Residential Care Initiative (RCI) Evaluation Report

Fraser Northwest Division of Family

Practice August 2018

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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 objective 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). To build on previous evaluation reports and to support future planning, this report compares data from fiscal year 2016/2017 (April 1, 2016 - March 31, 2017) and fiscal year 2017/2018 (April 1, 2017 - March 31, 2018).

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.

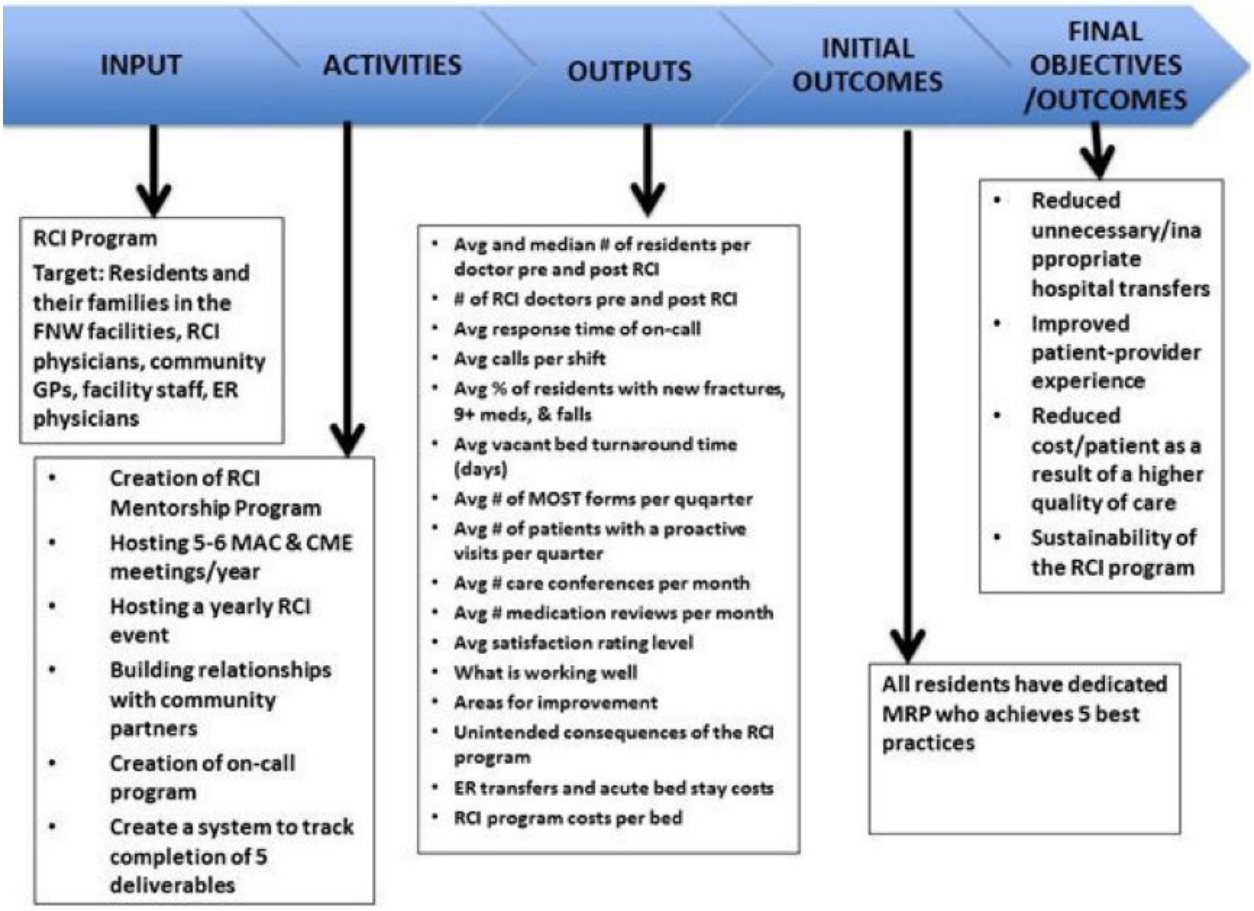

Figure 1: Fraser Northwest Residential Care Initiative Logic Model

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 first 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. - Avg # of residents/Dr. - # of RCI Dr. - % of gender of RCI Dr. - Avg $ of years in practice - Avg. % of residents on 9+ medications - Avg. % of residents on antipsychotics without diagnosis - Avg. # of unscheduled ER transfers per 100 residents	RCI Program Database Residential Care Site Quality Performance Feedback report	Improved Patient/Provider experience 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 - Facility satisfaction against proactive visits - Facility satisfaction against med reviews - Facility satisfaction against completed documentation - Facility satisfaction against care conferences - Facility satisfaction against patient/provider satisfaction	GPSC Facility Satisfaction Survey	Improved Patient/Provider experience Sustainability of RCI Program
To what extent did the program contribute to improved practice environments for physicians	- # of meetings held - 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 - Acute care admissions - Avg. length of stay	ER Statistics	Reduced unnecessary/inappropriate hospital transfers Reduced cost/patient as 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 - Areas for improvement	Physician satisfaction survey 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.

The previous evaluation report included data from October 2015 until August 2017. To build on that evaluation report and to support future planning, this report compares data from fiscal year 2016/2017 (April 1, 2016 - March 31, 2017) and fiscal year 2017/2018 (April 1, 2017 - March 31, 2018). 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) 2016/2017 and FY 2017/2018 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 commiting to providing the 5 best practices in residential care has increased to 23. Over the last year, the average years

of practice for MRP has continued to decrease to 16 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 16/17	FY 17/18
