



ALTERNATE RELATIONSHIP PLAN AT INTERCARE—CHANGING LONG TERM CARE TOGETHER

Dr. Paddy Quail presented at the Alberta Continuing Care Association Quality Improvement and Measurement Long Term Care Tradeshow & Symposium June 2 & 3, 2009.

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I'd like to share with you my experience in establishing an alternate relationship plan or ARP for physicians in LTC. As an attending physician in LTC I have a strong belief that physicians have a lot more to contribute to quality improvement in this area of health and are not being fully leveraged by owners, administrators, managers and medical directors. This is a story of physicians who want to make a difference in terms of quality improvement and their engagement in the culture of LTC.

I believe this is a relatively novel project which pertains to the intent of this quality improvement symposium. So, over the next 10 minutes I will provide a narrative account of what we think is an original approach to physician engagement in LTC.

Margaret MacAdam (a Canada Policy Research Network Senior Research fellow) states in her Frameworks of Integrated Care for the elderly review released April 2008, *"The strongest programs also include active involvement of physicians"*

I am the medical director to Intercare Corporate Group, a private LTC provider in Calgary. We provide care to 604 LTC patients and I believe we are typical of many private providers in the province.

I am also the medical leader for our ARP at Intercare with my colleague Dr Oyebanji. There are 12 participating physicians. These 12 physicians provide primary medical care in partnerships with site based nurse leaders known as associate team leaders (ATLs).

Our purpose is to effect real improvements in the quality of care and quality of life of our patients and residents. Our vision for our ARP is *strong and effective teams working together for the best care and life for our patients and residents.*

On July 1st our ARP will have been in operation for one year. This time last year 55% of the residents at Intercare were under the ARP, today we have 71%. Our plan by the end of year 2 is to have 90% coverage. Most patients admitted to our facilities are without a family physician who is willing or able to follow them to our sites. These admissions are assigned to one of our 12 physicians.

The physicians visit once a week and are paid at a set hourly sessional rate. They commit to a set number of sessional hours according to their patient census calculated at 6.8 patients an hour. There is a range of caseloads from 13 to 85.

∴ HISTORICAL CONTEXT

I think it is important to provide some historical context to our ARP. The idea for this project had originally been developed out of a sense of urgency regarding physician supply to LTC in Calgary, also about workplace issues in the Calgary region and of course about quality of care and patient outcomes. While these imperatives have not diminished the ARP has evolved and grown more into a story of relationships.

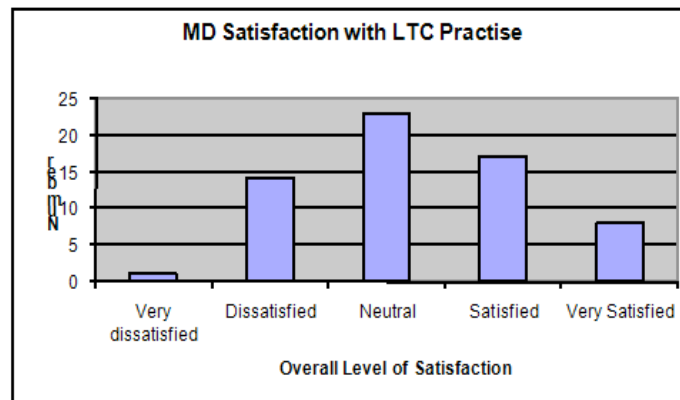
Back in 2002 we undertook a workplace survey of our physicians in the Calgary region. We had a 50% response rate from physicians who carried most of the patients in the region. Of that group 70% expressed a desire to quit practice within 5 years.

TABLE 1

Length of Service	N	%
1–2 years	14	23
3–5 years	28	45.9
6–10 years	9	14.8
> ten years	10	16.4

In this same survey we found that only 39% were satisfied or very satisfied with their practice in LTC.

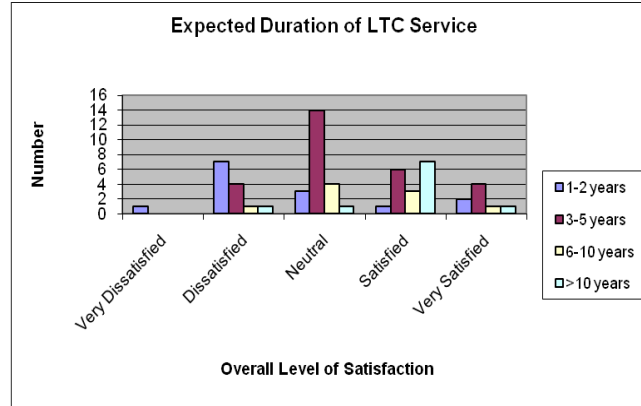
GRAPH 1



What is interesting here is the large measure of neutrality to and dissatisfaction with practice.

So it is clear that there was a problem with intention to quit and also satisfaction with practice.

