Summary Report of

THE EXPERT PANEL

on

SPECIALIZED GERIATRIC SERVICES (SGS)

prepared by

Policy Planning Plus Inc.

Hamilton, Ontario

Submitted
to the
Ministry of Health and Long-Term Care
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EXECUTIVE SUMMARY

DISTINGUISHING FEATURES OF SPECIALIZED GERIATRIC SERVICES

SGS are distinguished from other health and social services used by older people in the following ways:

- They are **specialized,** meaning that they offer a higher level of knowledge and skill in caring for the elderly than do mainstream health and social services.

- They are **consultative** in nature, meaning they are a resource to mainstream health and social services to be used on an episodic basis when they run int(Aifficulty and also meaning they do not assume the primary responsibility for care on an ongoing basis.

- They are **multi-dimensional,** meaning they bring the knowledge and skills of a team of different health professionals to bear on the multiple causes of an older person's ill health or disability.

- They are concerned first and foremost with **assessment,** meaning that SGS start by trying to understand WHY an individual has experienced a decline in health or function and WHETHER the conditions are remediable to treatment, rehabilitation or better management.

- They provide **short-term treatment** only when mainstream medical care cannot provide what is required.

- They provide **geriatric rehabilitation,** meaning that the nature of the functional and concurrent medical problems exclude them from general rehabilitation programs and call for highly individualized interventions.

CORE FUNCTION OF SPECIALIZED GERIATRIC SERVICES

"Core" services and functions that need to be available in all areas of the province,. though some may be regionally-based, are:

- Direct clinical care
  - o consultation - this is the traditional way specialized geriatric services are delivered, as a resource to mainstream health services
  - ❑ "shared care" - this is a newer concept, proposing that SGS remain more closely involved with mainstream health services in particularly complex cases

- Indirect clinical care
  - ❑ ways that SGS support mainstream health services with regard to specific patients/clients without seeing them face-to-face, e.g., telephone or electronic consultation, case conferences

• . Education
    - ❑ SGS need to keep current in geriatric care and they have a major role in transferring knowledge to professionals and workers in mainstream health services

• Program and system development
    - o SGS need to be able to develop individual services and a system of services that clients/patients can easily and move through as their needs dictate

• Dissemination of research and program evaluations
    - ❑ SGS (especially in academic health sciences centres) should disseminate research findings that will help providers of mainstream health services to care more effectively for the elderly. SGS should be actively involved in evaluating the cost-effectiveness of their services. SGS do not typically conduct research (although geriatric researchers may use the clinical SGS settings to conduct applied research studies.)

PEOPLE WHO NEED SGS

The people who need SGS are seniors (and their caregivers) with complex medical, functional and/or psychiatric and social needs of recent onset.

KEY ISSUES

The following issues need to be addressed if we are to improve the delivery of SGS throughout the province:

- access
- delivery systems
- human resources
- financial resources
- the capacity for data collection and research

SERVICE PRINCIPLES

The following reflects service principles:

- SGS should be based on a patient needs-driven entitlement for basic level of care
- SGS core functions should be comprehensive, integrated and. provincially mandated
- SGS should be delivered through coordinated local/regional structures and networks
- SGS should address complex health problems using a multidimensional approach
- SGS should have a responsibility for the development and dissemination of knowledge and best practices

- SGS should use partnerships to extend knowledge and skills throughout the health and social service systems

KEY STRATEGIES

The five strategies that were widely endorsed by the expert panel recommended that the government should:

- declare care of the elderly a government priority, and develop a policy framework for Specialized Geriatric Services.
- develop and implement a Human Resources Strategy for health professionals (nursing and other non-physician groups) related to SGS
- seek advice from an external expert panel and establish a provincial policy framework and guidelines, to define core services including the range, mix and funding for both SGS and specialized health professionals
- acknowledge that there is a crisis in physician resources for specialized care of older people and take the appropriate actions.
- develop and implement a coordinated provincial SGS infrastructure that addresses regional needs and supports demonstration projects.

KEY FUNDING PRIORITIES

The top five items identified by individual members of the expert panel were:

- fund existing programs and services in order to upgrade to meet minimum standards and benchmarks
- fund local/ regional planning processes
- expand community outreach initiatives
- fund the development of standards and benchmarks
- fund multidisciplinary APPs.

