



**The College of
Family Physicians
of Canada**

**Le Collège des
médecins de famille
du Canada**

Alberta College of Family Physicians

**FINAL REPORT
ON
CARE OF THE ELDERLY**

**APPROVED BY
THE BOARD
ALBERTA COLLEGE OF FAMILY PHYSICIANS**

October 19, 2002



The College of
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of Canada

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du Canada

Alberta College of Family Physicians

October 31, 2002

LETTER FROM THE PRESIDENT

Re: Final Report on Care of the Elderly

On behalf of the Board of the Alberta College of Family Physicians (ACFP), it is my pleasure to present this report to the many groups and organizations that are involved in the planning, delivery and evaluation of health care for the elderly and their families.

This report is the outcome of a Working Group, established by the ACFP Board, to begin the process of defining the future role of family physicians in caring for the elderly. The Working Group identified the current situation and limitations of the current system in relation to: (a) the role of family physicians in caring for the elderly, (b) the role of the College in caring for the elderly, and (c) the role of the university (educational) in training family physicians in caring for the elderly. This was followed by a description of the desired future, and recommendations that focused on closing the gap.

While we recognize that the recommendations are preliminary, they do offer an excellent starting point for a second task force that will begin early in the New Year on refining the recommendations and developing implementation plans.

On behalf of the ACFP Board, I extend my gratitude to all members of the Working Group who developed this Final Report. It is an excellent beginning to an ongoing process that will lead to significant improvements in the service delivery, education and research arenas for family physicians working in Alberta with the elderly population.

Sincerely,

Tuhin Bakshi, M.B.B.S., CCFP, Dip. Sports Med. (CASM)
President

Executive Summary

Introduction

In the summer of 2001, Dr. Bryn Whittaker and Dr. Jean Triscott approached the Alberta Chapter to request information on how to form a provincial family physician group that could plan manpower and address issues in geriatric care. An Internet bulletin board discussion, held during the summer of 2001, invited family physicians to post issues concerning care of the elderly. Drs. Whittaker and Triscott were invited to attend the October 2001 Alberta Chapter Board meeting to present an overview of the bulletin board discussion and offer some potential recommendations to address identified areas of concern.

The Board requested that a Care of the Elderly working group be established with wide representation by geography and practice setting to develop recommendations on the:

- (1) Role of family physicians in caring for the elderly,
- (2) Role of the College in caring for the elderly, and
- (3) Role of the university (educational) in training family physicians in caring for the elderly.

Recommendations

Over the past six months the Care of the Elderly Working Group has reviewed and analyzed the roles of family physicians, the College and the University in caring for the elderly with regard to the current situation, its limitations and a desired future. This working group has developed recommendations designed to close the gap between the current situation and a desired future for family physicians in caring for the elderly:

1. Awareness, understanding and respect of the diversity among family physicians will give family physicians a stronger collective voice.
2. The ACFP should take a lead role in developing new models of service delivery in caring for the elderly. Family physicians should be leaders on multidisciplinary teams and take responsibility for the patients' medical records and the coordination of patient care.
3. Increase and encourage collaboration and integration of physicians working with the elderly (Family Physicians, Care of the Elderly Physicians, Internal Medicine, and Internal Medicine Geriatricians) in clinical venues, educational and/or research initiatives.
4. The ACFP needs to become more politically active in lobbying and advocating for the unique role of family physicians in caring for the elderly
5. The ACFP needs to work with the University Departments of Family Medicine to enhance Care of the Elderly programs for medical students, family medicine residents and family physicians
6. AFPRN (Alberta Family Practice Research Network) should encourage family physicians to conduct or participate in primary care research on areas related to care of the elderly
7. The ACFP, in collaboration with the university CME departments, should encourage the development of and participation in CME courses addressing care of the elderly issues.

8. The ACFP should work actively with the AMA Section of General Practice to develop and negotiate different remuneration plans for family physicians caring for the complex and frail elderly
9. The definition of “Comprehensive” care needs to be revisited
10. Standards must be set for all health providers working with and caring for the elderly regardless of the setting (e.g. homes; institutions; alternative community living accommodations such as assisted living, group homes and family care homes)

Conclusion

Caring for the elderly will become a certainty for the majority of family physicians in the future. It is the goal of this Working Group to become a catalyst in implementing changes that will shift the ideal situation into reality.

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Care of the Elderly Working Group - Final Report

Background

In the summer of 2001, Dr. Bryn Whittaker and Dr. Jean Triscott approached the Alberta Chapter to request information on how to form a provincial family physician group that could plan manpower and address issues in geriatric care. As an initial step, a bulletin board was posted on the internet in order to generate discussion on the many issues facing family physicians in caring for the elderly.

Internet bulletin board discussion held during the summer of 2001 inviting family physicians to post issues in caring for the elderly.

A number of issues were identified on the bulletin board. In the fall of 2001, Dr. Bryn Whittaker and Dr. Jean Triscott were invited to attend the Board meeting of the Alberta Chapter to present an overview of the issues and some potential recommendations to address these areas of concern.

Major themes of the Working Group on Care of the Elderly:

- ♦ *Role of family physicians*
- ♦ *Role of the College of Family Physicians*
- ♦ *Role of the university in training*

Drs. Triscott and Whittaker attended the October 13, 2001 meeting of the Alberta Chapter Board; valuable discussion followed their presentation. As an outcome of this presentation and discussion, the Board requested that a working group be established with wide representation by geography and practice setting to develop recommendations on the:

- (1) Role of family physicians in caring for the elderly,
- (2) Role of the College in caring for the elderly, and
- (3) Role of the university (educational) in training family physicians in caring for the elderly.

Using the nominating process of the Chapter, a Chair and members were selected and approved by Executive and the Board. The Working Group is listed in **Appendix 1**.

Process of the Working Group

Teleconference meetings were held about every three weeks beginning January 21, 2002. Between meetings members exchanged email to ask questions, identified issues and followed up on external reports and working papers completed by working group members.

Subgroups were formed around the three major themes of the Working Group

The Working group was divided into three subgroups, each addressing one of the areas identified by the Board. As a first task, each subgroup was asked to develop a working paper on the current situation. Members highlighted the key points of their papers followed by discussion as a group.

The discussion then focused on identification of key limitations facing family physicians in caring for the elderly and some recommendations to address these issues. This led to a discussion on characteristics of the ideal situation. Once the desired future on caring of the elderly was articulated, the Committee then worked on recommendations to close the gap between the current situation and the desired future for family physicians in caring for the elderly.

Broda Report

A key document relating to care of the elderly in Alberta is “*Healthy Aging: New Directions for Care*” (referred to as the Broda Report named after David Broda, the Chair of the Long Term Care Policy Advisory Committee), November 1999. This Committee met for two years to consult with Albertans, review trends and alternatives, consider the impact of an aging population, and develop comprehensive directions for moving Alberta’s continuing care system into a new millennium.

The Broda Report excludes an understanding of the role of family physicians in caring for the elderly. The focus is on multidisciplinary Teams.

Members of the Working Group noted that the report was written in good faith and with the welfare of seniors in mind. However, the Broda Report assumes that all health care workers will work and communicate with physicians in an integrated manner to maintain seniors in their home settings for as long as possible. What is missing from the Broda Report is an understanding of the role of family physicians and the current stresses that face family medicine; coupled with an attitude that family physicians will simply be there whenever called upon. It is unfortunate that family physicians had such limited input in the development of the Broda Report.

Family physicians had little input in the development of this report

Implementations of the Broda Report are forging ahead, and still, family physicians have not defined their key role in caring for the elderly

With the recommendations of the Broda Report being implemented ‘around’ family physicians, it is paramount that family physicians become far more proactive in defining their role in caring for the elderly. Progress on the nine implementations of the Broda Report is attached as **Appendix 2**. Models of care need to be developed that will benefit both patients and their physicians.

Summary of Current Situation

Each subgroup prepared discussion papers on the current situation of family physicians providing care to the elderly and there was discussion of these papers by the full Working Group.

(1) Role of Family Physicians in Caring for the Elderly

Traditionally, family physicians provide coordination of care across the spectrum of the health care system and throughout a patient’s life. Consequently, family physicians are well positioned to offer the coordination of care when other members of the health care team become involved.

Continuity, comprehensiveness, coordination and advocacy are hallmarks of the traditional role of family physicians

When a new level of care is anticipated, the family physician provides the information needed by the patient, their families and their caregiver(s) to make a decision appropriate to their values and beliefs, and then advocates on behalf of the patient's decision to accept or decline that next level of care.

Family physicians provide care for the elderly in a multitude of settings

Family physicians are often the first point of access of seniors to the health care system, and provide care to the elderly in a variety of rural and urban settings: the physician's office, the patient's home, long term care facilities, specialized seniors' programs and acute care facilities.

Traditionally, family physicians are responsible for providing continuity of care, following their patients' transition from birth into their senior years and into frailty; care that ranges from promoting health and preventing disease and injury to the investigation, diagnosis and management of acute and chronic illness (comprehensive care).

Family physicians are becoming increasingly frustrated in providing quality care to the frail elderly patient

Increasingly, many family physicians are finding that they can no longer provide high quality care to the frail elderly. These patients require much longer office visit times and more complex coordination with other medical specialists and health disciplines. As well, there is an increasing loss of continuity as patients move into other care settings often beyond their home regions. While there is no documentation on the numbers of family physicians opting out of this type of care, informal networking among family physicians supports this growing trend.

(2) Role of the College in Caring for the Elderly

For some years, the National College of Family Physicians of Canada has had a standing committee dealing with the care of the elderly – Health Care of the Elderly Committee. Dr. Jean Triscott chairs this Committee.