# of MRPs practicing in RCI	20	23
Median # of residents per MRP	35	30
Female MRPs	8	11
Average years of practice per MRP	24	16

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

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.

Facility Metrics for Quality of Care	FY 16/17	FY 17/18	Difference in Change
Average % Residents on 9+ Medications	36%	33%	⬇

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

Average % Residents on antipsychotics without diagnosis	19%	19%	=
Average # of unscheduled ER transfers per 100 residents	13%	11%	⬇

Table 4. Comparison of Facility Quality of Care Metrics Between FY 16/17 & FY 17/18 of RCI program implementation[2].

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 2016/17 and FY 2017/18 continues to show an increase in satisfaction for physicians. Specifically, physicians conducting proactive visits, completing documentation and attendance at care conferences 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	N/A	N/A	N/A
Completed Documentation	⬆	=	=

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

Care Conferences	⬆	⬆	⬆
Patient Provider Experience	=	=	=

Table 5. Comparison of Changes in Satisfaction for Facilities (FY 16/17 & 17/18) Across Regions[3]

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

Data that was collected over FY 17/18 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 11 formal engagement sessions for this committee - with 5 occuring within the timeframe that this evaluation is reporting on (FY 17/18). Additionally, the Transitions Networking Committee is comprised of over 50 stakeholders who are invited monthly 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. Additional engagement sessions were held throughout the year to identify contingency medication lists from facilities; contract renewals; and appropriate physician coverage. In addition to the learning opportunities presented at these regular engagement sessions, the program was able to fund 18 RCI physicians to attend the UBC Care of the Elderly Intensive Review Course and also support RCI physicians in other Residential Care Leadership conferences.

Results from RCI poll questions to physicians that attend the MAC meetings indicate that the majority of physicians communicate with the ER physician and staff when on shift. This data indicates that communication with the ER is imperative to the RCI physicians work for seamless transfer of residents. Feedback suggested that there are opportunities to strengthen and improve this communication and RCI physicians suggest that they are engaged and open to working together to strengthen the system of support for residents.

