

Regional Geriatric Program Executive Committee

Forging Ahead

Progress Report of RGP Central
April 2002

A Draft Consultation Paper

* RGP Central is the proposed name change for SHCERP

Executive Summary

The purpose of this document is to lay out a pathway for the direction that the Regional Geriatric Program Central will follow in the next five years. This document is written to act as a catalyst to move our agenda ahead and continue to develop Specialized Geriatric Services in our region. This document was written to facilitate:

- 4 Consensus Building
- 5 Communication
- 6 Recognition of unique regional needs related to service, resources, education and evaluation.
- 7 Accountability to program members and to those we serve.

This is the first in a series of regular reports highlighting progress in all strategic areas. We welcome feedback as we recognize the richness of work created through collaborative relationships is invaluable.

We acknowledge the support of those who assisted in strategic planning from January 2001 to September 2001. This group developed consensus on the mission and vision of RGP Central and identified four core areas for development: service inventory; linkages; best practice; outcomes and evaluation. The feedback strongly recommended the need to restructure the Executive to make it more inclusive and responsive to regional needs.

Our greatest challenge is the shortage of human resources - individuals who are trained to provide specialized services. Section 3 identifies the growth projected due to demographic changes. The strategic planning process and activities in the four core areas are described in section 4. The proposed execution of the strategic plan, including restructuring of the Executive Committee, short and medium term goals, are described in section 5.

We have embarked on our course, following our vision and our strategic plan. This document describes the challenges, our progress to date and lays the groundwork for our course over the next few years.

We trust our hallmark statement will be practically felt in all our planning stages together: ***Wisdom through experience.***

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1.0 Participants in Strategic Planning Process - 2001

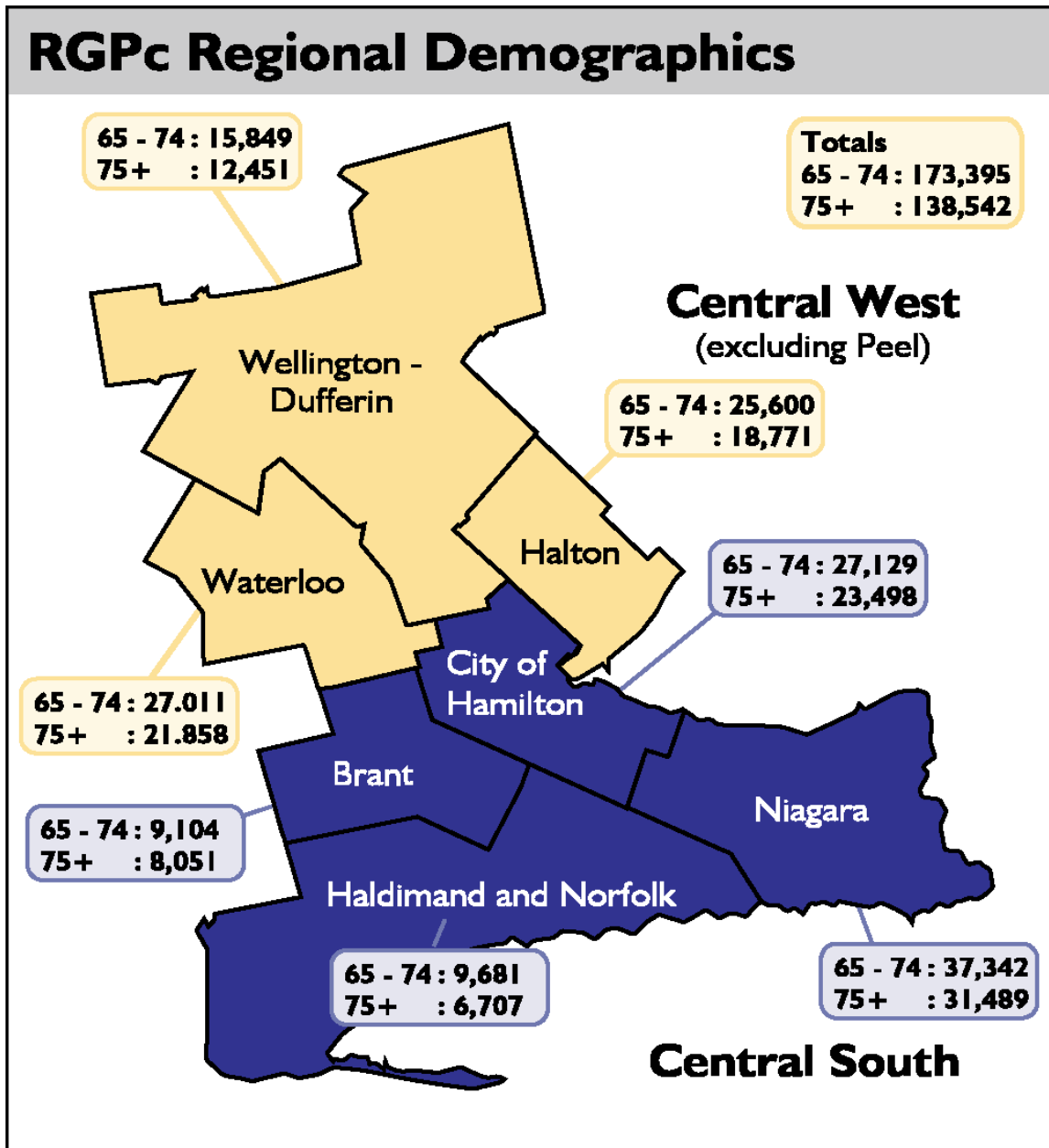
The following individuals participated in 6 evening workshops facilitated by Susan Watt and Susan Goodman. We gratefully acknowledge the contribution made by everyone.

Name	Organization
Christine Anderson	Hamilton Health Sciences
Julia Baxter	Halton Psychogeriatric Outreach
Julie Bodden	RGP Central and R. Samuel McLaughlin Centre
Karen Conway	Grand River Hospital, Kitchener
Donna Cripps	St. Peter's Health Care System
Anne Crowe	Grand River Hospital, Kitchener
Marion Emo	Hamilton District Health Council
Michelle Gagnon	St. Joseph's Healthcare, Hamilton
Joan Kaden	Waterloo Region – Wellington – Dufferin DHC
Sheri Lynn Kane	St. Joseph's Hospital, Guelph
David Lewis	St. Joseph's Centre for Ambulatory Services/RGP Central
Barb MacKinnon	Hamilton CCAC
Dilys Haughton	Brant Health Care System, Brantford
Sunny Luthra	St. Peter's, HHS
Victoria Madsen	Niagara and Brant Mental Health Outreach
Pat Mandy	Hamilton Health Sciences
Carrie McAiney	Division of Geriatric Psychiatry
Jane McKinnon Wilson	Community Mental Health Centre, Dufferin
Wendy McPherson	Niagara General Hospital
Willie Molloy	Hamilton Health Sciences/RGP Central
Christopher Patterson	Hamilton Health Sciences
John Ruetz	St. Peter's Health Care System
Karen Saperson	Division of Geriatric Psychiatry, St. Joseph's Mountain Site
Neil Tarswell	Haldimand-Norfolk Psychogeriatric Outreach
Irene Turpie	Division of Geriatric Medicine, St. Joseph's Ambulatory Care
Irene Tuttle	Family Physician