GRAPH 2



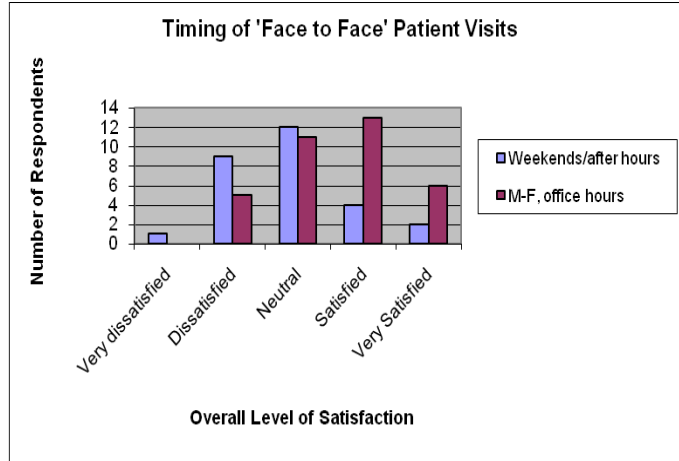
As if to reinforce these findings, three years later in Sept 2005 the MLA task force (in response to the Auditor General report from June of that year) said that there is a “shortage of physicians with geriatric training. It is difficult to recruit physicians to LTC” and “physicians and other health care workers would like to be more involved in residents’ assessments and the care planning team.”

My own observations were that LTC sites were not typically orientated towards physician practice and through no deliberate action on their part did not engage this group of providers. In the day to day busyness of the nursing home physicians were often out of sight out of mind from the nurses. Physicians would visit before or after their office or on weekends. A case of two solitudes. In other words, a real lack of physician engagement and participation in the life of the facility.

Funds were made available in 2002 following the Mazankowski report in which it was stated that the government wanted 50% of physicians on some form of alternate payment plan by 2005. We were successful in our application for MSDIF funding contingent on approval of an APP (now known as a ARP).

From that time on we were actively recruiting physicians to join our group. They would work under the FFS until the ARP was approved. It took some time to consolidate our physician group. The original 8 physicians in our original application look very different to our younger and more diverse group of 12 physicians today. The ARP was going to be a sessional model. We wanted to have physicians in the facility during regular office hours and not before or after their other commitments or on the weekend. We really wanted to work with a group of physicians who made this area of practice their first priority. Interestingly our findings from the original 2002 survey supported a daytime approach to physician visits.

GRAPH 3



The only prerequisite for joining our group was an interest in care of the older adult and a desire to work in a team setting. We would meet as a group to consolidate our interest and generate a sense of the medical staff. Evening meetings over dinner helped develop that esprit de corps.

The physicians were to work in partnership with a nurse coordinator called an associate team leader (ATL). Physician visits would be scheduled on a regular day of the week. The ATL would manage the physician's time while he or she was in the facility. She would round with the physician ensuring that his or her work would be managed during the session. The ATLs would visit the units and talk to staff prior to the physicians visit and would prepare an itemized list of concerns.

The physician would be able to attend to a wide range of duties from health and wellness to episodic medical issues and of course shared care planning.

In addition to the physician visit and rounding with the ATL, which was to be the core of our ARP, we had also identified 12 quality improvement domains that the physicians would lead over the 3 years of the MSDIF funding. These included falls/osteoporosis, advanced care planning, wounds, hospital transfers, delirium, quality of life, management of behaviours in dementia, medication management, infectious diseases, EOL care, end stage chronic disease and UTI.

∴ CURRENT STATE

The model went live July 2008 and it has more or less grown as I have described. We now are very fortunate to have a group of physicians who are dedicated to change and who have made LTC a priority in their professional lives. The commitment of the VP Intercare (and the organization Intercare) is a key part of the project.

Our physicians attend to new admissions, care conferences, meeting with families, medication reviews with clinical pharmacy teams and ad hoc meetings with other team members as they would under FFS. However their time is more managed and coordinated with the ATL and their visits are typically during the day when the teams are present.

Six months into the first year of the ARP we began our first QI project in falls and fractures. A second QI project has just begun in hospital transfers. Both of these projects are physician-led. In terms of quality improvement we have given the relationship-building a greater importance in the first year but we felt that it was important to develop the medical staff as an entity and strengthen the relationship with the ATLs.

In addition one of our physicians is a care of the elderly grad and has a special interest in wounds and does wound rounds on a regular basis at all sites.

We also have a physician who is taking a palliative fellowship who has agreed to lead an End of Life QI project in the middle of year 2.

Our physicians also do 'just in time' teaching at the bedside which is received very well by the staff.

We have allowed the physician duties to develop in an organic way supporting their work and time while they are in the facility. In a way the primary quality expectation is captured in the commitment to spend sessional hours in the facility. I believe this has not been undertaken before in this province.

To quote one of our physicians,

It is a good project with excellent vision, it will revolutionize LTC.



Dr. Paddy Quail