TORCH
Towards Optimal Residential Care Health

TOWARDS OPTIMAL RESIDENTIAL CARE HEALTH (TORCH)

A Victoria Division of Family Practice: A GP for Me Initiative

FINAL EVALUATION REPORT

April 2016

Victoria Division of Family Practice
A GPSC initiative

BRITISH COLUMBIA

doctors of bc

GPSC
General Practice Services Committee

REICHERT & ASSOCIATES
PROGRAM EVALUATION & RESEARCH

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Abbreviations & Acronyms

AHP	Allied Health Provider
CME	Continuing Medical Education
GP	General Practitioner
GPSC	General Practice Services Committee
IHA	Island Health Authority
LPN	Licensed Practical Nurse
MOA	Medical Office Assistant
MRP	Most Responsible Provider
NP	Nurse Practitioner
RAI	Resident Assessment Instrument
RCI	Residential Care Initiative
RN	Registered Nurse
SP	Specialist Physician
SW	Social Worker
TORCH	Towards Optimal Residential Care Health
VDFP	Victoria Division of Family Practice

Executive Summary

This is the final evaluation report for the Victoria Division of Family Practice's (VDFP) Towards Optimal Residential Care Health (TORCH) initiative. The TORCH initiative was a pilot project that operated between January and December 2015 and is a component of the Division's A GP for Me initiative. The evaluation was designed to operate in alignment with the activities of the project, and comments on the initiative's operations, processes and outcomes relative to its stated goals and objectives.

Evaluation Methods

The evaluation used a mixed methods approach to obtain information from a variety of sources and key stakeholders. Information sources included Ministry of Health Resident Assessment Instrument (RAI) data, patient chart reviews, and administrative data collected by the project team. Key informants were involved in surveys and interviews, and included TORCH physicians, patients, caregivers, facility and Island Health staff, as well as project staff. The inclusion of multiple lines of evidence increases the reliability and validity of the findings, and ensures the evaluation is reflective of the experiences of all stakeholders.

Evaluation Findings

Organization and Operation of the Project

The TORCH project operated within the scope of the Victoria Division's larger A GP for Me initiative. The project was overseen by an advisory committee consisting of GPs, facility representatives, Island Health residential care services, and resident/family experience advisors. In addition, regularly scheduled meetings were planned to invite feedback from participants and engage stakeholders. Generally, the evaluation found that the project was organized and operated in a way that was consistent with the stated goals and objectives.

Implementation

TORCH was prototyped by 19 physicians in four care facilities in Victoria between January and December 2015. Evaluation findings indicate that the model was implemented as planned, which encompassed:

- GPs becoming the most responsible provider (MRP) for at least 20 patients in a single facility (or groups of 20 in more than one facility).
- GPs visiting that facility once per week.
- GPs becoming part of a network of care providers.
- Additional funding available to integrate GPs into the facilities.
- GPs receiving education on caring for patients in residential care.

Outcomes

1. **Increased attachment and improved continuity of care for patients in residential care, most of whom are frail older adults:** TORCH physicians cared for 356 residents across four residential care facilities. Of those residents, nearly 50% (176) were complex, newly attached patients. Through weekly facility visits, TORCH GPs provided regular, proactive patient care. According to facility chart

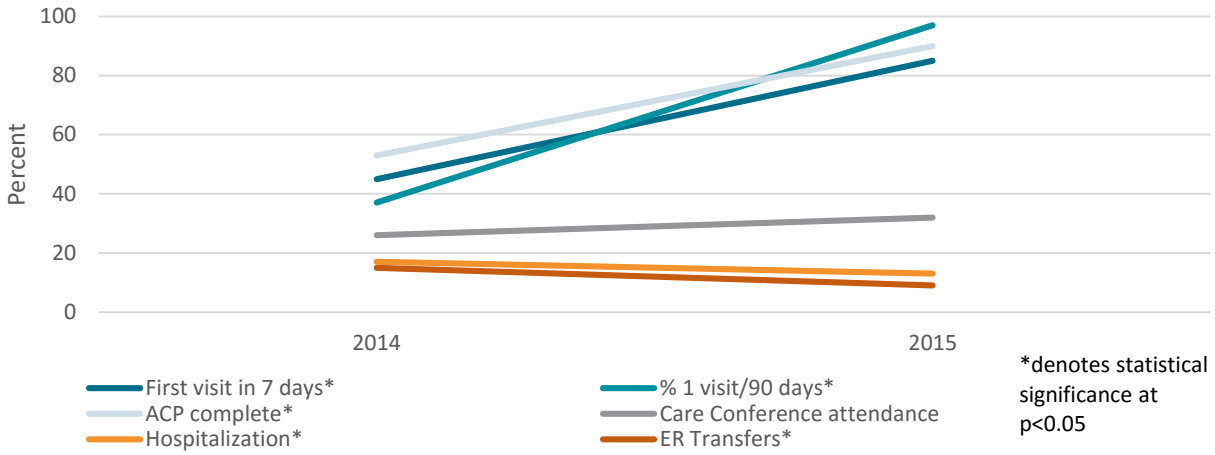
reviews, the percentage of patients with at least one visit per 90 days increased from 37% prior to TORCH to 97% with TORCH. In addition, there was a statistically significant decrease in the percent of residents with 1 or more hospital stays and 1 or more emergency department visits after TORCH was implemented (Fig. 1).

2. Both physicians and residential care staff reported **improved collaborative and team-based care.** One nurse shared, "*We get an opportunity to ask questions when the [doctors] are here. There's more communication with the patients, families, nursing, all around. Holistically, it works great."* Physician survey data revealed that physicians always or often feel that they are part of the care team, and 93% of GP survey respondents (14 of 15) indicated that they always or often work with nursing staff to prioritize care.

3. **High quality of care provided by GPs in residential care facilities: GPs are meeting or exceeding provincial standards.** As part of the GPSC's Residential Care Initiative (RCI), five best practice expectations have been outlined. The extent to which TORCH met these criteria are outlined in the following table:

Provincial Standard	Evidence
24/7 availability and on-site attendance when required	• Call schedules were organized for each facility to enable 24/7 coverage • GPs visited the sites at a regularly scheduled time once per week • Most days of the week a TORCH physician was onsite
Proactive visits to residents (i.e. regular visits to residents)	• Percentage of patients with at least one visit from a GP in 90 days increased from 37% to 97% • Percentage of first GP visit within 7 days of admission increased from 45% to 85% • Average number of days from admission to first GP visit decreased from 25 to 5 days
Meaningful medication review	• Anecdotal evidence indicates that GPs are more involved in reviews: "*In some situations with patients, there are decreased medications because the doctors are doing medication reviews as part of their commitment with TORCH. Meaningful medication reviews, not just signing off on a 6-month review, and looking at each patient as an individual."* – Social Worker
Completed documentation (i.e. medical summaries/ ACPs)	• Completion of Advance Care Plans that were signed by a physician increased from 53% to 90% of patients
Attendance at care conferences	• Significant adaptation is occurring within care facilities to improve ability for GPs to attend conferences • A modest increase (6%) more GPs were able to attend care conferences since TORCH was implemented

Fig. 1 - Changes in Key Indicators



4. Patients, family caregivers, physicians and facility care staff all **reported high levels of satisfaction with the model**. Specifically, patients and their caregivers rated the care received from TORCH physicians highly (8/10 from patients, 9/10 from caregivers). Physicians rated their experience with the TORCH model as 8.75/10. Interviews with facility staff and managers revealed high satisfaction as well, in particular with regards to streamlining the admissions process, and reduction in stress for allied health and nursing staff who now have easier access to physicians.

5. Lastly, the project has worked towards **developing a sustainable model of care.** Although the TORCH pilot project is complete, TORCH GPs continue to provide care to residents at Glengarry, Gorge Road Hospital, the Heights at Mt. View and Kiwanis Pavilion. In the evaluation process, key stakeholders generally indicated that the model is sustainable.

Discussion & Conclusion

Factors that contributed to the success of the project included having a collaborative approach, gaining strong commitment from stakeholders, and developing a supportive, learning focused environment. The project faced challenges in the early stages of implementation with patient recruitment and integration of GPs into facilities, as well as deciding upon the core TORCH processes. Considerations and opportunities identified by key stakeholders include: expanding the “team”, providing additional education sessions, supporting quality improvement and increasing communication with all stakeholders about the future of TORCH.

This report concludes the prototype of the TORCH initiative in Victoria. The evaluation found that the project was organized and operated in a way that was consistent with its goals and objectives. Evaluation findings indicated that the TORCH model effectively supported physicians to be a consistent presence in residential care facilities, leading to increased team-based care as well as improved quality and continuity of care for residents. Furthermore, the model has been met with high satisfaction among key stakeholders, and can be feasibly sustained going forward.

