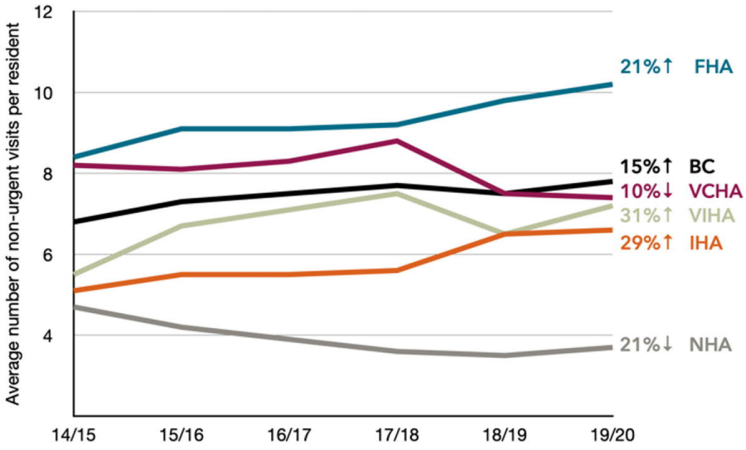


Facilities have also become more satisfied with physician 24/7 availability since LTCI was implemented. From 2015/16 to 2020/21, we observed a 31% increase in the proportion of facility staff who are satisfied with provider availability.

Proactive visits to clients

Figure 4 illustrates the average number of non-urgent long-term care visits per client over time. At the provincial level, non-urgent client visits have increased since LTCI was implemented. However, the data shows variability in progress at the health authority level, with increased client visits in Fraser, Island and Interior Health over time, and decreased visits for Vancouver Coastal and Island Health.

Figure 3. Average non-urgent visits per client, 2014/15 to 2019/20[2]



Meaningful medication reviews

Table 1 shows changes in the average number of ordered drugs per client over time. Results show that LTC clients have been prescribed slightly fewer drugs across the six fiscal years examined, at both the regional and provincial levels.

[2] Figure 4 data is based on physician fee-for-service data (MSP Fee Item 00114) and relevant nurse practitioner codes (36422, 36423, 36424, 36425, 36428, 36429, 36430, 36431, 36434, 36435, 36436, 36437, 36438, 36317, 36318, 36319, 36280, 36281, 36285, 36374, 36640). Data is not included from private facilities nor services paid through APP or sessional models. The data also exclusively focuses on long-term care clients with a length of stay of 30 days or longer (excludes temporary stay/hospice clients).

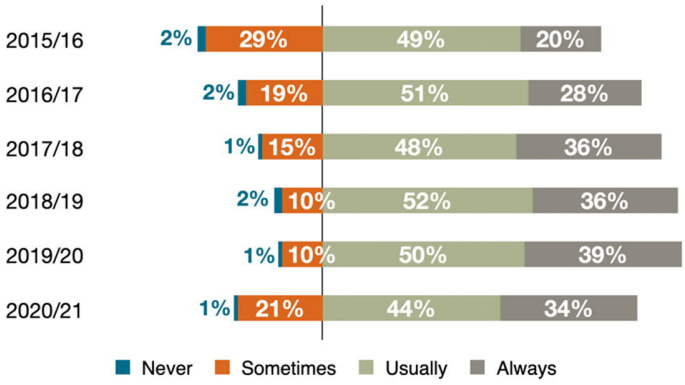
Table 1. Change in the average number of ordered drugs per client, 2014/15 to 2019/20[3]

Health Authority	14/15	19/20	Net change	% change
FHA	6.5	5.5	1.0 ↓	15% ↓
IHA	6.6	5.8	0.8 ↓	12% ↓
NHA	6.1	5.5	0.6 ↓	10% ↓
VCHA	6.4	4.7	1.7 ↓	27% ↓
VIHA	6.6	4.9	1.7 ↓	26% ↓
BC	6.5	5.2	1.3 ↓	20% ↓

Completed documentation

As seen in Figure 5, facility staff across BC report that physicians are more frequently completing documentation for clients since LTCI was implemented. This positive finding was also consistent for each of the health authorities.

Figure 4. Facility ratings of the proportion of time physicians complete documentation for each client, including: (i) advanced care plan to include DNR; (ii) MOST intention plan; (iii) client summary - medical summary and progress notes, BC averages

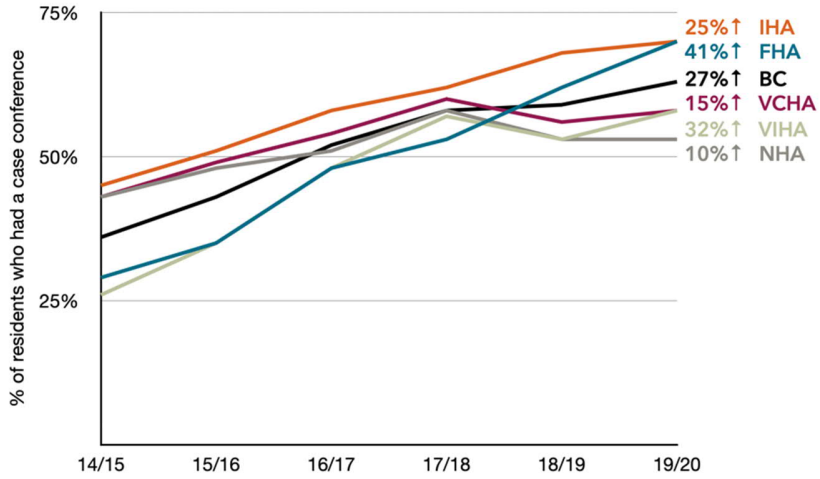


Attendance at case conferences

Since the implementation of LTCI, we have observed gradual increases in the percent of LTC clients who had a care conference in each of the health authorities and across BC (see Figure 6). Fraser Health demonstrated the strongest increase in this indicator over the time period examined (41% increase from 14/15 to 19/20). These positive results were confirmed by data from the facility survey showing increased satisfaction with physicians attending care conferences over time.

[3] Data in Table 1 is based on information from the Pharmacare and Home and Community Care databases. The drug counts are based on therapeutic classes level 4 (TC4) drugs, with the exclusion of some 'interval drugs'.

Figure 5. Percent of LTCI clients who had a care conference attended (14015, 14077), 2014/15 to 2019/20[4]



4.6. Progress Towards System Level Outcomes

Reduced unnecessary or inappropriate hospital transfers

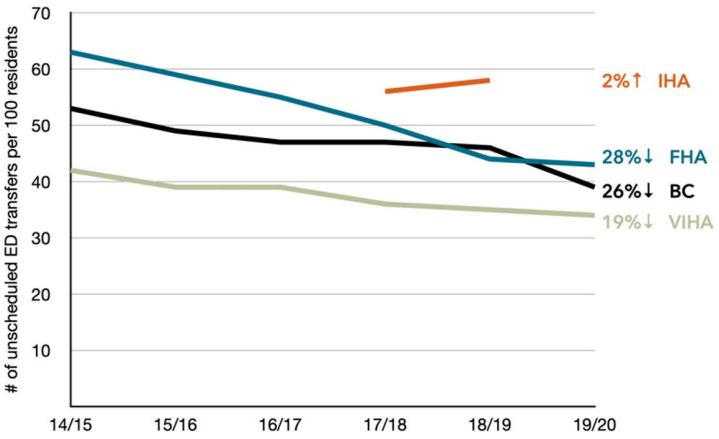
The LTCI has made progress in obtaining some data from individual health authorities to measure progress towards the system level outcome of reducing unscheduled emergency department (ED) transfers in BC. Fraser and Island Health have provided the most comprehensive data over time so far, showing substantial declines in ED transfers since the implementation of the LTCI (28% and 19%, respectively) (Figure 7). Initial data provided by Interior Health shows that rates have remained relatively stable over the two years of results available. There has has not been success thus far in obtaining ED transfer rate data from Vancouver Coastal and Northern Health.