While the National College of Family Physicians of Canada has had a standing committee on care of the elderly for years, there has been limited movement in translating reports into action

While this Committee has been in existence for some time, there has been limited action. Members are spread across Canada and it is challenging to find the energy and commitment to move forward on advancing care of the elderly at this level. While the National College is slowly acknowledging the challenges of family physicians in caring for the elderly (three documents were written by the CFPC: (a) Primary Care for Seniors: Results of a Canadian Needs Assessment, 1998, (b) The Role of the Family Physician in Home Care, December, 2000, and (c) Primary Care and Family Medicine in Canada: A Prescription for Renewal, October 2000), the issues of caring for the elderly have not reached a political or policy level.

The most recent paper drafted by the National Committee on Care of the Elderly is included in Appendix 3

The current Care of the Elderly Working Group is the first step taken by the Alberta Chapter, College of Family Physicians in addressing issues on care of the elderly

To effect change, action must first occur by family physicians at the provincial level

(3) Role of the University (Education) in Training Family Physicians in Caring for the Elderly

Care of the Elderly Fellowship recognized by the CFPC since 1989

Subspecialty training in Geriatric Medicine requires 3 years in Internal Medicine

Three training programs in care of the elderly are available in Alberta

The U of A offers short mandatory rotations in Geriatric Medicine to medical students and family medicine

The Health Care of the Elderly Committee recently drafted a paper "A Discussion of the Health Care of the Elderly Committee" February 2002, which presents a comprehensive view of changing demographics, end-of-life care, problems in education and research, and solutions for improving care of the elderly in Canada. This paper is a working draft and is included in **Appendix 3**.

The Alberta Chapter has not been involved in specifically addressing care of the elderly by family physicians. The current Working Group is a positive step toward the Chapter taking a more active role in this area. Generally, members of the Working group believe that action must occur at the provincial level in order for change to occur.

At this time, there is no proactive responsibility to appoint family physicians to sit on key committees involved in writing policy and implementing recommendations regarding the care of the elderly. The voice of the family physicians is not heard and must be to ensure that recommendations are relevant and practical for family practice. ***This is a critical issue!***

At a national level, the College of Family Physicians of Canada has officially recognized the Care of the Elderly Fellowship since 1989. This Fellowship recognizes elective, supplementary training in care of the elderly of 6 or 12 months duration, available after the two-year core family medicine residency program.

The Care of the Elderly Fellowship is distinct from subspecialty training in Geriatric Medicine leading to certification by the Royal College of Physicians and Surgeons of Canada. Prerequisites for this certification in Geriatric Medicine are three years of training in Internal Medicine.

In Alberta, there are three training programs: (a) the University of Alberta, (b) the University of Calgary, and (c) an integrated program offered to rural family physicians through the Rural Physician Action Plan and the universities.

One-month Fellowships in Care of the Elderly are also available to family physicians through the Royal Canadian Legion Bursary (College of Family Physicians of Canada) and the provincial Rural Physician Action Plan. Since 1982, 27 physicians have taken the opportunity to improve their skills in care of the elderly.

At the University of Alberta, since 1988, every medical student does a two-week mandatory rotation in Geriatric Medicine and

residents

The U of A Care of the Elderly Program has undergone increased development in recent years, graduating 20 family physicians since 1992

Family Medicine residents do a one-month rotation in Geriatric Medicine in their second year. Geriatric Medicine is an elective for other subspecialty residents.

Since 1992, there has been increasing development of the Care of the Elderly Diploma Program at the University of Alberta - designed for practising family physicians - that takes 6 months to one year to complete. There are two protected funded positions per year. To date, 20 physicians have completed the program. Of those graduates, 55% are in university academic, teaching and administrative positions, 70% of these graduates spend more than 75% in clinical geriatric practices, and 95% of these graduates are actively involved in geriatrics in general. Most of these family physicians still reside in Alberta.

The U of C offers a course "Aging and the Elderly" to medical students.

At the University of Calgary, medical students take the course "Aging and the Elderly" once they have mastered the objectives of earlier courses. This course must be taken by the end of their second year and is the last pre-clinical course before clerkship. The general goal of this course is to prepare the student to competently manage older patients with dignity and understanding. A key component of the course includes assignment of the medical student to a family physician. The family physician identifies a patient from his/her own practice and the medical student then interviews that elderly patient in their home.

Family medicine residents at the U of C complete a one-month rotation in Geriatric Medicine in their second year

Family Medicine residents at the University of Calgary must complete a one-month geriatric rotation in their second year. Residents follow patients on the Assessment and Rehabilitation Unit at the Rockyview Hospital, and also spend time in relevant outpatient clinics.

U of C has a new Care of the Elderly program designed for practising family physicians

The University of Calgary now accepts family physicians into their newly established (July 2002) 'Care of the Elderly' diploma program that will take 6 months to one year to complete. This program is modeled after the excellent program offered at the University of Alberta.

The Rural Family Medicine Streams will offer an integrated program for family medicine residents in their first and second years during rural rotations

The Integrated Program for Rural Family Medicine Streams in southern and northern Alberta, through the Rural Physician Action Plan and the universities, is in the early stages of implementation. It is proposed that during the PGY1 year, family medicine residents will spend a minimum of two days with a visiting geriatrician at the regional centres doing geriatric assessment. Over the course of their family medicine rotation, residents will see elderly patients in their homes, in the office and hospital, and in continuing care centres.

The PGY2 family medicine resident will be responsible for the care of elderly patients, and also spend a minimum of three-half days with community health professionals working with the elderly, for example home care and mental health. Lecture sessions on the four major problems in geriatrics (falls, immobility, incontinence and confusion) will be delivered through the Alberta Rural Family Network website.

The U of A and U of C offer CME courses on caring for the elderly to family physicians; however, there is a need to develop more courses.

There are CME courses on caring for the elderly offered through the Departments of Family Medicine at the U of A and the U of C. These courses include both MAINPRO-1 and MAINPRO-C credits. However, there is a need to develop new courses and to offer these through a variety of educational strategies such as individual reflection on practice, internet, and group sessions.

Appendix 4 provides a listing of MAINPRO® M1 courses accredited by the Alberta College of Family Physicians of Canada – October 1999 to September 2002, and a list of current MAINPRO® C courses accredited by the College of Family Physicians of Canada.

Limitations of the Current System

Working Group members identified the following limitations and barriers that impact the care provided to the elderly by family physicians. These limitations were not subdivided into the three subgroup topics due to their interdependence but were placed into seven categories.

Lack of continuity creates frustration and discouragement for the family physician, the patients and their families

Lack of continuity

In caring for the elderly and in particular the frail elderly, there is often a breakdown in continuity of care. These individuals move in and out of acute care facilities, geriatric rehabilitation units, and into long term facilities sometimes beyond the patient's home region. In many of these instances, the patient's family physician is no longer involved in their care and communication between the specialists and the family physician is minimal to none. The patients and their families become discouraged, frustrated and fearful of transfer in the providers of their care. The elderly require a comprehensive, integrated, team-approach to their medical care.

Providing comprehensive care to the frail elderly in the traditional mode is becoming increasingly difficult.

Difficulties providing comprehensive care

While one of the four principles of family medicine is to provide comprehensive care in the traditional sense (i.e. the patient's family physician provides and/or manages all of the care required by their patients), this principle is very difficult to

maintain in caring for the frail elderly. The complexity of their care creates a need for the patient to “follow” the caregivers’ advice whether in hospitals, specialized outpatient settings or other facilities. Family physicians who continue to try to provide comprehensive care to the frail elderly will become even more frustrated as cutbacks and limitations within the system further restrict access of the frail elderly to their primary care physician. A comprehensive, integrated, team-approach to caring for the frail elderly must be developed.

The amount of time it takes to coordinate the care required by the frail elderly is a real issue for family physicians practising in all settings.

Lack of coordination

Lack of coordination is a major problem in caring for the elderly. When a frail elderly patient visits his/her family physician, not only does the office visit itself require a longer time, coordinating and attending to visits at the laboratory, radiology, physiotherapy, occupational therapy, etc. often becomes an all day event; frustrating both the patient and the physician. The family physician must then spend a significant amount of time reviewing and coordinating the plans implemented by the other service-providers.

Access to specialists continues to be a major challenge for family physicians in coordinating the care of the frail elderly

Access to specialists is a particular challenge. Appointments must be made that are often weeks or months following the office visit with their family physician. Further, issues of all day and/or overnight travel to regional or tertiary care centres for radiological investigations and other specialist appointments require significant time and effort by family physicians and the families/caregivers of frail elderly patients. These patients continue to see their family physicians, becoming increasingly ill or disabled, as they wait to be seen by specialists.

The patient’s care becomes fragmented and results in a situation whereby the patient will have many different people looking after them with limited or no communication between service providers. Often care is diffused and no one individual will take responsibility for the overall care of the patient.

Emergency Departments, particularly in urban settings, has become a point of access for primary care by seniors.

With both the shortage of family physicians and the increasing number of family physicians who are closing their practices and no longer seeing the frail elderly, the elderly are often forced to visit emergency departments for primary care. Emergency departments are ill equipped to deal with primary care; hence these patients are discharged only to revisit emergency when their health problems escalate. This brings with it a host of problems and it is not unusual to have a unit in the large urban hospitals that “holds” frail elderly patients with complex needs waiting for days, weeks and months to transfer these individuals to continuing care centres when beds are available.

There are no formal Divisions of Care of the Elderly at the U of A or the U of C Departments of Family Medicine.

Geriatric rotations for medical students and family medicine residents are mainly provided from a specialist point of view

Support via commitment and funding in education and research for Care of the Elderly programs in Departments of Family Medicine varies across Canadian universities.

There are few family physicians funded as GFT positions at the U of A and the U of C.

Lack of support and funding for education and research

Family Medicine does not have formal Divisions of Care of the Elderly, in the Departments of Family Medicine at the U of C or the U of A, with targeted academic funding. This is an essential requirement to promote primary care and research in this area. The Geriatric Programs at the U of A have been under the direction of the Clinical Regional Geriatric Director/Division of Geriatric Medicine, Department of Internal Medicine. This Department manages specialized funding for these programs. Minimal funding is provided for the Program Directors, Care of the Elderly Programs, in the U of A and U of C Departments of Family Medicine.

