Priorities for Specialized Geriatric Services in the Hamilton Niagara Haldimand Brant Local Health Integration Network (HNHB LHIN)

Brief Report

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EXECUTIVE SUMMARY

Following a review of Year 1 proposals submitted for funding for the Aging at Home (AAH) Strategy, the Hamilton Niagara Haldimand Brant Local Health Integrated Network (HNHB LHIN) Board recognized the need to have Specialized Geriatric Services (SGS) priorities that could be used to assist them in making future funding decisions related to Year 2 and 3 AAH proposals. The Geriatric Access and Integration Network (GAIN) was asked to lead this process.

In addition to reviewing the literature on geriatric service models and continued work on a geriatric service inventory, GAIN undertook a two-part consultation process. Part one involved 13 focus groups conducted across the LHIN with 146 stakeholders from all sectors to identify gaps in SGS and suggest possible ways to address these gaps. Results from the focus groups informed the second part of the consultation, a Delphi consensus building process. Thirty-five experts, representing all sectors and geographic areas, were identified by existing networks/groups represented in GAIN. The Delphi expert panel members were asked to rate (and in Rounds 2 and 3, rank) various items related to improving and enhancing SGS. The response rate in each round was excellent, with 91% completing the Delphi surveys in Rounds 1 and 2 and 97% completing the survey in Round 3. Analysis of the data indicated consensus on SGS priorities in 5 areas: 1) SGS needs by geographic region; 2) areas of focus to improve SGS; 3) approaches to enhance or increase SGS; 4) SGS needs of various subpopulations; and 5) policy issues that could improve SGS. Examination of these priorities revealed some overall themes or **directional priorities for SGS**, specifically:

1. Improving access to core SGS
2. Increasing SGS in Haldimand and Niagara
3. Capacity building to support SGS
4. Supporting medical and non-medical approaches to promote seniors' health and well being.

A more detailed description of the directional priorities is found on Table 7 on page 10.

The directional priorities and the specific results from the SGS priority setting process will be used by the LHIN in two ways:

1. To establish priorities for the Year 2 AAH Call for Proposals related to SGS.
2. To evaluate proposals related to SGS submitted for AAH funding.

While proposals on any SGS initiative can be submitted for AAH funding, it is likely that the LHIN will seek proposals that focus on one or more of the priority areas identified through this consultation process.

BACKGROUND

In August 2007, the Minister of Health and Long-Term Care announced the Aging at Home (AAH) Strategy. The goal of the strategy was to promote and enhance healthy aging and independent living as people age within their communities. Within the Hamilton Niagara Haldimand Brant Local Integrated Health Network (HNHB LHIN), approximately $60 million is being invested over 3 years.

In November 2007, the LHIN issued a call for pre-proposals for Year 1 of the strategy. Of the 128 pre-proposals submitted, 45 were approved for service plan development. In February 2008, 32 service plans were approved in principle. A list of the plans funded in Year 1 is available on the HNHB LHIN website (www.hnhblhin.on.ca).

After reviewing the Year 1 service plans that had been submitted, the LHIN Board identified the need for planning and stakeholder consultation in a number of areas including falls prevention, supports in the home, transportation, and specialized geriatric services. In the spring of 2008, the Geriatric Access and Integration Network (GAIN) was asked by the HNHB LHIN to lead the process of identifying priorities for Specialized Geriatric Services (SGS). Information regarding these priorities could then be used in planning for Years 2 and 3 of the AAH Strategy and assist the LHIN Board in making funding decisions regarding proposals for SGS.

The purpose of this report is to:

1. describe the process undertaken to identify the SGS priorities;
2. share the results from these activities; and
3. outline the directional priorities related to SGS for Year 2 of the AAH Strategy.

SPECIALIZED GERIATRIC SERVICES

SGS provide a range of services to support older individuals with chronic and complex conditions, including specialized geriatric assessment, consultation, short term treatment, rehabilitation, and short-term specialty case management. SGS use interdisciplinary teams with expertise in care of the elderly, and include geriatric medicine and geriatric psychiatry services that have specialty physicians (geriatricians and/or geriatric psychiatrists) as part of the team. SGS rely on other services (e.g., community support services) to be effective. SGS can significantly contribute to an older person's ability to remain in their home

METHODOLOGY FOR IDENTIFYING SGS PRIORITIES

The process undertaken to identify priorities for SGS involved two phases. The first phase included a literature review and document scan of existing models of geriatric health services and an inventory of existing geriatric services in the HNHB LHIN. The literature and document review served as background information to the second phase of the priority setting process and hence will not be described here. A summary of this review can be found on the Regional Geriatric Program Central (RGPc) website (www.rgpc.ca). The service inventory is being led by the Dementia Networks in the HNHB LHIN and GAIN. The service inventory is anticipated to be ready for use in late August 2008. Information on the service inventory can also be found on the RGPc website.