Community Spotlight:
Fraser Northwest

The Division's work continues to enhance and nurture relationships among key stakeholders. The program aims to ensure that all clients (1,722 beds in total) have a dedicated MRP committed to providing the 5 best practice deliverables. Since inception, emergency transfer rates from facilities reduced by 39% and acute care admissions reduced by 45%.

[4] Data is based on GPSC incentive payments (GPSC Fee Codes 14015 and/or 14077) and NP case conference codes 36372 and 36377. Services paid through APP or sessional models have been excluded. Information from private facilities is not included in this report. The data also exclusively focuses on long-term care clients with a length of stay of 30 days or longer (excludes temporary stay or hospice clients).

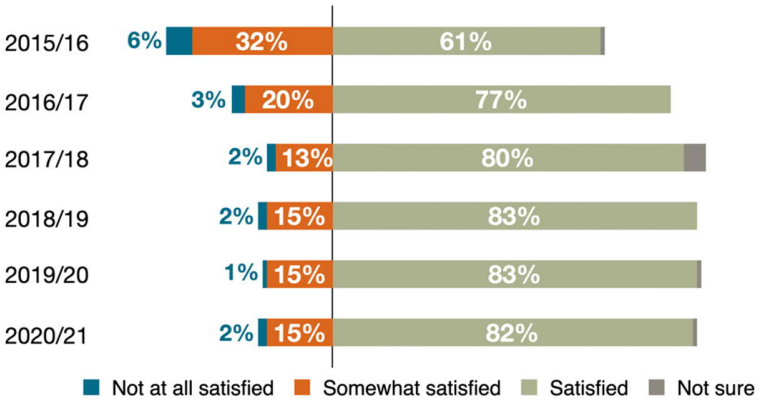
Figure 6. Number of unscheduled emergency department transfers per 100 clients from 2014/15 to 2019/20, by HA[5]



Improved provider experience

Results from the facility survey also demonstrate that there have been improvements in facilities' satisfaction with their working relationships with physicians over time at the provincial level (Figure 8). The most substantial changes were observed in the 2016/17 and 2017/18 fiscal years. Improvements in physician/facility staff relationships were also observed for each of the health authorities, with the exception of Northern Health where no change was observed.

Figure 7. Facilities' satisfaction with physicians' working relationships with facility clinical staff, BC overall 2014/15 to 2020/21 (Source: Facility Survey)



Note that the LTCI has also explored the feasibility of conducting a client survey to assess the difference the initiative has made on their experience over time. Consultations were conducted with Divisions of Family Practice and Health Authorities to explore if and how to conduct a client experience survey. Given the mental and physical state of LTC clients and difficulty with cognition, it was determined that a family survey would be most appropriate to assess experience. A client experience survey (to be

[5] Data has been obtained from the health authorities independently. It is important to note that there are slight differences in how each health authority defines their ER transfer rates (e.g. IHA provides the rate per 100 beds, VIHA reports per 100 clients, and FHA uses an average daily client count for their denominator), and therefore caution should be taken when comparing data between health authorities. The BC average is based on data from IHA and VIHA exclusively.

completed by family) was drafted in early 2019, which explored the quality of care provided by LTCI physicians for each best practice expectation and system level outcome. After reviewing the survey questions, Divisions, Health Authorities and LTCI Physician Leads expressed a variety of concerns with the idea of conducting a survey, as follows:

- substantial time and resources would be required to survey clients/families;
- ethics/privacy clearance would likely be required;
- attribution issues between client experience and influence of the LTCI;
- families are often unaware of the work physicians are doing, therefore results would be inaccurate and possibly negatively skewed;
- length of stay for clients is typically quite short in LTC homes, which limited ability to measure changes in experience over time; and
- the Office of the Seniors Advocate already conducts a provincial LTC survey with clients and families.

The potential of conducting a client/family survey was put on hold after this feedback was considered.

Reduced cost/client as a result of higher quality of care

Communities' substantial progress towards achieving LTCI best practice expectations and system level outcomes provides logical evidence that the initiative is saving the healthcare system money through cost avoidance. In particular, the results showing reduced medications and emergency department transfers offer strong evidence to substantiate this claim. If the GPSC is interested in confirming and quantifying the cost savings to the system, it is recommended that a health economist should be commissioned to facilitate this process.

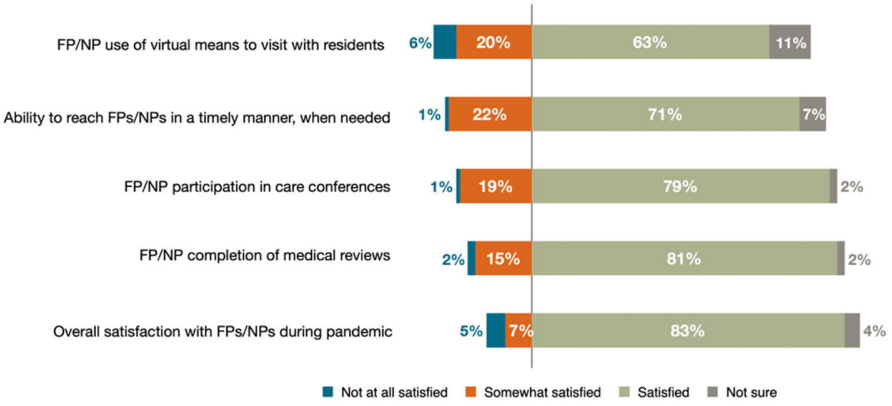
4.7. Physician/NP Services During the COVID-19 Pandemic

We included a series of questions in the Q1 2020/21 facility survey to assess the quality of care provided by family physicians and NPs during the COVID-19 pandemic. As seen in Figure 9, 90% of facility survey respondents reported that the overall quality of care provided to clients during the pandemic by family physicians/NPs was good (36%; n = 40) or very good (54%; n = 60).

Figure 8. Facility ratings of the overall quality of care provided to clients by FPs/NPs during COVID-19, BC overall (n = 112)

Figure 10 illustrates facilities' satisfaction with family physician/nurse practitioner during the pandemic, including results related to their completion of best practice expectations and use of virtual means to visit clients during this time. Overall, 83% (n = 92) of facilities reported that they have been satisfied with family physician/NP services during COVID. At least 70% of facilities reported that they are satisfied with family physicians'/NPs' ongoing adherence to best practice expectations, including completion of medical reviews, participation in case conferences, and being available when needed. Roughly two-thirds of facilities were satisfied with their use of virtual means to visit with clients during the pandemic.