SUMMARY RECOMMENDATIONS

When panel members were asked to summarize their best advice to the Ministry of Health and Long-Term Care, they indicated:

"The aging of the population and its impact on health and social services is the single most important issue of the next decade."

*"There is a serious immediate gap in human resources and the skill set among MDs, health care professionals and clinicians, and health care providers to meet the **present** needs of the elderly What are we going to do in the future? "*

"The current system is inadequate to meet the needs of the 65 + users, but this is not an insurmountable problem. There is expertise in Ontario willing to work with you to correct this."

REPORT OF THE EXPERT PANEL
on
SPECIALIZED GERIATRIC SERVICES

PURPOSE AND BACKGROUND

On October 12 and 13, 2000, the Ministry of Health and Long-Term Care convened an expert panel to provide advice to the government on strategies to improve access to specialized geriatric services (SGS) across the province and better integrate these services into the continuum of care. The expert panel was comprised of key users and providers of specialized geriatric services. (See Appendix A)

Each panel member was provided with a copy of a Background Discussion Document. This document presented a brief overview of specialized geriatric services in Ontario and identified five key questions that formed the basis for the deliberations of the expert panel. The questions were:

1. What distinguishes specialized geriatric services from other health and social services? Is there a "core" group of specialized geriatric services that is dependent on one another for maximum effectiveness?

2. Who needs specialized geriatric services?

3. What do providers need from specialized geriatric services? What would it take to satisfy the needs?

4. What barriers and opportunities exist with respect to making specialized geriatric services accessible throughout the province and better integrating them within the continuum of care?

5. What do we need to do and what conditions must be in place to make specialized genatric services accessible throughout the province and better integrated within the continuum of care?

The session began with presentations from Mary Beth Valentine, Director, Program Policy Branch, Integrated Policy and Planning Division, Ministry of Health and Long-Term Care and three keynote speakers, Dr. Duncan Robertson, Professor, Geriatric Medicine, University of Alberta, Dr. Rory Fisher, Chair, RGPs Ontario and Dianne Anderson, VP, North York General Hospital.

Each of the speakers challenged the expert panel to provide advice that supported the Ministry's vision of an accessible health system promoting wellness and ¡mproving people's health at every stage of their lives. They described specialized geriatric services as timely interventions that make a difference and optimize health, independence and the quality of life of seniors. They each described innovative approaches and encouraged the panel:

- to develop a common understanding of what we mean by SGS
- to consider the unique rehabilitative needs of older persons
- to provide elder friendly environments both in the community and in institutions
- to prepare for the wave of impending need for services by older persons
- to recognize the special role of SGS in supporting and integrating with the rest of the health care system.

The deliberations of the expert panel focused on the five key questions identified at the beginning of this report plus additional challenges posed by the guest speakers. This document provides a summary of the key findings of the expert panel.

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PART ONE
COMMON UNDERSTANDINGS ABOUT SPECIALIZED GERIATRIC SERVICES

The first purpose of the consultation was to develop common understandings about specialized geriatric services and to identify key issues in the delivery of services. Participants were asked to discuss what distinguishes specialized geriatric services from other health and social services and to identify a "core" group of specialized geriatric services.

What are the distinguishing features of SGS?

The panel's comments:

- SGS are concerned with increasing the functional ability and quality of life of older persons with complex and multiple health problems of recent onset
- SGS enhance the understanding of health providers and patients/caregivers about aging and those aspects of frailty *that can be contained or are reversible*
- SGS provide consultations about unexplained and recent decline - function, cognitive, behavioral, psychiatric and social - to improve the type of care, to ensure the continuity of care and to foster coordination of care
- SGS are team-based and multi-dimensional in a variety of inpatient, outpatient and rehabilitation settings; they assume many roles, including clinical consultation and management over the continuum of service from prevention to rehabilitation, education, community development and research
- SGS are a specialized backup resource for all other components of the health care system for best practice, providing information sharing, while acting as a complement and support to primary and secondary care providers
- SGS aim to transfer their knowledge and skills to others in an effort to raise the usual level of care for older persons to a higher level

The expert panel agreed that SGS are distinguished from other health and social services used by older people in the following ways:

- They are **specialized,** meaning that they offer a higher level of knowledge and skill in caring for the elderly than do mainstream health and social services.