The second phase in identifying SGS priorities was a consultation process that included: 1) focus groups and 2) a Delphi consensus building process. The following provides a description of these activities and the results obtained.

Focus Groups

The first phase of the consultation process involved focus groups to examine existing SGS in the LHIN, identify gaps, and begin to suggest strategies to address these gaps. Contact people from each of the networks/groups represented on the GAIN Network (e.g., Dementia Networks, French language community, End-of-Life Network, Community Support Services Network, Hospital Network, Geriatric Psychiatry Services, Geriatric Medicine Services, Rehab Network, Not for Profit Homes and Services for Seniors, Long-Term Care Executive Directors group) were asked to identify individuals to invite to participate in both the focus group and Delphi phase of the consultation process. Responses to these requests were overwhelming. Between April 21st and May 8th, 13 focus groups (including 1 with French-language speaking stakeholders) were conducted across the LHIN (i.e., Brant, Burlington, Haldimand, Hamilton, and Niagara). A total of 146 stakeholders participated in these groups including: geriatricians; geriatric psychiatrists; outreach team staff and managers; staff and managers from long-term care, acute care and community support services; volunteers; and clients.

Each focus group was approximately 2hrs in length. Three additional 1:1 interviews were held with geriatricians unable to attend the focus group. Additional data were also received electronically from stakeholders (N=2) who were unable to participate in a focus group. All groups were digitally recorded and transcribed verbatim. Two research team members reviewed transcripts and themes were extracted and summarized.

Delphi Process

The second part of the consultation phase was a Delphi process to determine the SGS priorities. The Delphi technique is a structured process for obtaining consensus through iterative survey questionnaires.[1] This process uses a series of questionnaires, each referred to as a 'round', to collect and share the opinions of experts. The process continues until consensus is reached. Mean ratings of items are used to determine relative rankings of importance and standard deviations serve as a measure of consensus. For time and cost efficiency the questionnaires were administered electronically (Microsoft Word attachment).

Data from the focus groups were used to identify the items to include in the Delphi surveys. The following describes how each round of the Delphi was structured.

Round 1:

- Rating of items in terms of importance (where1= not important; 10=extremely important)
- Participants were able to add new items

Round 2:

- Used all items from Round 1 including the new items added in the first questionnaire

[1] Fleuren M, Wiefferink K, & Paulussen T. (2004). Determinants of innovation within health care organizations. *International Journal for Quality in Health Care, 16*, 107-123.
Rodriguez, C., Kergoat, M.J., Latour, J., Lebel, P., & Contandriopoulos, A.P. (2003). Admission criteria in short-term geriatric assessment units. Journal of Public Health, 94(4), 310-314.

- Because a number of the Delphi panel gave high ratings to all/most items in round 1, in round 2 participants were asked to **rank** the items from most important (1) to least important (10)
- For questions with more than 10 items, participants asked to rank the top 10 only

Round 3:

- Items with the highest rankings (i.e., least important items) were eliminated.
- Participants were asked again to **rank** the items again from most important (1) to least important (10).

As described above, the panel of Delphi experts was identified through the groups/networks represented on GAIN. A total of 35 experts representing all areas of the LHIN were identified including: geriatricians; geriatric psychiatrists; outreach team staff and managers; and staff and managers from long-term care, acute care, and community support services.

Three rounds of the Delphi were conducted. Because of the extremely tight timelines involved, experts were given only 1 week to complete the questionnaire in each round. As with the focus groups, the response to the Delphi process was outstanding. The response rates in each round were as follows:

Round 1	91.4% (32/35)
Round 1	91.4% (32/35)
Round 1	97.1% (34/35)

RESULTS

I. Summary of Themes from Focus Groups

Table 1 provides a summary of the themes that emerged from the focus groups.

