Vancouver
Division of Family Practice
A GPSC initiative

Residential Care Baseline Research Project

Summary Report

May 2014

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Executive Summary

This report provides a snapshot of the current state of residential care in Vancouver Coastal Health (VCH) contracted facilities. The overall picture depicts a system populated with dedicated frontline professionals – Family Physicians, House Doctors, and Medical Directors, Directors of Care, Facility Nurses and Facility Staff – all of whom speak passionately about their desire to provide effective quality care for residents. They speak with equal openness about the challenges and barriers that exist within the current system and their desire for change.

> "Residential Care is the forgotten side of medicine."
>
> *– Anonymous residential care physician*

Introduction

On February 21, 2014, the Vancouver Division of Family Practice (VDoFP) began an examination of the nature of the provision of physician care in VCH contracted residential care facilities. The intent of the project was to:

- Assess the nature and magnitude of the issue of succession planning for physicians who have residential care patient panels in VCH contracted facilities and who are planning to retire in the near future
- Identify key challenges in the VCH contracted residential care facilities with regards to physician resources
- Provide a baseline for the evaluation of future work
- Identify challenges facing residential care physicians in terms of the perceived barriers to taking on more patients in residential care and potential solutions
- Evaluate newer physicians' interest with regards to working in residential care

The project involved telephone interviews with Directors of Care in VCH contracted residential care facilities and focus group discussions with both physicians currently engaged in the residential care system, and physicians who are not.

In the spirit of partnership, VCH Directors of Care generously provided meeting time to introduce the project and encourage staff and physician participation. Discussions during the meeting provided additional valuable insight that enriched the baseline data. In sum, 17 Directors of Care were interviewed by telephone and 18 physicians participated in the three (3) focus groups.

Current View From the Facilities' Perspective

> "We're really happy to have our House Doctor. Other than him, there is little doctor engagement."
>
> *– Anonymous VCH Director of Care*

A lack of understanding with regards to the role of the House Doctor was one of the most significant and apparent findings. There is no common definition for House Doctor across residential care facilities and the role of the Medical Director is equally unclear. Although Medical Directors are certain to be physicians, there is little consensus regarding what the duties of the Medical Director should be. Similarly, there is no common understanding of what can be expected of the House Doctor or of any physician who attends to residents at a facility.

While a few Directors of Care instinctively knew what was meant by House Doctor, others did not. Moreover, for those that instinctively knew the term House Doctor, it was not clear if their understanding was consistent regarding the role and responsibilities tied to the term. When directly asked to define the role of the House Doctor, loose definitions were given that included the acknowledgment that House Doctors have significant patient panels and a regular presence in the facility.

Despite this inconsistent understanding, the Directors of Care collectively agreed that they would like to resolve the issues surrounding physician engagement and retention in residential care.

Standards of Operation

VCH Directors of Care strongly favor the House Doctor system, as they believe that House Doctors are more engaged with the facility and have more familiarity with the care staff and the facilities' systems.

Directors of Care unanimously reported inconsistencies in physicians' responsiveness to phone calls and faxes, particularly after office hours. While physicians designated as House Doctors tended to be more "available", those with only one or a few residents were much less reliable, ranging from being extremely difficult to contact to being reasonably easy.

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House Doctors are perceived to be much more engaged in the operations of the residential care facilities when compared to Family Physicians with fewer residents in their care (typically 1 to 3 patients). When asked to rate the level of physician engagement at their facilities, Directors of Care consistently gave their House Doctors the highest ratings (average of 4.5 on a scale of 1 to 5). Conversely, Family Physicians with a small patient panel consistently scored on the lower end of the scale (average of 1.5 on a scale of 1 to 5). One Director of Care commented:

> "There's no number that can express the lack of engagement of other doctors (non-House Doctors)."