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 16/17 to FY 17/18. Residential client emergency department (ED) visits,

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

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 16/17 & FY 17/18	-16%	-16%	-17%	- 11%

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

Analysis of ED data reveals that there has been 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 cost savings to the overall healthcare system.

Cost savings can be compared by looking at the changes between FY 2016/17 and FY 2017/18. 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 cost savings of $504,215 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, 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 16/17	$550,719	$4,746,356	$5,297,075

[4] Information shared in Table 6 is from the Fraser Health Authority Analytics, Paris & Meditch extract- MA 16211 Updated Report (Oct 2, 2018).

FY 17/18	$463,504	$4,329,357	$4,792,861
Total Cost Savings between FY 16/17 & FY 17/18			**$504,215**

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 4.3. This indicator reveals increased optimization of the 5 best practices in the Fraser Northwest. It's important to note a variation between the ease/challenge of the best practices depending on the years in practice by GPs: 88% of the first 5 years in practice GPs rated that proactive visits were the most challenging; comparatively, 100% of GPs with over 26 years in practice rated proactive visits as being the easiest of the best practices to achieve.

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 supports for GPs that has shown an increase in collegiality and dialogue between GPs through champions stepping into leads positions within the MAC and amongst GPs, Nurse Practitioners, Hospitalists and other service providers.

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

3) Overall satisfaction for patient coverage during after hours and weekends due to the on-call network that was created. Physicians rated 4.2 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) The realization that there are inconsistencies when working in residential care that involve communication, research and review of care across sites and facility teams.

2) Recognition that facility staff need to be more aware and educated in the purpose and benefit of the RCI program.

3) The availability of EMR access across sites for physicians that are a part of the RCI program.

4) Patient and family education with regards to realistic expectations when clients are entering long term care facilities.

5) Strengthened communication and collaboration between residential care site staff, MRPs, 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 4.6 on a scale of 1-5.

2) Overall satisfaction with the RCI program score was 4.5 on scale of 1-5. Facilities reported that the quality of care from the RCI physicians has been prompt and attentive.

3) Improved access and communication with RCI GP MRPs.

Main themes of areas for improvement - Facility Satisfaction

1) It can be challenging as new doctors enter into the RCI program and the dichotomy of the environment where the turnover of residents can be incredibly high and continuous.

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

3) Further opportunities for relationship building between the long term care homes and doctors.

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 number of FNW RCI physicians continues to increase since the program's inception in 2015. It can be inferred that the accessibility of care for residents in the FNW has improved as every resident has a dedicated MRP in the community. Additionally, with a significant increase in the number of female physicians, from 0 to 11, residents are more able to access female physicians if desired. As the median age of RCI doctors in the community continues to decrease, the sustainability of the accessibility to care has improved, as there are younger doctors to sustain this level of care when older doctors retire.

Prior to the RCI program, a standardized 24/7 call system was not available or included in all FNW facilities and system of tracking the 5 best practices for all doctors in residential care was not being completed or monitored. Some medical directors may have been performing all of these expectations, but perhaps not necessarily all doctors with residents in the community. Thus, since implementation, facilities now know they can reach a doctor after hours, reducing the need to send a resident to the emergency department if possibly avoidable, and have confidence that their RCI doctors are optimizing care through the 5 best practices.

2. Residential Care facility staff practice environments

Since the RCI Program's inception, facilities and physicians have had access to a structured network of RCI doctors committed to the program which created opportunities for new partnerships and strengthened existing relationships. Facilities are now able to reach a physician 24/7 due to the creation of a standardized on-call system for all 15 facilities in the community. The total number of calls from facilities to the on-call system increased significantly since the RCI program began. In 2016 there were a total of 1068 calls and in 2017 there were a total of 2369 calls. This suggests that facilities are more comfortable in using the call network and are overall more trusting of the on-call care. Based on the data collected and shared in this report, facilities have reported an increase in satisfaction related to proactive visits, care conferences and completed documentation from physicians. Facilities have noted that there are still opportunities for further collaboration between physicians and facility staff. Nevertheless, Facilities noted that since the RCI program's inception, there have been significant improvements related to quality and accessibility of care.