Current Regional Geriatric Program Executive Team

Name	Organization
Christine Anderson	Hamilton Health Sciences
Julie Bodden	RGP Central, R. Samuel McLaughlin Centre
Donna Cripps	St. Peter's Health Care System
Marion Emo	Hamilton District Health Council
David Jewell	RGP Central
David Lewis	St. Joseph's Centre for Ambulatory Health Care, RGP Central
Barb MacKinnon	Hamilton CCAC
Pat Mandy	Hamilton Health Sciences
Willie Molloy (Chair)	Hamilton Health Sciences, RGP Central (Chair)
Christopher Patterson	Hamilton Health Sciences
Karen Saperson	Division of Geriatric Psychiatry, St. Joseph's Mountain Site
Irene Turpie	Division of Geriatric Medicine, St. Joseph's Centre for Ambulatory Health Services

3.0 Map of Regional Geriatric Program Central



Figures indicate number of people 65-74 years of age and 75 and older based on Statistics Canada 1996 projections for the year 2000

4.0 Introduction

Regional Geriatric Programs (RGPs) were established in 1986 by the Minister of Health. The Ministry strategic plans for a comprehensive system of health services for the elderly was entitled “A New Agenda”. Hamilton and Ottawa had the distinction of being the first RGPs. Eventually one RGP was established in each of the cities of the five Universities with health science centres:

- Ottawa
- Kingston
- Toronto
- Hamilton
- London

Part of the plan was to use the expertise developed by the academic health sciences centres to help improve the quality of geriatric services provided by Ontario’s acute and chronic hospitals. Since the RGPs inception in Hamilton, leadership for this program has been provided by Dr. Christopher Patterson, Dr. Kevin Smith and our current chair, Dr. Willie Molloy. The RGP in Hamilton has not been a static entity, and in 1997 amalgamated Geriatric Medicine, Geriatric Psychiatry and Complex Continuing Care under the RGP umbrella.

It is recognized that Specialized Geriatric Services are interdependent on the quality and accessibility of community based care. Close liaison with providers such as Primary Care, CCAC and LTC facilities will enhance the capacity of the program to improve the quality of life of senior citizens in our region through service coordination, education and evaluation. **The Seven (7) regions covered by RGP Central include: Niagara, Brant, Haldimand and Norfolk, Hamilton, Halton, Waterloo, Wellington-Dufferin.**

4.1 Context of Change

In October/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 and integration of specialized geriatric services (SGS) across the continuum of care. The summary recommendations in 2001 were:

“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.

SGSs are a small but critical component in the continuum of health and social services required by a minority of older people. SGSs are a resource to the four major components of the system: primary care, acute care, community care and long-term facility care.¹

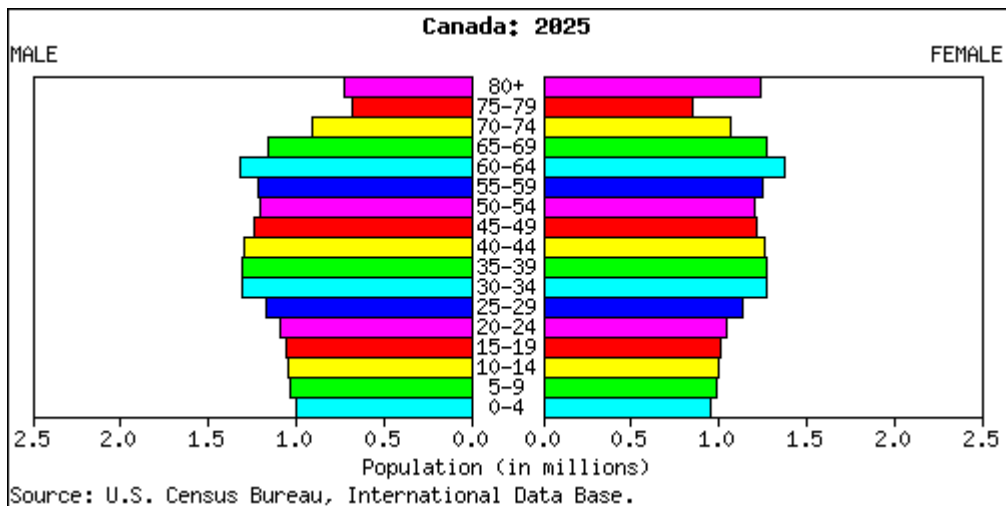
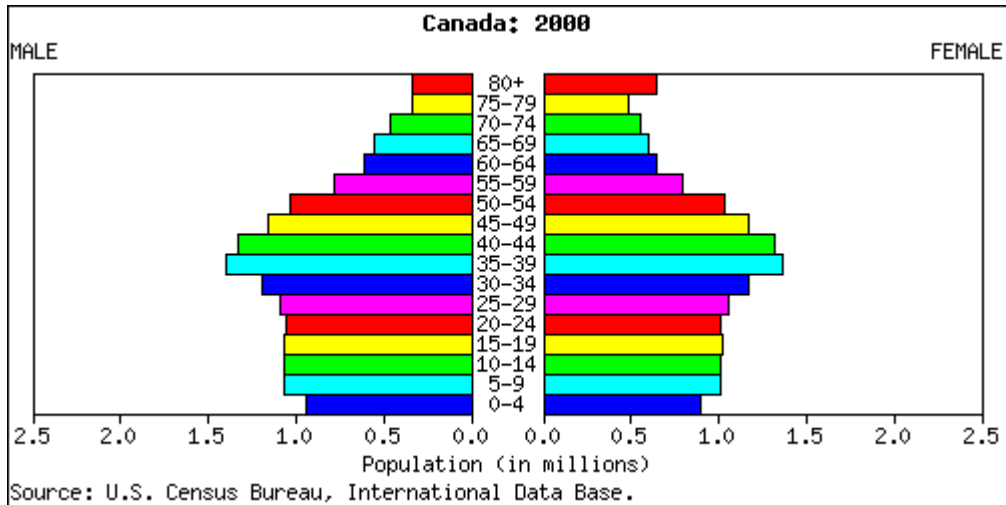
4.2 Demographic Picture

It has been well documented that there is a growing demand for specialized geriatric services. The following information provides a profile of these demographic pressure points for the 65 plus age group:

- Seniors in this age range represent 12% of the total population but consume over 44% of the province’s health budget
- Represent 50% of acute hospital days
- Projected to the year 2026/27, seniors will make up about 21% of the population and approximately 60% of health spending will be directed to caring for this age group.
- People are more likely to require SGS’s in the later stages of old age - the 75 + population which is growing faster than the generally cited 65 + Population.
- Capacity to meet current demand is limited and will be under increasing

pressure as 75 + population grows by more than 18,000 per year

- SGS's are particularly inaccessible to the 50% of Ontario's elderly who live outside a major urban area.²



4.3 Challenges

One of the key challenges in implementing our strategic plan is **recruitment and retention** of Geriatricians, Geriatric Psychiatrists and allied health specialists. In *Geriatrics Today*, Dr. David Hogan states 1.25 Geriatricians are needed for every 10,000 adults aged 65 or more.³ This figure was developed through a Delphi consensus process of Ontario Geriatricians based on

consensus figures from different groups of Geriatricians from various countries. Based on figures listed on Table 2 (296,287 people aged 65 or more reside in this RGP - 1996), and according to the Delphi consensus process we should have 30×1.25 Geriatricians = 37.5 Geriatricians. With only 13 funded positions in the RGP Central there is little prospect of meeting the goal of 37.5 Geriatricians. The same is true of Geriatric psychiatrists. At the direction of the Regional Executive Steering Committee we will promote strategies to **build capacity and specialty services in under serviced areas.**

A number of significant challenges face many aspects of care coordination and planning. Most of the Geriatric specialists are in urban areas like Hamilton, yet there are regional areas with a large proportion of seniors, such as Niagara, with very limited resources.