Table 1: Themes Identified in Focus Groups

- **Service-related Gaps**
  - transitions between/within sectors
  - waiting times for specialized geriatric services
  - greater focus on prevention & early detection

- **Health Human Resources**
  - lack of geriatric specialists (geriatricians and geriatric psychiatrists)
  - lack of specialized clinicians

- **Lack of family physicians**

- **Sub-populations who are under-serviced or emerging as a group in need**
  - Francophone population; non-English speaking
  - Aboriginal people who are aging
  - homeless people who are aging
  - older people without family physicians

- **Region-specific gaps/needs**
  - need for more SGS in under-serviced areas / smaller communities
  - transportation (particularly for people in remote/rural areas)

- **Information Gaps**
  - lack of awareness of services & providers – among care providers and among the general public

- **Other Gaps**
  - need for elder friendly health care system (buildings, services, policies)

II. Results from Delphi Process

The items included in the Delphi questionnaires were categorized into 5 areas: 1) needs by region; 2) areas of focus to improve SGS; 3) approaches to enhance or increase SGS; 4) needs of various subpopulations; and 5) policy issues that could improve SGS.

The following tables present the results from Round 3 of the Delphi for each of these 5 areas. **The items are presented in order from most important to least important.** One should be cautious, however, not to interpret items that were ranked as less important as *not* being important. The rankings provided are relative rankings. All of the items included were identified by focus group participants or Delphi expert panel members and thus considered important.

Table 2: Delphi Results – SGS Needs by Region

SGS Needs by Region	Final Ranking
More geriatric medicine services in Haldimand	1
More geriatric medicine services in Niagara	2
More geriatric psychiatry services in Niagara	3
More geriatric psychiatry services in Haldimand	4
More geriatric medicine services in Brant	5
More geriatric psychiatry services in Brant	6
More geriatric psychiatry services in Hamilton	7
More geriatric medicine services in Hamilton	8
More geriatric medicine services in Burlington	9
More geriatric psychiatry services in Burlington	10

Table 3: Delphi Results – Areas of Focus to Improve SGS

Areas of Focus to Improve SGS	Final Ranking
Interventions that aim to improve care transitions (e.g., hospital to home, hospital to long-term care home)	1
Expansion of geriatric medicine and geriatric psychiatry home visit services (i.e., outreach)	2
Interventions that aim to decrease waiting times for SGS	3
Provision of Comprehensive Geriatric Assessment for the frail elderly in inpatient and outpatient settings	4
Interventions that aim to improve access to outreach adult psychiatry & geriatric psychiatry & medicine in long-term care homes	5
System navigation for older persons and their family members	6
Improved transportation for clients/patients to SGS	7
Interventions that aim to provide more streamlined access to SGS (e.g., centralized information source or intake centre)	8
Provision of more hospital programs that are elder friendly	9
Interventions that aim to improve communication between care providers and SGS groups	10
More health maintenance programs such as Staywell (an exercise maintenance program for frail seniors recently discharged from hospital)	11

Table 4: Delphi Results – Approaches to Increase or Enhance SGS

Approaches to Increase or Enhance SGS	Final Ranking
Initiatives that aim to increase the number of specialized geriatric non-physician clinicians (e.g., advanced practice nurses, case managers) in the LHIN	1
Initiatives that aim to increase the number of geriatric specialists (geriatricians, geriatric psychiatrists) in the LHIN	2
Establishment of interdisciplinary teams to support geriatric medicine in working in the community	3
Provision of SGS using the "shared care" approach in primary care (i.e., geriatricians and geriatric psychiatrists spend time in primary care and support family physicians/teams by conducting case reviews, indirect consultations and/or direct consultations)	4
Initiatives that aim to attract students/residents to geriatric medicine or geriatric psychiatry	5
Initiatives that aim to attract learners to become specialized geriatric clinicians (e.g., advanced practice nurses, case managers)	6
More capacity building in SGS among family physicians	7
Diverting SGS resources from acute care settings to non-institutional settings (e.g., CCAC offices, primary care, Community Health Centres)	8
Specialty clinic for older persons with multiple chronic conditions who require SGS (possibly incorporate Chronic Disease Model of care)	9
SGS satellite offices in rural / under-serviced areas	10
Have SGS take a greater focus on wellness, prevention, and early detection	11