There are blocks of teaching in geriatric medicine for medical students and family medicine residents. Although specialists such as internists do some of the teaching, family physicians are required to spend a considerable amount of time with each student.

The quality of theory taught is high; however, there is difficulty translating this knowledge into a family practice setting. Specialists cannot accurately portray family practice because their practice settings are not reflective of a typical family physician's practice and the specialists do not always understand the realities of family medicine.

There are different levels of commitment for support and funding in education and research not only across Canada, but also within Alberta. The U of C has particularly low funding in this area relative to other universities. This discrepancy in the provision of a recognized and viable teaching program for family physicians interested in specializing in the care of the elderly has resulted in a lack of trained and committed family physicians required in caring for this population sub-group.

While the U of A has good funded support for the present academic Care of the Elderly program, and an excellent teaching and training program, it cannot be expanded due to funding limitations.

There are very few family physicians in both universities funded as GFT positions in the Departments of Family Medicine. Funding for the Joint Program, Geriatric Medicine and Care of the Elderly Program, at the University of Alberta is through Clinical Regional Funding.

Nationally, funding differs from province to province; program directors may or may not receive remuneration for their work and often funding is received through clinical practices. This lack of infrastructure funding is largely contributing to the

difficultly in encouraging family physicians to take further training that is required to adequately serve the growing needs of the elderly.

Care of the Elderly Programs for family physicians are appendages to Geriatric Medicine.

In summary, the Care of the Elderly Programs for family physicians become appendages to Geriatric Medicine that do not promote primary care or family physician role modeling for students, residents and practising family physicians. As well, there is a lack of primary care research in care of the elderly whether it is the clinical care provided by the family physician or models for delivering care within the system.

It is crucial that new and innovative practice models be developed by and for family physicians choosing to provide care for the elderly only. Revised roles of family physicians will need to be evaluated and supported by their peers.

Lack of understanding and support among family physicians

There is a concern among geriatric family physician specialists whose practices focus on care of the elderly. Many of these family physicians are isolated as they are not well regarded by either their peers or by their specialist colleagues. By focusing on this particular area of interest, they are no longer perceived to be credible family physicians.

The voice of the College of Family Physicians – locally and nationally – is not speaking out on issues related to care of the elderly. Policy development, advocacy and new models of care needed in this area are not occurring

Lack of advocacy and policy development by provincial Chapters and the National College of Family Physicians of Canada

The College of Family Physicians of Canada and its Chapters are the only collective voice for family physicians. Although the changing demographics is clear evidence that more emphasis needs to be placed on family physicians caring for the elderly, the voice of family physicians is not being heard in the political arena – in practice, education or research. Advocacy by family physicians who understand the dilemma is limited to small pockets of family physicians throughout Canada.

Fee-for-service is not a viable payment system for family physicians providing care only to the frail elderly and other patients with complex needs

Remuneration issues

Members agreed that caring for the frail elderly and other complex patients is not financially feasible under the current fee-for-service system. These patients usually require an office visit of 30–60 minutes and this situation is further compounded by the time needed to coordinate other required services. When submitting a billing code, only the most responsible diagnosis is recognized which clearly does not reflect the care that is provided by family physicians to this group of patients.

It is imperative that alternative fee payment programs be developed and implemented in order to both allow and encourage family physicians to provide quality care to the elderly

Members of this working group realize the implications of the current fee-for-service system and are adamant that without changes to this system, care of the elderly (particularly the frail elderly) by family physicians is in jeopardy. The Committee discussed several payment options/practice plan scenarios that would not only allow family physicians to continue to

provide quality care to the elderly population group but would also encourage new graduates and foreign physicians to retain and support a high proportion of elderly patients in their practice.

Family physicians wishing to specialize in care of the elderly cannot make a living under the existing fee-for-service payment system

As a result, some family physicians are closing their practices to the complex and elderly patients. Graduates of the Care of the Elderly program cannot sustain a geriatric practice and must open their practice to other age groups in order to make a living. Who then will care for the complex and elderly patients? Specialists and other health disciplines are picking up the slack resulting in fragmented and uncoordinated care.

Recommendations to Improve the Current Situation

Awareness, understanding and respect of the diversity among family physicians makes us a stronger collective voice

The following recommendations are designed to close the gap between the current situation and a desired future for family physicians in caring for the elderly.

The ACFP should take a lead role in developing new models of service delivery in caring for the elderly.

Family physicians should be leaders on multidisciplinary teams and take responsibility for the patients' medical records and the coordination of patient care.

1. Family physicians are strongly encouraged to rely on each other's strengths, respect the unique differences and acknowledge the value of these differences. Fundamentally, regardless of the areas of interest and expertise, family physicians are trained with the same principles and values and carry these into whatever practice setting they find themselves in. A good example of this is contained in **Appendix 5** which describes an alternate model of service delivery. While the family physician in this model does not have the traditional wide scope of practice and has not been the patients' family doctor throughout their lives, he does practise with the philosophy and values of Family Medicine and understands the need to communicate with the 'home' family physician, family, and others.
2. The Working Group believes that new models of service delivery are required to improve the continuity and coordination of care for the elderly. The ACFP is encouraged to take the lead role in developing alternate service delivery models on providing care to the elderly, particularly the frail elderly. Models should reflect the unique needs of service delivery among and within rural and urban regions throughout the province. While a needs assessment may be required, the Working Group feels that these models could be developed by having the ACFP strike another task force of the ACFP composed of a wide representation of family physicians.

While it is recognized that closer integration of family physicians on multidisciplinary teams is likely a core component of alternate models of care, family physicians need to assume leadership roles on the team and take responsibility for the patients' medical records and the coordination of patient care. This role was not articulated in government reports on the

elderly (e.g. Broda Report) and must be emphasized in all forms of communication that are generated by the College that deal with multidisciplinary teams and care of the elderly.

Increase collaboration and integration of physicians working with the elderly (Family Physicians, Care of the Elderly Physicians, Internal Medicine, and Internal Medicine Geriatricians) in clinical venues, educational and/or research initiatives.

The Alberta Chapter needs to become more politically active in lobbying and advocating for the unique role of family physicians in caring for the elderly

The Alberta Chapter needs to work with the University Departments of Family Medicine to enhance Care of the Elderly programs for medical students, family medicine residents and family physicians

AFPRN should encourage family physicians to conduct or participate in primary care research on areas related to care of the elderly

The Alberta Chapter should encourage the development of and participation in CME courses addressing care of the elderly issues.

The Alberta Chapter should work actively with the AMA Section of General Practice to develop and negotiate different remuneration plans for family physicians caring for the

3. Encourage the collaboration and integration of all physicians working with the elderly whether in clinical, educational and/or research venues. This solidarity will result in a stronger effort in developing and implementing consistent standards of care, and in improving education programs and research initiatives associated with caring of the elderly.
4. As the voice of family physicians in Alberta, the Alberta Chapter needs to adopt a more proactive role in the political arena, lobbying for the unique role of the family physician in caring for the elderly and advocating on their behalf. In order to advance the role of the family physician in caring for the elderly, family physicians need to be involved, recognized and appropriately funded in policy building, teaching, research, academia and administration.
5. The Alberta Chapter should take the lead role in working with the University of Alberta and University of Calgary Departments of Family Medicine to seek additional funding for Care of the Elderly programs and for family physicians providing teaching to medical students and family medicine residents. Efforts should be made to increase the number of family physicians involved in the basic geriatric training of students and residents and to increase the number of GFT positions in Family Medicine.
6. The Alberta Family Practice Research Network (AFPRN) – an initiative of the Alberta Chapter – should encourage and support research projects related to caring of the elderly. AFPRN can assist family physicians to identify and acquire funding for these research projects and to facilitate and coordinate the stages associated with developing research proposals, i.e. proposal writing, recruitment, analysis of data, workshops, dissemination of results etc.
7. The ACFP, in collaboration with the university Continuing Medical Education departments, should encourage the development of, and participation in, CME courses and opportunities for practising Family Physicians in rural and urban Alberta.
8. Since the present fee for service system has a negative impact on family physicians who elect to care solely for the frail elderly, the Alberta Chapter needs to support the development, acceptance and endorsement of alternate payment plans for these family physicians, recognizing that there are differences

complex and frail elderly

in practices among family physicians and among regions in the province.

The Chapter needs to take an active role in discussions with the Section of General Practice at the AMA regarding the issues associated with the current fee-for-service schedule in caring for the elderly, and work with the Section to lobby the Government and regional health authorities for alternate funding plans more reflective of the age, complexity, and needs of these patients and their families.

Payment plan scenarios may range from a blended model of fee-for-service and a salary to manage elderly patients in a mixed family physician practice to a salaried family physician who elects to care only for elderly patients. Payment of office visits for complex and frail elderly patients must also reflect the time required to care for these patients and often their families.

A model of one family physician's approach in providing both improved quality care to the elderly while ensuring adequate financial compensation for service is attached as **Appendix 5**.

The definition of "Comprehensive" care needs to be revisited

9. The Alberta Chapter needs to collaborate with the National CFPC in redefining "comprehensive care" provided by family physicians.

Standards must be set for all health providers working with and caring for the elderly regardless of the setting (e.g. home, institutions, alternative community living accommodations such as assisted living, group homes and family care homes)

10. Standards must be set to ensure that regardless of where the elderly population lives within Alberta, each will receive the same high quality standard of care. The elderly population requires "a health care system that is community based, preventative, health promotion-oriented, continuous, seamless, flexible, accessible, client oriented, caregiver friendly, comprehensive quality-based and cost-effective". ("Health-Care of the Elderly and Family Practice Involvement", an editorial published in *Geriatrics Today: Journal of Canadian Geriatrics*, May 2002, 5, p. 61; **Appendix 6**; a Letter to the Editor following this article is attached as **Appendix 7**).