The shortage of family physicians and nurse practitioners limits our ability to build capacity in the system to help alleviate the human resource issues. These staffing shortfalls are an enormous challenge for recruitment and retention of Geriatric specialists as other health sectors are also competing for these same limited resources.

Due to this working reality, we need to develop models of care that will offer opportunities for capacity building in service, education and evaluation. We need to create efficiencies in the system while promoting quality of care.

The RGP is assimilating **profiles of each community**, to include demographics, mapping of resources, reviewing utilization reports and determining appropriate health outcome indicators that are amenable to interventions. In addition we will analyze the Canadian Institute for Health Information (CIHI) and non-institutional databases for each community. By profiling these communities and the services currently available we will obtain information that can be used as a planning tool. It is expected building capacity (i.e., sharing best practice, evaluation of new models of care, advising on best use of limited resources) in targeted areas will be based on a sound evidence-base and committed to a system perspective.

5.0 Strategic Planning Process 2001: Engaging Community Partners:

Our strategic planning process began in January 2001. Our community partners were engaged in a series of workshops facilitated by Susan Goodman and Susan Watt (Policy Planning Plus Inc.). Consensus was reached on the role of SHCERP (mission and vision), services were described and from this a strategic plan was developed.

This process also identified the need to be more inclusive of the regions outside Hamilton and to focus on Specialized Geriatric Services. Stakeholder feedback defined SGS's as those services provided by Geriatricians and Geriatric Psychiatrists". Specialized services include "direct hands-on service provision and services provided in affiliation with at least one of these medical specialists." **The strategic plan identified four priority areas: Service Inventory, Service Linkages, Dissemination of Best Practice and Health Surveillance and Outcomes Evaluation.** This process was documented and lead people were identified for each priority area. In addition, the human resources required to help implement the plan were reviewed and a job description for a Manager was developed as well as the process to move to a full time chair. This strategic plan is described in:

"The Future of Geriatric Service in Central South and Neighbouring Areas (June 2001)".

Since the completion of the strategic planning process, a Manager and Chair have been hired and are in the process of implementing the strategic plan. Milestones to date are:

- Completed the strategic planning process culminating in four (4) strategic directions (June/01)
- Hired a manager (David Jewell - Nov/01)
- Confirmed the chair (Dr. W. Molloy - March/02)

Significant effort is being made to communicate progress with our community partners in an effort to keep them engaged and informed.

The manager's orientation included meeting the strategic planning participants, and learning about the various programs, their scope of service, workflow issues and different practice models.

Four Strategic Planning Task Groups

5.1 Service Inventory: Lead - Willie Molloy, Chair, RGP Central

In order to outline the extent of existing services in the area, we have instituted a multi-phase data collection process. Phase I – an inventory of geriatrician services based on self-report – provides some information about the location and scope of services; it will eventually be paired with utilization data, demographics and more specific information about models of care.

Phase I is a self-report by Geriatricians on three-hour time slots. Overall response was 85% among the 13 Geriatricians active in the area in January 2002. In that time, Geriatricians reported working a total of 527 clinical time slots (3 hours), or about 1581 hours per month. Using 37.5 hours of *clinical time* per week (i.e. 150 hours per month) as our standard, there were 10.5 FTE Geriatricians active in the RGP Central catchment area in January 2002. Data on the distribution of these slots is presented below (Table 1).

Table 1: Geriatric Medicine Service Inventory Profile January 2002 Average Number of 3-hour time slots per month

	Out Patient Clinic	Day Hospital	Inpatient Consults	GARU/ GAU*	Outreach	Totals by Site
HHS	73	6	24	30	28	161
Other Hamilton	85	20	52.25	8	0	165.25
Niagara, Haldimand & Norfolk, Brant	42	0	20.5	4	2	68.5
Waterloo, Wellington-Dufferin, Halton, Northern	75.5	0	40.75	16	0	132.25
Totals by Service	276	26	138	58	30	527

(see Pie Chart in Appendix B)

The breakdown of geriatricians' time is 62% in Hamilton and 38% in other locations in the RGP Central area. However, the proportion of elders is 24% in Hamilton and 76% in areas outside Hamilton (see Table 2 Geriatrician supply). Table 2 indicates that Hamilton approaches the "Hogan consensus standard" of 1.25 geriatricians per 10,000 people over 65, while other areas fall considerably short of that ideal. The Clark consulting Group established benchmarks for Psychogeriatric Outreach Programs and concluded in their 1996 report that 6.5 fte staffing was required per 10,000 older persons. One fte medical specialist (Geriatrician, Geriatric Psychiatrist) was included in this benchmark.⁴ This recommended benchmark is very close to Hogan's consensus standard.

Table 2: Geriatrician Supply by Area

	Geriatrician Est FTE	N Aged >=65	"Hogan Standard" Requirement (1.25/10,000)
Hamilton	6.8	71,587	8.94
Other	3.7	224,700	28.09

Phase two is also a self report, profiling hours of clinical service (3 hour time slots per month) for Geriatric Psychiatry.

Table 3: Geriatric Psychiatry Service Inventory Profile January 2002 Average Number of 3-hour time slots per month

	Out Patient Clinic	Day Hospital	Inpatient Consults	GAU/A1	Outreach
Hamilton	54	4	38	10	50
Waterloo	2		14		26
Niagara & Brant			4		29
Halton			24	8	20
Wellington-Dufferin			24		9

(See Pie Chart in Appendix C)

5.2 Linkages: Lead - W. Molloy, Chair RGP Central

Service linkage information will fall out of the additional information gathered from the service inventory. We want to capture information about referral patterns, gaps in service, underutilized areas, potential areas for collaboration and capacity building. We also want to explore how organizations link with one another to facilitate timely communication.

We have completed an RFP for the development of the **RGP Central website** and Stephen Kingston from Media Doc has been chosen. A small task group is assisting with this project. The goal is to have this website as interactive and functionally useful as possible. For example, we plan to post best practice documents such as information from the Delirium Prevention and Education committee. This best practice information will be available for anyone to review and download from the website.

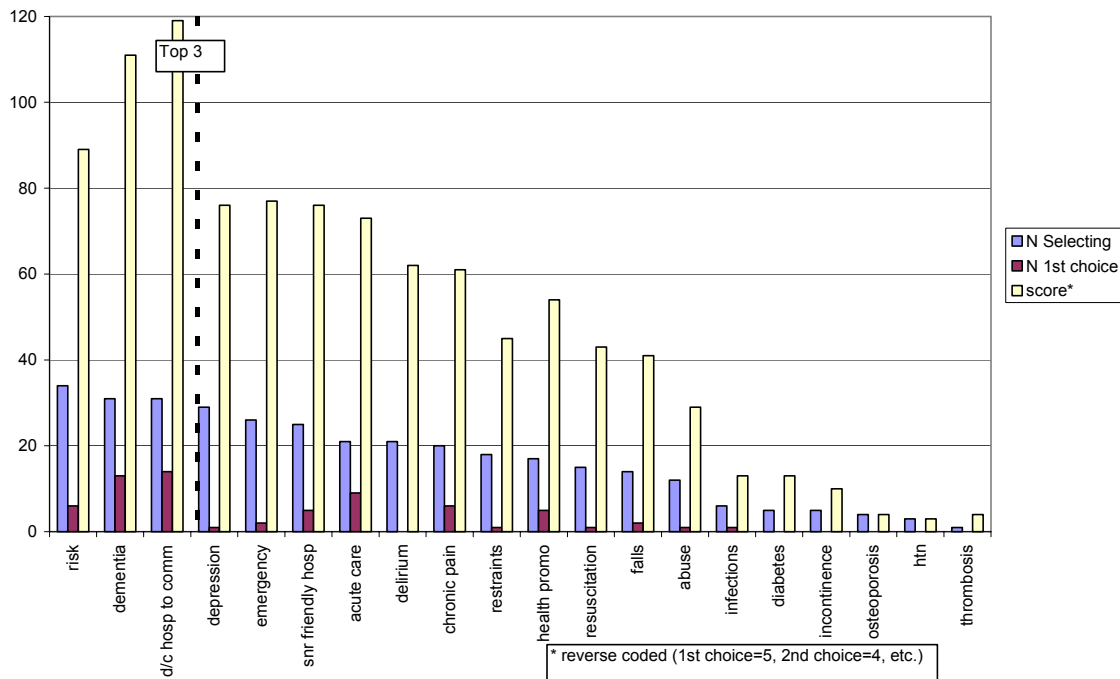
The RGP Central website will be available to use in the near future. All posted information; design, colours and navigation issues will be “under construction” to ensure edits can be made based on feedback. More information will be circulated about this.