- They are **consultative** in nature, meaning they are a resource to mainstream health and social services to be used on an episodic basis when they run into difficulty and also meaning they do not assume the primary responsibility for care on an ongoing basis.

- They are **multi-dimensional,** meaning they bring the knowledge and skills of a team of different health professionals to bear on the multiple causes of an older person's ill health or disability.

- They are concerned first and foremost with **assessment,** meaning that SGS start by trying to understand WHY an individual has experienced a decline in health or function and WHETHER the conditions are remediable to treatment, rehabilitation or better management.

- They provide **short-term treatment** only when mainstream medical care cannot provide what is required.

- They provide **geriatric rehabilitation** meaning that the nature of the functional and concurrent medical problems exclude them from general rehabilitation programs and call for highly individualized interventions.

What are the "core" services/functions?

The panel's comments:

The panel identified many functions of SGS in a variety of settings:

- Functions
  - ❑ risk identification and triage
  - ❑ assessment, treatment and rehabilitation of elderly people assessed as needing SGS in the community, LTC facility and hospitals (acute continuing care)
  - ❑ education and training of family physicians, health and social service providers, care givers and the public
  - ❑ research , information dissemination and evaluation
  - ❑ systems development and partnerships (horizontal, vertical and virtual integration)

- Settings -- Hospitals, LTC facilities and the Community
- Types of delivery mechanisms
    - ❑ inpatient consultation
    - ❑ outpatient clinics
    - ❑ community outreach
    - o inpatient geriatric rehabilitation units
    - ❑ day hospitals
- There are organizational variances relating to location such as large urban centres, academic health science centres, cities, and rural and remote areas. At minimum, all locations should have the capacity to provide thé core services of geriatric assessment and treatment.

How should services be connected to each other?

The panel's comments:

- There is a need to develop a provincial policy framework and guidelines to support the coordinated development of regional and local SGS plans

- Single intake and triage

- Collaboration in planning, education and research, as well as service

- Support the role of a "supra specialists"

- Common data base

The expert panel agreed that the following described the Core Functions of SGS. It was noted that these core functions must be integrated and comprehensive.

"Core" services and functions that need to be available in all areas of the province, though some may be regionally-based, are:

- Direct clinical care
    - ❑ consultation - this is the traditional way specialized geriatric services are delivered, as a resource to mainstream health services
    - o "shared care" - this is a newer concept, proposing that SGS remain more closely involved with mainstream health services in particularly complex cases

- Indirect clinical care
  - ❑ ways that SGS support mainstream health services with regard to specific patients/clients without seeing them face-to-face, e.g., telephone or electronic consultation, case conferences

- Education
  - ❑ SGS need to keep current in geriatric care and they have a major role in transferring knowledge to professionals and workers in mainstream health services

- Program and system development
  - ❑ SGS need to be able to develop individual services and a system of services that clients/patients can easily move through as their needs dictate

- Dissemination of research and program evaluations
  - ❑ SGS (especially in academic health sciences centres) should disseminate research findings that will help providers of mainstream health services to care more effectively for the elderly. SGS should be actively involved in evaluating the cost-effectiveness of their services. SGS do not typically conduct research (although geriatric researchers may use the clinical SGS settings to conduct applied research studies.)

PART TWO
WHO NEEDS WHAT FROM SPECIALIZED GERIATRIC SERVICES?

The purpose of this part of the discussion was to develop a common understanding about "who needs what" from specialized geriatric services. These needs were viewed from both the patient and provider perspectives.

Who needs specialized geriatric services? (PatientlClient Groups)

The panel's comments:

- As starting point -- seniors with medical, psychiatric, and psychosocial problems that cannot be adequately addressed by a primary care team.

- Target population defined by needs and types of services required.

- Concerns were expressed about defining frail elderly as an exclusive client population since this precludes prevention as an appropriate role.

The expert panel agreed that the people who need SGS are seniors (and their caregivers) with complex medical, functional and/or psychiatric and social needs of recent onset.