Figure 9. Facility satisfaction with physician services during COVID-19 pandemic, BC overall (n = 112 to 117)



Facilities were asked to describe ways in which physician/NP services can be improved in anticipation of a second wave. Their responses have been grouped into common themes, as follows:

> "Having one primary physician for our site was very beneficial. Limited levels of exposure to clients and that physician was involved in COVID planning at the site and understands the site very well..."
>
> - Clinical Nurse Leader

- Continue with models of care initially implemented in response to the pandemic, such as having one primary physician per site to reduce transmission (12%; n = 14).
- Continue to use and implement virtual means to visit with clients (11%; n = 12). Some recommended that consistent virtual meeting software should be used and that family physicians should become more familiar with such platforms.
- Improve communication between family physicians/NPs and facilities and families (10%; n = 11). Facilities were at times unclear about how to care for clients during the pandemic (e.g. whether send to hospital if an outbreak occurred or keep them at facility) and who was on-call after hours. Families would benefit from proactive conversations about expectations for care during COVID and update on health of family members.
- Family physicians should follow COVID safety and screening protocols (e.g. properly wearing and removing PPE, cleaning equipment, screening procedures upon entry to sites, etc.) (5%; n = 6).
- Increase the frequency of visits to the facilities (5%; n = 6).
- Family physicians/NPs to have updated goals of care/advanced care planning conversations in the context of COVID (4%; n = 4).
- Implementation of one site, one provider rules (4%; n = 4).

4.8. Other Areas of Impact

Interviews with Physician Leads and health authority representatives reported that the LTCI has also made a difference in the following areas.

- Increased collaboration among long-term care stakeholders. The LTCI funding provides a mechanism for key stakeholders to collaboratively discuss local challenges and develop strategies to address them in response. Interviewees described the value of stakeholders sitting at the same table together to address issues, rather than working in silos. Some explained that the initiative has

provided the platform for overdue conversations between physicians, long-term care facilities, Divisions and Health Authorities. Others highlighted the value of effective partnerships between Divisions and Health Authorities, explaining that when meaningful partnership and collaboration is taking place positive results are achieved.

- Increased physician engagement and leadership. The LTCI has provided the resources and platform to increase physician engagement and leadership in long-term care. Physicians are actively engaged in networking, strategic planning, and QI activities. They are also acting as ambassadors for change by recognizing issues within their communities and advocating for improvements.
- Increased physician collegiality and collaboration. Interviewees reported that the LTCI provides a platform for physicians to work in team-based care models and build stronger relationships amongst each other, and other stakeholders involved. They also explained that since LTCI implementation, physicians are more likely to support one another, provide coordinated coverage and collaborate on complex client cases.
- Increased physician recruitment. Using LTCI funds, communities have created models of providing long-term care that are attractive to physicians, which is resulting in increased numbers of new recruits. Communities that were previously experiencing crisis level numbers of physicians working in long-term care now have waitlists of providers keen to participate. On the other hand, some communities have restricted LTCI participation and funds to a small group of physicians, excluding others from participating in the initiative.
- Improved physician knowledge. Physicians interviewed explained that LTCI educational opportunities have been useful since they provide up-to-date information about best practices.
- Reduced burden on physicians through team-based care. The ability to use lump sum funding for dedicated on-call groups relieves physicians from having to be available for clients 24/7, 365. As a result, physicians explained that they have better vacation coverage and work-life balance.

5. Summary Findings: LTCI Annual Funding Report

Of the Divisions of Family Practice participating in the LTCI, 100% (n = 35) completed the Annual Funding Report in June and July 2020.[6] While provincial results have been presented below, community level responses are available upon request.

Table 3 provides a provincial summary of how LTCI funds were allocated across participating communities in their last complete year of work. A total of $11,192,396 was reported to be spent. Of this total, roughly three-quarters of the funding was dedicated to different forms of physician compensation (MRP payments, on-call payments, and physician leadership payments). Division of Family Practice administrative and project management support accounted for 17% of funds. Communities reported that 4% of funding was spent on quality improvement and educational activities. A small proportion of funds were dedicated to other costs, such as other physician compensation methods (e.g. unique local incentives), catering, meeting costs, and EMR costs.

Table 2: LTCI Provincial Expenditures Summary in Their Last Complete Year of Work (n = 48)

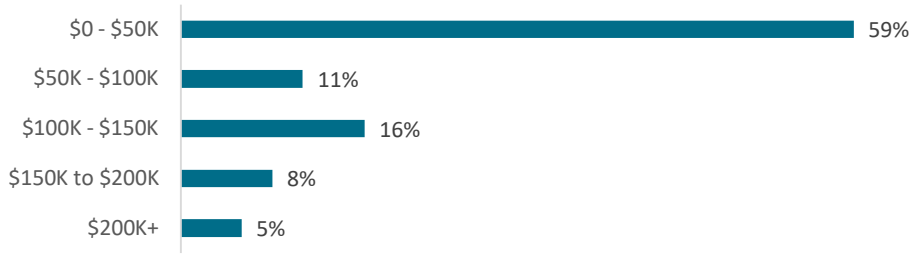
LTCI activities	Amount	% of total
Compensation: MRP payments	$5,397,497	48%
Compensation: On-call payments	$2,667,161	24%
Compensation: Physician leadership payments	$507,098	5%
DoFP administrative support staffing or project overhead	$1,334,907	12%
DoFP project management support	$520,973	5%
QI and education	$472,826	4%
Other (e.g. other physician compensation, catering, meeting costs, EMR costs, etc.)	$291,934	3%
TOTAL REPORTED AS SPENT IN ANNUAL FUNDING REPORT	**$11,192,396**	**100%**
ESTIMATED SURPLUS (from last complete year of work)[7]	**~$807,604**	
TOTAL DISTRIBUTED	**~$12,000,000**	

Divisions were asked to report if they had a LTCI funding surplus from their last complete year of operation. The majority reported (77%; n = 37) that they had funding surpluses in their last complete year of LTCI work, while roughly one-fifth did not (23%; n = 11). The reported surplus amounts totaled to $2,157,774 across communities, which included surplus accumulated over the years. Surplus amounts ranged from $402 to $220,467 and were an average of $58,318. As seen in Figure 11, roughly two-thirds of funding surpluses were under $50K. Surpluses over $100K were reported in medium and large sized communities located in Fraser, Interior, Island and Vancouver Coastal Health.

[6] For some DoFPs, service review responses were submitted separately for individual communities within them. Results presented in this section reflect responses from each community that submitted.

[7] Given that annual funding for LTCI is approximately $12 million, it has been estimated that approximately $707,949 of surplus was accumulated in the last complete year of work. When directly asked, communities reported having surplus amounts totalling to $2,094,241, however some of this amount was accumulated over past years of funding.

