# Residential Care Initiative (RCI) Evaluation Report

***Fraser Northwest Division of Family Practice August 2019***

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# Executive Summary

## Introduction

The Fraser Northwest (FNW) Residential Care Initiative (RCI) program is comprised of 15 long-term care facilities with a total of 1722 beds throughout New Westminster, Coquitlam, Port Moody, and Port Coquitlam. The FNW RCI Program's intention is to ensure that all patients in a residential care facility have a dedicated Family Physician Most Responsible Provider (MRP) who is committed to providing the 5 best practice deliverables: participation in an on-call program, proactive visits to residents, meaningful medication reviews, attendance at care conferences and completed documentation of resident charts. The objectives of this RCI evaluation is to: (1) to evaluate the effectiveness of the Residential Care Initiative (RCI) in the Fraser Northwest community, and (2) to identify areas for quality improvement for FNW RCI Program and document lessons learned in this year of the RCI program. These objectives are reached by answering the following evaluation questions:

a. To what extent did the program contribute to improved patient care?
b. To what extent did the program contribute to improved practice environments for residential care facility staff?
c. To what extent did the program contribute to improved practice environments for physicians?
d. To what extent does the program contribute to appropriate health care utilization and reduced system costs?
e. What worked well, what are the challenges, and what can be improved?

## Methods

The evaluation approach was through a mixed-methods design (i.e. collection of both qualitative and quantitative data). This report compares data from fiscal year 2017/2018 (April 1, 2017 - March 31, 2018) and fiscal year 2018/2019 (April 1, 2018 - March 31, 2019).

## Conclusions

Since the RCI Program's inception, every resident in the FNW communities has a dedicated MRP. ED visits, admissions, length of stay and average number of bed days have all continued to decrease over the last year. Strengthened systems of support between physicians, facilities, and health authority staff continue to enhance the RCI program as well as support the sustainability of practices within the health system.

# 1. About Us

The Fraser Northwest Division of Family Practice (FNW DoFP) encompasses family physicians in New Westminster, Coquitlam, Port Coquitlam, Port Moody, and parts of Burnaby, representing the traditional catchment area of the Royal Columbian and Eagle Ridge Hospitals. Together, members and division staff work to improve patient access to local primary care, increase local physicians' influence on health care delivery and policy, and provide professional support for physicians.

# 2. Introduction

## a) Background and Context

With the partial program launch in October of 2015, the FNW DoFP began the work of the Residential Care Initiative (RCI) program in the long-term care facilities within the communities of New Westminster, Coquitlam, Port Moody, and Port Coquitlam with program implementation in January 2016. These communities are comprised of 15 facilities with a total of 1722 residents. The RCI program has intended to ensure that all residents in a facility have a dedicated MRP committed to providing the 5 best practice deliverables which include:

1. Participation in one of two on-call groups (New Westminster/West Coquitlam) and PoCo/East Coquitlam)
2. Proactive visits to residents (minimum once every 3 months)
3. Meaningful medication reviews (twice per year)
4. Attendance at care conferences (once per year)
5. Completed documentation of resident's charts

Building on the initial evaluation report which documented that every resident in the FNW community attained a dedicated MRP, this report continues to explore the program's effectiveness, quality of care improvements for residents, physicians, and facilities, and the overall cost-effectiveness of the RCI program to the BC health system.

**Please see Figure 1 Below for the Program Theory/Logic Model.**

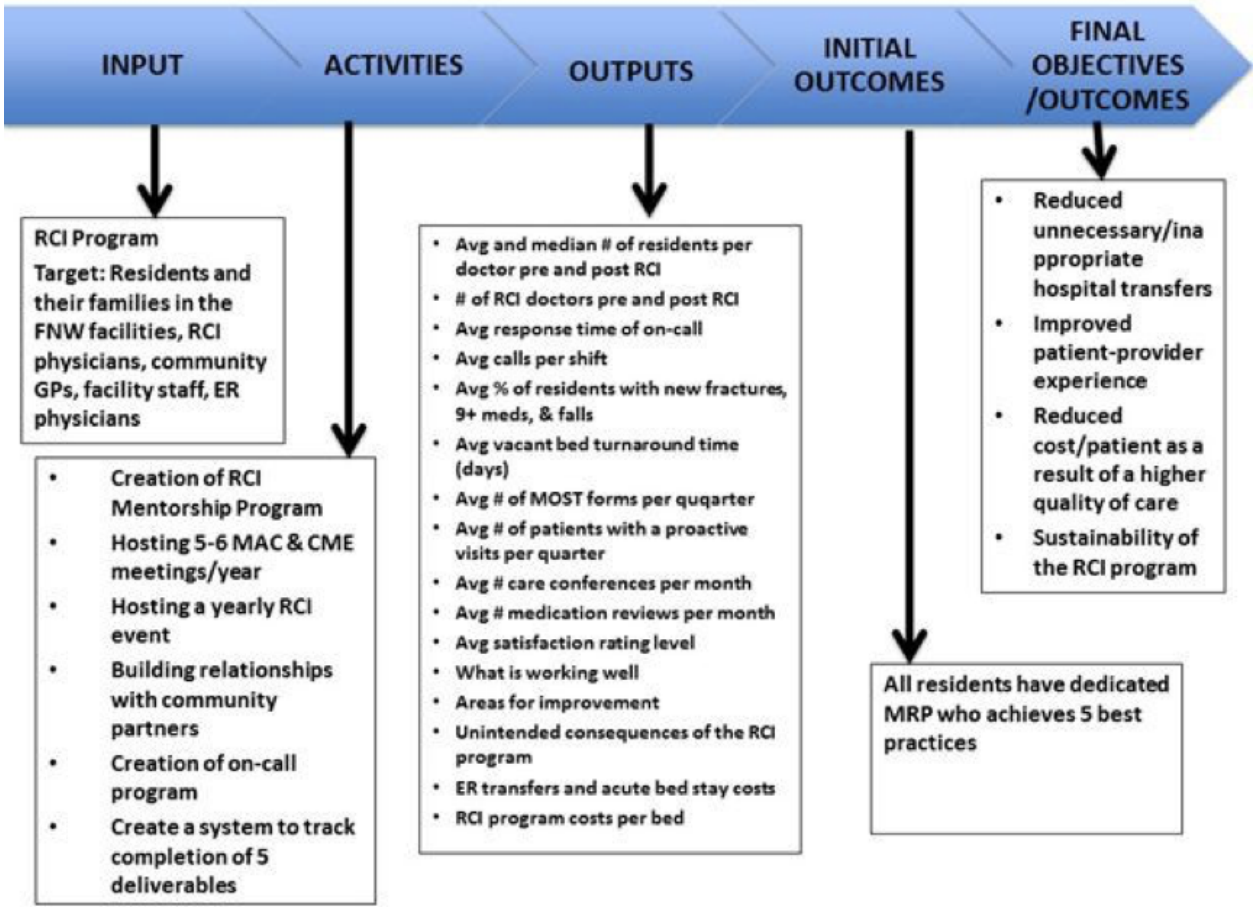



**Figure 1: Fraser Northwest Residential Care Initiative Logic Model**

# 3.Evaluation Objectives and Questions

This evaluation had two main objectives and their subsequent evaluation questions below:

1. **To evaluate the effectiveness of the Residential Care Initiative in the Fraser Northwest community**
    a. To what extent did the program contribute to improved patient care?
    b. To what extent did the program contribute to improved practice environments for residential care facility staff?
    c. To what extent did the program contribute to improved practice environments for physicians?
    d. To what extent did the program contribute to appropriate health care utilization and reducing system costs?

