Residential Care Initiative
Supporting Guidelines

General Practice Services Committee

Overview

In its continued efforts to further foster longitudinal, comprehensive care throughout a patient's lifecycle, and to improve the health system and quality of care for the frail elderly, the GPSC's Residential Care Initiative aims to ensure that each patient in a residential care facility has a dedicated GP MRP. For the purposes of the initiative, a dedicated GP MRP is defined as one who delivers care according to five best practice expectations and promotes three system-level outcomes, which are outlined below. The GPSC has made funding available for divisions, or self-organizing groups of family physicians in communities where no division exists, that are interested in enhancing local residential care services.

Through the leadership and knowledge of local divisions/self-organizing groups, it is anticipated that each division/self-organizing group will design a local solution that cover all residential care facilities in its community. The local solution will deliver dedicated GP MRP residential care services.

The GPSC is committed to work with divisions/self-organizing groups to collect and/or develop additional planning resources to facilitate the sharing of best practice information across the province. Additionally, the GPSC will provide each community with high level metrics to support the collection of data for the five best practice expectations and three system level outcomes as a part of its provincial evaluations process.

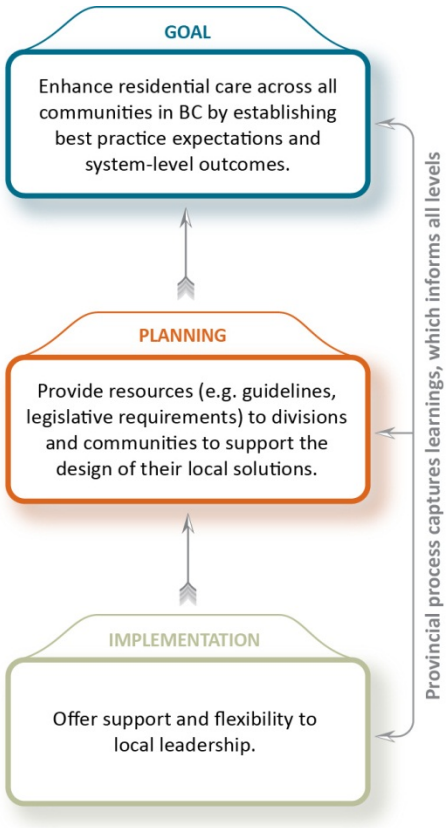
To assist communities in developing their local solutions, this document outlines planning guidelines for the best practice expectations and system level outcomes.

Five best practice expectations:

- 24/7 availability and on-site attendance, when required
- Proactive visits to residents
- Meaningful medication reviews
- Completed documentation
- Attendance at case conferences

Three system-level outcomes:

- Reduced unnecessary or inappropriate hospital transfers
- Improved patient-provider experience
- Reduced cost/patient as a result of a higher quality of care



Five Best Practice Expectations

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

This expectation means that all day, every day, there will be a clear system in place for physician coverage. This will inform residential care staff how to access medical assistance in a timely manner, whether by phone, fax, other electronic media, or in-person.

Additional information:
It is acknowledged that communities will solve this responsibility differently, and this is not intended to create a new "MOCAP" system. It is aimed that communities will work to ensure effective communication systems so medical concerns can be promptly addressed, including having someone come to assess the patient on-site when that is appropriate. Prototype residential care programs have shown that this can reduce unnecessary transfers to acute settings with its associated costs and risks, and improve teamwork between physicians and facility staff.

To foster effective communication between staff and physicians, it will be important to identify and implement improvements to communication flows for physicians with nurses and care aides and to the organization of patient information in charts and computers.

Proactive visits to residents

Each community will have established expectations for regular visits to residents.

Additional information:
Recognizing that regular visits can improve teamwork and can help identify problems in a timely manner, the frequency of visits may vary depending on local conditions. For example, if a physician has a case load of around 20 residents or more, scheduled presence at the facility would be required to be more frequently, perhaps a minimum of monthly, even if not every patient needs to be seen at every visit; physicians with few patients may need to be on site less often, perhaps a minimum of every three months. However, it is still expected that residents will also be seen when need arises. The details for scheduled, proactive visits will need to be outlined locally. Effective case conferences and medication reviews are also types of proactive visits, as addressed elsewhere in this document.

Meaningful medication reviews

The expectation will be for a meaningful medication review to be completed as soon as possible after admission, and thereafter, at least every six months and at any change in the resident's status or after any transfer back from acute care

An onsite review is preferable, but may be completed by videoconference or teleconference

- Preferably, a pharmacist and other team members would be available to provide their expertise; a faxed page with a "tick box" for approval with no discussion is not adequate.
- Although six monthly pharmacist-led medication reviews are already mandated by the College of Pharmacists, the engagement of physicians in these reviews can improve the effectiveness of these reviews.
- There should be documentation to support the benefit of a medication in the context of:
    - The Goals of Care for the individual resident
    - Current indications versus potential for adverse events/side-effects
    - Total number of medications

- Medications that may be of low value or no longer needed
- Care-staff time taken up by administration of multiple medications

The Shared Care-funded Polypharmacy Risk Reduction Initiative can provide physician mentoring, clinical updates, quality improvement tools and resources to develop a Meaningful Medication Reviews.