5.3 Best Practice: Lead - I. Turpie, Head, Division of Geriatric Medicine

The overall goal of this group is to determine priorities and disseminate and promote consistent utilization of best available practice guidelines. We have circulated a “**ONE MINUTE**” survey asking team members working in Specialized Geriatric Services (SGS) and affiliated organizations to prioritize (from the list provided) their “most pressing work issues”. We received 67 responses. The top three responses were:

- ◆ Discharge planning
- ◆ Dementia care
- ◆ Risk management

Chart 2: Best Practices: Rankings



Over the next few months we will confirm priorities for 2002/03, and identify multiple strategies for dissemination.

An excellent example of the dissemination and promotion of best practice guidelines is the **Delirium Prevention and Education project committee**. Tapping into a significant volunteer force of over 100 health care professionals, a one day audit of the prevalence of Delirium was completed in Hamilton (four acute care sites) on October 17, 2001. This information has been analyzed by Dr. C. Mcainey and the results are available in Appendix B. Committee members have designed a resource manual providing in depth information on Delirium (clinical and risk factors, prevention strategies and management) including specific tools and relevant articles. To help promote this educational initiative and sustain a high level of skill in this area, a large laminated poster has been designed for staff and patients/families. Finally, each acute care site has designated leaders who are committed to the ongoing education of staff (including administration) about this health care problem.

These designated leaders are members of the Delirium Prevention and Education Committee and include:

10.0	Esther Coker	HHS, Chedoke
11.0	Pat Ford	St. Joseph's Healthcare
12.0	Carrie McAiney	Dept. of Psychiatry
13.0	Christopher Patterson	Dept. of Medicine/HHS
14.0	Ann Pizzacalla	HHS McMaster
15.0	Lori Pokaradi	HHS Henderson
16.0	Cathy Reis	HHS General
17.0	Jackie Turner	HHS General
18.0	Brett Sanderson	HHS Henderson
19.0	Ann Tassonyi	St. Joseph's Healthcare
20.0	Julie Bodden	RGP Central
21.0	Mary White	RGP Central
22.0	Michelle Gagnon	Dept. of Medicine, St. Joseph's Health Care
23.0	Debbie Belowitz	HHS McMaster

A task group is focusing on the role of medications in Delirium. The relationship between medications and Delirium status will be examined among the 554 patients screened as part of Delirium Day.

5.4 *Health outcome evaluation:* Lead - M. Emo, Executive Director, DHC

We have established a collaborative working relationship with the District Health Council (DHC) and Central West Health Planning Information Network (CWHPIN). The work plan incorporates 4 stages:

- 10.0 Development of a comprehensive profile of seniors health issues
- 11.0 Mapping of resources utilized by SGS
- 12.0 Analysis of utilization data
- 13.0 Establishment of health outcome indicators.

In this first stage, CWHPIN will obtain demographics, general health and functioning and service utilization (hospital separations) data, from a combination of the Canadian Institute of Health Information (CIHI) and the Discharge Abstract Data base (DAD), census information and the National Population Health survey. We also are in the process of obtaining detailed and comprehensive data reports on utilization for each hospital in the region. The result of this work will be a comprehensive profile of the population health, trends and service needs for people 65 and older across the seven (7) areas in our region.

A second initiative will focus on obtaining regular access to data on inpatient and outpatient care. We will be receiving CIHI data on a monthly basis as well as outpatient visits including selected emergency rooms. Once a regular reporting relationship is established, specific requests can be made as the need arises. Key contacts have been established at some of the acute care sites (Decision Support Services) to facilitate this information.

An overall evaluation component will be developed for all task groups, with a specific focus on developing indicators that will help us evaluate core issues such as: Capacity building, streamlining work flow processes, standardization of intake and protocols etc. Evaluation will be in the form of process and outcome evaluations

Process: This will concern issues such as capacity building, visibility, streamlining work flow processes, standardization of intake tools etc.

Outcome: Will concern the impact of these activities on population health status including, goal attainment, mortality and morbidity, population service use and overall net benefit.

Other key steps:

⇒ **Promote increased awareness of the RGP** and in conjunction with the web site development, revise the logo from SHCERP to RGP Central. Initial feedback strongly indicates this change would increase visibility and understanding about this program. We will need to ensure people understand our RGP is unique as our program scope includes Geriatric Medicine, Geriatric Psychiatry and Complex Continuing Care.

⇒ Develop a **marketing plan**, incorporating key tactics that will help increase awareness about SGS's in our Region.

6.0 Education Activities

RGP Central has been supplied a report from McMaster University's Faculty of Health Sciences Postgraduate Education Office, which contains information about McMaster residents doing rotations across the province. This report shows that there were 2601 rotations involving a mean of 75 days (including weekends and holidays) between April 1, 2001 and Mar 31, 2002. Of these, 54 placements were in Geriatrics, and 4 in Geriatric Psychiatry, with a mean of 56 days between them.

Of the 58 placements, 33 were family medicine residents, 2 were residents in physical & rehabilitation medicine, 12 in internal medicine, and 5 each in geriatrics and geriatric psychiatry residency programs.

Chart 1 shows the percentage of all medical residents' placements which involve learning in a geriatrics or geriatric psychiatry setting. Only 2% of electives were in geriatrics and geriatric psychiatry. Given that family doctors spend more than 70% of their time caring for older adults, the fact that only 2% of electives are in geriatrics shows the mismatch between training and practice needs. Faculty have taken positive steps to address this issue. All undergraduate students now have a two week rotation in geriatrics. It is also incumbent on RGPs to address this issue as the current shortage of geriatric specialists challenges the efforts required to expand training in this area. Chart 2 shows the physical location of these geriatrics and geriatric psychiatry placements: 56% were at St Joseph's Charlton Site, 18% at its Centre for Ambulatory Health Services; 2% at its Centre for Mountain Health Services. In turn, 7% were at St Peter's, and 13% at Hamilton Health Sciences' Chedoke campus; the remaining 4% were in "community practice."

Finally, Chart 3 shows the chosen specialty or sub discipline of residents who were placed in a geriatrics setting: 57% were family medicine, 4% in physical medicine or medical rehabilitation, 21% in internal medicine, and 9% each in psychiatry and geriatrics. In other words, of the 2% of placements which were in geriatrics or geriatric psychiatry, only 9% involved future geriatricians, while as many as 9% involved future geriatric psychiatrists: that is roughly 10 placements each.