What- do providers need "to give or to get", to achieve better SGS care for clients?

The panel's comments:

The following chart summarizes the special needs identified by each group.

.KEY NEEDS	PRIMARY CARE REFORM	COMMUNITY CARE	LTC FACILITIES	**HOSPITALS**	FAMILY AND **CAREGIVERS**
Access Needs	Consultation Shared care Telemedicine	Better transportation Access to urgent psychogeriatric assessment	Faster access to assessments Access to psychogeriatric beds	Effective case management Ongoing priority assessments for respite admissions	Realistic expectations of both professionals and families Right to expect help in providing care
Delivery System Needs	Responsiveness to rural/urban differences Responsiveness to Francophone needs Guidelines and care maps Clinical communication for complex cases	Partnerships & networks that share assessments Service templates and policy frameworks with service standards (benchmarks) All professionals & paraprofessionals involved in care planning All hospitals and CCACs with capacity for geriatric assessment	Facilities specializing in specific care issues LTC as teaching centres Active web site technology to access best practice Better understanding of acute care hospital geriatric care	Senior friendly policies A forum to come together on planning and care issues Change in attitude Throughput and seamless care Increased SGS capacity in hospitals, community and LTC Step down capacity	Preplanning and progressive disease education to prevent crisis Continuity though ongoing linkages to professional care providers
Human Resource Needs	Better education at all levels PCR must reflect geriatric needs Best practice for all providers	Training and education	Expanded "PIECES" training with funding	Educational resources for hospital personnel	A consistent coach Education for family caregivers Education of family doctors & CCACs re family caregiver needs
Financial Resource Needs	Appropriate compensation	APPS for family physicians, geriatricians and geriatric psychiatrists	Eliminating wage disparities Nurse practitioners funded to help carry out ideas of SGS	Appropriate funding for services determined by local community planning	Rapid response to needs is essential
Information and Research Needs	Evidence re multi-cultural practice	Evidence re best practices in community care	Evidence re best practices in LTC	Elder friendly care and benchmarks for complex acute care	Information about when and how to access services and what will happen

PART THREE
KEY PRINCIPLES FOR SPECIALIZED GERIATRIC SERVICES

From the discussions on the preceding topics the following principles were developed:

- SGS should be based on a patient needs-driven entitlement for basic level of care

- SGS core functions should be comprehensive; integrated and provincially mandated

- SGS should be delivered through coordinated local/regional structures and networks

- SGS should address complex health problems using a multidimensional approach

  SGS should have a responsibility for the development and dissemination of knowledge and best practices

- SGS should use partnerships to extend knowledge and skills throughout the health and social service systems

PART FOUR
THE ISSUES

This component of the forum addressed the question, "What do we need to do and what conditions must be in place to make specialized geriatric services accessible throughout the province and better integrated within the continuum of care?" The key needs identified were: access, delivery systems, human resources, financial resources, and the capacity for data collection and research.

Participants were asked to identify the barriers and opportunities and to develop three strategies for each of these topic areas. The following summarizes the barriers and opportunities and the strategies.

What are the barriers and the opportunities to the provision of SGS?

The panel's comments:

	BARRIERS	OPPORTUNITIES
Access	Distances makes access difficult Lack of multicultural/multilingual practitioners	Technology Telemedicine
The Delivery Systems	Lack of interest and negative attitude Cumbersome referral processes No agreed upon mechanisms to identify local gaps and needs Limited methods/models that ensure access Lack of accountability Lack of technology infrastructure	SGS recognized as a priority program Development of models that are culturally sensitive Mechanism for local planning to identify gaps Two approaches to delivery: build on what exists, recognizing that current structures need to be changed and/or establish core programs and core population and then establish standards of-practice Planning process that are open and creative while being based on accepted benchmarks
Human Resources	Inability to recruit and retain staff for SGS at all levels Critical shortage of geriatricians and nurses with geriatric specialization (Factors contributing to shortages	Mentoring to encourage the transfer of knowledge and skills Primary care reform can reshape the system Generalists could be equipped with specialist skills