Physician engagement and its impact on the quality of care is of enormous importance to Directors of Care. Directors recognize that the absence of any standard protocol for communicating with House Doctors and Family Physicians contributes to the challenges they face. While in a limited number of cases, the Situation Background Assessment Recommendation (SBAR) is being used, there is no overarching guidance on when (and when not) to call physicians about a patient and how to communicate the particulars of the patient's condition. The result is a communication breakdown that is presumed to contribute to poor physician response. This exacerbates the significant challenges and barriers Directors of Care and Facility Staff face. The need for an effective, efficient, standard system of communication between facilities and physicians is apparent.

During the discussions with Directors of Care, the use of Nurse Practitioners arose as a potential solution to these communication issues. Many Directors of Care felt having a Senior Nurse or Nurse Practitioner would offset some of the difficulties experienced in communicating with the physicians, particularly in times when the resident has developed an acute illness and the facility is unable to reach the responsible Family Physician.

Another critical issue examined was physician participation rates in care conferences. Across the various facilities there was no consistent definition and approach to care conference and in some facilities, physicians did not attend care conferences at all. In other facilities, while House Doctor participation in care conferences was generally good, participation by other physicians was essentially non-existent. The Directors of Care would welcome greater involvement by all physicians in care conferences.

Directors of Care recognized the importance of establishing consistent policies and procedures regarding patient charts and documentation. In their view every physician has a unique preference for how charts should be handled, presented, and maintained. Most Directors of Care believed that physicians would prefer to have the nursing staff prepare for their arrival by having their patients' charts available for review, and this was confirmed by the physicians attending the focus groups. However, in the absence of regularly scheduled visits, it is impossible for the Facility Nurses to prepare.

While a few facilities use electronic chart systems, most are in a transition between electronic systems used by the nurses and physical hard copy charts used by the physicians. It is the perception of many facilities that physicians would prefer to use hard copy charts since each facility has a different procedure and login for accessing the electronic files. Some Directors of Care noted that some physicians (primarily those who are not House Doctors) perform their visits during times in which the facilities are either overburdened with other tasks or have a minimal nursing staff complement. The physician may come and go without communicating with any of the staff: sometimes orders will only be "seen by accident".

The overall consensus is that a more organized approach to scheduling physician visits and maintaining patient charts would result in better communication and, ultimately, better patient care.

A common theme arising from these conversations was that many Directors of Care see the benefit of having a form of agreement or contract between the physicians and the facility. This would detail the expectations of both parties and outline the rules of engagement. The matter of having a contract or agreement between the facility and physicians applies most particularly to physicians who care for only a few residents. If a resident (or his or her family) insists on retaining their Family Physician, it was suggested by several Directors of Care that the Family physician be required to commit to a certain standard of care and frequency of attendance at the facility. In the case of House Doctors, an agreement would ensure a degree of understanding between the physician and the facility and the expectations of each. The Directors of Care acknowledged that currently there is no system in place that enables the enforcement of expectations of engagement with the physicians. They are acutely aware of the difficulty often experienced when trying to find a physician to take on the care of newly admitted residents; it is believed that this creates a reluctance to creating and enforcing standards of care.

Approximately one third of respondent Directors of Care reported that they had residents in their facilities who visited their Family Physicians in their offices. Although it appears that this is most often a result of the choice of the resident or his or her family, it is clearly undesirable from a clinical perspective. These Family Physicians lack the input of the residential care Facility Nurses and in many cases, the residents have physical or mental challenges that make such visits unnecessarily arduous.

Directors of Care were asked for their views on unnecessary trips to the ER during the survey. It was difficult to get a complete picture on this issue and the Directors of Care were consistent in their commitment to doing everything possible to avoid unnecessary transfers to ER. There seemed to be no agreement as to whether it was problem or not. Several Directors of Care pointed to the fact that ER transfers could become a problem when they are caused by family pressure (e.g. a family member insisting that the resident attend the ER) or an inability to reach the Family Physician in a timely way. Where there is a House Doctor system in place, it is generally thought that there are few, if any, unnecessary trips to E.R.