Figure 10. Breakdown of LTCI funding surplus amounts from communities' last complete year of operation (n = 37)



Those reporting budget surpluses explained that they existed for the following reasons:

- accumulation of surplus funds over the years (24%; n = 9);
- physician participation not at 100%, but community receives funds for 100% bed coverage (19%; n = 7);
- quality improvement and education meetings not taking place (no further specification) (14%; n = 5);
- planned activities cancelled due to COVID-19 pandemic (14%; n = 5);
- other reasons (e.g. unspent planning funds, over adequate funding; leftover funds due to physicians reaching compensation cap; division staff vacancy, reserving funds for future purposes, etc.) (27%; n = 10); and
- no explanation provided (27%; n = 10).

Communities with funding surpluses reported that they plan to spend these funds on the following:

- quality improvement meetings, external evaluations, and education events (49%; n = 18);
- physician compensation, often related to additional call and coverage required during COVID-19 (43%; n = 16);
- response and planning efforts related to COVID-19 (14%; n = 5);
- other intentions for funds (e.g. filling DoFP staff position, staff appreciation, and offsetting future costs) (9%; n = 3); and
- no explanation provided (n = 4; 11%).

Across all responding communities, the average LTCI payment to individual physicians was reported to be $7,658 per year, ranging from $100 to $45,000 annually. The upper range of payments to physicians at $45,000 aligns with LTCI funding policies stipulating that compensation cannot exceed this amount per individual physician. An outlier was noted for one community where the physician is listed as MRP for over a quarter of the community's beds, but works with a team of FPs/NPs to provide care and call and distributes funds to this group accordingly (compensation = $68,000/year).

6. Summary Findings: LTCI Service, Business and Funding Model

Of the Divisions of Family participating in the LTCI, 100% (n = 35) completed the Service, Business and Funding Model survey questions in June/July 2020.[8] While provincial results have been presented below, community level responses are available upon request.

6.1. Service Model Information

Approach to Meeting Best Practice Expectations & System Level Outcomes

The survey asked communities to describe their local approaches to meeting BPEs and system level outcomes. Responses have been summarised below.

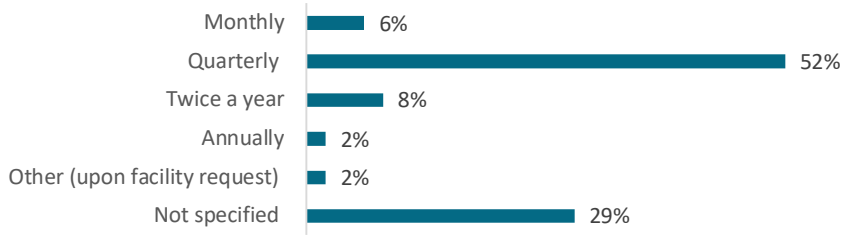
(i) 24/7 availability

Most communities reported that they meet this expectation by implementing team-based care models where MRPs commit to being available for clients through on-call groups (81%; n = 39). Depending on the community, on-call coverage is provided 24/7 (19%; n = 9) or after hours, weekends and/or holidays (41%; n = 18). Some in smaller communities indicated that on-call coverage is provided in combination with other services (e.g. Doctor of the Day programs, ER physician call). Participation in call groups is mandatory for physicians/NPs in some communities, while others allow providers to choose to join call groups or continue to provide 24/7 coverage for their clients independently. A handful of communities described some expectations for participating in on-call groups, such as responding to calls within 30-minutes and being on-site within 2-hours if required. Four small communities indicated that their physicians/NPs decided to cover their own clients 24/7 (8%; n = 4).

(ii) Proactive visits

Communities commonly reported expectations for the frequency at which proactive visits should take place. As seen in Figure 12, proactive visits are most commonly expected to take place at a minimum on a quarterly basis (52%; n = 25). Note that frequency expectations were variable within and across health authorities.

Figure 11. Frequency of expected proactive visits, at a minimum (n = 48)



A few communities mentioned additional expectations beyond frequency of visits, such as requirements to see clients within two-weeks of them being admitted, virtual and scheduling visits with facility staff to find mutually convenient times. Other comments were offered by communities, including mention of opportunity to attend virtually, client files being audited to monitor proactive visits, and that proactive

[8] For some DoFPs, service review responses were submitted separately for individual communities within them. Results presented in this section reflect responses from each community that submitted.

visits can be completed in conjunction with case conferences and medication reviews. Some also noted that their house physician and clustering models have greatly facilitated proactive visits given increased on-site presence.

(iii) Case conferences

When describing the frequency of case conferences, all communities reported that they are expected to take place on an annual basis. Some specified that conferences should take place within a certain amount of time after admission (e.g. 4 to 6 weeks) (14%; n = 6). Others noted that case conferences should be interdisciplinary, including attendance from MRPs, nursing staff, families, clients, and pharmacists (19%; n = 8). Communities also noted that MRPs can assign a designate to attend if they are unable to make the scheduled time. Some offer virtual options for attendance, which was at times implemented during COVID-19. A collaborative approach to scheduling case conferences was described as a key strategy to ensure attendance from all key parties.

(iv) Medication reviews

All communities reported that medication reviews are to take place twice a year. Some indicated that the initial review should take place at or shortly after admission (10%; n = 6). Roughly one-third (31%; n = 13) explained that medication reviews should be multidisciplinary in attendance, noting that nurses, pharmacists, MRPs (or designates) should be present. A few communities either encouraged or mandated that at least one of the medication reviews should take place at the same time as the care conferences to accommodate families to attend (7%; n = 3). Two explained that they have developed further expectations for what medication reviews should encompass, but did not provide further details (5%; n = 2).

When describing their approaches to medication reviews, two communities noted their ongoing professional development and education work with physicians/NPs to improve care in the area (e.g. alignment with Polypharmacy Risk Reduction Initiative).

(v) Completed documentation

Almost half of the communities described that specific documentation deliverables should be completed for all clients on facility care charts (46%; n = 22). While the documentation listed was variable from community to community, the following were most commonly mentioned:

- Client history/physical identifying active problems and reason for admission
- Advanced care planning, with review of Medical Orders for Scope of Treatment (MOST)
- Goals of Care conversation (client and families' understanding of the illness and their values/wishes for future care)
- Documentation of regular and urgent client visits, care conferences and medication reviews

Some specified that these deliverables should be completed twice-a-year (10%; n = 5) and within certain periods of time after admission (e.g. 60-days) (6%; n = 3).

Clustering Approach

The survey asked communities to indicate if they use a 'clustering approach' where MRPs care for larger groups of clients who are cohorted to a single facility. While 63% (n = 30) reported that they do use a clustering approach, 38% (n = 18) do not. Those using this approach represented communities of all sizes and geographic location. Clustering approaches typically involved physicians caring for larger panels of clients concentrated at individual facilities (35%; n = 17). Communities offered physicians the opportunity to care for cohorts of clients at multiple sites. Client panel sizes were often recommended or mandated, ranging from 10 to 100 clients per site.

63%

of communities use a 'clustering approach' where MRPs care for larger groups of clients cohorted to single facilities.

Given their size, small communities often had clustering models in place where one or small groups of FPs/NPs care for all clients (15%; n = 7). Other communities reported using a 'house physician model' where two to three physicians are assigned to facilities and care for most clients in them (6%; n = 3).