2. **To identify areas for quality improvement and document lessons learned for the third year of the RCI program**
    a. What worked well, what were the challenges, and what can be improved?

# 4. Indicators by Evaluation Objective and Question

### Objective 1: To evaluate the effectiveness of the Residential Care Initiative in the Fraser Northwest community

| Evaluation Question | Indicators | Data Source | Outcome/Impact |
|---|---|---|---|
| To what extent did the program contribute to improved patient care? | - Median number of residents/Dr.<br>- Avg # of residents/Dr.<br>- # of RCI Dr.<br>- % of gender of RCI Dr.<br>- Avg $ of years in practice<br>- Avg. % of residents on 9+ medications<br>- Avg. % of residents on antipsychotics without diagnosis<br>- Avg. # of unscheduled ER transfers per 100 residents | RCI Program Database<br><br>Residential Care Site Quality Performance Feedback report | Improved Patient/Provider experience<br><br>Sustainability of RCI Program |

| | | | |
|---|---|---|---|
| To what extent did the program contribute to improved practice environments for residential care facility staff? | - Facility satisfaction against 24/7 ability<br>- Facility satisfaction against proactive visits<br>- Facility satisfaction against med reviews<br>- Facility satisfaction against completed documentation<br>- Facility satisfaction against care conferences<br>- Facility satisfaction against patient/provider satisfaction | GPSC Facility Satisfaction Survey | Improved Patient/Provider experience<br><br>Sustainability of RCI Program |
| To what extent did the program contribute to improved practice environments for physicians | - # of meetings held<br>- Documents that were created post-RCI implementation | Program Documentation | Improved patient/provider experience |
| To what extent did the program contribute to appropriate health care utilization and reducing system costs? | - ER Transfers<br>- Acute care admissions<br>- Avg. length of stay | ER Statistics | Reduced unnecessary/inappropriate hospital transfers<br><br>Reduced cost/patient as a result of a higher quality of care |

**Table 1. Evaluation Questions and Indicator Sources for Objective 1**

### Objective 2: To identify areas for quality improvement for and document lessons learned for the first year of the RCI program

| Evaluation Question | Indicators | Data Source | Outcome/Impact |
|---|---|---|---|
| What worked well, what were the challenges and what can be improved? | - What worked well for the program<br>- Areas for improvement | Physician satisfaction survey<br><br>Facility satisfaction survey | Sustainability of RCI Program |

**Table 2. Evaluation Questions and Indicator Sources for Objective 2**

# 5. Methodology

The evaluation approach was through a mixed-methods design (i.e. collection of both qualitative and quantitative data). Quantitative data was collected from facility and program administrative records and Fraser Health Authority databases. Qualitative data from surveys and interviews with facility staff, physicians, Division staff and management, and program administrators was collected over the past year.

To build on that evaluation report and to support future planning, this report compares data from fiscal year 2017/2018 (April 1, 2017 - March 31, 2018) and fiscal year 2018/2019 (April 1, 2018 - March 31, 2019). It is acknowledged that some qualitative data may extend beyond these timeframes and that is due to resources available for data collection and analysis.

# 6. Results

All comparative data will look at any changes based on data collected for fiscal year (FY) 2017/2018 and FY 2018/2019 unless otherwise stated. The results shared in the next section are broken down by evaluation question.

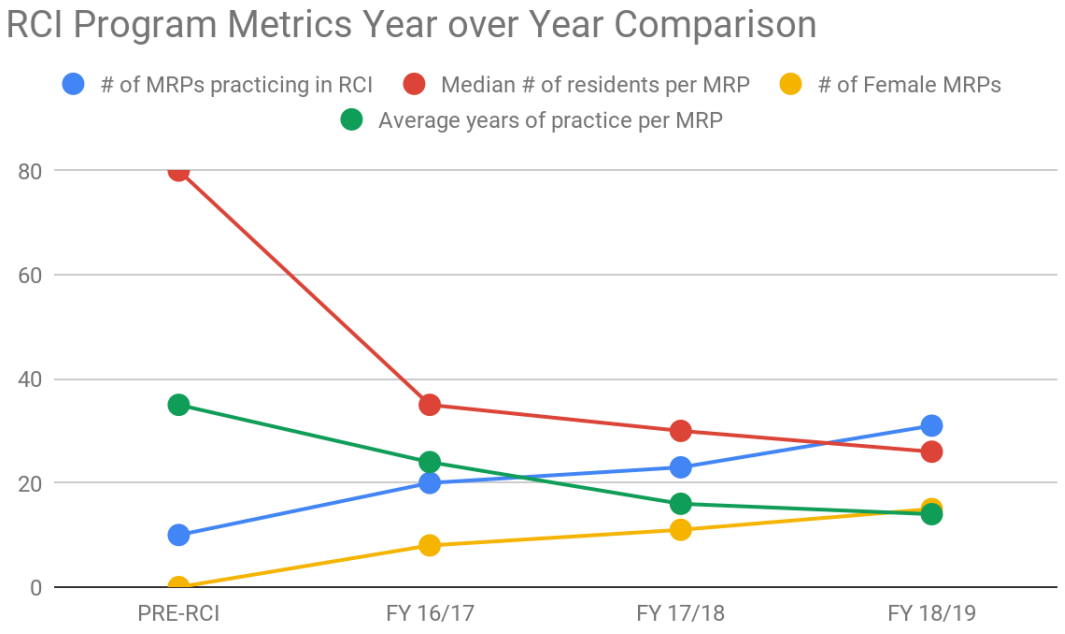
### Evaluation Question 1.A: To what extent did the program contribute to improved patient care?

Since the RCI inception, the number of doctors committing to providing the 5 best practices in residential care has increased to 31. Over the last year, the average years of practice for MRP has continued to decrease to 14 years and the number of

physicians has more than doubled since the program's inception. With this increase in physicians, the number or residents per MRP continues to decrease. There continues to be significant growth in the number of female MRPs practicing with a 27% increase over the last year alone. See Table 3 for a summary of changes in RCI program metrics.

| RCI Program Metrics | Difference in Change | |
|---|---|---|
| | FY 17/18 | FY 18/19 |
| # of MRPs practicing in RCI | 23 | 31 |
| Median # of residents per MRP | 30 | 26 |
| Female MRPs | 11 | 15 |
| Average years of practice per MRP | 16 | 14 |

**Table 3. Comparison in Residential Care Physician Metrics Post RCI Implementation**[1]

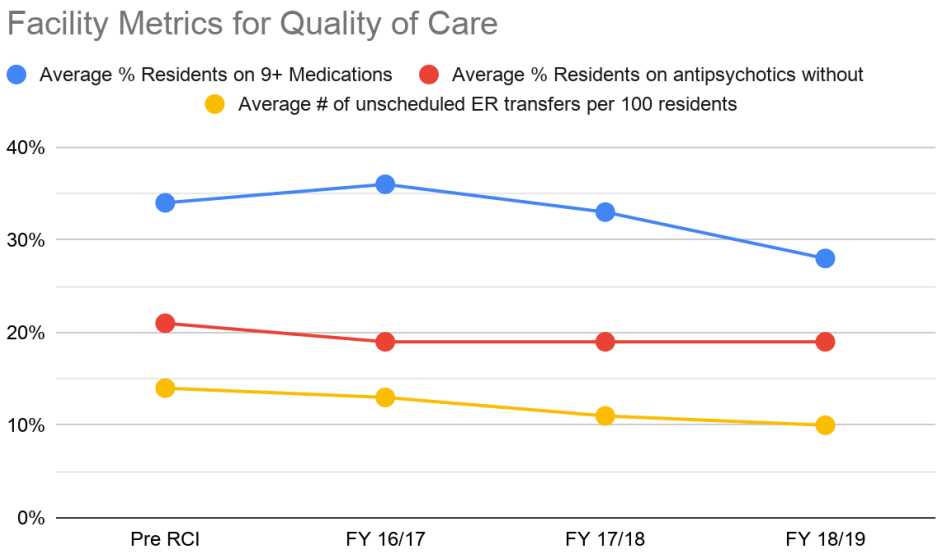



[1] Information shared in Table 3 is from the RCI program documentation data.