It was universally felt that a move to a House Doctor model would be beneficial, and in fact, most facilities have been moving in that direction either consciously or organically. It is felt that a number of House Doctors appropriate to the size of the facility with a relatively equal patient panel and regularly scheduled visiting hours would enable:

- Better and more efficient communication between physicians and Facility Nurses
- Greater physician familiarity with the facility and its systems and procedures
- Better on-call physician coverage
- Fewer unnecessary patient transfers to E.R.

The Directors of Care recognize that they are woefully ill-prepared for the retirement of their House Doctors, Medical Coordinators and Family Physicians.

The Need for a Human Resource Plan

The Directors of Care recognize that they are woefully ill-prepared for the retirement of their House Doctors, Medical Coordinators and Family Physicians. None of the facilities surveyed had any organized process for identifying the looming human resource issues or a plan to put into action to respond to the issue. In fact, for some it is a struggle to keep the House Doctors they have.

Many facilities would like to recruit additional House Doctors but lack any clear plan or authority to do so. As one Director of Care put it:

> "How am I supposed to do that? I have no funds to lure them. I can't offer a premium. I have no control over where people decide to work."

While the residential care facilities are not directly involved in the payment of physicians, the Directors of Care believe that the complexity (and in some cases, the inadequacy) of the payment system is an impediment to the physician's ability to meet patient needs. They suggest that incentives like sessional fees or a bonus system might enhance their chances of attracting and keeping House Doctors.

The Current View From the Physicians' Perspective

Due to the nature of physician work lives and schedules, it was determined that a focus group rather than a survey was a more effective means to gain physician perspective. Three (3) focus groups were held, for a total of 18 physicians involved in the focus group process. Physicians were a mix of those who are actively engaged in providing residential care and those who are not. While the groups were small in number, the insights provided by the participants were thoughtful and very valuable.

Standards of Operation

Physicians who currently provide residential care spoke passionately about their reasons for being involved in this fulfilling work that allows them to utilize a diverse and vast knowledge and skill set. Physicians spoke of the residents with compassion and shared a genuine desire to provide communities of frail elders with thoughtful medical care. Physicians appreciate well-organized facilities in which there is a strong sense of teamwork with other residential care staff. As one physician summarized:

> "It's an environment in which you have meaningful and realistic communication about providing really good care."

Although physicians who provide residential care typically maintain a full general practice, there is a growing trend in Vancouver for much of the residential care work to be concentrated in the hands of a few physicians who have taken an interest in the work. Many of these physicians are older and likely nearing retirement.

> It is felt overall that the billing system doesn't provide adequate compensation for the work Family Physicians and, particularly, House Doctors, do in the residential care environment.

The physicians' perspective on the current state of residential care is very similar to that of the Directors of Care. Physicians share the common view that there is no consistent definition and approach to the roles and responsibilities of House Doctors. With this lack of consistency, many physicians are reluctant to commit to something that may be open-ended and ill-defined. The perceived inconsistency in staffing and structure at the residential care facilities serves as a deterrent to new doctors who might be otherwise interested in taking on residential care.

Although it was noted that the billing system has been improved in recent years, the fee structure remains an impediment. It is felt overall that the billing system doesn't provide adequate compensation for the work Family Physicians and, particularly, House Doctors, do in the residential care environment. Physicians recognize and appreciate the value of having access to sessional fees and other bonus systems, especially in connection with the roles of House Doctors and Medical Directors. They felt that the payment system should compensate for the additional expectations of these roles. It was suggested that the incentive system used in Providence Health Care facilities may serve as a model for VCH.

Patient panel size is another major concern for physicians who do residential care as well as for those who are considering becoming involved. When asked, focus group participants felt that a group of 20-30 patients was an appropriate minimum for a House Doctor. With a panel size smaller than 20 to 30, Family Physicians can't justify the time away from their regular practice. A panel larger than 20 to 30 creates the scenario where visits to the facility become too time consuming. This was consistent with the perspective of the Directors of Care. It was also noted that large patient panels make residential care difficult for the physicians to manage, particularly if they need to arrange on-call back up or vacation coverage. In two of the focus groups a patient panel of 35 was suggested as the ideal number.