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. When a doctor unexpectedly retired, the program found MRPs for over 250 residents, within 3 weeks. Prior to this initiative, this task would not have been possible in this period of time and points directly to the impact the RCI has made in this community.
Finally, the RCI program has attempted 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 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.

3. Improved practice environments for physicians

The RCI program has developed a local residential care Medical Advisory Committee, where RCI GP MRPs have a forum to collaborate on common FNW residential care issues, strengthening the local network of physicians and facilities, improving quality of care through associated CME presentations and partnering with the Division on RCI goals.

Since the RCI program implementation, a mentorship program for physicians interested/embarking in residential care was created and offered. This allowed many physicians who were newer to residential care the opportunity to train under an experienced RCI physician. Over the past 2 years, the RCI Program Leadership team has been able to support 18 RCI physicians to attend the UBC Care of the Elderly Intensive Review Course. The program provided additional CME opportunities specific to residential care, allowing physicians to strengthen their skills in their area of practice.

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 $504,215 between FY 16/17 and FY 17/18 continues to convey the cost-effectiveness of this program.

8. Lessons Learned

Major themes surrounding the lessons learned collected by facilities and physician stakeholders that are involved in the RCI program are:

Communication strengthens relationships. Over the last year, the FNW RCI program has focused on increasing communication between stakeholders. The facilities, physicians and Health Authority strengthened existing relationships by keeping open channels for feedback through the RCI. Dedicated members of the local Residential Care Transition Networking Committee successfully formed working groups and began multiple quality improvement projects. Noteworthy collaborative projects include: contingency list standardization, family education guidelines on physician care, suture kit implementation, the ER communication working group and the CIHI data working group. Another example of success due to having strong communication ties is the physician patient transfer of care form. This form was created for facilities to respectfully ask community physicians if they wanted to transfer care of their patients to an RCI physician. This made the work more streamlined and efficient for facilities upon admission time.

There is great value in physician engagement. This evaluation period reveals the importance of RCI physician engagement. An increase in physician recruitment does not necessarily mean an increase in physician engagement. Over the last year, it has been learned that physician engagement drives productivity and interest. The FNW Medical Advisory Committee (MAC) supported physicians to become leaders within their group. Physician interest was seen in leading M&M rounds, analysing and presenting data, and leading quality improvement projects. A poll was completed in January 2018 that revealed how much the FNW MAC valued handover to the Emergency Room physicians. This information fostered the idea to further engage with ER physicians, create working groups and strengthen communication with hospitalists.

A significant amount of time during this evaluation period was also spent reviewing and revising the FNW RCI physician contract. Through engaging the RCI physicians, the program continued to progress at a local grass roots level to ensure that appropriate budgeting, incentive fees and commitments were upheld. An Enhanced Patient Support Incentive Fee was introduced. This recognizes the

additional time the physicians spend supporting residents and their families above and beyond the basic level of physician care in the community care that is not otherwise compensated. This includes family meetings, goals of care conversations, communicating with colleagues, hospitalists and emergency room physicians for each resident. This piece was instrumental in bringing the FNW RCI physicians together and in support of the same care goals for this residential care community.

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 were introduced over the last year. 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.

(3) Available Evaluation Resources

Lack of resources specifically dedicated to data collection and monitoring to support the program's evaluation resulted in a bottleneck of data to process and examine at the time of report writing. Mechanisms will be put in place for future evaluation reports for consistent data analysis and processing in real time.