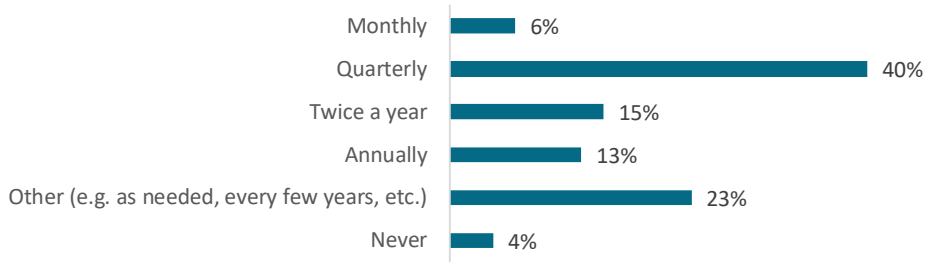
A handful of communities explained that the implementation of clustering approaches was expedited during the COVID-19 pandemic given recommendations to limit providers working at multiple sites to reduce transmission (8%; n = 4). These communities described the positive, unintended consequences of implementing clustering or 'house physician' models, such as reduced emergency department transfers and increased provider availability (8%; n = 4). Some communities continued on with this approach once transmission of COVID declined in Summer 2020, while others returned back to their original way of working given physician preferences.

Approximately one-third of communities with clustering approaches indicated that they incentivize physicians to care for larger client panels at individual sites (33%; n = 10). Most offered financial incentives for participating in clustering, which were structured differently depending on the community. Some offer stipends that incrementally increase with larger client panel sizes (up to a certain number of clients). Other communities have implemented more comprehensive 'team-based care' incentives, where additional funds are offered if physicians meet a variety of requirements, such as participation in team meetings and on-call rota, as well as participation in clustering.

Quality Improvement Meetings

As seen in Figure 13, nearly all communities participating in the LTCI host quality improvement (QI) meetings (96%; n = 46). QI meetings were hosted at different frequencies, but most commonly on a quarterly basis (40%; n = 19). Communities reported that diverse stakeholders are invited to such meetings, including: facility staff (e.g. pharmacists; nurse leads, etc.); facility leadership (e.g. Directors of Care, managers); physician leadership; DoFP staff; and health authority representatives. Ninety-six percent of communities reported that the LTCI quarterly QI reports are disseminated and discussed at their meetings, either sometimes (36%; n = 17) or always (60%; n = 28).

Figure 12. Frequency of quality improvement meetings for LTCI communities (n = 48)



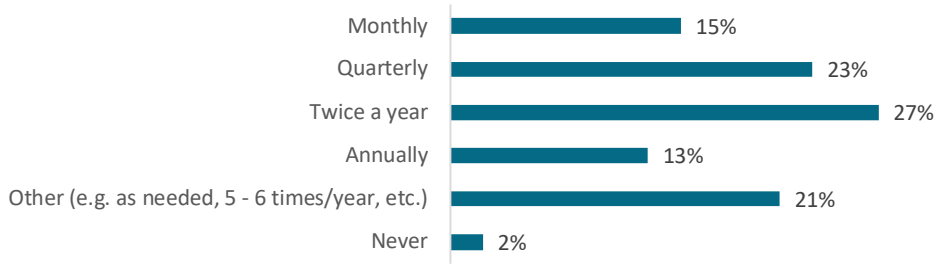
Without any prompting, a handful of communities illustrated that they deeply embrace QI approaches in their LTCI work where they continue to test ideas, learn, and adapt their solutions by making improvements (6%; n = 3). They noted that the flexibility of the LTCI model is a key factor supporting such approaches.

Throughout survey responses, some communities made some suggestions on how to refine the LTCI quarterly QI process (10%; n = 5). Suggestions included: providing more up-to-date reporting and MSP data to increase usefulness; considering integrating provider, client and family data collection related to BPEs; and adding telecommunication fee codes to quarterly reports. One community expressed challenges with the subjective nature of the questions asked in the facility survey. While this is true, the intention of the QI reports is to provide a starting place for conversation about what is working well and what can be improved.

Educational and Professional Development Opportunities

Communities were asked to report on how often they host educational and professional development opportunities for FPs/NPs. Most indicated that they do so twice a year (27%; n = 13) or quarterly (23%; n = 11) (Figure 14). Communities described a wide range of topics covered at such events, most commonly related to: polypharmacy; palliative approaches to care; dementia; and COVID-19.

Figure 13. Frequency of educational and professional development opportunities for FPs/NPs (n = 48)



Feedback on the Articulation of Best Practice Expectations

A series of survey questions gathered feedback on how the best practice expectations are currently articulated. All communities reported that the best practice expectations (BPEs) are either ‘clear’ (77%; n = 37) or ‘somewhat clear’ (23%; n = 11). When asked how GPSC can improve how the BPEs can be articulated, just over half of the communities provided suggestions (56%; n = 27):

- GPSC could create awareness tools or educational information to communicate what BPEs are and how to meet them for physicians, clients, families, and sites (e.g. posters, handouts, online modules, etc.) (21%; n = 10);
- adding minimum service standard expectations for BPEs (discussed in more detail below) (6%; n = 3);
- clarify the proactive visit and meaningful medication review BPEs, as well as the system level outcome of emergency department visits (6%; n = 3);
- clarify BPEs with increasing use of virtual care (4%; n = 2);
- review DoFP MOUs to identify consistencies and inconsistencies in how BPEs are being met and refine for alignment (4%; n = 2);
- clarify that DoFPs are not responsible for ensuring, monitoring or penalizing physicians not meeting BPEs (4%; n = 2);
- take a collaborative approach when refining BPEs with physicians and Directors of Care (2%; n = 1);
- frame BPEs and larger LTCI work in the context of PCN/PMH work taking place (2%; n = 1); and
- place an emphasis on palliative care (2%; n = 1).

LTCI communities were asked if the GPSC should more explicitly define what service standards look like for each of the BPEs. Sixty-two percent (n = 29) indicated that the BPEs should be more explicit, while 38% (n = 18) explained that they are fine as they are. Those hoping for the BPEs to be more explicitly defined offered the following comments:

62%

indicated that service standards for BPEs should be more explicitly defined.

- clarity on what is expected for proactive visits given room for interpretation (e.g. site leaders/nurses to be present during visits; need for physicians to physically see clients vs. consulting with nurses, etc.) (15%; n = 6);
- if expectations are revised, consult with physicians, Directors of Care and DoFP; leave room for local flexibility; and frame expectations as guidelines rather than being prescriptive (15%; n = 6);
- more specific expectations would support compliance and standardize expectations and quality of care provincially (10%; n = 4);
- clarity on what is expected for medication reviews (e.g. collaboration with pharmacists and nursing staff recommended) (5%; n = 2);
- refine how the 24/7 availability expectation is written to reflect the need for FPs/NPs to have time off (e.g. to be completed by MRP or suitably qualified deputy) (2%; n = 1);
- add virtual care participation option when attending care conferences (2%; n = 1);
- clarity on what is expected for completed documentation (local interpretation) (2%; n = 1); and
- clarify on overarching goals of LTCI would be helpful (2%; n = 1).