	• Lack of exposure at generalist level • Compensation • Disincentives for this field • Lack of government and academic commitment) Inadequate funding for provincial education of health care providers including SGS providers Lack of training and evaluation for new staff and existing practitioners Lack of inclusion in current curriculum Lack of training fellowships	Development of an overall HR strategy Nurse practitioner program Family medicine specialization in care of the elderly (third year fellowships)
Financial **Resources**	Lack of integration of funding mechanisms and flexibility; geriatric medicine and psychiatry have different funding sources Lack of LTC facilities and resources in the community sector Lack of provincial benchmarks for geriatric medicine (includes rehab) Inadequate funding mechanisms for physicians who care for the elderly Compensation inequities across sectors e.g. hospitals/communities Financial disincentives for service efficiencies No accountability of hospitals to provide SGS through global budgets Current RGP funding dollars. inadequate for current population served No funding for CCACs to cover physician services	Capitalizes on political will Funding that fits the different kinds of communities. Local coordinating networks optimize the use of SGS resources Benchmarking models could be defined and developed Identify the existence and scope of SGSs throughout Ontario then fund feasibility projects in areas where services are needed Using provincial regional networks on an interim basis with an evaluation component APPs for AHSC Accessing new federal/provincial transfers
Information and Research	Lack of information Lack of knowledge and expertise on the front line Lack of knowledge about resources	Information sharing across sectors Proactive dissemination of new initiatives Media coverage of health care pressures

What are the key strategies?

The panel's comments:

Panel members developed strategies aimed at addressing each of the five key issues: access, delivery systems, human resources, financial resources, and information and research. The strategies are presented in the order of priority as ranked by the expert panel. The first five strategies listed below were widely endorsed by the expert panel.

1. By January 2001, the government should declare care of the elderly as a government priority, and develop a policy framework for Specialized Geriatric Services

2. The development and implementation of a Human Resources Strategy for health professionals (nursing and other non-physician groups) related to SGS, including:
   - the development of formal and field-based training in SGS care and teamwork

   - recognition of training and mentoring (knowledge, skills, and attitudes) e.g. compensation, status, clinical career ladders

This recommendation is based on the assumption that human resource shortages in other parts of the system are being addressed, e.g., primary care, LTC and community.

5. Seek advice from an external expert panel and establish a provincial policy framework and guidelines, to define core services including the range, mix and funding for both SGS and specialized health professionals

6. The MOHLTC should acknowledge that there is a crisis in physician resources for specialized care of older people and take the following appropriate actions:
   - develop and implement a human resources strategy, focusing on recruitment and retention (with appropriate incentives) to achieve appropriate numbers and distribution throughout Ontario

- designation and funding of appropriate physician training opportunities, including
  - ❑ geriatric psychiatry fellowships
  - ❑ geriatric medicine fellowships
  - ❑ care of the elderly third year fellowships
  - ❑ short (two to four weeks) training opportunities for family physicians as is done for primary care

- expand and develop alternate funding arrangements for physicians

5. Develop and implement a coordinated provincial SGS infrastructure that addresses regional needs and supports demonstration projects by means of
   - provincial network
   - local/regional coordination
   - provincial, regional, and local advisory committees
   - marketing SGS
   - information sharing and education with linkages to other networks

6. Immediately dedicate $10 million to two initiatives:
   - government to identify and fund a capable organization to coordinate the development of local/regional plans (in accordance with provincial policy framework and guidelines),
   - government to identify and fund existing providers of SGS to work in partnership with under served areas to increase access and coordination

7. The province should place its research priorities in the short and mid term (three - five years) on the development, delivery and dissemination and utilization of practical clinical research related to care of the elderly. It should also fund provincial, regional, and local mechanisms to promote best practice information and its use in decision-making and performance improvement.

8. Support the development of a variety of models of delivery of SGS. Criteria include:
   - local community development
   - simplified access
   - using technology to extend knowledge
   - information systems and resources sensitive to community needs

13. To make the most appropriate use of SGS, establish a basic level of knowledge and attitude and skills to support delivery of quality seniors' services across the health care system

14. For all existing and future MOHLTC policy and funding initiatives (e.g. hospital global budgets, primary care, mental health, and CCAC allocations), MOHLTC must consider the health needs of older persons

11. Provide enhanced funding for program evaluation for SGS

12. MOHLTC should recommend to the Ministry of Training, Colleges and Universities that all health care personnel, in their training, should be required to demonstrate. discipline specific core competencies in caring for older persons

PART FIVE
FUNDING PRIORITIES

Each participant was asked:

- What are your top three priorities?
- What specifically would you fund to achieve these priorities?
- What criteria would you use to determine the funding allocation?