Conclusion

Caring for the elderly will become a certainty for the majority of family physicians in the future. It is the goal of this Working Group to become a catalyst in implementing changes that will shift the ideal situation into reality.

APPENDIX 1 ~ CHAIR AND MEMBERS OF WORKING GROUP

Members	Location
*Dr. Diana Turner, Chair	Calgary
*Dr. Jean Triscott	Edmonton
*Dr. Bryn Whittaker	Edmonton
*Dr. Paddy Quail	Calgary
*Dr. Bruce Wright	Calgary
Dr. Brian Willis	Edson
*Dr. Fred Janke	Sylvan Lake
*Dr. Donna Manca	Edmonton

*Denotes CCFP

Administrative Support: Peggy Maher, Executive Director, Alberta Chapter, CFPC
Shelley Veats, Coordinator, AFPRN, Alberta Chapter, CFPC

Appendix 2

Progress on the Nine Implementations of the Broda Report (February 12, 2002)

UPDATE ON THE PROGRESS MADE TOWARDS IMPLEMENTATION OF NINE STRATEGIC DIRECTIONS FOR LONG TERM CARE

In May 2000, the Standing Policy Committee approved implementation of nine strategic directions for long-term care in a document entitled *Strategic Directions and Future Actions: Health Aging and Continuing Care in Alberta*. Below is an update on the progress made towards implementation of these nine strategic directions. Policy and legislative planning activities will also proceed to facilitate the changes required to implement the strategic directions.

1. **HEALTHY AGING: Promote “healthy aging” as priority goals for Alberta to ensure Albertans are healthy and independent as they age.**

- As part of the Cross-Ministry Seniors’ Policy Initiative, a framework paper entitled *Healthy Aging and Seniors Wellness Strategy 2002-2012* was prepared. The primary purpose of preparing this conceptual model and framework for healthy aging was to provide a reference document for stakeholders and partners in addressing the opportunities and challenges posed by an aging population. As well this document will assist the regional health authorities in developing their 10 year continuing care strategic service plans, in which healthy aging is one of the nine strategic directions.
- A Healthy Aging forum took place in October 2001. Key stakeholders, including seniors and provincial organizations, were invited to provide feedback to the task group on the framework.
- This framework paper was presented to the Continuing Care Leaders Council in December 2001, and the Council of Medical Officers of Health in January 2002. It was well received by both groups.
- It is anticipated that the paper will be presented to Executive Committee and the Minister by March for final approval. Once approved, this framework paper will be circulated to stakeholders for their reference.

2. **CONTINUING CARE SERVICES: Development of a Ten-Year Continuing Care Service Plan and Provincial Continuing Care Needs Projection Model**

- Regional health authorities (RHA’s) were asked by the Minister of Health and Wellness to prepare ten-year strategic service plans for continuing care services. Historically service projections within continuing care have focused heavily on bed needs within long-term care facilities. With Alberta’s new vision of *aging in place* and the view towards shifting from institution to community, the plan will cover a broad range of services, including a home living stream, supportive living stream and facility based stream to respond to the future needs of an aging population.
- Phase I of the plan was submitted to the department for review in November 2000 and the Minister of Health and Wellness has provided feedback to the regions.
- Phase II is due to the department in July 2002. The Minister of Health and Wellness issued Continuing Care Strategic Service Plan Phase II Expectations to Board Chairs of RHA’s in August 2001. Planning for Phase II Expectations has been initiated and includes a series of workshops: Strategic Development, Setting the Stage for Change, was held September 14,

2001. The Model Training workshop is scheduled for January 28 - February 1, 2002, and the Pre-Submission Workshop is scheduled for March 14 and 15, 2002.

3. DEVELOPMENT OF CO-ORDINATED ACCESS POLICIES: *Implement "Co-ordinated Access" province-wide to ensure there is no barrier to Albertans in receiving continuing care services.*

- The purpose of coordinated access is to implement an improved, streamlined process for entry to continuing care services based on assessed needs, implement seven day a week entry to services, mandate discharge planning processes and develop new referral processes for wait list management to divert clients to lower cost alternatives.
- A task group was formed with representatives from health authorities to develop the draft policies. This draft policy paper was forwarded to the Executive Team for review and feedback in September 2001 and circulated to the Council of CEOs in December 2001. Dave Broda, Chair of the Implementation Committee, will lead any further consultation with stakeholders, if necessary.

4. DEVELOPMENT OF SUPPORTIVE LIVING POLICIES: *To identify issues and barriers relating to the expansion of supportive living and develop short-term strategies to address some of the issues and barriers, as well as identify future policy issues that may assist in the development of legislation.*

- Two focus groups were conducted with representatives from all health authorities to identify barriers and issues, to develop policies and strategies to expand supportive living as an alternative to institutionalization.
- to confirm the above and identify short-term strategies for addressing them and develop a policy framework paper, including a definition of supportive housing. This definition was approved by the Continuing Care Leaders Council.
- Alberta Seniors is currently using the task group framework paper to develop a provincial housing policy paper.
- Alberta Health and Wellness is working with Alberta Seniors to design a collaborative strategy to address common issues as identified in the policy paper.

5. HOME CARE AND COMMUNITY CARE: *Expand home care and community care services to meet the increased needs of Albertans in the community.*

- \$40 million was allocated to RHA's to expand home care services in 1999/2000 and 2000/2001.
- Home care policies will be reviewed and recommended for amendment as part of the continuing care legislative changes, if necessary.

6. REGENERATION OF LONG-TERM CARE CENTRES: *Regenerate long-term care centres to meet the needs of residents with high and complex needs.*

- \$259 million capital funding for infrastructure for continuing care was approved to expand and modernize long term care facilities to meet the needs of residents with high and complex needs.
- \$38 million HAPI funding was transferred to Alberta Seniors.
- 1,030 additional supportive housing spaces will result from the HAPI funding.
- Over the next three years, approved capital projects are expected to result in 1,236 additional long-term care beds and 1,348 replacement beds.

7. DEVELOPMENT OF ALZHEIMER'S INITIATIVE: Year 1 Priority (2000/2001) Needs of Persons with Alzheimer's Disease, Dementia And Other Special Needs.

STATUS AND NEXT STEPS:

- A working task group with representatives from the health authorities and the Alzheimer's Society was formed in November 2000 to develop a provincial strategic directional reference document to assist the regional health authorities in preparing their 10 year continuing care strategic service plan.
- International and national experts attended a planning symposium in Edmonton, April 25-27, 2001, to provide advice on quality Alzheimer's and dementia care and core components of services needed for this special population.
- Over thirty public consultations were held across the province during June and July 2001.
- A provincial paper is now available and will be presented to Executive Team and the minister for approval in the near future. Once approved, the paper will be distributed to the stakeholders for their reference.

8. COMPREHENSIVE CARE FOR THE ELDERLY AND PRIMARY HEALTH CARE: Develop comprehensive care for the elderly to address the special needs of older adults with multiple and complex health problems.

- The development of this strategy will commence in the next fiscal year.

9. HUMAN RESOURCES, EDUCATION AND TRAINING INITIATIVE:

- A Continuing Care Work Force Task Group is developing a comprehensive recruitment, retention and training strategy for continuing care support workers.
- A competency profile for continuing care support workers has been established, with training modules and resource materials in the works.
- A career promotion and recruitment/retention action plan for continuing care support workers is under development, along with strategies for addressing the role and educational needs of clinical nurse specialists/nurse practitioners in gerontology.
- A proposal reviewing strategies for enhancing the geriatric in-service mentoring program for health professionals is also being developed.

Prepared by: Strategy Development Branch
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Date: February 12, 2002

Appendix 3
Working Draft 2 Confidential
“A Discussion of the Health Care of the Elderly Committee” February 2002

In the Era of Primary Care Renewal: Empowering Family Physicians to Meet the Challenge
A Discussion Paper of the Health Care of the Elderly Committee

Dr. Jean AC Triscott-Chair, AB
Feb. 1,2002

WORKING DRAFT 2 CONFIDENTIAL

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A. CHANGING DEMOGRAPHY:

The older population, those 65 of age and older, have increased and is projected to increase from 12% of the Canadian population in 2000 to 23% in 2041. The increase in the proportion of the population aged 85 and over, those with the greatest need for health care and social support services, will be even greater. In 1991, Canadians 65+ had a life expectancy of 18 years, nine of which were expected to be disability –free, while the remaining nine years were expected to include three years each of slight, moderate, and severe disability. ¹ Seniors often become frail from multiple chronic diseases, which cause physical and functional limitations. The leading causes of hospitalization for Canadian seniors are coronary heart disease, cerebrovascular disease, prostate disease and accidental falls. ² Alzheimer Disease is a significant illness of later life as it presently affects 316,000 Canadians. This number is expected to increase to approximately 750,000 in the next 30 years. It is also known that approximately 25% of people aged 85 and over have Alzheimer Disease, however, one in three Canadians over age 85 are affected by primary Alzheimer Disease and related dementias. 67% of people with this disease are women. ³

B. DEFINING THE PROBLEM: SERVICE DELIVERY

Home care is the fastest growing sector of health care in Canada with a reported annual growth of 11%. Statistics confirm that the downsizing of the hospital sector has been dramatic and ongoing. According to Health Canada, from 1989-1994, the number of hospital beds nationally per 100,000 population declined 14% from 654 to 562. ⁴ Hospital admissions are also falling. ⁶ the result has been a significant increase in number of people requiring care and support in the home. In 1994/95, for example, the number of people 65 and over receiving home care (335,200) exceeds the number of seniors living in institutions (185, 600). ^{7,9} Other factors driving growth in home care are consumer demand. ⁸ Government cost containment,

changing attitudes towards institutionalization and new advances in technology, less intrusive surgical techniques and new drugs have driven the growth of home care.⁹