Communities were also asked if the GPSC should place parameters around the best practice expectations, such as setting a floor on the minimum number of proactive visits. Responses showed that opinions were fairly evenly split – 51% (n = 24) would like to see parameters added, while 49% (n = 23) would not. Those seeking BPE parameters commonly cautioned that while additional detail would be beneficial, any parameters should be framed guidelines rather mandatory service requirements given the importance of paying attention to local context and unique clients' needs (11%; n = 5). Two communities expressed concern that adding parameters could create the need for monitoring of services provided to ensure BPE are met, which they do not have the capacity to take on (4%; n = 2). One community that currently audits proactive visits to determine incentive eligibility explained that this has been a very challenging aspect of their work. Others more strongly supported the addition of parameters, explaining that this would offer consistency in care, provide clout for meeting expectations, and accountability for funding (9%; n = 4).

Responses were divided on whether GPSC should add parameters to BPEs.

Those not in favour of additional parameters expressed concern with the proposed approach given the importance of responding to the unique needs of clients (no one size fits all approach) (11%; n = 5) and the potential for additional barriers to already challenging recruitment efforts (6%; n = 3). They explained that if further parameters are developed, they should be framed as recommendations rather than being prescriptive (6%; n = 3).

Involvement of Nurse Practitioners

Over time since LTCI's implementation, the involvement of NPs in local solutions has increased. Roughly half of the LTCI communities now utilize NPs in their local solutions (47%; n = 22), while the other half do not (53%; n = 25). Most communities that have engaged NPs described their high-level of involvement and that they provide services in the same way physicians do (17%; n = 8). Despite their level of involvement, it was often noted that NPs are not compensated through LTCI funding, but rather through alternative means (e.g. sessional fees, health authority funding for positions, etc.) (15%; n = 7). Two communities that do not have NPs currently participating indicated that they are exploring the potential for the involvement in the near future (4%; n = 2).

47%

of communities utilize NPs in their local solutions.

Other Model Success Factors

Without prompting, some communities identified specific factors that have been key to the success of their local solutions. Success factors noted included the following:

- strengthening relationships between physicians, facility staff and leadership, and Divisions of Family Practice where there is increased communication and trust, and a shared responsibility of care (13%; n = 6);
- using team-based care models where there is a dedicated group of physicians for LTC, rather than having all community physicians follow their clients if admitted (8%; n = 4);
- focusing on QI and evaluation (4%; n = 2);
- implementing a house physician model given benefits for overall quality of care, facility staff, clients and families (2%; n = 1);
- offering a new client attachment incentive (2%; n = 1);

- implementing attachment mechanisms for orphaned clients admitted to LTCI (2%; n = 1);
- establishing physician champions or leads given their ability to foster teams of providers and encourage their colleagues to participate (2%; n = 1);
- encouraging a culture based on mentorship where newer physician members learn from the standards set by senior members of the group (2%; n = 1); and
- ongoing leadership and support from the Division of Family Practice (2%; n = 1).

Opportunities for Learning Amongst LTCI Communities

A small group of communities expressed the desire for the LTCI to facilitate provincial opportunities for sharing ideas and learning from others' experiences implementing their local solutions, such as an annual conference (12%; n = 5). They explained that they often face similar challenges to despite geographic differences and that a gathering would help share learnings, strategies, tools, and solutions.

Recruitment and Retention Challenges

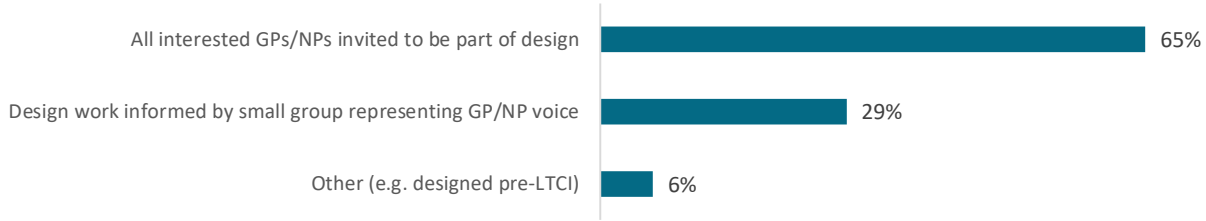
Two communities specifically noted challenges recruiting and retaining physicians to participate their local solutions (5%; n = 2). Key barriers included: variability in procedures/systems between facilities leading to frustrations among providers; more lucrative LTC programs available to physicians in nearby communities; physicians retiring; and need for physicians to speak same languages of clients.

6.2. Business Model Information

Provider Engagement in LTCI Design

The large majority of communities reported that all FPs/NPs were given the opportunity to be consulted and/or engaged on the local solution when it was initially designed (96%; n = 46). As seen in Figure 15, providers were involved either by: engaging all interested FPs/NPs to inform the design (65%; n = 31), or forming a small group of providers to represent the GP/NP voice in the design process (29%; n = 14). One community explained that while they engaged physicians in the design process, they were unsure if the NP was consulted. Another community indicated that GPs/NPs were not engaged in the design, but did not specify why not.

Figure 14. Method used to engage GPs/NPs in LTCI design (n = 48)



Communities also reported that they use a variety of methods to periodically engage with their members to ensure that local LTCI solutions continue to be agreeable to the majority of members, most frequently being: ongoing meetings (e.g. LTCI meetings, chapter meetings, QI meetings, etc.); newsletters; and surveys.

Provider Signatures to Participate

Communities were asked to indicate if their DoFPs require FPs/NPs to sign a contract or agreement prior to participating in LTCI. Responses were largely split with 57% (n = 27) requiring contracts/agreement and 43% (n = 20) without this requirement.

Use of a Concentrated Model

Communities were asked to specify whether they use a 'concentrated model' where there are a limited number of FPs/NPs participating. Roughly one-third indicated that they do have concentrated models (35%; n = 17), while the remaining two-thirds do not (65%; n = 31). Those without concentrated models explained that their programs are open to all FPs/NPs willing to commit. For those using concentrated models, an average of 17 GPs/NPs are participating (range: 1 to 56) and none of them have waitlists to participate.

35%

use 'concentrated models' where limited numbers of FPs/NPs can participate.

Further Evaluation of Local Solutions

Just under half of the participating communities reported that they have conducted or commissioned some additional evaluation work of their local solutions beyond what is completed by GPSC at the provincial level (45%; n = 21). In their comments, these communities offered further details about the evaluation work that has been completed, such as scope of questions asked, stakeholder groups consulted, and how results were shared. The evaluation work completed varied greatly in terms of scope and level of rigour. More comprehensive evaluation processes have been implemented in medium and large sized communities.

45%

conducted/commissioned additional evaluation work of their local solutions

6.3. Funding Model Information

Recommendations on Funding Parameters

Communities were asked to reflect on the LTCI lump sum funding model and share any recommendations with the GPSC about clarifying parameters on how funds can be allocated. They were offered some examples of what parameters could be, such as minimums/maximums for on-call payments, administrative support, or QI activities. The most common response to this question was that the funding model should not be changed moving forward (59%; n = 22). Communities appreciate the simplicity of the funding model and emphasized the importance of having flexibility to use funds in ways that cater to local needs and ongoing adaptations (41%; n = 15).