Introduction

This is the final evaluation report for the Victoria Division of Family Practice's (VDFP) TORCH initiative. The TORCH initiative was a pilot project that operated between January and December 2015 and is a component of the Division's A GP for Me initiative. The evaluation was designed to operate in alignment with the activities of the project, and comments on the initiative's operations, processes and outcomes relative to its stated goals and objectives.

Organization of the Report

1. "About the Victoria Division of Family Practice's TORCH Initiative" provides a brief overview of the Victoria Division's TORCH project, including details of the TORCH model, the overall goals, and key stakeholders involved in the project.

2. "About the Evaluation" describes the scope of the evaluation, the main questions that the evaluation was designed to address, and the evaluation methodology. This section outlines the data collection methods that were used and describes the data collection and analysis process, as well as the evaluation's limitations.

3. "Evaluation Findings" are organized into three sections: 1) organization and operation; 2) implementation; and 3) outcomes, which are measured against the project's original stated goals.

4. "Discussion" addresses the strengths of the project, challenges faced, and lessons learned as well as considerations and opportunities for the future.

About the VDFP's TORCH Initiative

Project Overview

The Victoria Division of Family Practice (VDFP) is a community-based organization established in 2011 that represents family physicians in Victoria, BC. The purpose of the Division is to bring together local physicians and partners from the community, specialists, and Island Health Authority to identify local health care needs and work collaboratively to develop and implement solutions.

In 2013, the Division embarked on a study to understand challenges and gaps in local residential care. The study was instigated by observations from physicians and medical coordinators of challenges in providing care in residential facilities. Research methods utilized by the study included surveys of residential care physicians, a review of existing literature and the identification of alternative models of service delivery from elsewhere in BC and Canada. To this extent, the Division sought both evidence-based best practices, and then validated findings with practice-based evidence from local physicians. The study's findings identified key barriers experienced by GPs with patients in residential care, including:

- Geographic distribution of residential care facilities;
- Issues with remuneration;
- Call and locum coverage challenges; and,
- GPs' level of confidence in providing care to residential care patients.

Project Goals

The stated goals of the TORCH model were to:

1. Increase attachment and improve continuity of care for patients in residential care, most of whom are frail older adults.
2. Improve collaborative and team-based care.
3. Provide high quality of care by GPs in residential care facilities – i.e., GPs are meeting or exceeding provincial standards
4. Develop high levels of patient and provider satisfaction with the care model.
5. Develop a sustainable model of care.
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To address these barriers and therefore, to improve the sustainability of care to patients residing in residential facilities, the project proposed three interconnected solutions:

1. Implement a **Concentrated-Care Network service delivery model prototype** called TORCH, based on a concentrated service delivery structure that includes patient grouping at facilities, regular facility visits, and meeting existing Island Health residential care quality standards, plus additional Network standards.
2. **Incentive-based accountability framework** that encourages consistent, longitudinal care and accountability to quality standards.
3. Residential care **professional development program** to support current and future Network physicians to more confidently and competently address this population's complex medical needs.

Key Stakeholders

The key stakeholders that were involved in the TORCH project included:

- Local GPs
- Residential care staff, including Directors of Care, NPs, RNs, LPNs, SWs, and administrative staff
- Patients and their families
- Island Health Authority

About the Evaluation

Generally, the evaluation was designed to provide both formative and summative information about the project. That is, it provided an opportunity to learn about the effectiveness of operational processes as well as comment on the project's impacts as they relate to the stated goals and objectives.

Evaluation Objectives, Questions and Approach

The key objectives of the evaluation were to:

- Document and assess how the project is organized and operating.
- Identify the project's on-going data collection needs and work with staff to develop workable processes for addressing them.
- Identify and assess how the program goes about successfully engaging stakeholders and assess stakeholder impact and satisfaction with the project.
- Identify indicators of the project's impacts from the perspectives of project stakeholders, including project staff, Family practice physicians from Victoria Division of Family Practice (VDFP), Staff at residential care facilities, Directors' of care, patients, and Island Health representatives who have had significant contact with the project.
- Assess the project's short and medium term outcomes according to available information.
- Assess the program's overall strengths and challenges as well as identify developmental opportunities (including sustainability and spread) and analyse ways in which challenges can be addressed, and strengths and opportunities can be built upon.

Based on the objectives, the **primary questions that the evaluation team explored** included:

- How was the project organized and operated?
- To what extent has the project been able to identify and successfully engage stakeholders?
- To what extent has the project been implemented as planned?
- To what extent is the project achieving its planned results?
- What lessons does the project provide that could be used to improve patient care and efficiencies in other populations or locations?
- To what extent are the outcomes of the project sustainable?

Methods

The evaluation used a mixed methods approach, including both qualitative and quantitative data collection and analysis techniques, and obtained information from a variety of sources and key stakeholders. Methods included:

Administrative Data Review.

1. GP Billing Data: Billing data was tracked by TORCH GPs to assess billing patterns and physician remuneration. In total, 17 TORCH GPs submitted billing data between January and December 2015.

2. Residential Assessment Instrument (RAI) 2.0 Data[1]: accessed through the Ministry of Health. RAI data was reviewed to better understand the impact of the TORCH initiative on the facility and patient outcomes. The evaluation team reviewed data between January 2014 - December 2015.
3. Call Data: The project assistant maintained a record of how many calls physicians received when they were the physician on-call. Data was reviewed to assess the number of after-hours calls. Call data was monitored between January and December 2015.

Chart Review. Chart audits were conducted at each of the four participating TORCH facilities. The purpose of the chart review was to assess a number of quality of care metrics as outlined by the residential care initiative and the impact of the TORCH model on patient care. In total, approximately 10% of TORCH patient charts were reviewed at each time period.

Document Review. The evaluation team reviewed and assessed the following project documents:

- TORCH Brochure/ Communication materials
- Victoria Residential Care Concentrated-care Network Service Delivery Model Proposal
- Other TORCH documents
- Meeting Minutes
- A GP for Me Quarterly Reports

Key Informant Interviews. The evaluation included a selection of telephone interviews with key project stakeholders. The purpose of the interviews was to capture the stakeholder's perspectives on the key project activities and the overall project including strengths, challenges and future priority areas. The format of the interviews were semi-directed and open-ended. Stakeholders were identified through a review of project documents and discussions with project staff. The interviews were conducted in February and March 2016, and lasted between 15 and 45 minutes.

Twenty-seven stakeholders were invited to participate and 21 interviews were conducted (78% response rate). In addition, caregivers who completed the online survey were invited to participate in a brief follow-up interview to assess the impact of the TORCH program on residents and caregivers. In total, 7 caregivers were contacted and 4 interviews were conducted, corresponding to a 57% response rate.

Stakeholder Group	# Interviewees
TORCH GPs[2]	5
Advisory Committee Members (non-GPs)	3
Project Staff	2
Facility Staff	
Managers	4
Care Providers (NPs, Social Workers, CNLs, pharmacists)	7
Caregivers (Family/ Friends of Residents)	4
TOTAL	**25**

[1] RAI data is collected by each care facility, and submitted to CIHI on a quarterly basis. Data includes a wide variety of indicators used to assess quality of care and overall patient health in residential care facilities.

[2] Physicians interviewed were provided a half hour sessional payment to participate. 2 of the 5 GPs were also members of the Advisory Committee.

Surveys.

1. A *physician survey* was developed and distributed to 19 TORCH GPs to assess physician satisfaction with the TORCH model. The survey was available online. There were a total of 15 responses, corresponding to a 79% response rate.
2. A *caregiver survey* was developed and distributed to caregivers (i.e. family or friend) of residents at each TORCH facility to receive feedback about caregiver satisfaction with the TORCH model. The survey was available online and in hard-copy. A total 68 surveys were received; of those who completed the survey, 39 caregivers' residents (57%) were in the TORCH program.
3. *A resident survey* was developed and conducted in person with residents at two care facilities (one private and one Island Health) to assess resident satisfaction with the TORCH model. There were a total of 16 responses.
4. *Post Event Surveys* were distributed at each of the TORCH education sessions. There were a total of 5 events and 104 completed responses.