Over the last year, there is a decrease in the number of unscheduled ER transfers per 100 residents, and in the average % of residents on 9+ medications. The number of residents on antipsychotics without diagnosis have stayed consistent when comparing the FYs and this rate continues to be below the target rate.

| Facility Metrics for Quality of Care | FY 17/18 | FY 18/19 | Difference in Change |
|---|---|---|---|
| Average % Residents on 9+ Medications | 33% | 28% | ⬇️ |
| Average % Residents on antipsychotics without diagnosis | 19% | 19% | = |
| Average # of unscheduled ER transfers per 100 residents | 11 | 10 | ⬇️ |

**Table 4. Comparison of Facility Quality of Care Metrics Between FY 17/18 & FY 18/19 of RCI program implementation[2].**




[2] Information shared in Table 4 is from the Residential Care Site Quality Performance Analysis Dashboard.

### Evaluation Question 1.B. To what extent did the program contribute to improved practice environments for residential care facility staff?

Data collected from the quarterly RCI Quality Improvement Report conducted by the GPSC indicates that the comparative data between FY 2017/18 and FY 2018/19 continues to show an increase in satisfaction for physicians. Specifically, physicians conducting proactive visits, completing documentation and 24/7 availability has increased in overall satisfaction for facilities who responded to the report conducted by the GPSC.

Changes in satisfaction for facilities across the 5 best practice deliverables were mainly consistent with changes across Fraser and British Columbian facilities (Table 5).

| Program Outcomes | Difference in Change for FNW | Difference in Change for FHA | Difference in Change for BC |
|---|---|---|---|
| 24/7 Availability | ⬆️ | = | = |
| Proactive Visits | ⬆️ | = | = |
| Medication Reviews** | = | = | = |
| Completed Documentation | ⬆️ | ⬆️ | = |
| Care Conferences | = | = | = |
| Patient Provider Experience | = | = | = |

**Table 5. Comparison of Changes in Satisfaction for Facilities (FY 17/18 & 18/19) Across Regions**[3]

**Meaningful Medication Review data was not previously available through the GPSC Quality Improvement Report. Data was based on information from the Pharmacare and Community Care databases. *Data from private beds and facilities licensed under the hospital act have not been included.*

[3] Information shared in Table 5 is from the Quarterly GPSC Facilities Survey.

*The data also exclusively focuses on long-term care patients with a length of stay of 30 days or longer (excludes temporary stay or hospice patients).*

## Evaluation Question 1.C. To what extent did the program contribute to improved practice environments for physicians?

Data that was collected over FY 18/19 suggest an increase in physician engagement - both at an individual level, as well as at the collective level. The Medical Advisory Committee (MAC) was formed to support an increase in the overall standard of care for residents and an overall increase in physician engagement. Since its inception in early 2016, there have been 16 formal engagement sessions for this committee - with 5 occurring within the timeframe that this evaluation is reporting on (FY 18/19), with these meetings yielding high member attendance rates. Additionally, the Transitions Networking Committee is comprised of a large number of stakeholders who are invited every other month to network around Residential Care transitions in health care. The RCI leadership team continue to meet monthly to ensure the program is meeting targets and support sustainability planning. The MAC meeting CME topics included: Infectious diseases; geriatric nephrology; and round table discussions and M&M case examples that included GJ Tubes, Fall protocols, BPSD and end of life discussions. In addition to the learning opportunities presented at these regular sessions, the program allocates funding for 10 RCI physicians to attend the UBC Care of the Elderly Intensive Review Course each year and also supports RCI physicians in other Residential Care Leadership conferences.

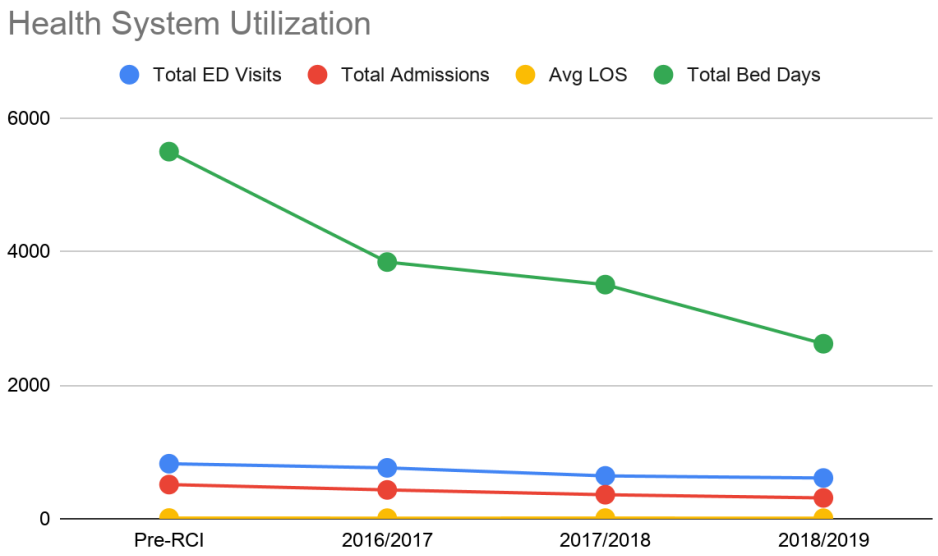
Both a Peer Support program and a Mentorship Support Program were explored and strengthened with RC practitioners and all were invited to connect with the Division's RCI Program Manager to provide input, support and guidance on this work moving forward. Members of the MAC were able to discuss with their peer support partner on various RC issues that arose in their work. It can be inferred that this relationship strengthened collegiality, collaboration and practice environments through peer to peer support.

## Evaluation Question 1.D. To what extent did the program contribute to appropriate health care utilization and reducing system costs?

The findings show that the program is contributing to the appropriate use of health care services. Decreased measures of acute care utilization were found when comparing data from FY 17/18 to FY 18/19 Residential client emergency department (ED) visits, acute care admission, length of stay (LOS), and total bed day data was compared in the FNW community (Table 6).

| | % Difference ED Visits | % Acute care admissions | % Difference Admission LOS | % DIfference in Bed Days |
|---|---|---|---|---|
| Comparison between FY 17/18 & FY 18/19 | -5% | -12% | -15% | - 22% |

**Table 6. Comparison of Emergency Department Statistics Between Post RCI and Pre RCI Implementation[4].**




Analysis of ED data reveals that there continues to be a reduction in ED visits, acute care admissions, ED LOS and total bed days by residential care patients in the FNW. This data suggests that over this period, the RCI program has contributed to a decrease in health care utilization which suggests a decrease in costs to the overall healthcare system.

