

RESIDENTIAL CARE INITIATIVE IMPLEMENTATION GUIDE

Prepared by Ruthann Robinson, Practice Specialist, PSP Regional Support Team

Acknowledgments

The author is grateful for insights, first hand experiences, constructive comments and suggestions from Dr. Steve Larigakis, Eric Chi, Ken Becotte, Michelle Favero and Joan Rabillard.

Summary/ Overview

The General Practice Services Committee (GPSC) introduced the Residential Care Initiative (RCI) to improve care for one of BC's most vulnerable populations of patients. There has been a downward trend in the number of physicians providing services to seniors in residential care. And with the senior population growing larger, the GPSC is supporting local groups of physicians through the RCI to build local, scalable, and sustainable solutions. 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 RCI aims to ensure that each patient in a residential care facility has a dedicated GP Most Responsible Provider (MRP). The program goals have been stated as:

Five "best practice" expectations (physicians):

- 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

Program Funding

Similar to other GPSC programs, funding for this program is available for the planning phase as well as for the actual program operation, once an application has been approved.

Goal/Aim of the Guide:

Building on the experiences and lessons learned in the 3 prototype programs in our region (FH), provide a flexible framework for RCI implementation that can be adapted to the unique circumstances of each Division, as local solutions are developed in collaboration with GP providers, Residential Care partners, FHA and the PSP Regional Support Team.

For details on the RCI and the Request for Planning Funding (template) go to:

<http://www.gpsc.bc.ca/family-practice-incentive/residential-care>

Note that an RCI Education Guide is also planned.


6 Steps to Implementation

Each section of this guide outlines the possibilities to consider and decisions that must be made in the development and planning of a local residential care solution. Key areas of consideration are highlighted and examples from the prototype communities are provided. At the end of each section one or two key milestones are identified. These milestones can be used to build momentum and monitor progress. The steps are:

1. **Creating a Vision**
2. **Developing the MOU (“the plan”)**
3. **Articulating local Roles & Responsibilities**
4. **Engaging Stakeholders**
5. **Implementing the new RC Model**
6. **Sustaining the Change**

1. Creating a Vision

This work usually begins with a small group of key stakeholders (defined locally – could be Residential Care GP Lead, DoFP project lead, Medical Director, one or two residential care directors and interested GPs) coming together to develop a draft outline of a possible service model for residential care support.

Action Item	Description	Resources
A)	<p>Hold one or more discussions to review current state and create vision of for new local residential care program:</p> <ul style="list-style-type: none"> ○ Current landscape/practice – How many beds and residents? ○ What’s working well? ○ Who provides care now? ○ Where are the challenges/issues/gaps? E.g. Many physicians visiting one site to provide care to a number of patients – could there be a way to enhance efficiency ○ What is the vision for the future of residential care in your community? ○ How would you see it being supported? ○ How do you see your local solution meeting the five best practices? 	<ul style="list-style-type: none"> ○ Review MOU template to see what level of detail will be required in your proposal (link to the web page is on Page 1 of this document) ○ Review lessons learned and successes from FH or Provincial prototypes to see what others have done (see Appendix A) ○ Additional RCI information from non-FH prototypes, etc. may be found on Div IT.
B)	<p>Communicate results of A) with the rest of your community stakeholder group (e.g. GPs interested in providing service to residents, residential care directors)</p> <ul style="list-style-type: none"> ○ Explain how the new service will work, including compensation & potential FFS billing ○ Usually done via in-person meeting ○ May also be supported by email, etc. 	<ul style="list-style-type: none"> ○ Example from TORCH for billing guidelines <div style="text-align: center;">  <p>Residential Care Billin Guide May 19 2015 TC</p> </div>
C)	<p>Deepen engagement :</p> <ul style="list-style-type: none"> ○ Engage GP(s) who are not yet committed to the process ○ Hear their concerns and address them out on a one-on-one basis ○ Ally yourself with them and ask them to contribute to the vision of the project ○ Involve them as an unofficial "advisor" 	

Milestone: Validation of the new RC service model by the larger stakeholder group. This will provide the foundation of MOU development.