Increasingly, home care is being used as an acute care substitute affecting shifts in the mix of patients being treated and in the mix of services being used in the home. "What was once a menu of non-medical, person and social support services now encompasses a growing list of increasing complex medical interventions."¹⁰ With the shift from acute care, the complexity of care need in the home is increasing, and with it, the need for an enhanced level of medical management. The aging population also has increased the medical complexity due to atypical medical presentations, multiple diseases, decrease functional ability and lack of reserves. In 1998 CFPC National Home Care Survey, members reported steady and significant increases in patient demand including an increase in the number of active medical treatments required by their patients. Concern was expressed about the impact of the shift to home care on the health of the patients. A majority (75%) said that their patients were going home from hospital sicker and often in need of more complex medical care than in the past.⁹

Time constraints and lack of remuneration were the two major obstacles for physician's lack of involvement with home care. Time pressure was flagged in the 1998 CFPC Home Care Survey by 57% of respondents as the most significant barriers to carrying out clinical and administrative activities related to home care.¹¹ McWhinney contends that the lack of organization of medical services in a cohesive structure outside of the hospital is a major obstacle to physician involvement. He adds that family practice needs some form of institutional structure to link community-based physicians with home care and hospital services.¹² The other major obstacle for family physician involvement is remuneration. Forty-five % of the family doctor identified compensation as a factor limiting their involvement in clinical and administrative services related to carrying out home care.¹¹ Comprehensive geriatric assessment of an elderly patient requires involvement medically from skilled family physicians and functional issues need to be addressed by the interdisciplinary team. The elderly have atypical illness presentation, acute diseases, multiple chronic diseases, and multiple medications, decrease reserves and loss of function, which makes their care complex. There needs to be an alternative fee payment for this frail elderly patient. The present fee for service approach does not work for these patients who required major medical expertise and time for the family physicians to interact with the family and the interdisciplinary team. There needs to be APP (alternative funding), sessional or hourly remuneration for these types of medically complex frail elderly patients.

Strong evidence suggests that physicians have concerns about the quality of acute patient care in the home. The Hospital to Home Study conducted in 1994 showed that four of nine patients followed were readmitted with medical complications. Some of the problems identified were fragmentation of services, family doctors not informed of discharge, and limited hours for accessing home care. Further studies as noted by McWhinney illustrate that readmissions are common, typically occurs within 30 days of discharge, are usually for problems that arose during the previous hospitalization (but that they are preventable and can be reduced with in-home monitoring).^{12,9}

There is a recent published document "Shame of Canada's Nursing Homes", Sept. 2001, by FAIRE (Families Allied to Influence Responsible Eldercare) which expressed concerns regarding the quality of care, lack of universal standards and growing problem of lack of physician coverage for Nursing Homes. More and more physicians are refusing to care for residents or to take any new residents into their practice.

¹³

The CFPC National Family Physician Survey reported 31% of family physicians are planning to leave or substantially alter their present practices within two years, and the Angus Reid/Alberta Medical Association 1998 Survey identified 51% of physicians in Alberta as dissatisfied with their medical careers and 29%

considering leaving the province.²⁹ Recent medical school graduates are concerned there is a lack of support for family doctors in our system and are no longer choosing careers in family medicine as they once did. Between 1995 and 2000 the percentage of graduates selecting family medicine as their choice careers fell from 40% to 29%.²⁹

End of Life Care

Family Physicians are feeling more disillusioned working in the present system with their frail elderly complex patients with chronic end-stage organ diseases both in the community and in institutional settings.

In the past, our specialty colleagues defined Palliative Care as care given only to cancer patients in need of symptom management. As a result there has been a huge gap in care for most of our seniors who suffer from end-organ disease failure from chronic diseases at the end of their life. They have been typically excluded in being able to access Palliative Care (symptoms control for cancer patients). We must view end of life care on a continuum. Geriatric care is typically viewed as the care of persons who are aged 65 and over. Geriatric care encompasses a wide range of treatment from intensive care to end of life care.²² It can work together with palliative care to meet the needs specific to the senior. Such care, which is proper and appropriate for older people who are dying includes symptom control, care within seniors; facilities, continuity of care, flexibility and multidisciplinary teamwork.²³

Summary: Defining the Problem; Service Delivery:

1. Increasing complexity and acuity of elderly patients in the community
2. Increase fragmentation of services provided
3. Decrease coordination of services
4. Lack of continuity
5. Decrease communication to primary care physicians
6. Increasing time commitment to manage these complex elderly patients
7. Decreasing remuneration
8. Poor integration of team resources
9. Increasing pressure to manage these patients in the community (hospital cutbacks and social pressure)
10. Lack of Standardization of Care and Guidelines (e.g. LTC – Long Term Care)
11. Decrease quality of services available to manage complex elderly in the community

C. DEFINING THE PROBLEM: EDUCATION AND RESEARCH:

The Primary Care for seniors: Results of a Canadian Needs Assessment was conducted in 1998.²⁴ The survey aims to identify core issues for primary health care physicians in caring for the elderly. Second, it gathers general and family practitioner's perceptions of the quality of current health care services for the elderly, examines the changes needed in primary care and identifies possible CHE opportunities to initiate this change process. The "Primary Care Physician Canadian Need Assessment"²⁴ identified dementia, polypharmacy early signs and symptoms in chronic elderly and depression as areas needed for more education for primary care physicians. Most physicians expressed concern for screening early-stage symptoms of chronic diseases, (almost 70% rated themselves not at all, not very or only somewhat effective in this respect). Approximately one-third of physicians identified unique difficulties in diagnosing and caring for seniors of different ages (e.g., from 65 to 74 years, 75 to 84 years and 85 years plus). More than half of physicians surveyed rated themselves not at all, not very or only somewhat effective in

diagnosing depression in senior patients. Adverse drug reactions and polypharmacy are considered among the top ten geriatric problems in primary care. Approximately half of respondents surveyed reported using methodologies or instruments for assessing the health of their patients 65 years and older (e.g., Mini Mental Status Exam, Canadian Periodic health Exam).²⁴

The background document on Education of Future Physicians of Ontario identified obstacles in senior primary care as follows:²⁵ This working paper is based on information collected through written responses from 22 groups/organizations serving seniors in Ontario. Although the focus is Ontario, the issues are pertinent nationally.

1. Lack of knowledge and training
2. Lack of available resources including time
3. Lack of coordination of support services
4. Lack of support services
5. Lack of effective monitoring (e.g. medication use)
6. Lack of effective communication skills, and
7. Lack of funding in general for training and compensation for geriatrics

History of Geriatric Training Programs: In 1973 the Canadian Medical Association (CMA) a resolution was passed “that the Royal College of Physicians and Surgeons of Canada (RPCSP) should recognize a subspecialty of Geriatric Medicine and that one or more university centers provide training programs as soon as possible”. The Council of College eventually granted recognition in January 1977, but entry was limited to those with prior certification in internal medicine. The CMA then expressed concerns about this decision of the RCPSC and in 1977 passed a motion “That the CMA recommend that the RCPSC, the CFPC, the Association of Canadian Medical Colleges (ACMC), the Canadian Association on Gerontology and the CMA work together to develop training programs and this opportunity should be open to all physicians”. The RCPSC turned down the option to open up entry to other specialties and declined to consider a proposal for conjoint certification with the CFPC.^{14, 15} It was felt that a consultant role should be restricted to (RCPSC) recognized specialists whereas the primary care of the older people should be let to family physicians.

The CFPC at this time did not acknowledge the need to establish a clinical specialty in geriatric medicine though it did recognize the need for a limited number of physicians to fulfill academic requirements. From a clinical standpoint, the CFPC favored consolidating care of older people within the framework of family medicine.¹⁶⁻¹⁹

The Care of the Elderly Fellowship has been officially recognized by the College of Family Physicians of Canada (CFPC) since 1989. It represents elective, supplementary training in care of the elderly of 6 or 12 months duration, available after the 2-year core Family Medicine Residency. Most trainees undertake the program as third-year residents, and are funded as such. The program is also available to primary care physicians who are already in practice. Depending on the province, self-funding may be necessary. The Care of the Elderly Fellowship is distinct from subspecialty training in Geriatric Medicine leading to certification by the Royal College of Physicians and Surgeons of Canada, as prerequisites for the later are three years of training in Internal medicine. Unlike Canada, in the USA a training program leading to a Certificate of Added Qualifications in Geriatric Medicine is available to both family and internal medicine graduates.²⁰

Graduates of the Care of the Elderly Programs can develop a primary care geriatric practice, but they can also perform functions typically done by consultants. This consulting role for family physicians with appropriate training and/or experience exists and will continue to exist in Canada because of the insufficient number of RCPSC-trained specialists in geriatric medicine. This is particularly true for rural areas, towns,

and smaller cities. These qualified individuals have made very sizable contribution to many university-based training programs across the country. The CFPC views the care for the elderly programs as distinct from the RCPSC specialty-training program in geriatrics. While this add-on training for family physicians was greeted with some opposition, family physicians with additional training in care of older adults and RCPSC-trained specialists in geriatric medicine have collaborated closely on both clinical and academic levels.²¹

Family Physicians will continue to play an increasingly important role in the primary care of the well and frail elderly in a spectrum of settings including office, home, hospital, and long-term care institution. This reality will be reinforced by a second trend: changes in the Canadian Health Care system to download care from hospital to outpatient and community resources. Another factor adding to an increasingly important role for primary care physicians in the care of the frail elderly, particularly in rural areas, is the small number of specialists in Geriatric Medicine, and their understandable preference for urban academic settings, which facilitate research.²⁰

The Care of the Elderly program provides in-depth training for Family/Primary Care physicians who:

- Wish to improve their knowledge of the special needs of the frail elderly as well as their skills in managing this population;
- Will be acting as resources in care of the elderly in the community, urban and rural;
- Will take on leadership roles including program development in settings such as Long Term Care, Geriatric Assessment Units, Home Care and other specialized services for the elderly.²⁰