Physicians also shared the Directors of Care's concerns over charting. They note the range of approaches taken by each residential care facility, echoing the facilities' descriptions of the range of physician preferences. The lack of a consistent protocol for handling charts compounds the perception that taking on residential care patients is more trouble than it is worth.

In a related vein, physicians have serious concerns about some of the calls they received from the Facility Nurses. Phone calls whereby staff member are ill-prepared to effectively communicate their concerns regarding a resident leave the physician in a compromised position due to lack of proper information and communication. Physicians would welcome the adoption of a standard protocol such as SBAR when communicating with the residential care staff. Moreover, Family Physicians value and deeply appreciate experienced Registered Nurses and Nurse Practitioners because the physicians have confidence in their skill and knowledge.

Physicians regard many of the care conferences as unproductive; they often deal with non-medical issues, making these meetings an inappropriate use of a physician's time. A more standardized and organized format would help to streamline the nature of the content and efficiently use the meeting time.

Physicians agree there is currently no human resource plan in place to address the looming issue of retirement.

The Need for a Human Resource Plan

Physicians agree there is currently no human resource plan in place to address the looming issue of retirement. In searching for solutions for the possible shortfall in Family Physicians, it was suggested that practicing in residential care has to be made more appealing. In the long-term the system can't afford not to make itself attractive, especially in terms of workload and compensation.

Physicians also noted that there is little-to-no training in residential care during medical school. Residential Care is an elective, thus new doctors are unsure of what to expect and rely on what they hear from their colleagues. New physicians supported the suggestion of having a formalized mentorship program similar to the one currently being piloted by the Vancouver Division of Family Practice. This would give them a full understanding of what to expect in residential care, a sounding board for issues, and the chance to acquire some patients of "their own" at a facility.

Another suggestion that emerged was that a possible strategy for recruiting physicians would be to increase the appeal of the House Doctor role, particularly to those Family Physicians who are winding down their general practice. For example, one of the focus group participants did this with his own practice; in his retirement, he gave up his general practise and assumed the role of House Doctor for two facilities. This suggestion was supported by another physician not currently doing residential care but nearing the end of his medical career.

Physicians participating in focus groups also suggested that more Continuing Medical Education courses, focusing on issues in residential care could be offered on an ongoing basis. This would provide extra training and familiarity to those physicians considering residential care.

Emerging Themes and Issues

From the surveys of the Directors of Care and the focus groups with Family Physicians, the two broad issues that emerged concerned the lack of clear standards and the lack of a structure to support accountability and problem solving around the facility / physician relationship. The questions we need to ask are:

- What are the Standards of Care that any facility resident can expect to receive from the house or attending Family Physician?
- What structure would best support an engaged, accountable physician – facility relationship focused on providing excellent resident care?

The key points that emerged with the most frequency are:

- The Directors of Care universally support the House Doctor model. This was generally supported by the physicians as well
- Where possible, definitions, procedures and system best practices should be identified and standardized across all residential facilities
- The billing system has to adequately remunerate the complexity of residential care work
- Emerging human resource issues related to retirement need to be addressed by developing a comprehensive plan for identifying the gaps and developing the means to fill them
- The system would benefit by having clearly identified leadership across facilities responsible for addressing the issue of physician resource planning
- Without a clear delineation of roles and accountability it will be difficult to make meaningful progress.

Summary

In conclusion, this research project verified the VDoFP Residential Care Committee's perception that significant structural and organizational issues exist, leading to inefficiencies within the larger system and an inconsistent level of patient experience.

The Vancouver Division of Family Practice is committed to working towards the improvement of residential care patient experience in collaboration with key stakeholders in the community. Such an effort will require partnership with organizations who are also impacted by and involved with these systems. Through these joint efforts, we can resolve to action on the issues highlighted in this report and work to improve the quality of the patient-provider experience.

This reported was prepared by the
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