Constraints and Limitations

Data for the evaluation came from several lines of evidence, including key stakeholder interviews, project documents, and administrative data. The inclusion of multiple lines of evidence increases the reliability and validity of the findings produced in any evaluation. However, limitations related to data collection include:

1. Billing data was not submitted from all GPs who participated in the TORCH model, and, some submitted forms were incomplete. As a result, findings from the billing data are calculated averages based on complete data forms, and are deemed to be reflective of the TORCH experience.
2. Chart reviews were conducted by four GPs who were able to access and report on information available in the patient's file. Limitations were identified in the ability to accurately report whether the patient's family physician had attended the care conference, and variations in documented advance care plans.
3. RAI data provides information about the quality of care across the entire facility, while TORCH GPs were responsible for approximately half of the residents at each facility. Therefore, the findings are diluted because not all patients experienced the same increase in physician involvement. In addition, the indicators measured by RAI are impacted by many factors other than physician involvement in care, including changes in facility processes/procedures, leadership/staff of the facility, and patient demographics, which all have a role to play in the quality of care experienced by patients.
4. Call data tracking was updated to include the time of the call in July 2015. Therefore, data for this measure was reported for July – December 2015. Data over Christmas holidays were also excluded, because physicians were on-call for 12 hour shifts (as opposed to 3-4 days).

In addition, limitations to qualitative data include the potential for response bias (i.e. social desirability bias, recall bias), in particular for interviews as many key stakeholders are closely involved with the project. This can make it difficult to be entirely objective and accurate when providing information. To mitigate this, a variety of stakeholders were asked similar questions to ensure that multiple perspectives were included when analyzing response data.

Evaluation Findings

Organization and Operation of the Project

The TORCH initiative was overseen by an advisory committee that included four GPs, facility representatives from each of the TORCH sites, the Island Health residential services medical director and operational director, and resident/family experience advisors. In addition, a project manager and project coordinator were hired to lead and implement the TORCH project and to work collaboratively with the advisory committee. Together, they represented a broad range of stakeholders and perspectives that were deemed essential to the successful implementation of TORCH.

Advisory committee meetings were chaired by the physician lead and project manager and held once every three months. Evaluation findings indicate committee members were satisfied with the structure and effectiveness of the meetings. As a committee member stated, "*The meetings were great. They were well run, and had a strong emphasis on open communication and respect."* In addition, advisory committee members agreed they felt like valued partners in the work. One steering committee member stated, "*I thought the steering committee meetings had great dialogue with a lot of ideas thrown around. I certainly thought I had a voice and everybody had a voice."*

To ensure active engagement in the project, regular engagement activities were organized for all stakeholders. For physicians and facility staff, quarterly meetings were organized between care providers across the four facilities and TORCH physicians. These meetings were designed to provide care providers with an opportunity to network and share ideas on areas for improvement. Interview data revealed providers valued the quarterly meetings because it provided them opportunities to hear about other experiences, and share stories between different TORCH care facilities. One interviewee specified, "*They were really good opportunities to check in and learn from other teams but the opportunity to meet all together was really great. I liked them – they were a great opportunity to meet together and find out what was and wasn't working."*

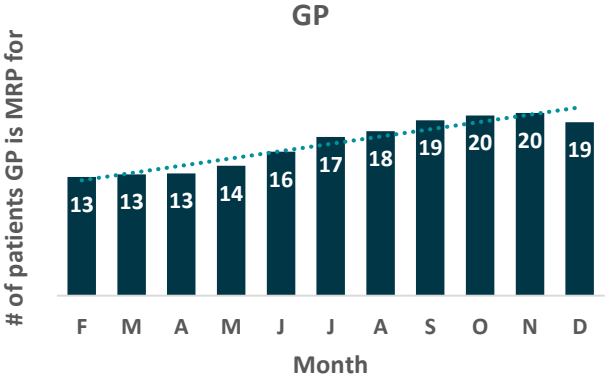
TORCH Implementation

TORCH was prototyped by 19 physicians in four care facilities (Glengarry, Gorge Road, Kiwanis Pavilion, and The Heights at Mount View) in Victoria between January and December 2015. Two of the facilities

were operated by Island Health, while the other two are private facilities. Evaluation findings indicate that the model was implemented as planned; the model included the following expectations:

1. **GPs become the most responsible provider (MRP) for at least 20 patients** in a single facility (or groups of 20 in more than one facility). Fig. 1 demonstrates that by October 2015 (9 months into implementation), the average number of patients for TORCH GPs reached 20.

Fig. 1 - Average # patients per TORCH GP



2. **GPs visit that facility once per week** at a scheduled time, during daytime hours. Fig. 2 details the actual experience of TORCH physicians, based on billing data submitted by GPs.

Fig. 2 - "A Day in the Life of a TORCH Physician"

- Visited the residential care facility once per week during daytime hours
- Average length of shift: 3 hours
- Average # of patients seen/shift: 12 residents
- Average earning: $159/ hour
- Provided cross coverage for other TORCH GPs approximately once per week
- Responded to calls or faxes from the facility once per week

3. **GPs become part of a network of care providers,** who support each other through shared after-hours coverage duties and daytime cross-coverage within the facility (Fig. 2). Call schedules were organized to further ensure 24/7 coverage of the facilities[3]. Moreover, TORCH GPs indicated that they felt part of a welcoming, collaborative team[4].

4. **Additional funding available to integrate GPs**: a limited number of sessional payments were available to GPs to integrate into the care facilities, including time to familiarize themselves with the processes and patients. Island Health also provided up to 18 hours compensation (sessional rate) per GP for otherwise unpaid clinical/ facility-based work during the start-up period.

5. **Provide education on caring for patients in residential care.** Six sessions were hosted, with topics included palliative care, symptom care, and Parkinson's disease. The majority of respondents indicated the content of the sessions better prepared them for clinical work in a residential care setting. In addition, the sessions increased the physician's confidence to provide care for patients in residential care.

[3] All physicians participated in the call schedule. On average, physicians responded to 2 calls while they were on call, and visited the facility every other shift (0.5 visits/shift). 79% of weekday shifts and 56% of weekend shifts experienced no calls.

[4] Physician survey, January 2016 – average score 4.4/5 for "Being part of a welcoming, collaborative team"

Overall, evaluation findings indicate the TORCH model was generally implemented as planned. One advisory committee member explained, "*I think the TORCH model is pretty much exactly where I'd like to see it go. It does require a commitment from the facility as well as from the physician but I think it has significantly increased medical care in those four buildings."* This was echoed by another committee member who shared that "*they have accomplished what they set out to accomplish and as far as I can tell, everyone is happy and I hope it continues."*

Outcomes: Achievement of Project Goals

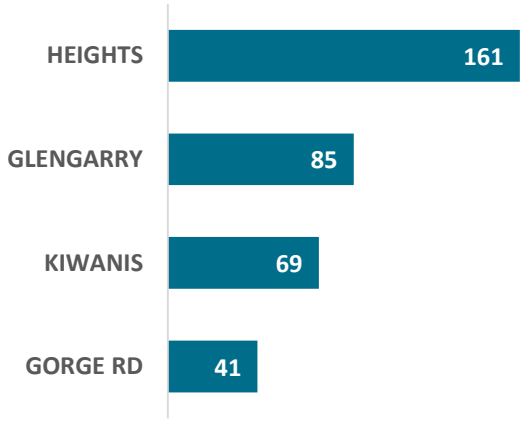
Overall, evaluation findings indicate the stated goals of the project were achieved:

- ✓ Increase attachment and improve continuity of care for patients in residential care, most of whom are frail older adults.
- ✓ Improve collaborative and team-based care.
- ✓ Provide high quality of care by GPs in residential care facilities – i.e., GPs are meeting or exceeding provincial standards
- ✓ Develop high levels of patient and provider satisfaction with the care model.
- ✓ Develop a sustainable model of care.

Increased attachment and improved continuity of care for patients in residential care, most of whom are frail older adults

The evaluation found that physicians who were involved in the prototype provided care for 356 residents across four residential care facilities in the Victoria region[5]. Of those residents, nearly 50% (176) were complex, newly attached patients.

Fig. 3 - # of TORCH Patients by Facility



Through scheduled, weekly facility visits, TORCH GPs were able to provide regular, proactive patient care to residents. According to a review of chart data, the percentage of patients with at least one visit per 90 days increased from 37% prior to TORCH to 97% with TORCH. This means that patients are receiving regular check-ups, which can allow the earlier identification of health problems that may negatively impact a residents' quality of life. A physician confirmed, "*We can catch things before they get too big."*

[5] Data current to December 31, 2015. See Fig. 3.

Improved continuity of care was also evident in Ministry of Health data,[6] which revealed that there was a statistically significant decrease in the percent of residents with 1 or more hospital stays and 1 or more emergency department visits after TORCH was implemented (Fig. 4+5). Reducing unnecessary hospitalizations is beneficial to both patients and the medical system, as transfers can be disruptive and confusing for frail patients, and costly to the system.