The change in healthcare costs can be compared by looking at the changes between FY 2017/18 and FY 2018/19. The downward trend in overall costs for ED visits and number of admissions from residential care clients suggests the impact that the RCI program has made in the FNW community, for a decrease in health system costs of $1,014,511 comparing the data from the FY's (table 7 below). These figures were calculated from FHA data for the approximate 1300 FHA subsidized residents, by extrapolating the data to a standard of 1722 residents, which is the number of residential care clients within,

[4] Information shared in Table 6 is from the Fraser Health Authority Analytics, Paris & Meditch extract- MA 16211

and using a conservative estimate of $723 for each ED visit, and FHA data for the cost per day of a standard medical ward bed of $1235. See Appendix A for calculation details.

| Year | ED Visit cost | Admission cost | Total Cost |
|---|---|---|---|
| FY 17/18 | $477,879 | $4,213,362 | $4,691,241 |
| FY 18/19 | $441,030 | $3,235,700 | $3,676,730 |
| **Total decrease in health care costs between FY 17/18 & FY 18/19** | | | **$1,014,511** |

**Table 7. Comparison of yearly ED visit costs and ED admission costs including LOS for FNW Residential Care clients.[5]**

### Evaluation Question 2. What worked well, what were the challenges, and what can be improved?

Data was collected from a physician satisfaction survey and a facility satisfaction survey to obtain feedback on the indicators of what has been working and areas for improvement. Raw data from the satisfaction surveys can be found in Appendix B.

## Main themes of successes - RCI Physician Satisfaction

1) Improved RCI GP MRP rating on themselves in delivering all 5 best practice expectations. Self reported scaling from 1-5 pre-RCI implementation was 3.4, and since implementation has increased to 4.6. This indicator reveals increased optimization of the 5 best practices in the Fraser Northwest. It's important to note the variation amongst physicians in self identifying which of the 5 best practices are the easiest to achieve or complete. Interestingly, proactive visits were noted as either the easiest to complete or the most difficult to complete with 35% or respondents noting them as the easiest and 41% noting the opposite. Feedback from multiple physicians noted that all best

[5] Information shared in Table 7 is from the Fraser Health Authority Analytics, Paris & Meditch extract- MA 16211 Updated Report (Oct 2, 2018).

practices were easily achieved and this feedback included physicians in their first five years of practice as well as those who have been in practice for 40+ years.

2) Improvement of infrastructure for RCI GP MRPs access to receive relevant education, to network, to learn from each other and express shared goals. Feedback from GPs notes that this infrastructure is key to providing care to patients. Since its inception in 2016, the Medical Advisory Council (MAC) has created a community network of support for practitioners that has shown an increase in collegiality and dialogue between practitioners through champions stepping into leads positions within the MAC. Physicians noted that peer to peer support and connection is a key aspect of what is working well with this initiative - a strong team approach facilitated by regular meetings, peer engagement, peer initiated support groups.

3) Overall satisfaction for patient coverage during after hours and weekends due to the on-call network that was created. Physicians rated 4.3 on a scale of 1-5 when asked to self rate themselves in delivering this best practice.

## Main themes of areas for improvement - RCI Physician Satisfaction

1) There can be inconsistencies when working in residential care that involve communication, research and review of care across sites and facility teams.

2) Changes in site administration can result in varying approaches to processes and site procedures. There was a recognition that facility staff need to be more aware and educated in the purpose and benefit of the RCI program and having a proactive approach can be more beneficial than a reactive one.

3) The availability of EMR access across sites for physicians that are a part of the RCI program and the lack of uniformity in charting across sites.

4) Strengthened communication and collaboration between residential care site staff, MRPs, specialists and hospital ED's.

## Main themes of successes - Facility Satisfaction

1) Consistent and improved on site and on-call medical coverage. The overall satisfaction from facilities with the RCI physicians providing the 5 best practices was 4.9 on a scale of 1-5 at their sites.

2) Overall satisfaction with the RCI program score was a 5 on a scale of 1-5. Facilities reported that the quality of care from the RCI physicians has been prompt and attentive. One facility noted that *"The nurses find the process reliable and know that someone (on-call physician) is going to be available to within minutes of calling."*

3) Improved access and communication with RCI GP MRPs. One facility noted that *"open dialogue with our physicians and a collaborative approach to caring for residents. For example, we can approach our physicians with any concern - medical, social or behavioural and know they will support and help problem solve."*

4) Up to date information on where to go and who to connect with when questions arise is key.

### Main themes of areas for improvement - Facility Satisfaction

1) Increasing the number of available physicians at facilities.

2) Feedback that data collection is tedious and time consuming.

# 7. Discussion Around the Impact of the RCI Program in the Fraser Northwest Residential Care Community

The results of this evaluation suggests that the RCI Program contributed to having impacts across four areas:

1) Patient care
2) Facility practice environments
3) Physician practice environments
4) Healthcare utilization by residents and subsequent decreased healthcare system costs

## 1. Patient Care

The measures used to evaluate patient care focused on the number of MRPs participating in the RCI, the # of residents per MRP, the number of female MRPs and the average years of practice per MRP. Over the past year and in trend since the program's inception, the number of FNW RCI physicians continues to increase. It can be inferred that long-term care patients in the FNW receive an increasing level of accessibility to clinical care due to the coordinated approach of the program. Along with improved access to care, it could also be deduced that the quality of care continues to improve as the median number of residents per physician decreases. More engaged physicians can take the time to complete onsite visits in a timely manner. Furthermore, an increase in the number of female physicians by 27% was reported and reveals a shift in overall physician engagement, passion and interest in long-term care. Lastly, sustainability of

the quality of care is suggested as the average years of practice per MRP has declined. Newer to practice MRPs are joining the initiative and can support MRPs who plan to retire.

The last reporting period also implicates improved patient care through data results on average percent of residents on 9 or more medications and average percent of residents on antipsychotics without a diagnosis. Results could be attributed to the way in which meaningful medication reviews, patient care goal conversations and completed documentation are conducted in the FNW. Another metric evaluated was the average number of unscheduled ER transfers per 100 residents. Since implementation of the RCI program in the FNW the results show a decrease in transfers. A standardized 24/7 call system and method of capturing the 5 best practice expectations has been organized in all long term care homes and staff continue to reach a doctor after hours, reducing the need to send a resident to the ER if possibly avoidable.

## 2. Residential Care facility staff practice environments

The relationships and communication methods between the RCI MRPs and the RC facility staff has continued to improve. Facilities are able to reach a physician 24/7 due to the standardized on-call system for all 15 facilities in the community. There was an increase in the total number of calls from facilities to the on-call system between reporting periods. In FY 17/18 there were 1270 and in FY 18/19 there were 1401. This signifies that facility staff are comfortable using the on-call network and are satisfied with the on-call care. Facilities have noted that there has been improved communication support between physicians and facility staff. On-call concerns are relayed back to the RCI Program Manager and methods of connecting both parties are made to assist in working through any challenges. Facilities feel supported and are confident in the delivery of care.

The RCI program has continued to support facilities in their ability to track best practice deliverables for quality improvement. Feedback collected from the GPSC, physician and facility surveys point to consistent communication between GPs and facility staff result in a stronger, more engaged team. Facilities have mentioned that they now have better access to and communication with their RCI GP MRPs and that their residents are seen in a timely manner.