Summary: Defining the Problems; Education and Research:

A recent survey of the Care of the Elderly Programs in Canada (Oct. 2001)²⁶ was completed which addresses several issues Program Directors are facing:

1. Little or minimal specific Care of the Elderly/Geriatric Medicine training in the Undergraduate Curriculum across the country.
2. Most Universities have a vertical (one –month block) during their Family Medicine training in Geriatric Medicine but some schools are taught from a Specialty approach and may not have Care of the Elderly FM faculty role models
3. There is minimal funding for the Care of the Elderly Program Directors and very few are funded as GFT positions in the Department of Family Medicine
4. Many Programs don't have Care of the Elderly FM faculty or role models due to lack of funding.
5. Once the Care of the Elderly FM graduates are trained, few positions (e.g. sessional or salaried positions) are available for them to practice their newly obtained skills in the community, both urban and rural
6. When there is low priority for Care of the Elderly in the Department of Family Medicine, The Care of the elderly Program becomes an appendage to the Geriatric Medicine subspecialty which results in poor Primary Care, Care of the Elderly FM role modeling for the students and residents.
7. It appears that in order for collaboration to be successful with our Subspecialty colleagues in Geriatric Medicine, both Programs need to retain their individual integrity.
8. There seems to be some collaboration with Care of the Elderly Programs with Geriatric Medicine in education and clinical venues for specialty training, but little Primary Care Research is done to develop Primary Care Health initiative in Care of the Elderly FM. As a result, the training becomes more sub specialized and does not often reach the Primary Care Physicians in the front line.

Solutions for Improving Care of the Elderly in Canada:

Canada needs to adopt a set of Principles in order to guide the further development of health Care in the Elderly. The Federal/Provincial/Territorial ministers Responsible for Seniors in recognition of the International Year of Older Persons in 1999 developed a **Vision Statement**: Canada, a society for all ages, promotes the well-being and contribution of older people in all aspects of life, promotes the well-being of seniors, recognizes their valuable contributions and reflects the goals of elimination of ageism in all sectors. It lays out the current challenges and the desired outcome and direction of efforts applicable to all policy areas. The principles associated with the National Framework on Aging (NFA) should guide the actions by which its Vision will be achieved. They reflect the core values of seniors inherent in the Vision Statement. The principles need to be considered together as they are interrelated in promoting the overall health and well being of seniors. Focus groups of seniors favored the following core principles: **Dignity, Independence, Participation, Fairness** and **Security** which were subsequently approved by Federal/Provincial/Territorial Ministers Responsible for Seniors, as the most important principles for policies affecting seniors. ²⁷

There is a policy statement on Medical Care of Older Persons, approved by the Canadian Medical Association, March 5,2000. These were first developed by the B.C.M.A. Geriatric and Palliative Care Committee and subsequently revised after a national consultation undertaken by the C.M.A These Principles for Medical Care of Older Persons are as follows; ²⁸

1. Access in old age
2. Health promotion and prevention in the care of older persons
3. Special needs of frail elderly persons
4. Team work among health professionals
5. Effective planning for geriatric services
6. Serving people in all regions of Canada
7. Ethical and legal issues in the Care of older persons
8. Education in the Care of older persons
9. Research in the care of older persons.

The Principles and Values of the College of Family Physicians of Canada (CFPC) are committed to the improvement of health in the elderly in Canada. Table 1&2 We need to develop a system which will empower the Family Physicians to provide the best quality care to their elderly patients and families.

Table 1-The College of Family Physicians of Canada (CFPC) strives to improve the health of Canadians by:

- Ensuring the highest standards of training, certification and maintenance of proficiency for Family physicians;
- Educating and informing the public about healthful living;
- Supporting Research and disseminating knowledge; and
- Championing the rights of every Canadian to high-quality health care.

Table 2 - The Family Medicine members are committed to the four Principles of Family Medicine:

- The patient-doctor relationship is central to all we do
- Family Physicians must be skilled clinicians
- Family Physicians should be a resource to a patient population
- Family medicine is a community-based discipline

Solution: Health Service delivery for Care of the Elderly:

Two documents have been written by the CFPC, Discussion Paper: The Role of the Family Physician in Home Care, Dec. 2000,⁹ and A Position Paper, Primary Care and Family Medicine in Canada, A Prescription for Renewal, Oct. 2000.²⁹ These offer recommendation for Primary Care Reform in the Elderly. Another document has been developed in Alberta, Strategic Directions and Future Actions: Health Aging and Continuing Care in Alberta, Vol No 1, May 2000.³² A few highlighted recommendation are relevant to the Care of the Elderly:

1. Develop new Primary Care Integrated models for the delivery of services to the elderly in the community both urban and rural. The family physician assume an active role in the home setting as a member of a multi-disciplinary team, and that mechanisms be developed nationally to facilitate the creation of such teams.⁹
2. To recognize the importance of the role of the family physician in home care as part of the multi-disciplinary team and support its development.
3. To provide financial incentives and flexible remuneration that will encourage the participation of all health professionals in providing comprehensive care of patients in the home (e.g. family physician remuneration including blended funding, telephone consultations, house calls and after-hour premiums, etc.)⁹
4. Family physicians must be appropriately compensated for the increasing numbers and complexity of services they provide, including incentives for carrying out specific services needed by patients across the country. Such services include emergency care, in-hospital care, palliative care (end of life care), services for rural and remote communities and other special-needs populations, house calls, and achieving preventive health goals.²⁹
5. Family physicians should be remunerated by the payment mechanism that best responds to their professional, practice and patient needs e.g. sessional, salaried, blended.²⁹
6. Where private-sector providers exist, governments must ensure that all medically necessary services are publicly funded and that the governments, professional Colleges, and Associations establish monitoring and disciplinary processes to guarantee that private providers and facilities will meet quality and standards of care.²⁹
7. Establish healthy aging as a priority for government including a greater emphasis on promoting healthy lifestyles, preventing illness and injury, and empowering and engaging seniors.³²
8. Adopt primary health care models for providing health services for older people, so services are well coordinated, teams of health professionals work together to meet peoples' needs, and there are effective and well managed plans in place.³²
9. Introduce a new coordinated access process to assess needs and ensure appropriate referrals to the full range of continuing care services, whether those services are provided at home, in supportive living arrangements or in continuing care centers.³²

10. Shift the focus so that the first priority is for people to remain in their homes and other types of supportive living arrangements. Expand home care services substantially. ³²
11. Encourage the private and voluntary sectors to expand the range of supportive living options available across province. Expand supportive housing to include light and medium care cases, people with mild dementias, and young people with disabilities. Set province-wide standards for supportive housing developments. ³²
12. Establish a new generation of continuing care centers designed to meet the needs of a selective population of frail older people. ³²
13. Increase supportive housing alternatives and home care to take the pressure off continuing care facilities and acute care. ³²
14. “Unbundle” health care services, other services such as personal care and food services, and housing arrangements. Give people a choice in the specific package of services they need to meet their assessed needs wherever possible. Bring services to people rather than requiring them to move into facilities or travel to where services are provided. ³²
15. Reorganize the delivery of acute care services for older people. Introduce a comprehensive case management strategy for meeting the needs of older people with complex, multiple health problems. Ensure that there is effective discharge planning. Enhance geriatric services and access to geriatric assessment services, especially in rural communities. ³²
16. Introduce a new Continuing Care Act to ensure there are consistent standards, appropriate monitoring, and clear responsibilities for the different organizations involved in continuing care. ³²

Service Delivery:

There is a model of care delivery, which fit, in all the above recommendations. Seniors need a system that is community-based, preventive and health promotion- oriented, continuous, seamless, flexible, accessible, client-oriented, caregiver friendly, comprehensive, quality-based and cost effective. Seniors and their families need a one-stop approach to their multiple complex medical and functional needs. This model needs to work in both urban and rural settings in Canada. Presently in the provinces, there has been rationalization of health care services. Each region needs to access their own resources e.g. interdisciplinary teams, FM physicians with Care of the Elderly or Geriatrics, and community resources. There can be Primary, Secondary and Tertiary Systems in place to meet the needs of the senior populations.

The Primary Level of Care for seniors could be a Family Practice Network (FPN) in the community with the team working closely with the Family Physician in the community Network. There will be emphasis on the Evidence-Based Guidelines for seniors with an emphasis on Periodic Health Examinations and Health Prevention and Promotion. ³³

The Secondary Level of Care for seniors may involve a referral to a Community Health Center, which would include a complete Geriatric Assessment with the specialized Geriatric Assessment Team in the home or outpatient setting. The team including the Family Physician would have extra skills in Care of the Elderly.

There would be access to a full range of services e.g. radiology, laboratory etc. Recommendations would be communicated to the Family Practice Network (FPN), which includes both the team, and Family Physician for management.

The Tertiary Level of Care for seniors would involve specialized inpatient Geriatric Assessment Units (GAU). These GAU would have the full complement of an interdisciplinary team, including Family Physicians and Family Physicians with extra training in Care of the Elderly. The senior patient who requires an inpatient assessment and rehabilitation will be referred to the inpatient Geriatric Assessment Unit (GAU). The patient's medical conditions are treated earlier in the course of their illness, which avoids loss of function. As function is preserved, this enables the patient to return home with community resources. Many patients may require an innovated continuing care alternatives, e.g. Choice Program, Hospice Care or Maintenance Day Programs. Model 2

In Model 2 the elderly patients is managed at home with a team. The multiple complex medical problems are addressed in order to maintain function for independent living. There is an integrated and coordinated team including the Family Physician. The FP is able to spend the time with the team and family due to a different payment scheme, e.g. Alternative Payment Plan, sessional or hourly fee. Services are integrated, accessible, coordinated, flexible, seamless, cost-effective, user-friendly, and quality-base with a health prevention and promotion orientation.