The following summarizes individual panel members' responses to those questions that in many instances were predicated on the contention that the province needs to provide leadership in the development of a policy framework for the care of seniors in Ontario.

What would be your top three funding priorities?

The panel's comments:

1. Improvements in the delivery system including:
   - development of guidelines for SGS and best practices for care of the elderly
   - adequate staffing of existing resources and services
   - overall provincial policy framework
   - strong planning processes at regional levels
   - demonstration projects of best practices and practice innovations
   - strengthening of community care system including home support workers and outreach teams
   - networking of all levels of service into a seamless continuum of care and including mental health services

2. Improving access to service in under-serviced areas (both urban and rural centres) including:
   - Population-based distribution of resources with special consideration for population demographics such as northern services, rural services, and services in languages other than English
   - recruitment and retention strategies for physicians and other health care providers
   - resources to train primary care providers

3. Improving payment systems for physicians to encourage recruitment and retention of family physicians, geriatricians and geriatric psychiatrists

What *specifically* would you fund to achieve these priorities? (Top five identified)

The panel's comments:

- Fund existing programs and services in order to upgrade to meet minimum standards and benchmarks
- Fund local/ regional planning processes
- Expand community outreach initiatives
- Fund the development of standards and benchmarks
- Fund APPs.

What *criteria* would you use to determine the funding allocation?

A number of criteria were identified in considering which services/priorities should be funded (not in any priority order).

The panel's comments:

- Access
  - ❑ outreach component
  - ❑ maximize access including geographic and cultural access
  - ❑ encourages provision of resources to rural and northern centres
  - o promotion of equity across services
  - o creative use of technology

- System
  - ❑ collaboration to achieve maximum coverage/access - with service agreements that ensure actual service delivery
  - ❑ promote partnerships across services
  - o commitment to integrated approach
  - ❑ ensures quality care
  - o based on established needs of the community it serves; accountable to that community
  - o not more of the status quo
  - ❑ integration of geriatric medicine and psychiatry services
  - o supports or is supported by regional geriatric centres

- Human Resources
  - ❑ must have educational component
  - ❑ develop expertise in a variety of disciplines, not just physicians

- Financial Resources
  - ❑ , equitable, population-based distribution of money
  - ❑ allocates scarce resources to the most complex situations
  - ❑ distinguish between planning, delivery, training and research funds to ensure that all aspects are funded
  - ❑ funded through or controlled by the most appropriate community or institutional base

- Research
  - ❑ must include research component addressing benchmarks and quality of care

PART SIX .
SUMMARY RECOMMENDATIONS TO THE MINISTER

As a concluding exercise panel members were asked: if they could have an opportunity to make a brief statement to the Minister of Health and Long-Term Care about specialized geriatric services, what would they say?

The panel's comments:

"The aging of the population and its impact on health and social services is the single most important issue of the next decade."

"Seniors and their families want to be healthy and independent. The service system is inadequate to achieve this goal."

"The current system is ***inadequate*** *to meet the needs of the 65 + users but this is not an* ***insurmountable*** *problem. There is expertise in Ontario willing to work with you to correct this."*

"There is a serious immediate gap in human resources and skill set amongst MDs, health care professionals and clinicians and health care providers to meet the present needs of the elderly. What are we going to do in the future?"

"There is consensus on both the crisis and the solution - A Health Human Resource Strategy. This is critical to the appropriate development of specialized geriatric services ***and should be*** *integrated into all other health strategies."*

"You were wondering why ***there has not been a change in the*** *ER situation.* ***You have*** *put in place many of the building blocks - except for one. What has been missing is a comprehensive strategy for seniors."*

"I was at a recent panel on health care for the elderly. I was impressed by the consensus at that meeting from people from all sectors. They have in my opinion an important solution which we need to capitalize on."

APPENDIX A
EXPERT PANEL PARTICIPANTS

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APPENDIX B
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