Since the implementation of the RCI Program, facilities and physicians were provided access to a well structured network of RCI doctors committed to the program and better relationships and new partnerships were formed. In this reporting period, the program was easily able to find MRPs to cover a maternity leave and 2 Nurse Practitioner patient panels other facilities at the same time. The facilities trusted and worked with the RCI network to make sure the coverage was set up in advance and had smooth patient handover.

### 3. Improved practice environments for physicians

The RCI program has developed a local residential care Medical Advisory Committee (MAC), where RCI practitioners have a forum to collaborate on common FNW residential care issues. This network continues to engage and empower new physicians and new to residential care physicians through strong peer support and an improved orientation process. Along with networking at CME presentations and Division events, the FNW MAC has also increased support and collegiality through technological platforms. By sharing and asking the broader group on this platform, responses and multiple suggestions are instantaneously provided, improving quality of care.

The RCI team had also coordinated and supported a clinical team meeting at a facility who had a newly formed team. Guidance from one of the RCI physician leads, program manager and medical director helped to engage the clinical team to understand the expectations of the RCI program.

### 4. Improved appropriate health care utilization and reduced system costs

Since the implementation of the RCI program, ED visits, acute care admissions, length of stay and the average bed days continue to decrease which thereby contribute to an overall decrease in the costs of the healthcare system for acute care utilization. A reduction in ED visit costs and acute care admission costs by $1,014,511 between FY 17/18 and FY 18/19 continues to convey the cost-effectiveness of this program. The past reporting period revealed that there were over 88 after hour onsite visits that did not result in an ER transfer. Improved appropriate health care utilization was also seen through the coordination of suture kit order forms and support of the local hospital for supplies.

In addition, decreased polypharmacy efforts also impact overall system costs. It could be said that the reduction in prescribed medication also contributes to lowering health care costs for LTC patients and the health care system.

# 8. Lessons Learned

Major themes surrounding the lessons learned for the FNW RCI program revolve around the importance of physician and stakeholder engagement and communication:

**Orientation needs to be a priority**. The importance of creating a supportive and clear understanding of the RCI program to new physicians was realized this past reporting period. This was the second year that the FNW RCI program worked with the Fraser Health Authority to include International medical graduates (IMG) as RCI MRPs. As new physicians were brought into facilities in the community a

standardized orientation process was not implemented. Each year the RCI program has learned more about what is required and how best to support the IMG physicians. Through mentoring and peer support, the RCI MAC has engaged new MRPs and assisted in bringing all FNW RCI MRPs together to work towards the same care goals for this residential care community. Notwithstanding, all of those IMGs who had dedicated their time in the FNW for their return of service obligations have chosen to continue working in residential care and two have also become Facility Medical Directors. It can be assumed that the encouragement from the local RCI MAC through physician engagement and peer support is attributed to this retention.

**The FNW RCI is didactic and evolving.**

Since the implementation of the FNW RCI program, multiple PDSA cycles and lessons have occurred. This evaluation period produced two new RCI facility attachment contracts to support physicians in their care. Through engaging the RCI MAC, the new program contract allowed physicians the option to participate in the on-call network dependent on their patient panel. This change supported new RCI physicians the opportunity to build up their patient panels over time and gain confidence to participate in after hours calls for all the FNW RCI facilities. The program also created a locum RCI contract. This attachment agreement provided an option for those community physicians who wanted to experience work in long term care. Those locum RCI physicians were supported and mentored as any other new RCI physician would be and were also provided the FNW enhanced patient support incentive fees for providing the RCI best practice commitments.

The FNW RCI program has continued to progress at a local grassroots level. One of the best practice expectations, meaningful medication reviews, has had MRP engagement and interest. Continuing with quality improvement work from the previous evaluation period, analysis of this care component was tried. Each FNW facility conducted a meaningful medication review in slightly different ways, but all had the same clinical team members physically present. This was significant, as after collaborating with other interdivisional communities on meaningful medication reviews, this standard was not always the case and suggests the impact the FNW RCI physician engagement has had.

**Communication strengthens relationships.**

The FNW RCI program continues to focus on increasing communication between stakeholders. The facilities, physicians and Health Authority strengthened existing relationships by keeping open channels for feedback through the RCI. A more formal process was developed this year to help support and improve the communication between the MRP provider and the facility or hospital. The RCI program outlined that the leadership team be central hub for the stakeholders to share information or concerns. General non-patient identifying information would be gathered and then each party would be connected to further discuss. The role of the RCI leadership team is to run operations of the RCI program, including compliance with the RCI mandate for the 5 best practices. The formal introduction between stakeholders allows for stronger relationships to be built and instant decisions to be made.

Dedicated members of the local Residential Care Transition Networking Committee continue to enhance stakeholder relationships. The RCI program has been successful in continuing to keep this working group interested and engaged. Communication channels and relationships between the hospitals, Health Authority, facilities and RCI practitioners maintain open and stable.

**Public and patient engagement holds value**

In Fall 2018, two open houses were held at local senior community centres to provide information, to older adults, family members and substitute decision makers, about what a journey may involve when someone is experiencing the need to move into a long term care home. Presentations included education regarding access, processes and available supports as well as expectations of what happens once placement has transpired. Attendees heard from an RCI physician, an RCI facility staff, and Fraser Health Authority representatives from Home Health and Access. Approximately 94% of those that responded to the end of day survey expressed that they felt satisfied or very satisfied with the overall event with approximately 90% expressing that this event was an effective way of communicating the necessary information on available services and resources. One respondent mentioned that it was *"excellent to have the steps in order – you could walk through the options from Home Health to Residential Care."* An overwhelming theme that emerged at these events was the access to the information and how the speakers were clear in their delivery and engaged with the attendees. Suggestions for future events centred on having a family member representative present on panels to share that perspective. Along with plans to conduct future information sessions, there has also been work completed in the creation of an educational video series to assist older adults in understanding the process of aging in the health system. Visual representations of the feedback received at these open houses can be found in Appendix C

**Physicians are okay with being on-call and going onsite**. Continuing the trend of the previous evaluation, it was learned that the FNW RCI physicians are still willing and interested in providing after hours on-call work. Filling the call sign up calendar was not an issue overall. The call volume has increased over the last year and so has the amount of on site visits from on-call physicians. It can be speculated that due to the MAC meetings, education provided, and engagement, the FNW RCI physicians are more willing to travel onsite to prevent unscheduled ER transfers. The notion of transfers being possibly avoidable rather than inappropriate has been advocated in the on-call network. In addition to this willingness to go onsite, supplemented by the Fraser Health Authority, suture kits continue to be provided to each FNW long term care home. Having access to these kits allowed the RCI physicians another support required to avoid unnecessary ER transfers.

# 9. Limitations of Evaluation

Limitations are evident in any evaluation report, below are a few areas of improvement for future evaluations related to the RCI program:

**(1) Measuring Patient Satisfaction**

Due to limited resources available, patient satisfaction and quality of care was measured through quantitative data. It is difficult to fully understand the patient

experience through this mode, therefore a more focused approach to collecting the patient experience is suggested for future reports in order to fully understand the residential care patient experience.

**(2) Available Data**

Due to the multiple systems of care that exist in the health system, accessing data from a variety of sources is required. That being said, utilizing a variety of data sources may result in overlap of data collected.

# 10. Conclusion

Since the RCI Program's inception, every resident in Residential Care in the FNW has a dedicated MRP. ED visits, admissions, length of stay and number of bed days have all continued to decrease over the last year, suggesting continued cost-effectiveness of the program to the BC health care system. This trend indicates that the mechanisms that have been implemented within the FNW Residential Care Initiative continue to be successful according to the original objective of the program. Strengthened systems of support between physicians, facilities, and health authority staff continue to enhance the RCI program as well as support the sustainability of practices within the health system.