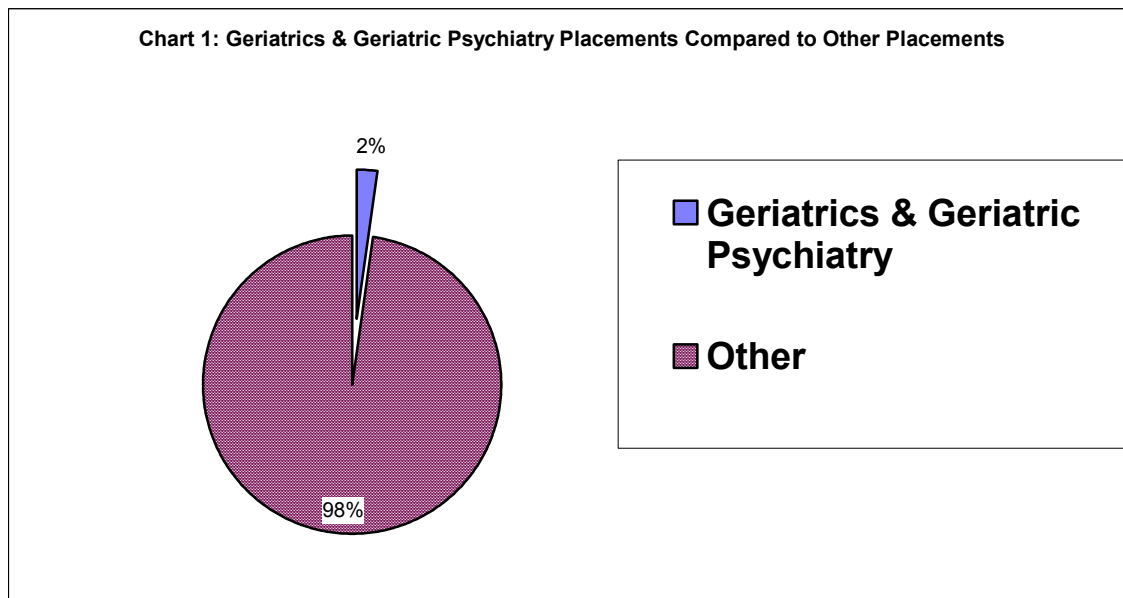


Chart 2: Geriatrics & Geriatric Psychiatry Placements by Site

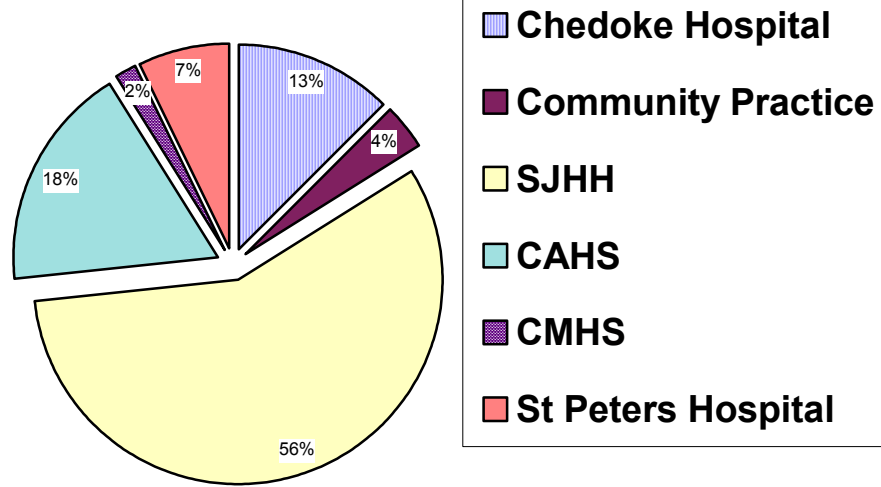
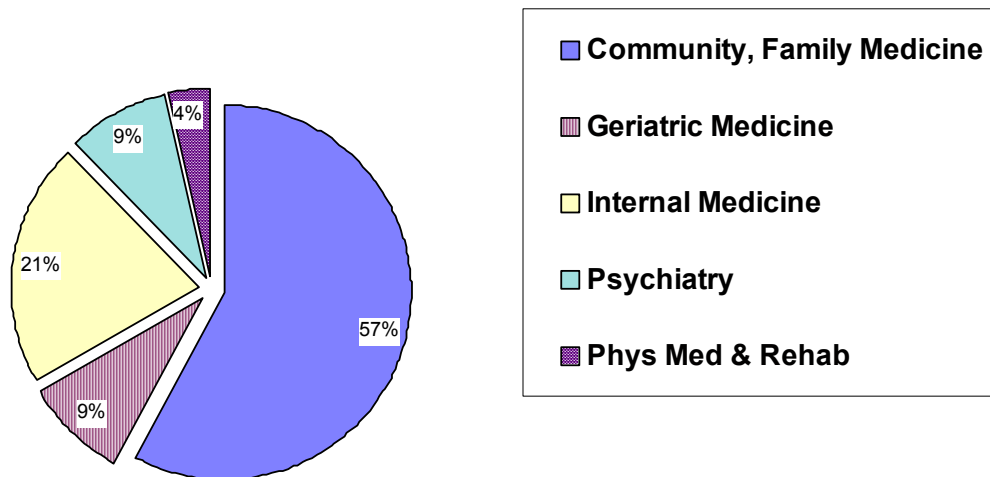


Chart 3: Programs of Geriatrics Residents



7.0 Strategic Plan:

7.1 2002 Short Term Goals

GOALS	Lead Person	Expected Completion Date	Complete
Human Resource Planning:			
● Hire Manager	Executive	October/01	Yes
● Hire Chair	Executive	March/02	Yes
Job Descriptions: 10.0 Manager 11.0 Chair 12.0 Administrative Coordinator	Executive Executive Manager	Sept/01 Sept/01 April/02	Yes Yes
Develop Strategic Plan and Task Groups: (4)			
1. Service Inventory	Molloy		
<ul style="list-style-type: none"> ● Collect data (3 hr time blocks) on GM and GP across region ● Examine feasibility of collecting data on allied health teams ● Examine feasibility of collecting info on models of service delivery ● Assimilate profile of regional areas: demographics, health of population data, service resources and identify priority areas 	J. Bodden D. Jewell	Jan/02 tbd tbd Nov/02	Yes
2. Linkages	W. Molloy		
<ul style="list-style-type: none"> ● Resource mapping in each area (7) - Focus groups/annual reports ● Assessment of resources available, gaps in service, utilization and referral patterns ● Communication strategies i.e. website ● RFP web site ● Web site construction ● Communication plan across regional SGS's ● Plan for revised Regional Executive Committee 	D. Jewell D. Jewell J. Bodden D. Jewell J. Bodden D. Jewell	July/02 Aug/02 July/02 Sept/02 Sept/02 Sept/02	Yes
3. Best Practice Guidelines	I. Turpie		
<ul style="list-style-type: none"> ● Phase One: Survey health care teams in SGS's - One Minute Survey ● Phase Two: Survey SGS's staff on top 3 priorities with structured "drill down" format ● Research best practice guidelines available on selected topics ● Plan an educational forum using multiple learning strategies ● Build in evaluation and follow up ● Publish article in Geriatrics in Aging journal 	Committee Committee Committee Committee D. Lewis I. Turpie	Feb/02 May/02 May/02 Oct/02 Oct/02 Jan/03	Yes
4. Health Outcomes and Evaluation:	M. Emo		