A small group suggested that while still keeping with a flexible model, some parameters should be implemented, such as the inability to fund on-call groups in MOCAP communities and dedicated funds to QI and physician leadership (11%; n = 4).

"Flexibility with this funding model has been paramount to the success to date."

- Coordinator, Division of Family Practice

"Flexibility allows us to focus on adapting to our context, shifting allocation as needed within a complex environment of a larger community."

- LTCI Physician Lead

Two communities described their interest in paying NPs to participate in their local solutions, but noted LTCI funding restrictions and other compensation barriers experienced through health authority and division-funded models (5%; n = 2). One communities' comment helps to illustrate the issues further:

> *"There is interest locally in compensating NPs for their local LTC contributions to client coverage that are considered beyond their health authority contracts. We have outlined some of the local challenges encountered in navigating this complex topic, such as IH contracts & concerns about the use of 'physician dollars'. The Division supports our local NPs through their associate membership privileges with the Division. However, there is a need for greater clarity/guidance at the provincial level as it relates to the allocation of GPSC dollars to NPs as the provincial direction impacts the relationships we have developed locally with NPs."*

Feedback on Sliding Funding Scale

The LTCI funding model used a local LTC bed count as a mechanism for equitably allocating lump sum funding across all communities in the province. The survey explained to respondents that in smaller communities with a limited number of LTC beds, this approach is reported to have resulted in too little funding to meaningfully enable the LTCI best practices. In some larger communities the funding model has resulted in budget surpluses. Communities were asked to consider whether LTCI funding should be offered on a sliding scale. For example, below a certain number of beds the funding is higher than $400, between x-y the funding is $400/bed, and above a certain limit the funding is less than $400/bed.

Just over half of the communities indicated that they are interested in the sliding scale proposed (54%; n = 26). Most of these communities are small in size, and some are medium-sized. They explained that the current funding model is insufficient for smaller communities, often noting that there is limited funding for QI, education, communication, and DoFP admin costs once the base cost to deliver the BPEs is accounted for. Some noted that the sustainability of their local solutions has been questionable with current funds. If new funding models are considered, a couple of communities suggested that the complexity of clients should be taken into consideration, as well as the geographic location of communities (i.e. more rural, less resources).

54%

of communities are interested in a sliding scale to address perceived funding inequity.

Most medium- and large-sized communities explained that they do not recommend changing the current funding model (29%; n = 14). They commonly explained that their current models are working well and that their sustainability would be in question if funding was reduced. Some noted that larger regions may encounter more complex clients, and therefore require additional funding to support this.

Some acknowledged that funding is inequitable for small communities and offered alternative ideas to resolve this issue (8%; n = 4), including:

- topping up current funding in smaller communities, while asking medium and larger communities to return surpluses over $50K;
- additional bonuses for proactive visits in smaller centres (similar to rural and retention incentives);
- centralized resources could be provided by GPSC to small communities to support QI, education, communication, etc.;
- restructuring funding by examining inequity in # of people vs. # of beds in communities; or
- sessional payment models.

Other Funding Feedback Recommendations

Some communities shared appreciation for LTCI funding, noting the positive outcomes achieved and physicians feeling that their work is acknowledged and appreciated by the initiative (12%; n = 5). Others shared funding recommendations for GPSC to consider, as follows:

- Continue to provide LTCI funding to support sustainability of current models (14%; n = 6). Communities explained that sustainable funding is essential to continue implementing current models of care and maintaining the positive outcomes achieved to date.
- GPSC to advocate for creating/increasing renumeration for the following services: initial work of taking on clients (not well remunerated with 114, CPx codes and 14077 for discussion with team members); accepting short term transfers; end of life paperwork; prevention of transfers to hospital; and safe transfers to hospital (7%; n = 3).
- Chronic care codes (diabetes, hypertension, heart failure) to be made available to LTC clients (7%; n = 3).
- Distribute LTCI funding in advance rather than in arrears (2%; n = 1).
- Provide parallel funding for Health Authority QI work so local LTCI funding is not relied upon for joint meetings (2%; n = 1).
- Funding for Medical Director positions at all LTC sites (2%; n = 1).
- Provide mechanism to compensate NP when taking care of clients at LTC homes (2%; n = 1).
- Consider increasing LTCI per bed funding formula to fully cover provision of care, physician leadership, project support and administration, etc. (recommendation made by a medium to large sized community) (2%; n = 1).

7. Other Feedback

Two communities provided other recommendations for GPSC to consider regarding the LTCI scope and role. One community explained that they would encourage the GPSC to consider expanding the LTCI or starting a new initiative to meet the needs of vulnerable populations in Assisted Living. The Division explained that they have received feedback from many of their care home partners who also manage Assisted Living sites that their residents are struggling to get the care that they need. Acuity has increased in Assisted Living in a similar manner to LTC – residents are unable to access care in the community the same way they have in the past. The Division also offered a comparison of ED transfers and acute admissions from Assisted Living and LTC to reflect resources of the Assisted Living community. Results showed that Assisted Living facilities have 2.7 to 5.0 times the number of ED transfer per 100 beds compared to the LTC, and 1.9 and 2.8 times more acute admissions per 100 beds. Another health authority completed the same analysis and produced similar results, demonstrating that this is an issue across regions.

Another community recommended that the GPSC should assume a stronger role in advocating to the Ministry of Health and Health Authorities for improvements and standardization of facility management, care aids and nursing support. They explained that many of the challenges in caring for LTC clients arises from facility disorganization, underfunding and under staffing.

8. Recommendations for Next Steps

Based on the results presented in this report, the following recommendations are proposed for consideration by GPSC. Recommendations have been grouped into short-term, medium-term and long-term suggestions given urgency of implementation.

8.1. Short-term Recommendations (3 to 6 months)

In the short-term, it is recommended that the GPSC should: more explicitly define LTCI best practice expectations; determine protocols for returning funding surpluses; set parameters on how lump sum funding can be allocated; reduce funding inequities for small communities; and learn from COVID-19 feedback. It is also suggested this service review report should be disseminated to DoFP and Health Authorities for review. A multi-disciplinary task group should be formed to implement these specific recommendations before the end of 2019/2020 to inform the subsequent funding cycle commencing April 1, 2021. Further details are outlined in the bullet points below.

- **Clarify and place parameters around best practice expectations.**
  The GSPC should aim to more explicitly define LTCI best practice expectations and system level outcomes based on service review feedback from communities. Specific parameters should also be explored for each of the best practice expectations, such as setting a floor on the minimum number of proactive visits expected for clients annually. Such parameters would support determination of what appropriate level of intervention is for delivering LTC services.

- **Determine policies and protocols for returning LTCI funding surpluses.**
  The GPSC should outline a process for DoFP to return funding surpluses up to a certain amount.

- **GPSC to provide further clarity around funding parameters.**
  The GPSC should continue discussion about setting parameters for how LTCI lump sum funding can be allocated. For instance, setting minimums/maximums for on-call payments, administrative support, and QI activities. Specific attention should be dedicated to ensuring LTCI on-call payments do not conflict with other types of on-call such as MOCAP. The GPSC should also consider specifying activities that cannot be supported by LTCI funding (e.g. staff appreciation events).