# Appendices

**Appendix A: FHA Data - ED visits, Admissions, LOS, Bed Days & Cost Saving calculation details**

This data was accessed by way of Fraser Health Analytics, Paris & Meditech extracts - MA 16211 Updated Report (August 2019)

| Year | Quarter | # of RC Clients | ED Visits | Admissions | Avg LOS | Bed Days |
|---|---|---|---|---|---|---|
| *PRE RCI 2015/2016* | *1. Apr - Jun* | *1301* | *167* | *96* | *12.6* | *1214* |
| *PRE RCI 2015/2016* | *2. Jul - Sep* | *1255* | *131* | *79* | *14.1* | *1111* |
| *PRE RCI 2015/2016* | *3. Oct - Dec* | *1262* | *168* | *106* | *8.4* | *893* |
| *PRE RCI 2015/2016* | *4. Jan - Mar* | *1276* | *144* | *98* | *8.7* | *850* |
| *2016/2017* | *1. Apr - Jun* | *1428* | *136* | *66* | *9.6* | *631* |
| *2016/2017* | *2. Jul - Sep* | *1468* | *171* | *106* | *10.4* | *1098* |
| *2016/2017* | *3. Oct - Dec* | *1459* | *165* | *98* | *9.2* | *901* |
| *2016/2017* | *4. Jan - Mar* | *1489* | *175* | *97* | *6.5* | *632* |
| 2017/2018 | 1. Apr - Jun | 1418 | 125 | 61 | 8.5 | 519 |
| 2017/2018 | 2. Jul - Sep | 1429 | 139 | 75 | 11.5 | 863 |
| 2017/2018 | 3. Oct - Dec | 1409 | 136 | 83 | 10.7 | 888 |
| 2017/2018 | 4. Jan - Mar | 1450 | 131 | 80 | 7.9 | 632 |
| 2018/2019 | 1. Apr - Jun | 1436 | 141 | 68 | 8.5 | 578 |
| 2018/2019 | 2. Jul - Sep | 1425 | 131 | 64 | 8.7 | 557 |
| 2018/2019 | 3. Oct - Dec | 1416 | 94 | 51 | 10 | 510 |
| 2018/2019 | 4. Jan - Mar | 1421 | 140 | 76 | 8.1 | 616 |

| Extrapolated data calculations | | | | | | |
|---|---|---|---|---|---|---|
| **Year** | **Quarter** | **# of RC Clients** | **ED Visits** | **Admissions** | **Avg LOS** | **Bed Days** |
| *PRE RCI 2015/2016* | *1. Apr - Jun* | *1722* | *221* | *127* | *13* | *1607* |
| *PRE RCI 2015/2016* | *2. Jul - Sep* | *1722* | *180* | *108* | *14* | *1524* |
| *PRE RCI 2015/2016* | *3. Oct - Dec* | *1722* | *229* | *145* | *8* | *1218* |
| *PRE RCI 2015/2016* | *4. Jan - Mar* | *1722* | *194* | *132* | *9* | *1147* |
| *2016/2017* | *1. Apr - Jun* | *1722* | *164* | *80* | *10* | *761* |
| *2016/2017* | *2. Jul - Sep* | *1722* | *201* | *124* | *10* | *1288* |
| *2016/2017* | *3. Oct - Dec* | *1722* | *195* | *116* | *9* | *1063* |
| *2016/2017* | *4. Jan - Mar* | *1722* | *202* | *112* | *7* | *731* |
| 2017/2018 | 1. Apr - Jun | 1722 | 152 | 74 | 9 | 630 |
| 2017/2018 | 2. Jul - Sep | 1722 | 168 | 90 | 12 | 1039 |
| 2017/2018 | 3. Oct - Dec | 1722 | 166 | 101 | 11 | 1085 |
| 2017/2018 | 4. Jan - Mar | 1722 | 156 | 95 | 8 | 751 |
| 2018/2019 | 1. Apr - Jun | 1722 | 169 | 81 | 8 | 648 |
| 2018/2019 | 2. Jul - Sep | 1722 | 158 | 77 | 8 | 616 |
| 2018/2019 | 3. Oct - Dec | 1722 | 114 | 62 | 10 | 620 |
| 2018/2019 | 4. Jan - Mar | 1722 | 169 | 92 | 8 | 736 |

| Cost Saving Calculations | | | |
|---|---|---|---|
| | | **Cost of ED Visit = $723** | **Cost of Admit** |

| Fiscal Year | Quarter | (extrap # ED visit x $723) | (extrap # of admit x $1235) |
|---|---|---|---|
| *PRE RCI 2015/2016* | *Q1* | *$159,783* | *$2,038,985* |
| *PRE RCI 2015/2016* | *Q2* | *$130,140* | *$1,867,320* |
| *PRE RCI 2015/2016* | *Q3* | *$165,567* | *$1,432,600* |
| *PRE RCI 2015/2016* | *Q4* | *$140,262* | *$1,467,180* |
| ***FY 15/16 Total*** | | ***$595,752*** | ***$6,806,085*** |
| *2016/2017* | *Q1* | *$118,572* | *$939,726* |
| *2016/2017* | *Q2* | *$145,025* | *$1,590,656* |
| *2016/2017* | *Q3* | *$140,799* | *$1,313,317* |
| *2016/2017* | *Q4* | *$149,668* | *$930,574* |
| ***FY 16/17 Total*** | | ***$554,064*** | ***$4,774,273*** |
| 2017/2018 | Q1 | $114,957 | $854,941 |
| 2017/2018 | Q2 | $123,716 | $1,290,527 |
| 2017/2018 | Q3 | $126,356 | $1,129,293 |
| 2017/2018 | Q4 | $112,788 | $938,600 |
| **FY 17/18 total** | | **$477,817** | **$4,213,361** |
| 2018/2019 | Q1 | $122,187 | $800,280 |
| 2018/2019 | Q2 | $114,234 | $760,760 |
| 2018/2019 | Q3 | $82,422 | $765,700 |
| 2018/2019 | Q4 | $122,187 | $908,960 |
| **FY 18/19 total** | | **$441,030** | **$3,235,700** |

**Appendix B: Physician & Facility Survey Results**

## Physician Survey Analysis

1. **How would you rate yourself in delivering the 5 best practices to your residents since RCI implementation?**

| | On-Call shifts | Proactive Visits | Medication Reviews | Completed Documentation | Care Conferences |
|---|---|---|---|---|---|
| ***Response Average*** | **4.3** | **4.7** | **4.7** | **4.5** | **4.8** |