Presently Model 1 the frail senior is in the community, services are fragmented, multiple visits to the solo FM office, difficult to get there due to transportation, FM not remunerated for time it takes to see multiple problems and poor interaction with the home care team and the Family Physicians. As a result, the elderly and stressed care giver are sent to emergency, admitted to acute care hospital often admitted later stage of the disease, loss of function e.g. iatrogenesis drugs, immobility. Permanent loss of function result in inability to return home and often leads to institutionalization. This Model 1 is presently what is happening in the hospital system.

Solutions: Education and Research:

1. There needs to be increasing emphasis on dedicated teaching specific to Care of the Elderly/Geriatric Medicine in the Undergraduate Curriculum across the country. There should be involvement of the teachers in Care of the Elderly FM in the curriculum.
2. The training needs to be specific in developing skills relevant to treating the elderly in the new model of interdisciplinary team management with emphasis on health prevention and promotion.
3. There must be adequate funding and other support resources for university departments, hospitals, and physician and nurse teachers involved in the training of family physicians, nurses and other health care professionals.²⁹
4. There should be adequate support for the Program Directors in Care of the Elderly.
5. There should be integration of the COE Program in the Department of family medicine with GFT positions for the Care of the Elderly Faculty. This is important in order to encourage Primary Care role models for the residents in clinical, education and teaching. This will also help integrate the development of knowledge in Care of the Elderly with other faculty and primary care physicians in the community e.g. urban, rural.

6. Take steps to increase the number of qualified professionals and health care providers working with older people. Increase the number of nurse specialists and Care of the Elderly Physicians FM in Geriatrics.
7. Establish designated, stand-alone funding for training in Care of the Elderly Family Physicians in Canada.
8. Set new standards for skills and competencies for people working in continuing care centers
9. Establish a new provincial Network of Excellence in senior's health and geriatric care.³²
10. Care of the Elderly should integrate and interact with our Palliative Care (End of Life) Family Medicine colleagues in order for further development of Primary Care Models and enhance the continuity of care and service delivery for end of life.
11. That the CFPC ensure that all family practice residency programs provide increased exposure to care of patients in the home, and training in the prerequisite skills to provide more acute care in the home setting.⁹
12. The Family Medicine residency experience should be setting relevant to a Primary Care Physician.
13. There needs to be the development of Primary Care Research in studying new models of providing Care in the Elderly.³⁰ The Canadian Institute of Health and Aging encourages research projects with a multidisciplinary primary care focus.³¹
14. There should be increasing collaboration with our specialty colleagues e.g. Geriatric Medicine, Neurology and Geriatric Psychiatry. Sharing of expertise in education, clinical and research will enhance all programs.

Recruitment and Retention of Family Physicians:

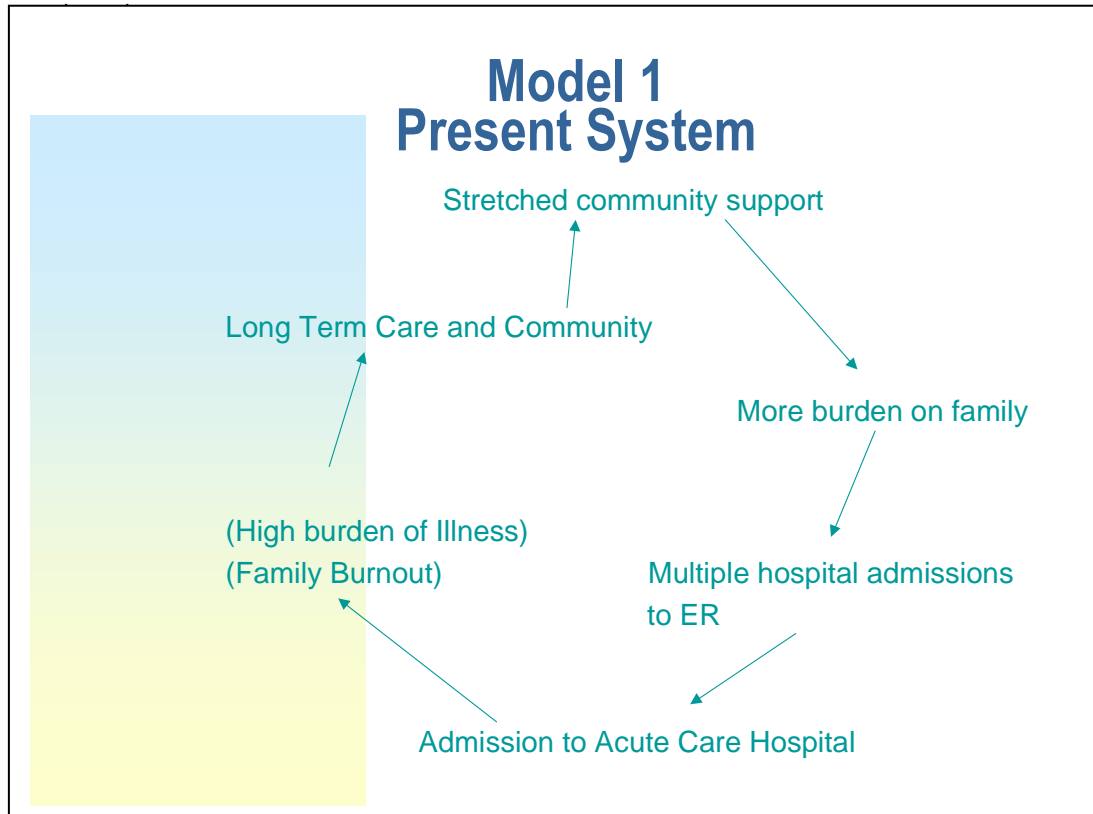
Concerns have been expressed in the decreasing enrollment of medical students in choosing Family Medicine as a career option. From the present system, Model 1, Family Medicine has not been rewarding both from an academic, lifestyle and monetary point of view. Due to the complexity of the elderly patient, it become not rewarding in trying to sort out the problems in a solo fee for service office with few supports. As we demonstrate new models (Model 2) of service delivery within our education programs more medical students will be choosing Family Medicine as their career option. As new job opportunities are created within integrated models, APP (Alternative Funding, sessional/hourly fee rates and role models are developed within our faculty more physicians will choose Care of the Elderly Family Medicine.

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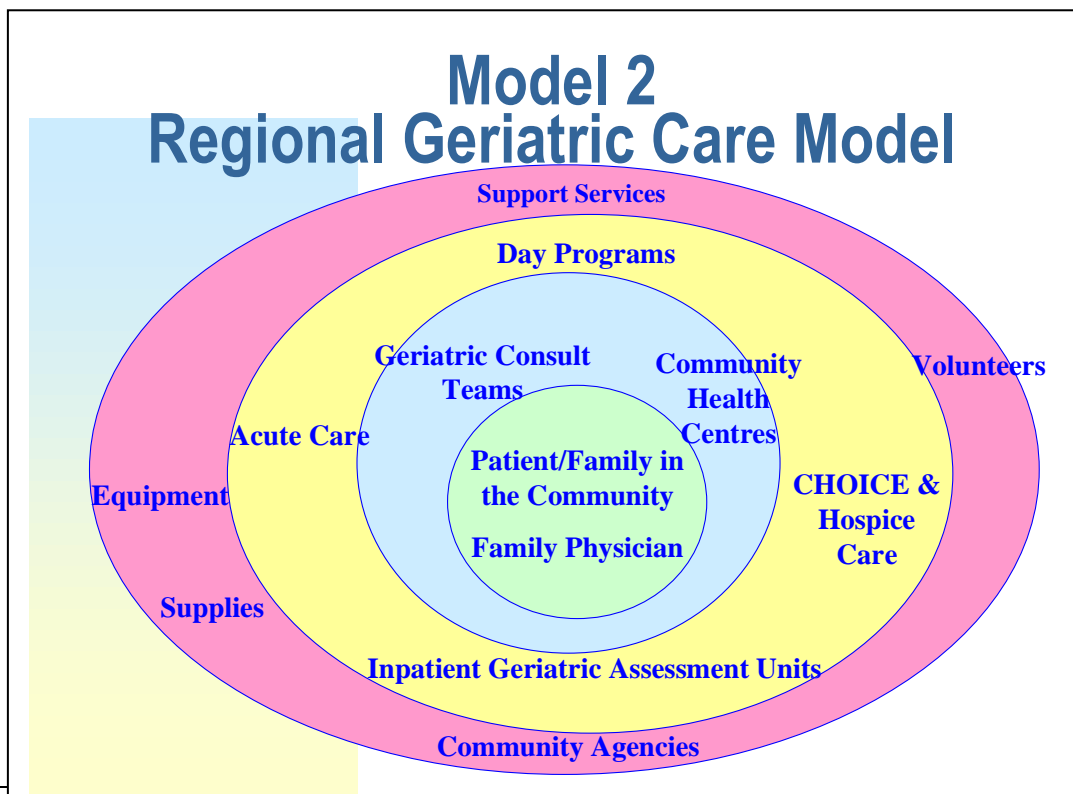
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Model 1

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Model 2



Appendix 4

Information gathered from **MAINPRO M-1** course listing in ACFP office and from National **MAINPRO C** listings noted on the website.