Fig. 4 - % Patients with at least one ER visit

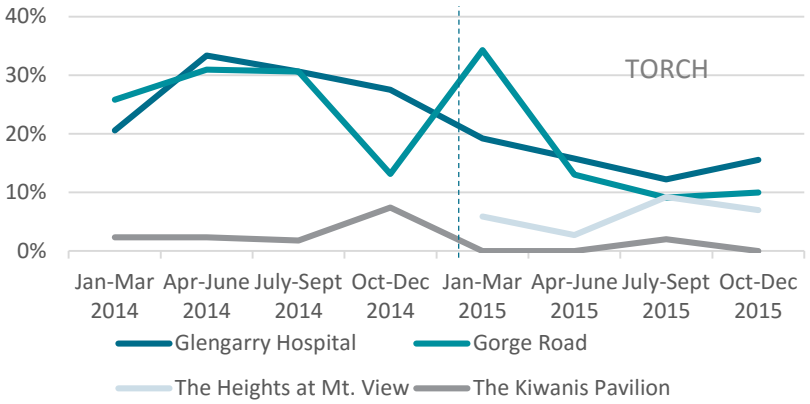
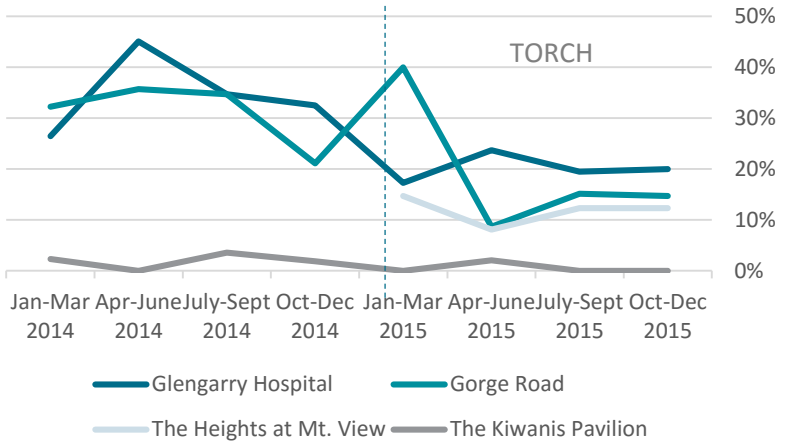


Fig. 5 - % Patients with at least one hospital stay



Are patients receiving proactive care?

"Patients are getting much more comprehensive care. They don't have to wait and we don't have to try and diagnose over fax anymore" – Nurse

"GPs are available so issues are being dealt with, and questions are being answered. There's better communication with families. It is a very noticeable increase in physician involvement in facilities. Staff have someone to turn to, and are dealing with issues proactively than something in the middle of the night." – Facility manager

"We've been able to reduce potential situations that ended up in the emerg[ency department]. For example, we've identified skin cancers and gotten them treated." - GP

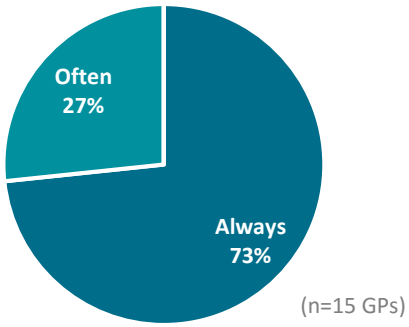
A physician shared an example of a prevented hospital admission: "*I had a patient who they thought had a stroke. I went in on a day that wasn't my regular shift and it ended up that [the patient] actually had a terrible infection. They trusted me to come in, I came in and saw the patient and called the family. We came up with a plan on how to treat the patient and we all understood where we were at. The patient didn't go to the hospital. If the staff would have called a different physician, the patient would've ended up in the ER. It would have required a trip to the hospital. There's a different level of expectation on ourselves that we will provide that service so that patients don't get transferred to the hospital unnecessarily.*"

[6] RAI data is collected by each care facility, and submitted to CIHI on a quarterly basis.

Improved collaborative and team-based care

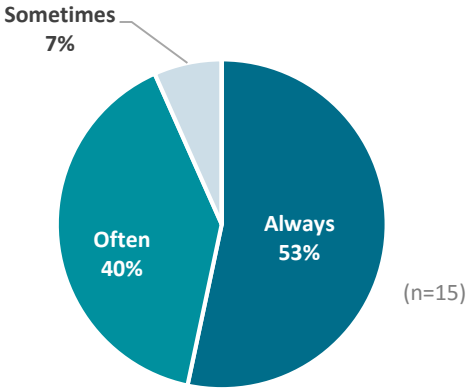
Information gleaned from interviews with both physicians and residential care staff indicates that there have been improvements in collaborative and team-based care as a result of the initiative. This was a key goal of the TORCH project, as a collaborative approach has been documented to improve quality of patient care. A nurse confirmed, "*We get an opportunity to ask questions when the [doctors] are here. There's more communication with the patients, families, nursing, all around. Holistically, it works great.*"

Fig. 6 - How often do you feel included in the care team?



Physician survey data revealed that physicians also feel that they are part of the care team (Fig. 6), and 93% of GP respondents (14 of 15) indicated that they always or often work with nursing staff to prioritize care (Fig. 7). A contributing factor to these findings is that GPs also generally find facility staff to be responsive to requests, enabling them to participate in team-based care.

Fig. 7 - How often do you work with nursing staff to prioritize care?



Interviewees further indicated that the increase in team-based care is having a positive impact on patients. A TORCH GP stated, "*For patients, it is just better care. There are so many people [patients can] bring their concerns to, so many people have their eyes on them and a well-rounded perspective on the patients needs when people are communicating that well.*" Similarly, one pharmacist stated, "*Issues are not left unresolved. There's quicker response, better relationships and mutual respect. And improved teamwork between physicians and pharmacists.*"

TORCH GP on Using a Team-based Care Approach

"There was a patient who I thought had Parkinson's so I treated him with Sinemet. The team noticed the patient was becoming more delusional so they convinced me to try tapering him off the medication so I did and his delusions decreased. Then, he reported some shoulder pain so we tried him on some tramadol but a couple of days later, he was struggling to move his arms. The team suggested he go back on Sinemet for his Parkinson's but I wasn't sure it was making a difference so we got a geriatrician to look at him. We realized as a team that the patient had a stroke. We were willing to have a discussion to get the best care for the patient. Like all good teams, we settled on a better answer than what we could have come up with on our own. NPs, care aides, nurses, the geriatrician and I were all on the team. The patient is doing well now – his symptoms have subsided."

Provided high quality of care by GPs in residential care facilities: GPs are meeting or exceeding provincial standards

An analysis of findings indicates that GPs within the TORCH program are meeting or exceeding provincial standards for quality of care. As part of the GPSC's Residential Care Initiative (RCI), five best practice expectations have been outlined.[7] These include:

- 24/7 availability and on-site attendance when required
- Proactive visits to residents (i.e. regular visits to residents)[8]
- Meaningful medication reviews (i.e. upon admission and every 6 months after)
- Completed documentation (i.e. medical summaries and ACPs)
- Attendance at care conferences

 **Achieved**

 **Improving**

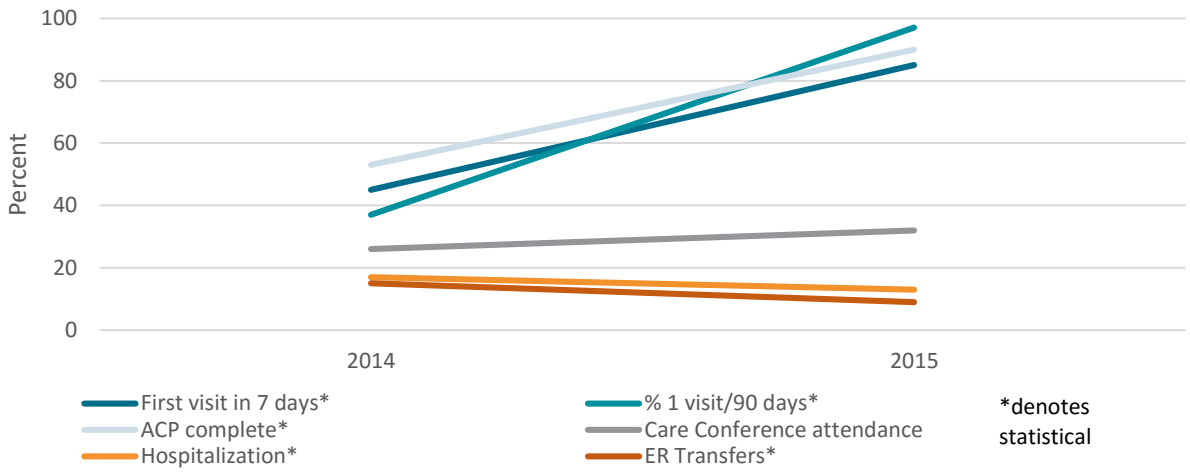
Table 1: Scorecard (See Fig. 8 for graph)