2. MOU Development & Submission

At this point, using the MOU template (see the RCI web page referenced on page 1), it should be possible to document your local plan to provide residential care. Once completed the plan is to be submitted to the Regional Medical Director for approval:

Dr. Larry Gustafson

Regional Medical Director, Residential Care
Fraser Health - Corporate Office
Suite 400 - Central City Tower
13450 - 102nd Avenue
Surrey BC V3T 0H1
Phone: 604-587-4483 x 765758
Fax: 604-587-7882
Cell: 604 613-3541
E-mail: larry.gustafson@fraserhealth.ca

For a completed example see Appendix B.

Milestone: MOU and local service model for residential care is approved.

3. Articulating Local Roles & Responsibilities

Taking the time to complete this step creates clarity and builds partnership as implementation is planned, launched and sustained. Sharing this information is a helpful step in the engagement process.

Role	Responsibility
GP Res Care Lead	Provide direction, liaise with other GP's
GP participants	Provide enhanced medical care to residential care patients/sites
Fraser Health	HA's are responsible for collaborating with local Divisions, removing systemic barriers, and helping refine the local solution
Residential Care on-site Point Person - Nursing Director of Care or Administrator	Work in collaboration with GP's to provide enhanced patient care; Communicate changes & provide updates to staff and families
Residential Facility Care Staff	Work in collaboration with GP's to provide enhanced patient care
Divisions/Self organizing groups	Design and implement local solutions for RCI e.g. scheduling, manages funding, may use a project coordinator to support this work
PSP Regional Support Team	Supports the DoFP through development & implementation of new service (e.g. facilitates planning process, assists with development of education (SGLS), related practice & quality improvement, etc.)
Patient Families	Participates in care meetings
Hospital (Emergency Departments & In-patient)/Fraser Health	Facilitates transitions in care (e.g. Process for admission/discharge), Collaboration/communication

4. Engaging Stakeholders

Creating awareness through a variety of communication methods is an important step. Physicians, residential care staff, local hospitals & Fraser Health leadership, clients & families and the community all need to know why this change is happening and how it will impact them. Armed with this knowledge, people can begin to recognize their role in supporting the changes and what to expect. New relationships emerge; partnerships are strengthened and as a result when bumps occur along the way people know who to reach out to for resolution.

To support engagement, a Key Messages document (i.e. “what’s in it for me”) for each major stakeholder group can be found in Appendix C. This document can be edited as appropriate.

Also, a link to a Key message video [RCI Key Messages](#) which may be helpful to support engagement events.

Stakeholder Group	Objectives:	References /Links /Resources Skills development
Division Leadership (Board, key working groups, etc.)	<ul style="list-style-type: none"> To create understanding of vision and purpose of Residential Care Initiative (RCI) Recruit interested physicians for participation Liaise with the Physician Residential Care Lead Understand the steps/planning for implementation; provide infrastructure Understand the role Division will play as leader in the initiative Highlight the five best practice expectations and three system level outcomes 	DoFP partnership with PSP to lead SGLS/workshops for GP’s and residential care teams.
Physicians: Note: applies to physicians already active with res. care responsibilities and for those physicians who have agreed to work in the new RC program or for new physicians who may be interested in participating.	<ul style="list-style-type: none"> Understand what the change and shift in approach will mean for the GP’s, residential care staff, local DoFP and ultimately residents. Understand how can they be involved and/or support the initiative Create awareness of communication flow Identify process for care planning Use best practice for polypharmacy Awareness of funding model (key consideration) Participate with education opportunities as they arise 	FAQ RCI Workshops for residential care staff and physicians (PSP could coordinate/facilitate in partnership with DoFP) Rounds Hallway conversations in the moment DoFP to lead this with GP’s
Residential Care Team	<ul style="list-style-type: none"> Understand what the change and shift in approach will mean for the GP’s, residential care staff, local DoFP and ultimately residents. Create awareness of communication flow Identify process for care planning Use best practice for polypharmacy Participate with education opportunities as they arise 	FAQ RCI Workshops residential care staff and physicians (PSP could coordinate/facilitate in partnership with local DoFP) Rounds Hallway conversations in the moment
Local Hospital & Fraser Health leaders e.g. transfer to/from ED guidelines	<ul style="list-style-type: none"> To develop/have clear processes To create strong partnerships 	workshops, SGLS (PSP could coordinate/facilitate in partnership with local DoFP)