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 (October 2, 2018)

Year	Quarter	# of RC Clients	ED Visits	Admissions	Avg LOS	Bed Days
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	853
2017/2018	3. Oct - Dec	1409	136	83	10.7	888
2017/2018	4. Jan - Mar	1450	131	80	7.9	632

Extrapolated data calculations						
Year	**Quarter**	**# of RC Clients**	**ED Visits**	**Admissions**	**Avg LOS**	**Bed Days**
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

Cost Saving Calculations			
Fiscal Year	**Quarter**	**Cost of ED Visit = $723**	**Cost of Admit**
		(extrap # ED visit x $723)	**(extrap # of admit x $1235)**
2016/2017	1. Apr - Jun	$118,572.00	$939,726.03
2016/2017	2. Jul - Sep	$145,024.54	$1,590,656.44
2016/2017	3. Oct - Dec	$140,799.17	$1,313,317.11
2016/2017	4. Jan - Mar	$146,323.74	$902,656.44
Total 2016/2017		**$550,719.45**	**$4,746,356.03**
2017/2018	1. Apr - Jun	$109,750.18	$778,379.22
2017/2018	2. Jul - Sep	$121,102.75	$1,283,591.93
2017/2018	3. Oct - Dec	$120,170.91	$1,340,451.12
2017/2018	4. Jan - Mar	$112,479.85	$926,934.79
Total 2017/2018		**$463,503.69**	**$4,329,357.06**

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	**4.2**	**4.2**	**4.3**	**4.3**	**4.6**

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
5	4	3	2	1	
5	4	3	2	1	
2	1	3	4	5	MOST forms still time consuming
5	4	3	2	1	
4	3	5	2	1	
3	1	4	2	5	I have a dedicated day per week for my patients
1	4	2	3	5	Getting used to on-call shifts
1	3	2	4	5	I have not done any shifts

2	**5**	**3**	**4**	**1**	**The first 3 are about on a par. On-call can be onerous but no more than a nuisance. My days at the facility are busy; I am not good at making sure I do specific proactive visits, but I go through the list with the nurses probably monthly and ask about any problems.**
1	**3**	**5**	**2**	**4**	
2	**3**	**1**	**4**	**5**	**Sometimes my schedule needs to be changed to attend care conferences**
4	**5**	**3**	**2**	**1**	**Sometimes a bit difficult for the proactive visits especially if patient is stable. Working on making sure I make these on a regular basis!**
1	**3**	**2**	**4**	**5**	
1	**4**	**2**	**3**	**5**	
2	**3**	**4**	**5**	**1**	
2	**1**	**3**	**4**	**5**	
5	**1**	**4**	**2**	**3**	

1	**4**	**3**	**5**	**2**	
					I sometimes lag behind sometimes in documentation

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

- **Having nurses and facilities fully support the bigger picture of patient centred care. Change is not easy, and takes leadership and belief in doing the right thing**
- **Improved consistency in nursing competency from one sit to another**
- **Improve access to lab/imaging – it would be ideal if all patients are on one EMR system and physicians can update notes and check labs online**
- **Availability of EMR access to all the patients when on-call would be the next huge step for RCI on-call efficiency improvement. All doctors should move to EMR documentation as opposed to paper.**
- **Increase in # of residents followed frequently. Better care**
- **You are doing a good job. I like having the suture kit -How can we ensure all of us are practicing at the same level? In terms of quality of charting, how end-of-life discussions are done, etc.? I have several times seen Resuscitate/C2 designations on residential care charts. This may be appropriate, but how clear is the documentation of the discussion and decision-making process?**
- **Improved the documentation process for on-call**
- **Educating nurses on how to manage various situations so they don't always think ER transfer is necessary**
- **CME**
- **The EMR system**
- **The RCI program is extremely well run**
- **Ongoing continued education of the palliative approach to care. Ongoing discussion with facilities to aim for consistency across sites.**
- **EMR**

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

- **Great colleagues, great network of support, confident in the on-call team to care for my patients**
- **Great rapport with nursing staff and admin at my facility.**
- **Collegiality/program support and organization**
- **Good coordination and mentorship and CME notifications.**