Provincial Standard	Score	Evidence
24/7 availability and on-site attendance when required		• Call schedules were organized for each facility to enable 24/7 coverage • GPs visited the sites at a regularly scheduled time once per week • Most days of the week a TORCH physician was onsite
Proactive visits to residents (i.e. regular visits to residents)		• Percentage of patients with at least one visit from a GP in 90 days increased from 37% to 97% (Fig. 8) • Percentage of first GP visit within 7 days of admission increased from 45% to 85% • Average number of days from admission to first GP visit decreased from 25 to 5 days
Meaningful medication review		• Anecdotal evidence indicates that GPs are more involved in reviews: "*In some situations with patients, there are decreased medications because the doctors are doing medication reviews as part of their commitment with TORCH. Meaningful medication reviews, not just signing off on a 6-month review, and looking at each patient as an individual.*" – Social Worker
Completed documentation (i.e. medical summaries and ACPs)		• Completion of Advance Care Plans that were signed by a physician increased from 53% to 90% of patients (Fig. 8)
Attendance at care conferences		• Significant adaptation is occurring within care facilities to improve ability for GPs to attend conferences • A modest increase (6%) more GPs were able to attend care conferences since TORCH was implemented

[7] GPSC Residential Care Initiative, 2015

[8] Defined by Island Health as a visit within 7 days of admission to long term care, and minimum one visit per 90 days

Fig. 8 - Changes in Key Indicators



**Denotes statistically significant differences at p<0.05*

Developed high levels of patient and provider satisfaction with the care model

Patient and Caregiver Satisfaction

Overall, findings indicate patients and their families are highly satisfied with the TORCH program. Of the 16 residents in the TORCH program who completed an in-person survey, all indicated they have seen their doctor when they needed to. In addition, the majority identified they felt like their doctor is part of their care team. Respondents were asked to rate the care they receive from their doctor on a scale from 1 to 10, from poor to excellent. The average rating was 8.1.

Residents' Comments on TORCH Program

"My doctor is very good, I've never had a doctor so good - he always asks about my puzzles. He comes every 2 weeks, very steady."

"I would like to see more like this. Doctor comes in on Friday, discusses any concerns. I'm very pleased with the doctors and connections here. I feel so happy here that if I need a doctor, I can get one. It is a great place. Anything that I have needed has been taken care of."

"He's new - the one before didn't come around very much. He talks to you."

"Come even more often - he comes on Thursdays. I'd like 2x/week."

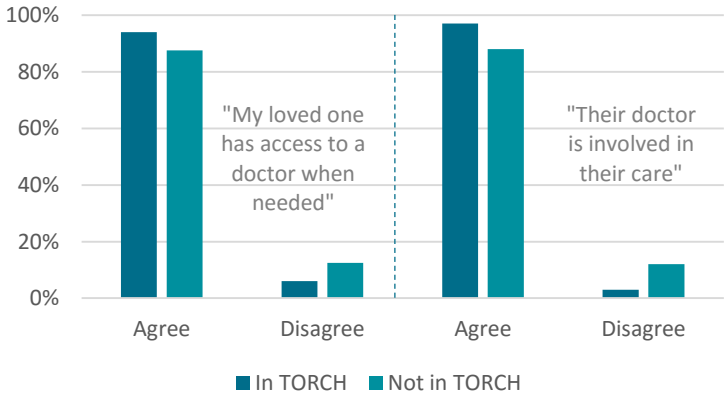
"I feel like they listen to what I am talking about."

Similarly, data from the caregiver survey demonstrated high satisfaction with the TORCH program. 39 of the 68 respondents (57%) had a loved one with a TORCH physician. The study revealed that 94% of these caregivers strongly agreed or agreed their loved one has access to a doctor when they need one (Fig. 9). In addition, 97% of respondents strongly agreed or agreed their doctor is involved in their care.

Caregivers were asked to rate the quality of care received from their loved one's doctor. On a scale from 1 to 10, where 1 is poor and 10 is excellent, the average rating of caregivers who had a loved one on the TORCH program was 8.6/10, compared to 6.3/10 for non-TORCH caregivers.

Many of the caregivers identified that the physicians are more accessible and it is more convenient to have the doctor on site. One caregiver stated the biggest difference of having a TORCH doctor care for their loved one is "*Quick access to a family doctor without having to leave the care home. Great comfort to family to know resident's doctor needs are taken care of. I like having complete medical records at the facility where the resident lives. Through the TORCH program, there is usually a doctor visiting everyday who can be called on to see any resident. Quick on site access to a doctor and continuity of doctor care if doctor's change."* Further, all of the respondents (n=14) indicated they would recommend the TORCH program to other patients and their families.

Fig. 9 - % caregivers who agree...



Findings from the interviews with caregivers revealed the TORCH program has also improved the well-being of the caregivers themselves. All of the caregivers interviewed agreed that the TORCH program has given them relief and alleviated some of the stress of caring for their loved one. As one interviewee stated, "*The biggest impact of TORCH is relief that I can step back and trust [my mom's] care. There is a lot less anxiety in my life."* This was echoed by another caregiver, who stated, "*The stress levels have gone way, way down. I was really stressed trying to deal with the doctors in emergency when my father-in-law had his stroke and trying to get a hold of his doctor. But now the stress is gone!"*

Caregiver Feedback About the TORCH Program

"Concerns are addressed and communicated in an efficient and effective way that keeps me informed too. Also, as a caregiver without a car and with my own extreme health challenges, this is so much better for me and the resident."

"It is great to have regular access to a doctor who is a part of the healthcare team."

"There is more attention to the resident's weekly needs as they go through rapid changes at times. The doctor is able to monitor their needs and address them."

"Would definitely recommend the TORCH program. Doctors are available immediately if there are any emergencies and can keep the family informed of any health issues of the patient."

"Very convenient to have the doctor there and not have to make appointments elsewhere."

Case Study - A Caregivers Relief

Providing care to patients in residential facilities can be geographically challenging and stressful for family physicians as well as families and patients. Prior to TORCH, Dr. Gerry described himself as a typical GP, only able to provide haphazard service to residential facilities. Care sometimes didn't reach patients in a timely manner, and it was stressful for him to realize "*I have to go see those patients!*" Or worse, to get a call or fax that a patient was in trouble.

To Dr. Gerry, TORCH was the solution to his challenge. The majority of his patients are now in one facility, and he has a regularly scheduled time to visit them. To make this work, he is supported by a team of other, committed GPs, and he feels like part of the larger team at the facility. He also has support from the administrative TORCH team to organize call schedules and provide billing support.

One of his patient's daughters shared how having the regular care from a physician has made a difference for her and her mom - Judy was struggling to take care of her elderly mom, Bethany, who had been living in a long term care facility for some time. Bethany suffers from dementia and depression and had recently been falling a lot. It got to the point where Bethany couldn't walk on her own.

Because of her recent deterioration in health, Bethany needed to see a doctor regularly, and although she lived in a long term care facility, it was more reliable to continue to visit her GP in the community. However, it was extremely hard for Judy to get her mom to the doctor because she also has a disability, doesn't have access to a car, and works part-time. When Bethany had a scheduled doctor's appointment, Judy had to schedule it around her own work as well as her Mom's schedule and then call HandyDART to pick them both up before they eventually arrived at the doctor's office. Often, Judy was so tired from taking care of her Mom that she would have to take time off work to recover, which meant she was losing income. Understandably, this was all causing Judy a lot of stress and she was burning out fast.