Divisions not already engaged in this Initiative are encouraged to contact Margaret English (menglish@doctorsofbc.ca) or Dr Keith White (kjwhitedoc@gmail.com).

Completed documentation

This expectation aims to have completed documentation, including medical summaries and advanced care plans expressing patient and family preferences at end-of-life, for 100% of residents in each facility.

Additional information:

- Advance care plans may include various documents and should guide the providers to respond according to the wishes and values of the patient and family at end-of-life. Advance care plans are required by licensing agencies and are kept in the "green sleeve." These need to include resuscitation preferences and many areas will use the MOST forms.
- Medical summaries are useful for communicating to anyone sharing patient care; Summaries should reflect why the patient is in residential care (e.g. a problem list) and any information useful for rapidly understanding the patient's issues. As the exact chart location will vary, charts should be easily referenced to help physicians covering each other's patients, and for patients on-transfer to acute facilities.
- Documentation of visits, case conferences, pharmacy reviews, care plans, and communications between physicians and staff need to be well-documented to ensure optimal patient care.

Attendance at case conferences

This expectation means that the dedicated GP MRP or designate will provide input into and attend the resident's initial and subsequent annual care conferences that are mandated under the care home licensing acts.

Additional information:

- Interdisciplinary care conferences are mandated under the government licensing acts. The first conference should occur within four to six weeks of initial admission, and annually thereafter. The participants at these care conferences are not defined under the act. The composition of the team varies for each institution. However, the term interdisciplinary is taken to include the leaders of mandated services in the care homes, such as dieticians, occupational/physiotherapy, and activity coordinators, along with senior nursing staff and the resident's care team, especially those who have daily interactions with residents. A resident may attend if well enough to comprehend the proceedings and/or may be joined by relatives or principal supporters. Medical Directors (where they exist) are considered to be part of the interdisciplinary care team, and MRP family physicians are invited for their valuable input.
- To be structured and efficient, care conferences may utilize existing local templates and best practices in addition to materials made available through the Initiative.

- The first care conference is particularly important as this is when the new resident's medical and social history can be collated. Input from a resident's relatives or principal supporters regarding their premorbid personality and interests is of vital importance. Goals of care, expectations, and end-of-life planning should be solidified at this initial care conference. An MRP's input, especially if they enjoyed a long association with the new resident, is valuable.
- Every effort will be made by the care home to accommodate family physician schedules. When possible, conferences on their residents will be held in the same session. There are, however, practical considerations: care conferences cannot be held early in the morning or during lunchtime when caregivers are attending to their residents. In many parts of the province, providers of mandated services are peripatetic and are only in the care home on certain days (particularly dieticians, OT/physiotherapists, and activity coordinators)
- If an MRP physician or delegate (e.g. Locum) cannot attend in person, then billing rules allow attendance by teleconference including telephone, video or Skype/FaceTime electronic attendance. These times can reasonably be booked into an office schedule.
- If an MRP physician cannot attend in-person or electronically, then the physician should give constructive and structured input in writing prior to the teleconference.
- Where there are medical directors and an MRP physician cannot attend the care conference, then the medical director will liaise with the MRP after the conference.
- Although increased participation in interdisciplinary teams for residential care patients may increase the confidence and skill levels of all involved, including physicians, communities are encouraged to incorporate more formal educational components into their programs.
- Patients in short term beds may not require case conferences, but if the need arises, the MRP should be invited to participate as they would be for other residential care patients.

Three system-level outcomes

Reduced unnecessary or inappropriate hospital transfers

This outcome aims to reduce the need for patients to be transferred to the hospital/emergency room for evaluation and care. This may be achieved through improving regular medical care at the residential facility, evaluating more medical problems on-site, reviewing medications regularly, and clearly documenting end-of-life plans. The GPSC will work with health authorities to obtain and report on the unscheduled hospital transfer rates where this information is available.

Improved patient and provider experiences

This high level system outcome of better patient and provider experiences is anticipated with the above measures that are aimed to improve residential care. As residential care is usually the last home for residents, residents, and their families, would likely prefer to live and to die with dignity in these residential homes. The GPSC will develop a provincial process for capturing and reporting on patient and provider experiences.

Reduced cost per patient as a result of a higher quality of care

This high level system outcome would be expected as a result of reduced unnecessary or harmful medications, reduced unnecessary transfers to acute hospitals, and increased on-site care by physicians who know the patient and therefore use less duplicative specialist, lab, and investigation resources. The GPSC will develop a process and methodology for determining cost per patient, which will be provided to communities.