Maintaining Communication

Communication efforts don't end with successful engagement. To maintain & further strengthen support from key stakeholders, communication must continue through implementation and sustainment. Key considerations:

Phase	Communication highlights:	References /Links /Resources Skills development
Implementation	<ul style="list-style-type: none"> • Strong planning and timelines identified • Engage others in understanding & supporting quality improvement (and tracking success) • Share lessons learned & success from prototypes 	
Sustainment	<ul style="list-style-type: none"> • Incorporate feedback & continue to improve • Track & share outcomes measures • Celebrate successes • Maintain momentum with education and sharing 	May be suitable for SGLS or other PSP supported learning

Milestone: Awareness achieved at all levels of leadership including those participating in front line delivery of care; having clients and families of aware of the changes and are involved in the activities of care planning.

5. Implementing the New RC Model

Implementation is more than just “informing” people of changes. A successful implementation allows any person working on the program to fully understand the goal of the program and how it is to be accomplished. This ensures that everyone working on the project is on the same page and any discrepancies are resolved before they become costly to the project. What follows is a guide to key activities; the time required to meet objectives and integrate the desired service solution.

Preparing for Implementation - Key Activities	Possible Time Line led by DoFP	Persons responsible
Identify project implementation lead; possible participants – GP's; Residential Care point person (nursing manager/lead); DoFP point person	Wk. 1-2 or Month 1	Division Lead or designate
Confirm participation of GP's and draft scheduling/plan -will GP's be assigned by site/#'s of patient e.g. 20 -will 24/7 coverage be a centralized call number with GP rotation or using a current on-call rotation	Wk. 3- 4 or Month 2	Division
Orientation/Awareness/review key desired expectations/outcomes with key stakeholders – anticipate this would include GPs' and local residential care staff – promotes collaboration and sustainability	Wk. 5- 6 or Month 3	Division and PSP using SGLS workshops
Supporting Implementation		

Launch <ul style="list-style-type: none"> decide on the day to begin communication of this to GP's and residential care facilities 	Wk. 7- 8 or Month 4	GP lead/Res Care Nursing Director/Division
Communication to families so they are aware of upcoming Care conferences	Consider timing - suggest early & ongoing.	Residential Care Director

Milestones: This would depend on key activities; decided by the local division and team delivering the new service model. Were the timelines met as planned?

6. Sustaining the Change – moving forward

The most successful implementations are ones that include plans for sustaining the changes, thus avoiding deterioration of systems and processes over time. Successful organizations take time to capture lessons learned and to celebrate and share success stories with their membership and beyond.

Building education learning opportunities across GP's, sites and local care teams is a key to sustaining change and will help develop and reinforce best practices as well as stimulate innovation in residential care delivery.



















Sustaining the Service	Time line - decided by DoFP	Resources
Maintain call schedule	ongoing	GP RC lead, DoFP, local participating GP's
Learning & Sharing sessions - What may need to change or be adjusted?	Wk. 9-10 or Month 5	GP RC Lead, DoFP, PSP via SGLS or other
Learning, Sharing & Education – regular opportunities to connect (e.g. polypharmacy updates; best practice for care of the elderly; PSP End of Life Module, etc.). Will be division-specific. Note: Highly recommended to set aside a portion of funds from each bed allocation for education and skill development	Monthly; every six weeks; bi monthly; quarterly (a regular commitment/ planned activity)	GP RC lead, DoFP, PSP via SGLS or other Provincial Education Hub with resources UBC Cont. Prof. Dev.
On-going recruitment of GP's	ongoing	Current GP's who may share their experiences; DoFP
Regular scheduling of visits and case conferences	ongoing	GP and Care Facility
Partnership with local hospital	ongoing	DoFP, GP RC Lead, FHA
Monitoring Outcomes	ongoing	DoFP, GPSC, FHA
PDSA review and continuous improvement	ongoing	DoFP/GP RC Lead possible support by PSP