When Bethany was transferred to the Kiwanis Pavilion in 2015, she was enrolled in the TORCH program. Immediately, Judy noticed a difference in her Mom's care. She is able to talk to Dr. Gerry during his regular visits, and he takes the time to sit and explain things to her instead of rushing to the next patient. Importantly, both Judy and her mom feel listened to and respected. This has helped Judy to develop trust in the care her mom is receiving. As Judy said, *"If I see something on Wednesday, I know that by Friday the doctor will be looking at it. This is reassuring because in the past she has had serious concerns that I think were life threatening and were not looked at. She would be in really bad shape and had to recover."*

*Names have been changed

Increased communication between physicians and caregivers also contributed to high levels of satisfaction among caregivers. One social worker stated, "*It is really a surprise to families almost to have a conversation with the physician caring for their parents or spouse. It helps clarify issues and allows us to do this sooner, not let things brew or simmer into problems. It is a proactive model, allows for productivity in a really human, and thoughtful way."* This was observed by a facility manager, who shared "*Families actually meet and speak to physicians responsible for the care. They have an opportunity for direct dialogue for the care plan of the residents and that's a really good thing. It was like the missing part of the puzzle."*

Physician Satisfaction

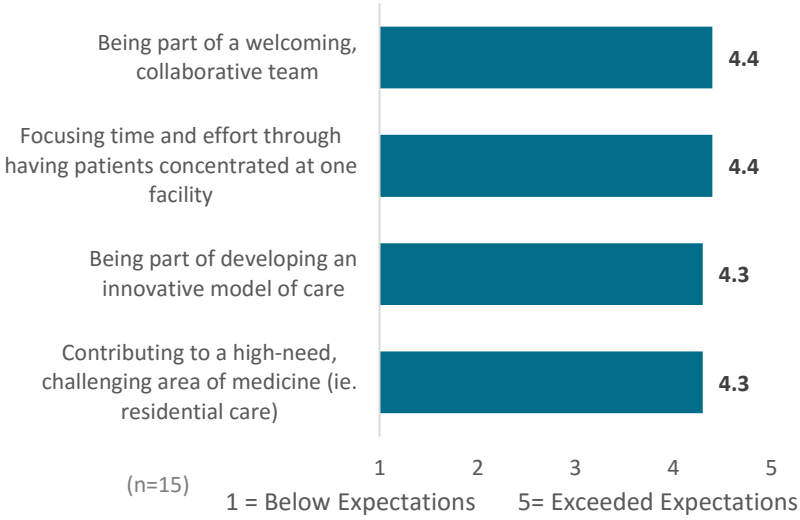
High physician satisfaction with the TORCH model was evident throughout the evaluation findings. On average, TORCH physicians rated their satisfaction with their experience in the TORCH system 8.75 out of 10. Furthermore, interview and survey data revealed factors that contributed to their positive experience:

Being a part of a physician network: All GP respondents (n=15) indicated that being part of a welcoming and collaborative team within the TORCH model exceeded their expectations (Fig. 10).

"I don't think I would have wanted to provide care to patients in residential care facilities if there wasn't a group like this." – GP

"I've really enjoyed working in this group. It's valuable to residential care, valuable to the patients and it's an area of medicine that gets neglected so much. The fact that it's receiving so much attention – it's about time." – GP

Fig. 10 - To what extent did the TORCH model meet your expectations?
(Scale of 1-5)



Having cross coverage of patient care: 14 of 15 GP respondents indicated the TORCH model is meeting or exceeding their expectations with regards to receiving cross-coverage for residential care patients.

"I love the idea of a group of people covering each other for that population of patients. It's very collegial. If I have a question for a colleague or they have a question for me, we have an ongoing dialogue and ask each other questions." – GP

Receiving targeted education: the education sessions increased physician confidence in providing care to residents of long term care facilities, ultimately increasing their job satisfaction. These early education sessions also helped create a sense of inclusion in the network of TORCH GPs.

Physicians at Glengarry specifically identified **high levels of satisfaction having a nurse practitioner[9] support the TORCH team**.

"It is great and has worked well. It has exceeded my expectations. [The NP] is there every day, and has a good handle on my patients. When I go on Wednesday, we have a session. [The NP] has a good handle on who I need to see, and points me in the right direction. There are three wards in our facility and

[9] At Glengarry there is an NP on staff who contributed to the TORCH program. This was unique to this site.

patients are scattered amongst. I would have to wander around to find the staff about who needs to be seen. [The NP] can certainly direct me – that's better." - GP

"*Because we have the NP that makes things easier for me. I get updates if there are things that come up and will review them when I come in. We can go over what comes up, and things are dealt with promptly and proactively."* - GP

Facility Staff Satisfaction

Further, findings indicate facility staff, including nurses and nurse practitioners, social workers, directors of care, managers, and care aides, are highly satisfied with the TORCH model. Key factors contributing to high satisfaction with the model include:

TORCH has helped streamline the admissions process. Interview data revealed the TORCH model facilitated smoother admissions processes, which has positively impacted facility-based care providers' ability to do their job.

- "*Admissions streamlined is a really big deal. We are under a certain amount of pressure and even though we know what to do and have resources for it, it is still pressure. Now, we can do it timely. We are all on the same page and we all work together as a well-oiled machine!"* - Social worker
- "*It helps get people in sooner and also it has just been great to talk with physicians and review files and speak about families and residents of course – we know they will be seen promptly on the physician's arrival and ongoing. They will cover for each other. It's really just a lovely collaboration."* - Nurse

Increased physician involvement has **reduced stress for allied health and nursing staff**

- "*Before, I had little contact with physicians. But now, there is a relationship, we are working together. It's a huge piece of professional satisfaction, knowing we are all working together towards something for patients and their families."* - Social Worker
- *"Before I would hear from nurses, stressing out about getting a hold of GPs when the patient had a turn for the worse. Locums or doctor is on holidays, can't get a hold of them. I don't hear that anymore for patients under the TORCH program."* – Manager
- "*If something comes up, we don't have to panic because you know the physician will be here tomorrow. It's like having a clinic in your facility, it's amazing!"* – Nurse

> *"[There is] a reduction in stress, knowing you have the burden of care for a resident and a physician will be coming in. Now we know things will be taken care of a lot sooner."* – Allied Health Provider

Developed a sustainable model of care

Although the TORCH prototype is complete, TORCH GPs continue to provide care to residents at Glengarry, Gorge Road Hospital, the Heights at Mt. View and Kiwanis Pavilion. In the evaluation process, key stakeholders generally indicated that the model is sustainable:

- All of the interviewees agreed they would like to see the TORCH program sustained.
- 13 of 15 GPs believe the facilities provide a working environment for GPs that supports the ongoing operation of the TORCH model of care, beyond the prototype
- There is a "*solid system in place now and the administration seems willing to adapt as required."* – GP
- "*There's pretty strong commitment, if not from everybody, but majority of people that we don't just want this to stop since this particular project is needed."* - Advisory committee member

Concerns about sustainability that arose in the interviews were around the administrative management of the TORCH program in the future. It was noted that certain activities, such as call schedule maintenance, are at risk of failing without the administrative support provided by the TORCH project team. The Division is currently exploring opportunities to provide additional support of the TORCH model through the RCI initiative, as findings indicate the TORCH model complies with the RCI best practices expectations.

Discussion

According to the information available to the evaluation, the TORCH model was implemented as planned, and achieved its intended outcomes. Moreover, it had a positive impact on patients, physicians, and residential care facilities. The following section outlines the key factors that contributed to the project's success, challenges faced and lessons learned. Lastly, considerations and opportunities for the future are discussed.

Key Strengths of the Project

The following section identifies factors that contributed to the success of the TORCH initiative.

A Collaborative Approach

Throughout the evaluation findings, it was evident that a collaborative approach was an essential component of the TORCH model's development and implementation. Interviewees indicated that this collaborative effort was enabled by the strong leadership provided by the project manager.

In particular, collaboration entailed the enhanced partnership between Island Health Authority and the Victoria Division of Family Practice, at both a leadership as well as clinical level. The value of this partnership was identified to support the implementation of the project, which included both community physicians (who the Division represents), as well as Island Health staff and facilities.

> *"How do we make change happen - it doesn't just happen from having a doctor with a good idea, or a health authority willing to put money in, or having people realize it's a best practice model. You need to have so many stakeholders with different expertise, you need to have an operational team"* – Advisory Committee member

It was recognized that working collaboratively had a bigger impact than each organization operating on its own. As well, it maximized the use of available resources, including being able to compensate

physicians to undertake this work. Furthermore, the collaborative approach lays the foundation for further work between the Division and health authority on the residential care initiative.

A Collaborative Approach: Indicators of Collective Impact

The following factors have been shown to contribute to a group's ability to create a collective impact through an initiative.

1. **A Backbone of Support**
   - ✓ Project Management Team
   - ✓ Administrative Support
2. **Common Agenda**
   - ✓ Project plans
   - ✓ Clear goals outlined at outset of project
3. **Continuous Communication**
   - ✓ Regular meetings to maintain engagement and involvement of stakeholders
4. **Mutually Reinforcing Activities**
   - ✓ Each stakeholder had a specific role and contribution to make to the team
   - ✓ Education sessions reinforced quality of care gains
5. **Shared Measurement of Progress**
   - ✓ Evaluation plan developed at beginning of project

Commitment from Stakeholders

Commitment from the TORCH GPs was a key strength and an essential factor in meeting the project's goals. TORCH GPs made a substantial commitment to be part of the TORCH network, and maintained that commitment throughout the project. This commitment enabled significant changes to be achieved in the way physicians provide care in residential facilities. As one interviewee explained, "*We asked a lot of GPs. Asking a lot produced the big results. The GPs were attracted to the bigness, commitment and stability of it all."*

In addition, there was strong buy-in from administrators, managers and care providers at each of the TORCH facilities. Without this level of support, change would not have been possible within the facilities. A physician shared, "*A supportive medical director is important. If they are willing to support the model – which means welcoming GPs to the facility, making sure they have enough patients to be viable for them, those things are obvious. That hasn't been an issue, they're bending over backwards to make us feel welcome. I had a good experience."*

Examples of changes made by GPs and facility staff include GPs adapting their schedule according to their work schedules and preferences. Moreover, facility staff have begun shifting schedules to accommodate TORCH GPs for care conferences. The administrative staff and directors of care have made efforts to adjust schedules to fit GPs to care conferences.