- **Regular proactive visits. Connection with the family, updated medications to name some**
- **Suture kits. Educational sessions at the MAC meetings. Pleasant, qualified colleagues. Recent grads joining the program**
- **Generating interest from new physicians and increase access to physicians for acute issues**
- **Medication reviews to reduce polypharmacy**
- **On-call program, support network**
- **Meeting and follow up of our concern**
- **Care conferences and med reviews**
- **All aspects**
- **On-call system and all residents have an MRP at their designated facility. Improvement towards a palliative approach to care**
- **Most things**

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

- **Patients coming in frailer, closer to the end of their life. Lots of keen, fresh new docs working with us. More struggles with families understanding what to expect when their loved one comes**
- **There is high turnover, which means increased admissions. This is very time consuming, and there is no longer the attachment fee bonus for taking on these patients as before. This is a financial disincentive for new MD's to take on this work.**
- **Developed a good working relationship with nursing home staff**
- **Palliative care protocols, new way of care conferences**
- **I just started, for me it is the same**
- **Better at advance care discussions, both proactive and at the time. Better communication with colleagues re: on-call issues. People taking on new projects**
- **Slightly easier as getting to know patient's better**
- **Reducing medications**
- **Taking a more palliative approach to LTC care**
- **Better proactive visits**
- **I have decreased my patient load and assisted in orienting new physicians into the RCI**
- **More residents have a MOST M2 rather than M3 – improved end of life care**
- **Started working at Felburn care home during last year**

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

Average Response Rating: 4.4

Comments:

- **There is still inconsistency in how the RN/LPN communicate to us when on-call. Sometimes, it is terrible, disorganized, unprepared. Other times, all the info is ready to go, and the questions are relevant and logical.**
- **Efficiency can still improve**
- **Keep up the good work!**
- **Educational sessions during MAC are very helpful**
- **Improved and Universal EMR between all care homes needed**

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	**4.5**	**4.6**	**4.3**	**5**	**4.8**

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

Average Response Rating: **4.3**

Comments:

- **Prompt and attentive care**
- **satisfied with most GP's. This is a complex and demanding field of work and GP's need to be able to effectively communicate and collaborate with the team.**

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

Average Response rating: **4.7**

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

Average Response Rating: **4.6**

Comments:

- **on-call MD's answer promptly and are on site prn e.g. sutures**

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

Average Response Rating: 4.6

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

Average Response Rating: **4.3**

Comments:

- **Very good to have back up whether to sent to ER etc.**
- **There is a consistency to the Doctors' visits; less need for the nurses to contact the doctors when they know what day the doctor will do his/her rounds.**

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

Average Response Rating: **4.4**

8. What are some areas for improvement?

- **Cannot think of one at this time. Thank you**
- **Not at the moment**
- **Documentation in Progress Notes for consults/visits or at care conferences.**
- **No suggestions at this time – very effective program at our site**
- **In-service on ROP for Accreditation Canada re: e.g. Dangerous Abbreviations**
- **None at the moment**
- **It was a challenge bringing up a new doctor up to their 20 residents' quota especially when there is a sudden "turnover" and the doctor is admitting several residents in that week and other doctors already have 20+ residents**
- **I am open to discussion regarding this**

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

- **Very clear program in place**
- **Good coverage**
- **Active participation iof physicians for the following initiatives: CLeARP.I.E.C.E.SPolypharmacy**
- **Availability for questions**
- **Prompt response and always having someone on-call. Definitely well needed and used resource**
- **Consistency with doctor's visits and no worries about whether we can admit a resident if we are unable to get a doctor**

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

- **Not able to think of anything at this time**
- **Active participation of physicians for the following initiatives: CLeARP.I.E.C.E.SPolypharmacy**
- **Dinner meeting with homes and on-call doctors appreciated**
- **Nothing**

- **No change I can think of at the moment**