- **GPSC to adjust funding to reduce inequity for small, rural communities.**
  Results from this service review demonstrated that the original LTCI funding model has been somewhat inequitable for small, rural communities. The GPSC should consider a sliding scale or lump sum of funding to be evenly distributed amongst these communities to allow for basic elements of local solutions to be implemented (e.g. QI strategies, educational offerings, etc.).

- **Learn and respond to facilities' feedback on physician services during the COVID-19 pandemic**
  This service review summarizes feedback from LTC facilities on the quality of family physician services during the COVID-19 pandemic during the Q1 2020/21 quarter, as well as recommendations on how services can be improved in anticipation of a second wave. These results should be considered and responded to accordingly.

- **Share this report with Divisions of Family Practice and Health Authorities.**

This report should be distributed to the DoFP and Health Authorities for their review. Both groups are keen to learn how local solutions are organized and funded.

8.2. Medium-term Recommendations (6 to 12 months)

Over the medium-term, it is recommended that the GPSC should prioritize more holistically integrating the LTCI with other strategic initiatives underway in the province, as outlined in the bullet point below. A multi-stakeholder working group should be created to work through the implementation of medium- and long-term recommendations.

- **Integrate LTCI with other strategic initiatives underway in BC**
  The LTCI should be more holistically integrated with other strategic initiatives in BC, including the Patient Medical Home (PMH) and Primary Care Networks (PCN). GPSC initiatives utilizing networks of family physicians should be harmonized and integrated to reduce siloed services and fragmented care. Recognizing that the LTCI predates PCN work, the initiative provides a useful example of what is possible when family physicians network together and utilize team-based care models. Lessons should be learned from this success.

Other recommendations to be implemented over the medium-term are outlined below.

- **Broaden engagement of key stakeholder groups in the design and delivery of the LTCI.**
  The LTCI should aim to broaden their stakeholder engagement efforts in the future to include other key groups and organizations, such as the FNHA's First Nations-led primary care initiatives and the Nurse Practitioners Association of BC. Such stakeholder groups can help to inform alignment of approaches, and the design and delivery of LTCI in the future.

- **Update LTCI policies on use of concentrated models.**
  The GSPC should update its LTCI policies to indicate that participation must remain open to FPs who have a local community longitudinal family practice and wish to participate/include LTC in their scope of client care services. Furthermore, the GPSC should consider restricting LTCI participation to physicians with community longitudinal practices.

- **Explore the use of contracts/MOUs in Division LTCI efforts and if/how to standardize.**
  The GPSC should continue discussions about the use of contracts/MOUs in DoFP LTCI efforts. If these are a valid tool, then need to standardize them to allow for some consistency in service across communities.

- **Explore how to integrate the work of NPs into the LTCI.**
  The GPSC should continue discussions about how to effectively incorporate the work of NPs as MRPs into community LTC service provision. A key principle to keep in mind is that NP services should only be paid for once.

- **Continue annual funding report process.**
  The GPSC should continue on with annual process of obtaining funding information from LTCI funding recipients. This data was collected for the first time in the Summer 2020.

- **Obtain fee-for-service, APP, and GPSC inventive expenditures to better understand total investment in LTC.**

The GPSC should request annual fee-for-service, APP, and GPSC incentive expenditure data for LTC services since the initiative was implemented. Data should be requested from the Health Sector Information, Analysis and Reporting Division at the Ministry of Health.

- **Access to emergency department transfer data.**
  The GPSC should work with Vancouver Coastal Health, Interior Health and Northern Health to prioritize access to annual emergency department transfer rate data since the implementation of the LTCI. A central hypothesis of the LTCI is that if we see provincial progress towards its BPEs, then system level outcomes will begin to shift. Despite our efforts, we have been unable to access annual transfer rate data over time from the aforementioned health authorities. In order to further assess progress towards this outcome, we require these health authorities to prioritize this data request.

- **Explore potential of obtaining shadow billing data to demonstrate work of family physicians paid through APP models.**
  The GPSC should explore the possibility of pulling shadow billing data to provide a more comprehensive picture of progress towards best practices expectations by family physicians compensated for LTC provision through APP models. Currently the LTCI QI/evaluation results are based on fee-for-service billing data exclusively.

- **Continue to explore the potential of conducting a client/family survey to assess progress towards improving client experience.**
  The GPSC should explore the feasibility of conducting a client survey to assess client experience within the LTCI. Previously identified barriers should be taken into consideration.

- **Explore how to enhance the quarterly QI reports based on DoFP feedback.**
  Through this service review and experience creating and distributing the quarterly QI reports, DoFP have shared feedback on how the reports can be improved. Based on this, we have created a revised report template and are in the process of gathering input from divisions on the changes made (see Appendix A).

- **Explore outstanding and follow-up questions in a subsequent survey with DoFPs.**
  After reviewing results from the initial service review process, the following questions remain:
  - Why are some communities never or rarely facilitating QI/evaluation activities?
  - What are the barriers to all clients having a case conferences completed by FPs/NPs annually? What can be implemented to ensure all clients receive annual case conferences?
  - What is the average and range of on-call payments made to family physicians/NPs for LTC?
  - What have been the linkages and influence of the partnerships between the Shared Care Committee Polypharmacy Risk Reduction Initiative and the LTCI?
  - To what extent is LTCI participation comprised of physicians focused on LTC work versus community longitudinal family physicians?

- **Keep LTCI documentation posted on the GPSC website.**
  The GPSC should keep key LTCI documentation and information posted for public viewing on their website (e.g. policies and FAQ documents). These documents have not been available for periods of time in the past, which may have limited communities' abilities to follow guidelines.

8.3. Long-term Recommendations (12 months to 24 months)

In the long-term or over the next 12- to 24-months, a multi-stakeholder working group should be created to work through the implementation of the following recommendations. This working group should prioritize their efforts on preparing for the projected influx in volume of LTC clients over the next two decades. Findings from this review also demonstrate that the GPSC should explore expanding the scope of the LTCI to Assisted Living. Consideration should be given to contracting a health economist to quantify cost savings due to the initiative.

- **Prepare for the projected growth in LTC clients over the next two decades**
  Based on statistics reported by the Ministry of Health Planning Division, it was anticipated that there would be 120% growth in the LTC population between 2011 and 2036[9]. The multi-stakeholder working group should prioritize their efforts on preparing for this projected influx in volume of LTC clients by learning about what is working well and what needs to be improved.

- **GPSC to explore expanding scope to Assisted Living**
  GPSC to consider how they might enhance the LTCI initiative to offer support to other vulnerable clients in assisted living. See report Section 7.0 for further details.

- **GPSC to consider contracting a health economist to quantify cost savings due to LTCI.**
  One of the LTCI's system level outcomes is to reduce cost per client as a result of higher quality of care. While it can be speculated that costs have been reduced due to decreasing client medications and emergency department transfers, the GPSC should consider hiring a health economist to quantify progress towards this outcome.

[9] BC Ministry of Health (2014). Setting Priorities for the B.C. Health System. Retrieved January 19, 2021 from: https://www.health.gov.bc.ca/library/publications/year/2014/Setting-priorities-BC-Health-Feb14.pdf