Table 5: Delphi Results – Needs for SGS among Subpopulations

Needs for SGS among Subpopulations	Final Ranking
Older adults at risk for premature admission to long-term care due to lack of available community support	1
Older adults with multiple morbidities	2
Older adults without family or caregivers/advocates	3
Older adults who do not have a family physician	4
Older adults aging with long-term psychiatric diagnosis	5
Older adults with developmental disabilities	6
Older adults with addictions	7
Older adults who are homeless	8
Older adults with acquired brain injury	9
Older adults who speak languages other than English or French	10
Older adults who are recent immigrants	11
Older Francophone persons	12

Table 6: Delphi Results – Policy Issues that could Improve SGS

Policy Issues that could Improve SGS	Final Ranking
Increased number of hours of service available to CCAC clients	1
Availability of homemaking services to CCAC clients who do not meet the eligibility criteria for CCAC but require homemaking services in order to stay in their home	2
Broaden CCAC criteria - narrow criteria currently in place for CCAC is preventing or excluding some very needy patients from receiving help	3
Availability of meal preparation and medication monitoring to CCAC clients who do not meet eligibility criteria for CCAC but require services to stay in their home	4
Establishing/funding specialty units within LTC homes for residents with high risk behaviours	5
Remuneration for geriatricians & geriatric psychiatrists	6
Establishment of population health standards or benchmarks for geriatric medicine care for frail seniors	7
CCAC in the past provided a specialty nursing service of 'mental health' to eligible clients. Resuming this service would support and act as adjunct to existing SGS	8

Other Issues for the LHIN to Consider

Three issues arose from the consultation process that are important to consider as the AAH Strategy process moves forward:

1. **Innovation vs. Evidence-based**. While “innovation” is appealing, many participants indicated that they hoped the LHIN would use the AAH resources to fund evidence-based services versus innovative (i.e., non-tested) services.

2. **The difficulty in separating SGS from the rest of the system**. SGS is one part of a larger system. Other supports and services must be available in order for SGS to be effective. While this report has focused on SGS, the importance of collaboration and integration with these other services should not be lost.

3. **Linkages between SGS initiatives and other initiatives of the LHIN**. While the AAH Strategy is the focus of this report, it is important for the LHIN and other stakeholders to consider and promote integration of activities across initiatives. For example, there is overlap between SGS and the LHIN’s Chronic Disease Prevention and Management strategy. As much as possible, the work of these groups should be shared and opportunities for collaboration explored.

DIRECTIONAL PRIORITIES FOR SGS

In Year 1 of the AAH Strategy, there was an open call for pre-proposals from the HNHB LHIN (i.e., pre-proposals related to any initiative could be submitted for consideration of funding). In Year 2 the LHIN plans to have a more limited call for proposals, identifying specific priority areas. One of these priority areas will be SGS.

In reviewing the priorities identified through the consultation process, some overall themes or directional priorities emerged. Table 7 outlines these directional priorities and provides some examples of highly ranked items from the Delphi process that could fall under these priorities.

Table 7: SGS Directional Priorities for Year 2 of the Aging at Home Strategy

1. **Improving access to core SGS**
   Examples could include:
   - Initiatives that aim to increase the number of specialized geriatric physicians (geriatricians and geriatric psychiatrists) and non-physician clinicians in the LHIN
   - Establishment of interdisciplinary teams to support geriatric medicine in working in the community
   - Increasing geriatric medicine and geriatric psychiatric outreach services
   - Utilizing shared care models to support SGS

2. **Increasing SGS in Haldimand and Niagara**
   While there is a need for enhanced SGS in all areas of the HNHB LHIN, the consultation process indicated a particular need for increased access to SGS in Haldimand and Niagara.

3. **Capacity Building to support SGS**
   Examples could include:
   - Capacity building in primary care and non-institutional settings
   - Initiatives that aim to attract learners to SGS

4. **Medical and non-medical approaches to promote seniors' health and well being**
   Examples could include:
   - Interventions that aim to improve care transitions
   - Programs or services that address special sub-populations
   - Develop programs that focus on wellness, prevention, and early detection
   - Improved home care entitlements

While proposals on any initiative can be submitted for AAH funding, it is likely that the LHIN will be looking for proposals that focus on one or more of these priority areas.

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