GOALS	Lead Person	Expected Completion Date	Complete
<ul style="list-style-type: none"> Develop comprehensive profile of seniors across 7 regional areas Define scope of system for SGS's - mapping of resources Examine utilization data Select health outcome indicators 	T. Abernathy	Aug/02	
	D. Jewell	July/02	
	D. Lewis	Sept/02	
	tbd	Oct/02	
Revise Regional Executive Committee	D. Jewell		
<ul style="list-style-type: none"> Recommend revised Regional Steering Committee structure Recommend transition plan Recommend RGP Central representation in each region in existing committees 			Yes Yes Yes
Support Ongoing Projects:	J. Bodden		
10.0 Delirium Prevention & Education – audit and statistical analysis	Committee		Yes
11.0 Next Phase – audit of medications and analysis		Sept/02	
Evaluation: Two core areas	D. Lewis		Yes
1. Over all evaluation of RGP Central activities: <ul style="list-style-type: none"> Evaluation support to 4 task groups Evaluation of HHS GAU - Phase 1 Programmatic evaluation - assessing service and RGP Central activities System evaluation including process indicators 		tbd tbd	Yes
2. Data collection (CIHI) - <ul style="list-style-type: none"> generate utilization data for SGS's on a monthly basis. Improve data quality Use data to inform practice/planning 		June/02 Oct/02 Nov/02	
Education:			
Co-chair - conference planning committee OGA/RGP - David Lewis	D. Lewis	Annual commitment	
Planning for OGA/RGP GEM Panel Discussion	D. Jewell	May/02	
Publication:	W. Molloy		
Progress Report: Draft Consultation Document "Forging Ahead"		June/02	

7.2 Restructuring the Executive Committee (May--September/02)

In consultation with regional stakeholders, we noted overwhelming agreement on the need to re-structure the current RGP Central Executive Committee to ensure that all the regions are represented equitably. This will give a voice to all the regions and allow each local area to communicate their unique needs more effectively. An audit has been completed regarding each region's key committees relating to health services for older adults. The attached chart outlines current committees and the status of developing structures. It is proposed that each regional area will nominate a representative/s for the RGP Steering Committee.

7.3 Rationale for New Regional Structure

It is recommended the number of representatives on the Regional Steering Committee be based on the population of adults 75 years of age or older in 2000 for each regional area. For example, there were 8,051 people aged 75 or more in 2000 in Brant, while there were 31,489 in Niagara and 23,498 in Hamilton (Statistics Canada/96), see Appendix B.

Based on the population data, we recommend there be one representative from each region with less than 15,000 adults aged 75 or more in 2000. Each region with more than 15,000 older adults aged 75 or more will have two representatives. Each region will nominate representatives from their local committees to represent them on the Executive committee. With representation from each of the different communities in our region, we also need to ensure we have representation from programs in the community across the continuum of care. To keep committee size manageable, individuals representing, for example, DHC's, will be responsible for reporting back to a cluster of DHC's in order to keep all organizations involved. As well, minutes will be directed to these sites to facilitate communication. Ad hoc committees may be struck as required to attend to specific, time limited tasks. However this is not expected in the early stages of this Regional Steering model. The programs to be considered for representation on the Regional Steering Committee include:

- Acute Care
- Long Term Care
- Community Care Access Centres
- Primary Care
- District Health Councils
- Complex Continuing Care
- Ministry of Health and Long Term Care
- Dementia Network
- Universities and Community Colleges
- Geriatric Psychiatry
- Geriatric Medicine
- Consumers

Next Steps:

If the above plan is accepted by the Executive Committee, Dr. Molloy and David Jewell will attend a meeting of the identified groups in each region to explain the mandate and get buy-in and commitment to our goals. This will also give us an opportunity to provide a progress report to these groups on RGP activities. We

plan to have the Regional Executive team selected prior to the summer with our first meeting in September/02.

7.4 Process of selection

We will request each region provide a list of **three names** with a short description of these people to the Management team. The most appropriate person based on the program needs described above will be chosen ensuring representation from the various services in the regions. We will give priority to individuals who are in a position of leadership in each region. Individuals on the Executive must have authority to bring issues forward within their own organizations to facilitate decision making. Candidates will be expected to link with their appropriate regional committee and key organizations and have the confidence of the region to speak on its behalf. The Executive will then decide, based on the submissions, which people will be chosen. Since the RGP's are affiliated with Health Science Academic Centres, the Executive will include a representative from McMaster University, Faculty of Health Sciences.

7.5 Size of Steering Committee

The Steering Committee will have 11 voting members from the regions. There will be one representative from the University and one from the Ministry of Health serving as ex officio members. The Management team will attend but will be non-voting. In the event of a tie, the Chair will cast the final vote. A quorum is 50% plus one voting members.

8.0 Accountability

The RGP Central accountability structure is as follows: The Manager, Evaluator and Planner, Administrative Co-ordinator and other team members are accountable to the Chair. The Chair is accountable to the Executive. The Executive is then accountable to the Ministry of Health and Long Term Care.

We are currently in the process of implementing our strategic plan by developing activities and timelines to ensure our operational plan is transparent to the RGP Central membership. Updates will be published on our activities on an annual basis with progress reports as appropriate at each Regional Steering Committee meeting. This document is the first of these reports to bring our membership up to date.

It is our goal to be open and responsive to our membership and Executive. We will seek regular feedback from our members to assess their impression of our progress and also to determine if the needs of our members are changing so we can adapt to these changes.

A process evaluation component will be designed related to our core activities and reported annually.

9.0 The Future

We will seek the direction of the RGP Central Steering Committee members for:

- (i) 2003-2005 Medium and
- (ii) 2006-2010 Long Term goals

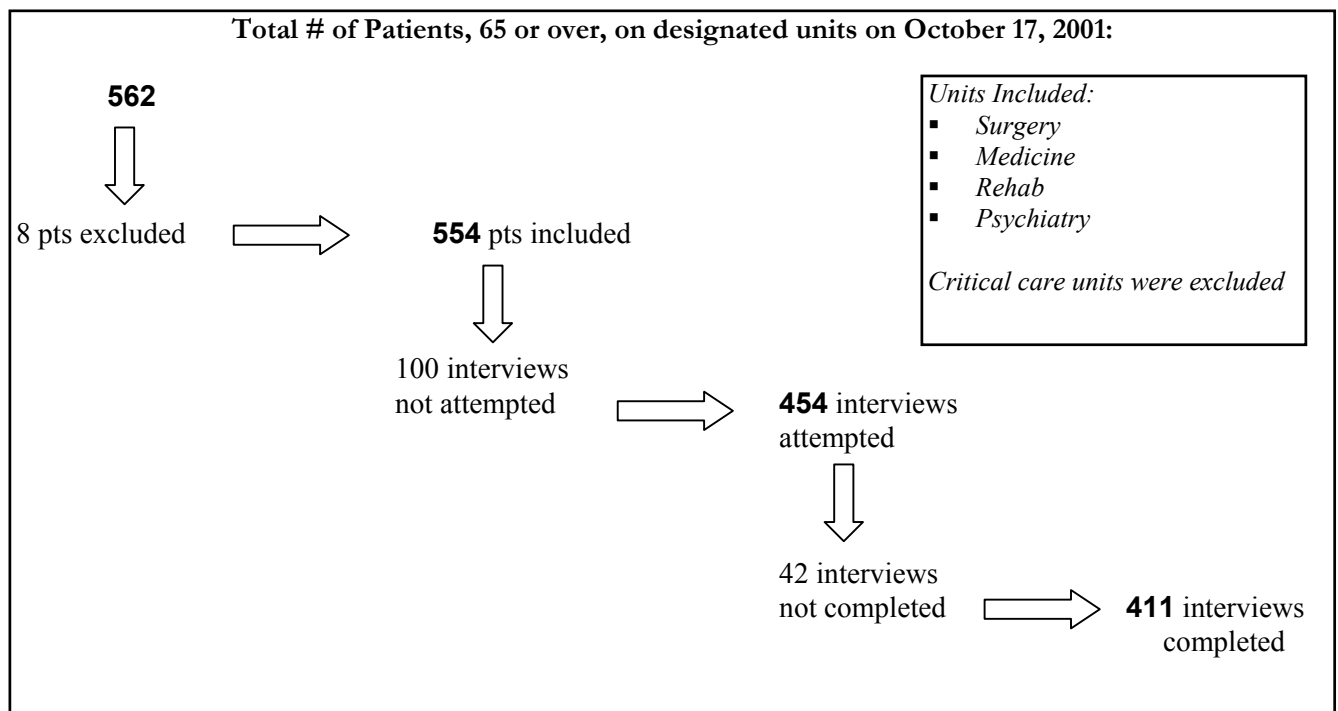
Appendices

Appendix A

Delirium Day: October 17, 2001 Summary of Results March 2002

Thanks to all of our Delirium Day screeners. Because of you, Delirium Day was a success! The following are some highlights of the delirium findings. Presentations will also be conducted at each hospital site in April. At these presentations, more information, including site-specific results will be provided. Watch for notices of these events!

The Population



On Delirium Day, October 17, 2001, there were 562 elderly patients across the 5 hospital sites (i.e., St. Joseph's Healthcare: Charlton Site and Mountain Site; Hamilton Health Sciences: General Site, Henderson Site, McMaster Site). Eight of these individuals were excluded because the patient and their chart were not available for the entire shift. Of the 554 patients included, interviews were attempted with 454 (80%) of them. The most common reasons for not attempting an interview were: patient refused (N=31); patient did not speak English (N=30); and the patient was too ill (N=11). Of the 454 interviews attempted, 411 were completed (90.5%). The most common reasons for not completing an interview included: language barriers (N=9); patient refused to finish the interview (N=7); patient was drowsy/kept falling asleep (N=5); patient was aphasic (N=5); and patient was too ill (N=5).

Assessing for Delirium

The delirium assessment consisted of 3 components: (1) an interview with the nurse, (2) a chart review, and (3) an interview with the patient. In cases where a screener was not able to complete an interview with the patient, the interview with the nurse and chart review were still to be done. The following table summarizes the percent of patients who screened positive for delirium for each component of the assessment, as well as overall.

Assessment	Percent (Number) who Screened Positive
According to Interview with Nurse (N=554)	5.6% (31)
According to Chart Review (N=554)	1.8% (10)
According to Interview with Patient (N=411)	2.2% (9)
Overall (N=554) (i.e., answered “yes” to CAM items #1, #2 and either #3 or #4 on either nurse interview, chart review or patient interview)	10.5% (58)

As indicated above, just over 10% of the elderly patients included in Delirium Day screened positive for delirium when all components of the assessment were considered. Almost 6% of patients screened positive according to the interview with the nurse, just over 2% according to the interview with the patient, and almost 2% according to a review of the chart.

It should be noted that the overall prevalence rate is lower than rates found in the literature, which range from 14% to 56%.

Frequency of Nurse Reports that Patients were Delirious that Day

During each interview with the nurse, screeners asked the nurse if they thought that patient was delirious today. In 89 cases (16%), the nurse reported that the patient was delirious.

Interview with Nurse (N=554)	Percent (Number) Responding “Yes”
Is this person delirious today?	16.1% (89)

Frequency of Specific Words being Recorded in the Chart

During the chart review, screeners reviewed the information in the chart and determined whether the words “delirium”, “acute confusion” or “confusion” were recorded in the chart during the 24-hours preceding Delirium Day. “Delirium” and

“acute confusion” were recorded in less than 2% of charts, and “confusion” was recorded in almost 15% of charts.

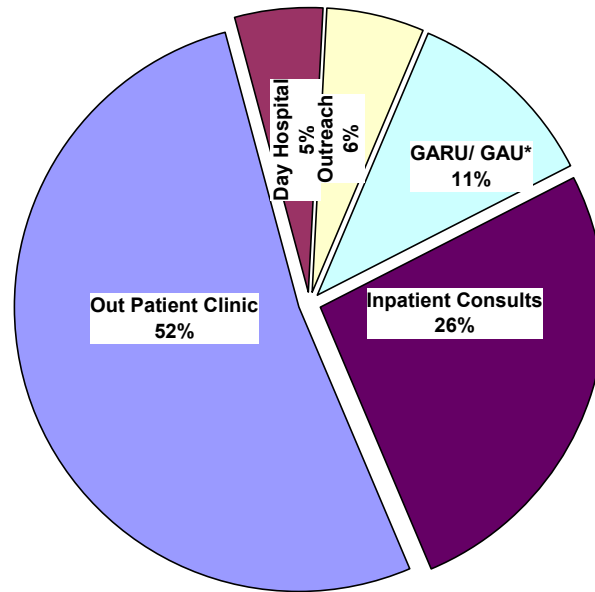
Delirium	1.4% (8)
Acute confusion	1.8% (10)
Confusion	14.8% (82)

More details to follow at the site presentations! Thank you again for all of your help.

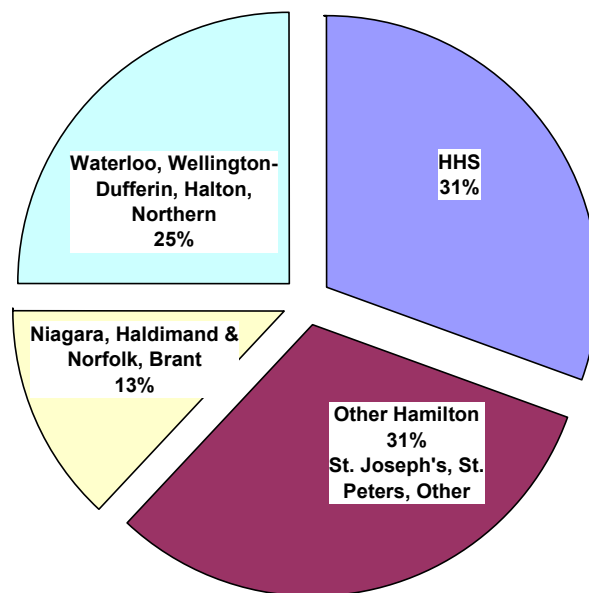
*Carrie McAiney, PhD
Member, Delirium Prevention & Education Committee
Specialized Health Care for the Elderly Regional Program*

