Localized solutions for provincial reform of residential care services

Residential care in BC is facing critical challenges. Residential care patients make up less than 1% of BC's population and consume approximately 25% of the combined budgets for MSP, Pharmacare, acute care, and home and community care.[1] At the same time, the number of family physicians who deliver residential care is steadily declining.

The number of general practitioners (with at least 50 longitudinal patients in the community setting) delivering residential care services dropped 13%[2] between 2003 and 2013. Most notable, the Fraser Health Authority and Vancouver Coastal Health Authority saw declines of 27% and 24%[2] respectively.

The Ministry of Health developed five residential care service agreements in 2011 with local divisions of family practice and their respective health authority partners in Abbotsford, Chilliwack, Prince George, South Okanagan Similkameen, and White Rock–South Surrey to address specific service delivery concerns in those communities. In July 2013, recognizing the needs for increased physician support for residential care services and refined quality patient care, the GPSC began discussing the need for a provincial solution. Funding for the five service agreements became part of the GPSC budget in April 2014 with the committee using these agreements to develop a better understanding of the underlying issues and concerns, to explore solutions, and to engender change to residential care in BC.

This article is the opinion of the GPSC and has not been peer reviewed by the BCMJ *Editorial Board.*

Lessons learned from the divisions' agreements and extensive consultations with other stakeholders helped establish five best practice expectations for the provincial initiative:

1. 24/7 availability and on-site when required
2. Proactive visits to residents
3. Meaningful medication reviews
4. Completed documentation
5. Attendance at case conferences

Residential care patients consume approximately 25% of the combined budgets for MSP, Pharmacare, acute care, and home and community care.

These best practice expectations are anticipated to reduce unnecessary or inappropriate hospital transfers, improve both patient and provider experiences, and reduce costs.

Localizing the design of care and the funding allocation empowered divisions and health authorities to determine how to best meet the unique needs of their communities. The five divisions' agreements achieved improvements in the following areas:

Consistency of care

The divisions each met some of the best-practice expectations, but there are further opportunities for development in some divisions. Collectively, the MRPs (most responsible physicians) served all residential care patients in 3261[2] residential care beds.

Polypharmacy

Effective medication management is a key part of quality patient care. In Abbotsford, all facilities had key medications on-site, which helps with consistency and quality improvement. The White Rock–South Surrey Division noted a clear downward trend for a number of patients on nine or more medications and of patients on antipsychotics. The Prince George Division observed some reduction in polypharmacy, particularly as a result of coached medication reviews with one pharmacist during in-facility meetings every 6 months.

Proactive care

Regular visits by MRPs to facilities promoted a standard of proactive care. The South Okanagan Similkameen Division reported an increase in the number of proactive visits by MRPs. In 2012, 23% of Penticton residential care patients received two or more visits every 6 months from the MRP. As of 2014, that number has increased to 51%.

Transitions in care

Several communities evidenced reduced ER transfers of patients. In Chilliwack, a designated residential care physician was available twice a week and on all weekends to provide MRPs an alternative to leaving their offices or the hospital to perform reactive visits, upon request by the facility or family of the residential care patient. This prevented 15 emergency room transfers per month. Similarly, the South Okanagan Similkameen Division recorded that local residents visited the Penticton Regional Hospital emergency department 88 fewer times during the 13 months after the

service agreement began than they did during the 13 months prior.

Based on the success of the service agreements, the GPSC is offering the initiative to 104 communities through the leadership of local divisions. With 97% of residential care beds sited in communities with a division,[2] working closely with health authorities, divisions are best positioned to determine local solutions. Starting in April 2015 this scalable, sustainable solution will cover all residential care sites (where no division exists in a community with a residential care facility, the initiative is available to groups of local family physicians) and will be standardized with best practice expectations for consistent and ubiquitous patient care.

The GPSC has allocated up to $12 million annually, the equivalent of $400 per residential care bed, for divisions to achieve a dedicated GP for each residential care patient while addressing other supporting functions such as service coordination, mentoring, and education. Local service delivery plans culminate in the signing of a memorandum of understanding with the health authority partner.

For further information on the residential care initiative, visit the GPSC website (www.gpscbc.ca).

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References

1. BC Ministry of Health. Setting priorities for the BC health system (February 2014). Accessed 30 March 2015. www.health.gov.bc.ca/library/publications/year/2014/Setting-priorities-BC-Health-Feb14.pdf.
2. BC Ministry of Health. Integrated Primary and Community Care. Internal Administrative Data, 2013.

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