A Supportive, Learning-Focused Environment

The development of TORCH involved a culture shift in the way GPs practice, including changing their practice routine, as well as increasing their involvement in a team-based care environment. The process of implementing an innovative model of care was made possible by the supportive, learning-focused environment surrounding the TORCH practitioners.

Ongoing support throughout the prototype was noted by stakeholders as an important factor in facilitating the implementation of TORCH. This includes practical support and guidance from the project team, especially for billing and one-on-one support, as well as the education sessions for physicians. As one facility staff reported, "*I wouldn't have been able [to implement the prototype] without the project manager*".

> *"We had a shift within medical practice culture, from a solo practice model to a collaborative model."* – Advisory Committee member
>
> *"I felt supported throughout the process of learning a new way of practicing"* - GP

Additionally, the TORCH model was designed to be fine-tuned during the prototype phase. To this extent, the project maintained a focus on learning, using education events, quarterly meetings and frequent communication with all stakeholders to identify and address challenges.

Challenges Faced and Changes Made

Patient Recruitment

TORCH advisory committee members identified that an early challenge encountered by the project was recruiting a viable number of patients into the TORCH program. They identified that some community GPs preferred to continue to care for their patients when they entered residential care rather than transfer them to a TORCH GP. Additionally, there were initial concerns expressed by community GPs that TORCH was trying to "poach" patients. The project lead and physician lead took the opportunity to address these concerns as they were raised, and develop a system of patient intake to ensure patients had an appropriate MRP when they enter residential care.

Currently, TORCH GPs provide care for about 50% of the patients in TORCH facilities. When a new patient is admitted to the facility, their community-based GP is contacted. If they do not wish to remain the patient's MRP, the patient is accepted by a TORCH physician. Furthermore, if a resident or their family decides they would like to be under the care of a TORCH physician, they notify their existing GP and the facility staff, who help with the transfer of care.

Integrating GPs into the facilities

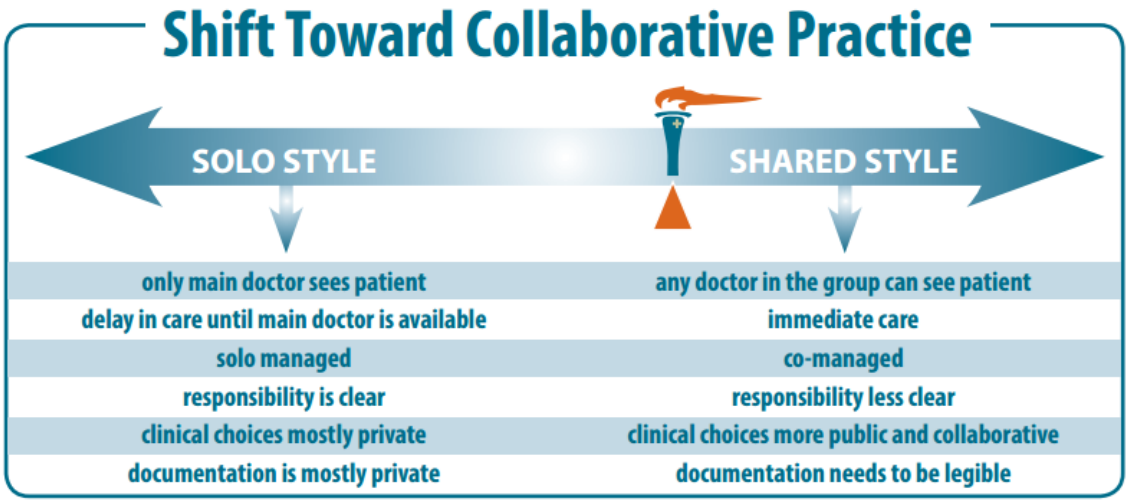
Another early challenge that the project faced revolved around physician familiarity with the facilities themselves and the need to provide orientation information. Information gleaned from interviews with both physicians and facility managers revealed that in some cases were unfamiliar with the operation of a particular facility. As a result, time was needed to provide physicians with information about things such as where to locate patient charts, how to access different floors, looking up lab results, and using PowerChart. This additional time was found to be beneficial to both physicians and care staff.

Determining TORCH Processes

In the early stages of the TORCH prototype, there were discussions regarding specific processes to guide the functioning of program. Several interviewees noted challenges encountered in the pursuit of determining TORCH protocols that would work for the majority of providers. These challenges included:

1. **Cross coverage** amongst TORCH GPs: There were a variety of conflicting opinions on the extent of cross coverage that TORCH GPs would provide for one another's patients. To have a consistent approach for the prototype, a cooperative shared model was adopted. Within the shared model, a TORCH GP would provide care for a colleague's patient in urgent situations. This was introduced to reduce the need for GPs to visit the facility when it is not their scheduled day.

Fig. 10 – The TORCH model of practice: Cooperative Shared Model



2. **Communication protocols:** Facility staff noted that there was a lack of communication protocols for connecting with the TORCH GPs, including which GP to call, and what communication method to use. To address this, TORCH sites implemented a variety of tools, including communication algorithms and processes. Having consistent communication processes in place ultimately reduced the reliance on phone calls and faxes, which was appreciated by all parties.

3. **Care Conference Attendance:** An ongoing challenge at each of the four TORCH sites involved scheduling care conferences in a way that accommodates each provider's schedules. While the percentage of physicians attending care conferences has increased (i.e. 6% more GPs were able to attend care conferences since TORCH was implemented), it remains difficult trying to accommodate GP schedules. As a facility care provider identifies, "*Our unit clerks worked long and hard to make a building wide schedule to group the TORCH physicians together so we had to completely change the times and getting everyone to changes times so the TORCH physicians could come."*

Improving communication and scheduling care conferences to accommodate everyone's schedules continues to be a priority at each of the care facilities. GPs indicated that continued support to attend conferences is of value: "*I am always surprised and pleased with the care reviews – I get a new perspective on the patient*."

Barriers to Participating in Team Based Care for GPs

Physicians identified a number of challenges encountered when providing TORCH care at the facilities. For example, 9 of 15 respondents[10] indicated that despite having a good working knowledge of each of the facilities, they often or sometimes have challenges finding key facility staff when needed. In addition, 9 of 15 respondents often or sometimes encounter disorganized charts or lab work. Further, respondents identified other challenges when providing care at the facility. These included:

- Arranging outside consults for patients who do not have family involved in their care
- Lack of consistent nursing staff and care aides
- Crowded nursing stations
- Standardized lab work information
- Dealing with signed forms and organizing referrals

Physician Remuneration

In the development stages of the TORCH model, it was identified that physician compensation is a systemic barrier to GPs practicing in residential care, since it requires more effort and time to travel to see the patients compared to an office-based practice.

A key component of the TORCH model was to cluster patient visits to reduce the negative effect that the time to travel to a facility would have. In this respect, typically ~20 patients per GP were assigned at each facility. Additionally, sessional payments were available to physicians during the early stages of implementation to provide them with an opportunity to get acquainted with the facility and non-clinical processes. The project team also supported the transfer of fee codes that were rejected[11]. Billing support/consultation from the Division was also made available to ensure each GP was able to maximize their earnings.

Despite efforts to mitigate financial challenges for physicians, several physicians continued to experience challenges in this regard. In this respect, and within the current MSP billing structure, being part of TORCH was not as financially rewarding for some as their current office practice. One GP adds clarity to this by saying it is still "*difficult to see enough patients to make this financially viable*". Having said this, some physicians also identify that they have been able to make this work form them. "*Starting TORCH felt like a financial and clinical risk at first, but after a couple months it was clear that there are more than enough clinical needs to make the job very financially and personally rewarding*."

Generally, TORCH physicians were able to bill between $115 and $248.50[12] per hour spent in a facility. The average billing was approximately 159.00 per hour. Discrepancies in income may further be related to experience and comfort providing residential-based care, as well as personal practice style, which includes the amount of time physicians spend with each patient.

[10] GP survey, January 2016

[11] The attachment fee code 14074 was rejected for some patients when they transferred into the TORCH program. This was rectified by the TORCH team through consultations with the Ministry of Health.

[12] Data was included if physicians reported billings for at least 3 months.