2. **Please arrange the 5 best practices in the order you find them easiest (1= easiest 5 = hardest)**

| On-Call Shifts | Completed Documentation | Care Conferences | Medication Reviews | Proactive Visits | Comments |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | |
| 1 | 2 | 3 | 4 | 5 | |
| 3 | 4 | 2 | 5 | 1 | Proactive visits go mostly hand in hand with progress notes and care conferences allow time to address the MOST form. |
| 5 | 3 | 4 | 2 | 1 | An improved emr would be good |
| 4 | 2 | 3 | 1 | 5 | They are all fairly even. Med reviews are useful. The pharmacist is somewhat helpful with info; he is a retail not a clinical pharmacist so doesn't often have high level advice or new evidence/guidelines. I am now using PCC for |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | **progress notes. There are many issues with PCC, we addressed some at our last facility doctors' meeting. PCC is nursing-based, not physician-based. I hope it can be made more useful for us. Still going back and forth between EMR and paper chart [labs/consults/MOST still in paper chart.Care conferences - attendance not a problem. Nice having all the clinical people there, but sometimes so much time spent on diet and rec therapy not enough time on goals of care [from my point of view; the families seem ok].On-call shifts sometimes busy but generally no major problems. Most of the facilities are prepared when they call and the calls are generally appropriate. Usually up-to-date notes from the MRP on chart. Better at proactive visits; some people are so stable they may drop off my radar.** |
| **3** | **5** | **1** | **2** | **4** | **Call is most demanding of your time** |
| **5** | **3** | **2** | **4** | **1** | **I find it easy to do all the best practices, probable the on-call shifts would be more demanding sometimes, but it is not that difficult** |
| **4** | **5** | **1** | **2** | **3** | |
| **3** | **4** | **1** | **2** | **5** | **I sometimes forget which very stable patients haven't been seen for 3 months** |

| | | | | | |
|---|---|---|---|---|---|
| **3** | **1** | **2** | **4** | **5** | **really none are hard to achieve, except maybe the proactive visits especially for stable patients.** |
| **1** | **3** | **4** | **2** | **5** | |
| **5** | **4** | **2** | **3** | **1** | **On call for sick elderly with diff family demands and not knowing the patient is challenging** |
| **1** | **2** | **3** | **4** | **5** | **Overall very good. Further improvements still possible.** |
| **5** | **3** | **1** | **2** | **4** | **They are quite easy to achieve** |
| **4** | **5** | **3** | **2** | **1** | **Annoying to complete ACP record in the electronic record, then have to manually write it out in the paper chart again!** |
| **5** | **2** | **3** | **4** | **1** | |
| **5** | **1** | **2** | **3** | **4** | |

**3. What are some areas for improvement with the Residential Care Initiative program?**

| |
|---|
| **Funding physician annual res care related conference** |
| **The EMR** |
| **One of our 2 administrators was off for the past year. The facility was not nearly as well run. There were more communication issues. There were major nursing re-** |

| |
|---|
| **assignments; nurses who were very familiar with and attuned to a particular set of residents were moved to another unit. The new nurses have taken a while to get up to speed. The leadership style was more reactive than proactive. The EMR needs to serve our needs better, so we can be more efficient; more time spent on patient care and less on navigating the system.** |
| **Continue to help disseminate best practice information** |
| **I am satisfied the way it is at the moment** |
| **Better uniformity in emr charting and on call physicians to attend to residents when required for suturing rather than refer to ED as EPS end up doing lots of unnecessary work up and pts suffer for no reason with lengthy ED corridor stays** |
| **Better compensation for proactive visits** |
| **More support in the care facilities from nurse practitioner or another physician with challenging patients.Set amount of sessions that can be billed monthly for being a medical director without the need to document every 15 min of time** |
| **To be discussed.** |
| **discussing on-call problems with the MRP (handover)** |
| **Better options for communication with specialists and specialty clinics (eg. dialysis clinic)** |
| **improved electronic medical record system, PCC really not doctor friendly.** |

4. **What is working well with the Residential Care Initiative program?**

| |
|---|
| **Collegial group Administrative Support** |
| **Care conferences** |
| **All our docs are collegial, capable and flexible. We cover for each other when needed, never a problem. The MAC meetings are social, educational and well-run. The nurses at all the facilities I attend on-call seem happy with the program [I ask them]. If the nurses** |

| |
|---|
| **are happy, we are doing ok.The What's App is great for clinical and billing/system discussions.** |
| **Good collegiality and people to help bounce ideas off** |
| **everything is working well, no complains** |
| **Great teamwork and good support via WhatsApp chat when on call** |
| **Good team approach, I like having others in the care home with me to help with vacation and questions** |
| **On call program** |
| **The meetings and help with recruitment.** |
| **Discussions +CME ++** |
| **Care conferences** |
| **Peer support from other physicians. Collegiality.** |
| **care conferences. Proactive visits.** |

**5. Reflecting back over the last year, what changes have you seen in relation to your practice in residential care?**

| |
|---|
| **Implementing Qi steps: we didn,Äôt have meaningful Med review and now it,Äôs done annually** |
| **N/a** |
| **More attention to details like vaccination status.** |
| **Continued to build relationships with team members** |

| |
|---|
| **better communication with the facilities during on-call shiftsMore flexibility regarding calls, as some people don't want to do them.** |
| **More QI** |
| **More palliative approach and reducing poly-pharmacy** |
| **Better team work and more support from the division** |
| **EMR - good and some hard change that comes with it e.g my poor typing skill!** |
| **improved proactive visits on all of my residents** |

6. **On a scale of 1-5, how satisfied are you with the Residential Care initiative Program?**

***Average Response Rating: 4.7***

**Comments:**

- **Well functioning and good support**
- **Keep up the good work!**

---

**Facility Survey Analysis**

1. **How would you rate your facility's Residential Care Initiative physicians in providing the following best practices (*with comments*)?**

| | On-call Shifts | Proactive Visits | Completed documentation | Care Conference | Meaningful medication |
|---|---|---|---|---|---|
| ***Response Average*** | **4.9** | **4.9** | **4.7** | **4.9** | **5** |

2. **How satisfied are you with the quality of clinical care for the Residential Care Initiative physicians?**

***Average Response Rating:*** **4.8**

**Comments:**

- **In general the in-practice and FU has been excellent. However, we had one incident of an RCI physician that would not provide his name and asked the nurse to call the service to get their name after providing orders.**
- **Our physicians work hard to ensure everything is running smoothly.**

3. **How satisfied are you with the after-hours on-call availability from the Residential Care Initiative physicians?**

***Average Response rating:*** **5**

4. **How satisfied are you with the after-hours on-call care from the Residential Care Initiative physicians?**

***Average Response Rating:*** **4.9**

5. **How satisfied are you with your facility's Residential Care Initiative physicians' openness to feedback?**

***Average Response Rating: 4.8***

6. **How do you feel the Residential Care Initiative Program has impacted your residents and their families?**

***Average Response Rating:*** **4.9**

**Comments:**

- **We have managed to keep medicines under 9. We are reducing restraints use with the help of physicians. These are just some examples. Our families have been satisfied with prompt and caring attention of our physicians.**

7. **Overall, how satisfied are you with the Residential Care Initiative program?**

***Average Response Rating:*** **5**

8. **What are some areas for improvement?**

| |
|---|
| **Other then ensuring all physicians are respectful to the calling nurse, the program is excellent!** |
| **We are happy with things as they are** |
| **none** |
| **I think we are good :-)** |
| **things are running very smoothly** |

| |
|---|
| **None so far.** |
| **More GPs in our Facility ( 230 beds) . More time spent in the home during their visits.** |
| **Our home needs one more physician. We currently have 2 physicians. Our home is very busy and 1 more physician can definitely help lighten up the load.** |
| **We are satisfied - all identified concerns are addressed in a timely and professional manner.** |