Appendix B

Total Geriatrician Hours by Service

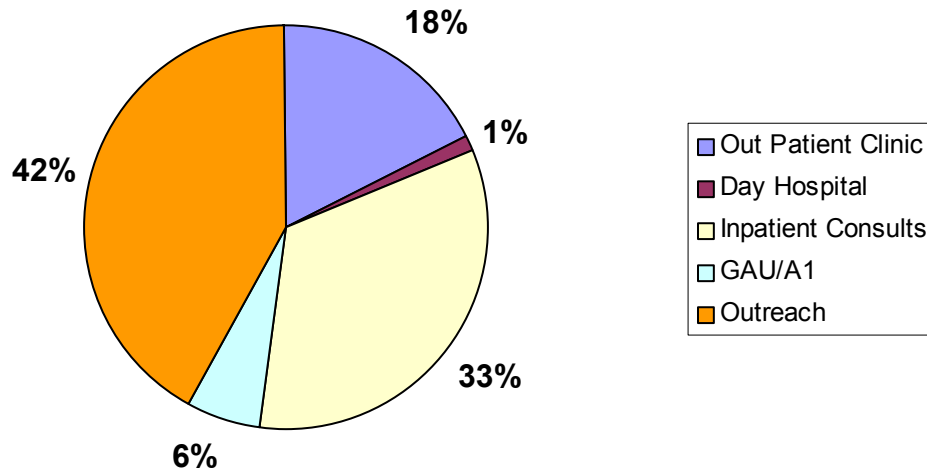


Total Geriatrician Hours by Site

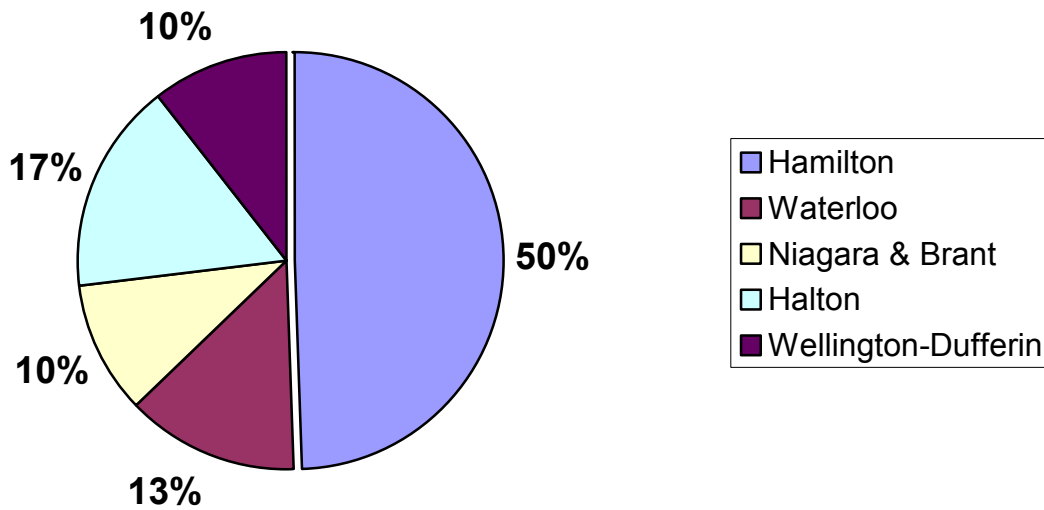


Appendix C

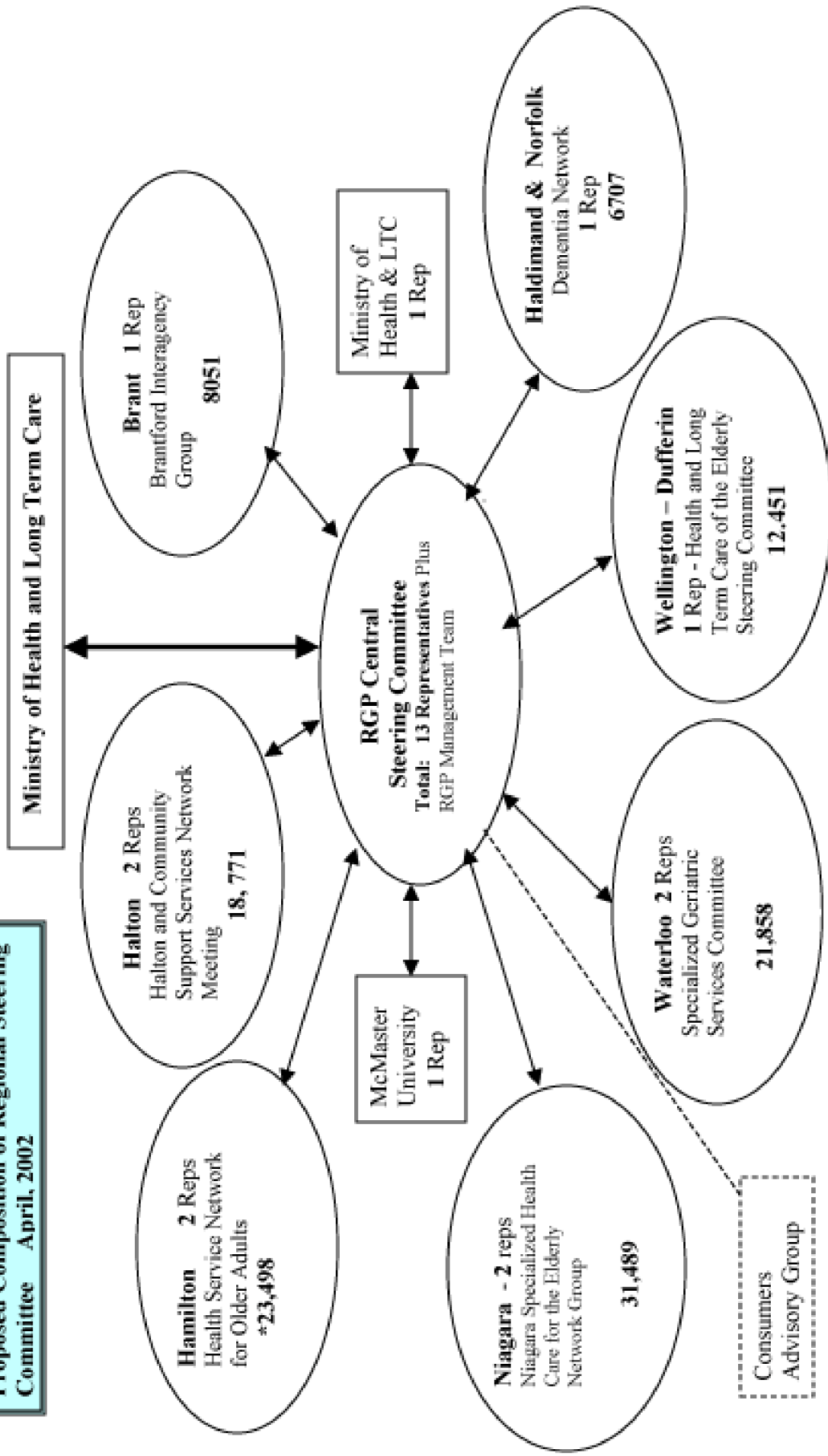
**Chart 5: Geriatric Psychiatry by Service Type
(Number of 3 hour Time Slots)**



**Chart 6: Geriatric Psychiatry by Site
Self-Reported in February, 2002**



Proposed Composition of Regional Steering Committee April, 2002



*Figures indicate number of people 75 years of age and older based on Statistics Canada 1996 Census projections for the year 2000

Rationale for Composition: < 15,000 over 75 = 1 representative
> 15,000 over 75 = 2 representatives

11.0 References

1. Ministry of Health and Long Term Care. (2000). *Expert Panel Report on Specialized Geriatric Services*
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3. Hogan, B (2001). Human Resources Training and Geriatrics. *Geriatrics Today: J Can Geriatric Society*. Feb 2001, 7-10
4. Clark Consulting Group. (1996). *Final Report: Establishing benchmarks for Psychogeriatric Outreach Programs.*