Milestones: Celebrating the successes; sharing the successes and stories - hearing stories of the difference it made to a GP, a client and their family; adjusting the service as/when necessary (quality improvement). Completion of regular education activities in partnership with Residential Care Lead, PSP or other identified resources. New ideas are introduced and considered.

Appendix A: Successes/lessons learned from Prototype case studies

Key Successes	Key Lessons learned
<ul style="list-style-type: none"> Build partnerships with local ER department and physicians.(ABB, CHWK, SOS) 	Take a systems approach; involve as many of the stakeholders as possible; communicate with other attachment communities; look at other DoFP proposals. Maintain a proactive relationship with your health authority, keep a continuous dialogue going, leverage partnerships (PG, SOS, ABB, CHWK)
<ul style="list-style-type: none"> Education and skills development 	Set aside a portion of funds from each bed allocation for education and skill development
<ul style="list-style-type: none"> Demonstrating value of time commitment through billing spread sheet (ABB) 	Grouping patients and time for site visits to 3-4 hours was more cost effective for both GP and facility (CHWK, ABB)
<ul style="list-style-type: none"> “A solution to problems around physician-facility communications was also found. This involved the implementation of the SBAR Technique (Symptoms, Behaviour, Assessment, Request) for facility staff.” (PG, SOS) Have education workshops with GP’s and residential care staff to build partnerships/communication(PG, CHWK) Case study conversations (PG, ABB, 	<ul style="list-style-type: none"> Having strategies to bring the GP and residential care staff together was essential to success. (CHWK) “Helped staff understand how doctors think and how they like to receive information” (PG) Ongoing education support is key (CHWK, WRSS, SOS)
<ul style="list-style-type: none"> Have equipped exam rooms and equipment. E.g. suture kits/ECG machines (SOS; PG 	<ul style="list-style-type: none"> GP better able to do proper exams and provide best service – reduces need to visit ER
The pre-existing “Doctor of the Day” inpatient program at the Penticton Regional Hospital (“PRH”) was extended to have the DoD attend residential care facilities as needed to provide care outside of MRP office hours. The DoD is provided an extra \$250 per day for this added responsibility (SOS)	<ul style="list-style-type: none"> Be open to innovation and building on current success. (SOS, PG, ABB)

GPSC Residential Care Initiative Comparison Table – Prototype Projects

	Penticton/ Summerland	White Rock – South Surrey	Chilliwack	Prince George	Abbotsford
Medical Lead/Coordinator					
MRP Funding separate from call					
24/7 Call funded					
Facility improvements (physical space, communications)					
Education					

Appendix B: Additional Resources

- **Structures/ways to Achieve 5 Best Practices (Victoria)**



Ways to achieve 5
Best Practices.pdf

- Educational videos from the TORCH program in Victoria i.e. https://youtu.be/r_O4VodCW0s
- Geriatric Prescribing App from the White Rock-South Surrey Division of Family Practice <https://goo.gl/mmHw3a>
- Drug Stopper program by Allan Cassels
- Polypharmacy Risk Reduction sessions throughout the province run by Keith White and Shared Care
- UBC Department of Geriatrics Rounds Video Archive, <http://geriatrics.med.ubc.ca/archived-rounds.php>
- [White Rock-South Surrey Division of Family Practice's Memorandum of Understanding](#)

Appendix C: Key Messages to Support Engagement

For Physicians/Divisions



Key Message GP RCI
v1 Aug 2015.docx

For Residential Care Staff/Patients



Key Messages Res
Care Staff and Patient

General



RCI One Pager
GP.docx