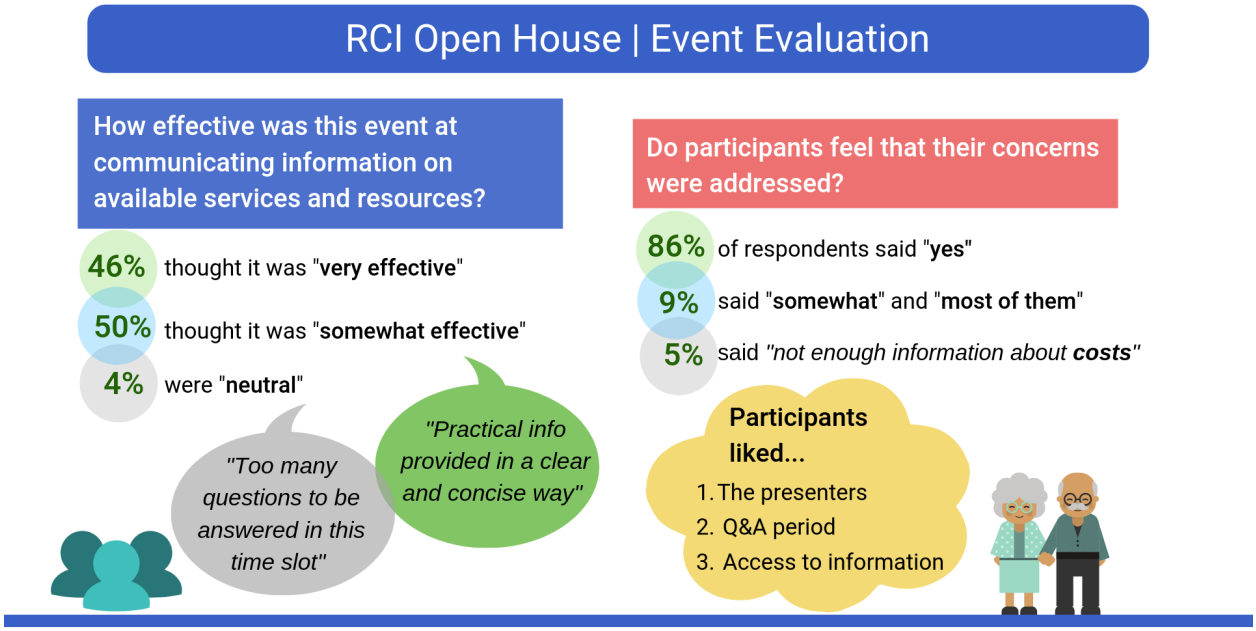
9. **What positive changes are you most happy with? (what would you like to see more of in the next year?)**

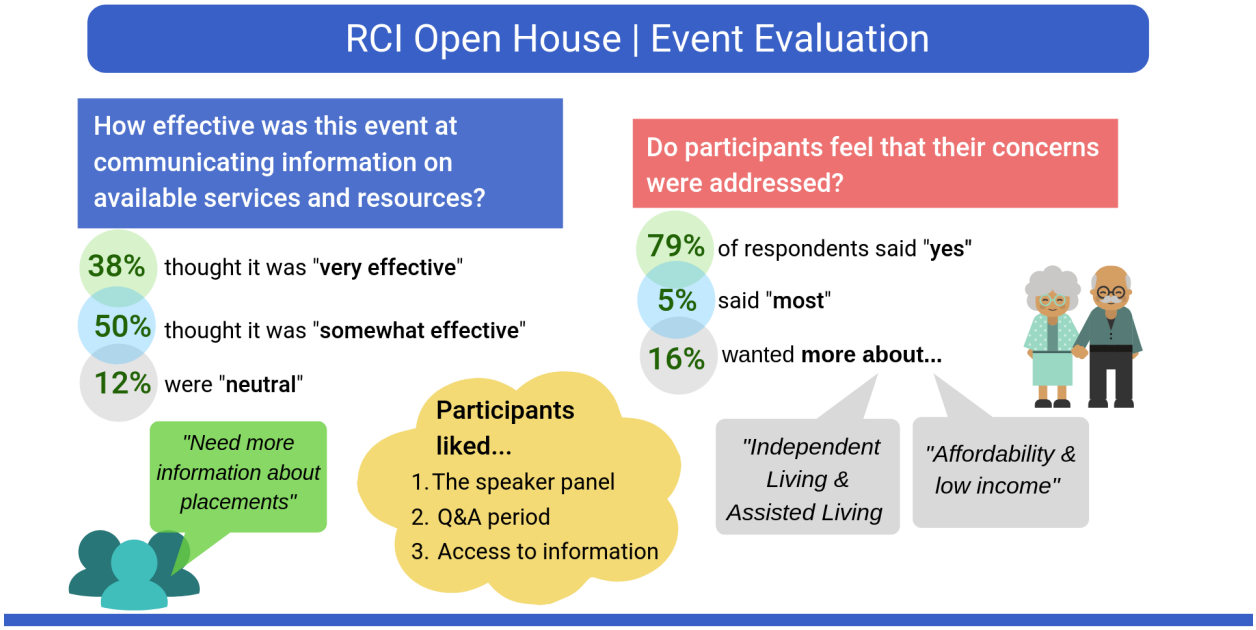
| |
|---|
| **I like the blue binder - and that the phone lists are regularly updated. Having information accessible to all nurses :)** |
| **Happy with timely response when requested** |
| **No comment** |
| **The relationship we have with our MRPs** |
| **I like that we have Dr. Zeifflie- she is wonderful and has taken some of the extra patients on** |
| **Easy to get ahold of the on-call physician** |
| **Easy Access for GPs when needed . Families are happy to have GPs on site.** |
| **Ongoing excellence in:Reduction of poly-pharmacymeaningful med reviews meaningful care conferences** |
| **Open dialog with our physicians and collaborative approach to caring for our residents. For example we can approach our physicians with any concern - medical, social or behavioural and know they will support and help problem solve.** |

10. **What would you like to see done differently in the next year?**

| |
|---|
| **Nothing at this time** |
| **Less frequent data collection** |
| **no comment** |
| **No ideas at this time.** |
| **I cannot think of anything** |
| **none** |
| **More GPs in our Facility ( 230 beds) . More time spent in the home during their visits.** |
| **one more physician added to the list!** |
| **Nothing at this time.** |

## Appendix C: Fall 2018 Facility Open Houses



## Appendix D: Program Funding

| Fraser Northwest Division of Family Practice Society<br>Residential Care<br>All Dates (October 1, 2015 - March 31, 2019) | | |
|---|---|---|
| | **Total** | **% of Income** |
| **INCOME** | | |
| **Residential Care Project** | **$ 2,335,247** | **100.00%** |
| **EXPENSES** | | |
| **RCI Human Resources** | **295,191** | **12.64%** |
| **RCI Physician Lead Sessional Fees** | **119,197** | **5.10%** |
| **RCI Physician Session Fees** | **136,110** | **5.83%** |
| **RCI On Call Payments** | **1,170,243** | **50.11%** |
| **RCI Mentoring/ Education** | **46,582** | **1.99%** |
| **RCI Professional Fees (Accounting & Legal)** | **5,109** | **0.22%** |
| **RCI Stipend/Rostering Bonus** | **301,828** | **12.92%** |
| **RCI Office & Administration** | **9,485** | **0.41%** |
| **RCI Travel, Mileage and Parking** | **4,029** | **0.17%** |
| **RCI Meeting Costs** | **43,900** | **1.88%** |
| **RCI QI Project Funds** | **2,959** | **0.13%** |

| | | | |
|---|---|---|---|
| **RCI Phone System for on Call** | | **17,042** | **0.73%** |
| **Total Expenses** | **$** | **2,151,675** | **92.14%** |
| **Net of Income over Expenses** | **$** | **183,572** | **7.86%** |