Lessons Learned

Over the course of the project, key stakeholders identified the following key lessons learned:

If you set high standards, there is the potential for big change. TORCH project staff, physicians and advisory committee members noted that the TORCH model required a commitment to change from all of the key stakeholders, and it challenged the status quo. However, they learned that by asking for a lot, they were able to see real changes. One GP noted "*They set the expectations high. And so you join knowing that these are the rules and this is how we're going to play the game – people know that if they don't want to do it this way, they can go somewhere else. But I liked having it set up this way."*

Build in additional time to orient GPs, especially if they haven't provided care in long term care facility before. Providing additional time was found to be beneficial both to the GPs and the care staff.

Each facility has a different capacity and will face different challenges. Interviewees learned that processes and protocols that work in one facility may need to be changed for another. An example of this was especially noticeable for the Heights at Mt. View facility, which was a brand new facility when TORCH began. The Heights needed additional support to implement the program as a result of all the other challenges of being a new facility.

What are the "Non-Negotiables"?

Interviewees identified the following factors they felt differentiate TORCH from other models of residential care.

- Visit the facility regularly, at a scheduled, predictable time to enable relationship building and proactive patient care
- Visiting during day time hours
- A more structured environment with administrative support
- Team-based care approach: support from other clinical team members and GPs
- Integration of GPs into the facility team
- At least 20 patients/GP to make the model financially sustainable for GPs

Communicate often and have a consistent message. Project staff identified that early in the project, there were a lot of ideas and rumours about what TORCH was going to be about, so they quickly learned to develop consistent communication with their partners. An advisory committee member commented on the communication strategy, noting, "*We shaped our communication around being part of building an innovative model—we have an idea, now it comes to life with everyone who wants to contribute to this*."

Considerations and Opportunities for the Future

Interviews with project stakeholders identified the following areas of opportunity. They are presented here for the consideration of the project team and steering committee.

Expanding the "Team"

Several physicians noted that the TORCH model could benefit from further expansion of the team-based care model to include additional specialists, such as geriatricians and geriatric psychiatrists. They would appreciate increased access to these specialists, and simplified referral pathways. Specifically, one

suggestion included creating more linkages and connections with geriatricians through the Rapid Access Consultative Expertise (RACE) line.

Additional Education Sessions

To further support the TORCH program, several GPs agreed it would be beneficial to host additional education sessions. One physician stated, "*Let's get back to training – round two of education sessions. We went through 6 but there is still more to learn."* Similarly, another GP identified, "*If they're able to continue with the education sessions that would be excellent."* One physician interviewee also noted that if new GPs are joining TORCH through the RCI funding, it would be beneficial to offer them the original training the first round of TORCH GPs received.

Continuing to Support Quality Improvement

Feedback from interviewees indicated that, if possible, they would like to see quarterly meetings continued. One allied health provider specified that, "*The meetings are never wasted time. There are always things to talk about like quality improvement and if we wanted to work on something."* Examples of quality improvement processes that TORCH facilities and physicians are interested in include:

- Continue to enhance communication processes between TORCH GPs and care providers. Specifically, respondents identified some remaining issues sorting out urgent and non-urgent issues, and ensuring faxes are being sent to the appropriate TORCH GP.
- More consultation with the family and/or caregivers regarding the care and medications of the resident, especially for residents who are rapidly deteriorating, receiving palliative care or end-of-life care.
- Developing an equipment list and acquiring equipment for clinical procedures (e.g. stitches) TORCH GPs conduct on site

In addition, some TORCH GPs identified that having a common MOA for their TORCH work would be beneficial to them. They further identified that this MOA could take on additional TORCH administrative duties including organize call schedules, cross coverage, care conferences and specialist referrals/ requisitions. This idea was typically forwarded by physicians without an office based practice. One allied health provider shared: "*What would be helpful is the physicians to have their own MOA, maybe a part-time MOA. In long-term care, the nurses already have their hands full and booking specialist's appointments was new to them. It takes up a lot of their time."* One physician specified, "*For GPs, having some support with the admin, the call schedules and some organization support is the most important.*

Physician Compensation

As noted in the previous section, challenges related to physician compensation was a theme throughout the interviews. Some further opportunities to reduce this as a barrier for physicians providing care through the TORCH model were also identified by interviewees. These include:

- Sessional support to be continued within the new Residential Care Initiative (RCI) funding[13]
- Continued billing support to optimize billing opportunities[13]
- Provide data to Ministry of Health to promote increased incentives for providing residential care

[13] Project manager confirmed this will be continuing

Communicating the Future of TORCH

Finally, findings from the interview data suggest many key stakeholders including residents and caregivers, facility staff and TORCH GPs are unaware or uncertain of the next steps in the TORCH model, including how the transition to RCI funding will impact the model. Key project members identified a need to ensure the successes, lessons learned, and next steps are clearly communicated to all stakeholders.

Conclusion

This report concludes the prototype of the TORCH initiative in Victoria. The evaluation found that the project was organized and operated in a way that was consistent with its goals and objectives. Evaluation findings indicated that the TORCH model effectively supported physicians to be a consistent presence in residential care facilities, leading to increased team-based care as well as improved quality and continuity of care for residents. Furthermore, the model has been met with high satisfaction among key stakeholders, and can be feasibly sustained going forward.

Appendix A – Data Analysis

RAI Data

An OLS time series regression was run on the 6 quality of care indicators in the RAI data set, as well as age and gender. The table below shows statistically significant decreases for the percent of residents on 9 or more medications (7% decrease), percent of residents with 1 or more hospital stays (10% decrease) and percent of residents with 1 or more ER visits (9% decrease). There was a statistically significant increase in the percent of residents with stage 2-4 pressure ulcers, of 1%. All other findings were not statistically significant.

Table X - Changes Post-TORCH Implementation	
Age	0.01
Gender	0.01
Stage 2-4 Pressure Ulcers	0.01*
UTI Infections	-0.01
Falls	0.02
9 or More Medications	-0.07*
1+ Hospital Stays	-0.10*
1+ ER Visits	-0.09*
* $p<0.05$ - Results from OLS Time Series Regression Model	

Limitations: This data represents findings from the entire care facilities population. TORCH doctors only serve ~50% of patients at each facility, therefore the findings may be diluted by patients not involved in the program. In addition, other quality improvement processes may also have an impact on these variables. We cannot attribute causation of these findings to TORCH without being able to control for all confounding variables.

Appendix B

Call Data Analysis

The following table summarizes the data collected from physicians regarding the number of calls they received when they were on call for TORCH. The data shows that nearly 80% of weekday on call shifts receive no calls, while weekend shift gets called half of the time.

Data is based on the calls that were tracked between July 2015-December 2015, when time of calls was tracked.

	Calls/shift	Time of calls			Visits/shift	% shifts with no calls
		7am – 5pm	*After hours* 5pm – 9pm	*After hours* 9pm – 7am		
Monday-Thursday (Weekday)	2	3% (0.07/2)	53% (1.05/2)	44% (0.88/2)	0.37	79%
Friday-Sunday (Weekend)	3.3	25% (0.84/3.3)	67% (2.2/3.3)	8% (0.26/3.3)	0.88	56%
Long Weekend (Friday-Monday) (*n=3*)	2.6	--	--	--	1.3	0

Appendix C – CES Guidelines for Ethical Conduct

Competence

Evaluators are to be competent in their provision of service.

1. Evaluators should apply systematic methods of inquiry appropriate to the evaluation.
2. Evaluators should possess or provide content knowledge appropriate for the evaluation.
3. Evaluators should continuously strive to improve their methodological and practice skills.

Integrity

Evaluators are to act with integrity in their relationships with all stakeholders.

1. Evaluators should accurately represent their level of skills and knowledge.
2. Evaluators should declare any conflict of interest to clients before embarking on an evaluation project and at any point where such conflict occurs. This includes conflict of interest on the part of either evaluator or stakeholder.
3. Evaluators should be sensitive to the cultural and social environment of all stakeholders and conduct themselves in a manner appropriate to this environment.
4. Evaluators should confer with the client on contractual decisions such as: confidentiality; privacy; communication; and, ownership of findings and reports.

Accountability

Evaluators are to be accountable for their performance and their product.

1. Evaluators should be responsible for the provision of information to clients to facilitate their decision-making concerning the selection of appropriate evaluation strategies and methodologies. Such information should include the limitations of selected methodology.
2. Evaluators should be responsible for the clear, accurate, and fair, written and/or oral presentation of study findings and limitations, and recommendations.
3. Evaluators should be responsible in their fiscal decision-making so that expenditures are accounted for and clients receive good value for their dollars.
4. Evaluators should be responsible for the completion of the evaluation within a reasonable time as agreed to with the clients. Such agreements should acknowledge unprecedented delays resulting from factors beyond the evaluator's control.

(Canadian Evaluation Society, 2001-2010)