List of MAINPRO® M1 courses accredited by the Alberta College of Family Physicians – October 1999 to September 2002:

Promoting Healthy Aging – Issues for Mid-Life and Aging Patients/October, 1999 - 6.5 MAINPRO® M1 credits

A Workshop on the Office Assessment of Dementia/October, 1999 – 1 MAINPRO® M1 credit/hr

Canadian Association/Gerontology CME Day for Family Physicians/October, 2000 – 6 MAINPRO® M1 credits

Clinical Issues in Geriatrics/ November, 2000 – 6 MAINPRO® M1 credits

Geriatric Rehabilitation/November, 2000 – 5 MAINPRO® M1 credits

Age, Anxiety, Anger and Antidepressants/July 2001 – 1 MAINPRO® M1 credit/hr

Overview of Atypical Antipsychotics in the Elderly/October 2001 – 1 MAINPRO® M1 credit/hr

Treating and Managing Complex Dementia Cases/January 2001 to December 2002 – 1 MAINPRO® M1 credit/hr

Octogenarian Review: NSAIDS & Coxibs in Your Most Difficult Elderly Patients/January 2002 – 1 MAINPRO® M1 credit/hr

Hands ON! Practical Applications for Psychosocial Assessment & Treatment in the Elderly/November 15 & 16, 2002 – 12 MAINPRO® M1 credits

2003 Northern Alberta Regional Geriatric (NARG) CME Day/May 2003 – 6 MAINPRO® M1 credits

List of current MAINPRO® C courses accredited by the College of Family Physicians of Canada:

2nd Annual Dementia Summit, The Regional Geriatric Institute of Ontario/Sept. 2002 to Mar. 2004 – 8.0 MAINPRO® C credits

Early Alzheimer Disease: Diagnosis, Treatment and Management, AXDEV Group – Internet program/Oct. 2001 to Mar. 2003 – 8.0 MAINPRO® C credits

Geriatric Small Group Series with Consultants, McMaster University, HSC, CE Program/Dec. 2001 to June 2003 – 3.0 MAINPRO® C credits

Geriatric Workshop Series 2000/2001, McMaster University, CE Program/Dec. 2001 to June 2003 – 3.0 MAINPRO® C credits

Introduction to the Assessment and Management of Dementia On-Line, The University of Calgary – Internet program/Dec. 2001 – June 2003 – 4.0 MAINPRO® C credits

Management of Challenging Behaviors in the Elderly, Region of Durham – Lakeridge Health Corp./Mar. 2002 to Sept. 2003 – 2.5 MAINPRO® C credits

Preceptorship in Dementia, University of Toronto, Dept. FCM/April 2002 to Oct. 2003 – 5.0 MAINPRO® C credits

List of archived MAINPRO® C courses accredited by the College of Family Physicians of Canada:

Alzheimer Disease and other forms of Dementia, Multiple sites, AB/Nov. 1998 to March 2000 – (# of MAINPRO® C credits not noted)

Cleared On-line Geriatrics, Cleared- Internet/ Feb. 2000 to Aug. 2001 – 54 MAINPRO® C credits (6.0 /module)

Maintaining the Therapeutic Alliance in Dementia, Sunnybrook & Women's Health Sciences Centre/Oct. 1998 to Apr. 2000 – 11 MAINPRO® C credits

file: ../my documents/documents/Care of the Elderly/MAINPRO® Course listing

Appendix 5

Primary Care Of The Frail Elderly: “Thinking Outside The Box” (May 2002)

Bryn Whittaker, MB.ChB. CCFP FCFP

...An alternative methodology of one physician’s approach of providing Care to the Elderly

Introduction

Four years ago, I totally gave up my established family practice. Since that time, I have focused on providing primary medical care and support to a group of frail elderly, while establishing a balance in my non-practice life commitments. This change has resulted in a win-win situation both for my patients, my office colleagues and me. This paper highlights my reason for this change, the advantages of a Broda-style approach to care and a summary of my current practice situation.

During the past six months, I have been involved with the Care of the Elderly Working Group (a committee of the Alberta Chapter, College of Family Physicians) that has documented the various challenges facing family physicians as they grapple with delivering care to an increasing number of elderly and frail seniors. Their review of the Broda Report, a document that provides recommendations in providing care to the elderly, was of great interest and the members agreed that while its recommendations have great merit, do not address the role of the family physician in caring for the elderly. While the implementation of these recommendations are encouraging, continued progress in delivering care in a team approach must be made and the family physicians’ role in such an approach must be clearly identified.

In the ongoing debate of Primary Care Reform, physicians are being encouraged to ‘*think outside the box*’ and embrace new models of care ~ the physicians appreciate that change needs to occur because the ‘status quo’ level of care is no longer a viable option. This is particularly so in the area of delivery of care to the frail geriatric population.

It is for these reasons that I decided to ‘think outside the box.’

Naomi Remen MD, inspirational speaker and author of *“Kitchen Table Wisdom”* states,

“...We must help physicians regain the meaning of their work... It is not about technique and skill but about relationships, this work is of the heart and soul”.

The relationships we have with our patients and our fellow healthcare workers are the source of fulfillment in our work. The greatest cause of stress in physician’s lives is the sense, when it comes, of not being able to offer the best care. This philosophy has encouraged me to design a practice arrangement that I believe allows me to offer the best care to my patients.

Practice Options in a Broda-Style Team Approach

There are different situations from which family physician could consider working with a Broda-style team approach, including:

- 1) A family physician that is prepared to reduce his/her practice size and dedicate repeated, fixed time to coordinate a multi-disciplinary health-care team to work with the frail seniors.
- 2) An experienced family physician that desires change and has a special interest in geriatric work. This physician may also have completed the Care of the Elderly program with the College of Family Physicians.
- 3) A family physician that needs to balance work with other commitments in his/her life. The physicians would be able to practice as both skilled clinicians and be a resource to patient groups in a team style approach in keeping with, not just these, but all the four principals of family medicine.
- 4) Family physicians with heavy practice workloads find it increasingly more difficult to satisfactorily provide a high level of care to frail seniors. In the future, one option may be to refer these patients to a primary care physician working with a Broda style team, rather than have the patient access episodic care in the emergency rooms. In the Capital Health Authority region, there has been a 33% increase in emergency room visits for patients over 75 over the four last years; this number is expected to increase (Source: Capital Health Emergency Visits and Medicine Program Inpatient Separations for Patients age 75 and older, fiscal 1997/98 to 2001/02, Clinical Performance, Information and Research, Capital Health Authority).
- 5) A new family physician graduate who has little family practice experience but who has completed the Care of the Elderly program. The experience of general family practice is considered far too rich to encourage new graduates to ignore it completely, but certainly newer graduates could still be encouraged to care for the elderly and frail elderly.

Current Practice Model

Having totally given up my established family practice, I am currently able to satisfactorily care for about two hundred and fifty frail seniors. I have made arrangements with two different senior lodges in Edmonton, recognizing that these settings are ideal to implement Broda-style care.

Ideally the lodge should have an RN or nurse practitioner on staff twenty-four hours a day, responsible for all initial assessments and distribution of medication. This person would work closely with a family physician or physicians who visit the lodge as well as the lodge administrators, pharmacy and homecare personnel. Also, preferably the lodge will have a doctors' examining room and each physician, (with a caseload of fifty to seventy residents), will work in a clinic and communicate with team members once per week for a half-day. On that half-day, the residents make appointments as necessary to see the physician, (usually ten to twelve patients/week.) Charts are stored in a colleague's office.

Team Members

1. REGISTERED NURSES - Lodge residents and/or family members can always access a nurse first. If extra help is required the nurse will arrange for homecare. Nurses arrange family conferences when necessary. After the nurses initial assessment the physician is called or an appointment is set up when necessary.
2. HOMECARE COORDINATORS meet face to face with the team. Once per month may be sufficient.
3. PHARMACISTS - involvement in a lodge setting is proving extremely valuable.
 - Repeat prescriptions are managed on a weekly basis as the physician visits.
 - Time is saved by avoiding frequent phone calls between physician visits
 - Polypharmacy is addressed and there is a chance for the pharmacist to provide input regarding safety.
 - The need for supervision of medications is addressed and a process developed when change is required.
 - Additional time can be spent reinforcing the directions for using medications.
4. FAMILY PHYSICIANS need to be readily available to speak to other team members. When a physician commits to returning calls quickly and effectively, quality of care is improved.

In the teams at the lodges where I work there is a pharmacist, nurse, nursing trained administrator, homecare coordinator, community mental health nurse, and when necessary for a given case a social worker or palliative care nurse is recruited. Recreation therapy varies between the two lodge settings I am associated with.

Advantages of the Team Approach

Teamwork is most effective if and when face-to-face meetings can be held regularly with the entire team. Members will learn each other's roles, thus improving the recognition of the value of active communication. Team members gain knowledge from each other and share responsibility for outcomes.

For each team player the others are the 'eyes and ears', and if information is pooled, the entire team can all be on the same page and avoid duplication and frustration. Working as part of a team serving a defined population enhances a sense of ownership for the management of problems that arise in that population. Working in a team generates a positive attitude towards working with the elderly.

Obstacles to the Team Approach

1. Team members may be expected to travel large distances.
2. Time must be freed up for teamwork meetings and communication sessions
3. Blocks may be set up in communication because of the personalities of team players
4. Unless the team is integrated well, there may be the risk of losing the sense of ownership.
5. Family physicians have historically worked in relative isolation; they are unaccustomed to pooling information to reach decisions on patient management

Perceived Improvements in Quality of life for Patients

1. More independence by residents (no longer relying on family for appointments)
2. Timely accessibility to nurse and physician
3. Strong sense of ownership to make things work

4. Less medication errors
5. Fewer admissions to acute and long-term care
6. Fewer visits to ER's
7. Time to address spiritual needs of residents
8. Less falls
9. Good communication between homecare and physician and nurses
10. Less duplication of services
11. Palliative care can be provided in the lodge setting.

There is a need for more research in this area to document these findings more specifically.

Remuneration

- At this time, physicians choosing to work in geriatrics in this way have little alternative but to severely limit their overheads. Staff in a colleague's office does my billing for my lodge and long term care patients; the staff also arranges consultant appointments and does the filing.
- I pay a percentage of what I bill to cover expenses (this averages \$1200/month). My colleagues appreciate this and they cover my patients while I'm away. I remain on the on-call schedule during weekends for their general practice. Another physician took over my old practice and contributes as a full partner.
- Physicians who chose to work totally with Broda style teams could organize alternative payment plans or continue fee for service billing.
- Physicians in this work may be well situated to perform the duties in geriatric assessment units or other senior programs in the large centers. I prefer to focus on continuity, primary care and the doctor-patient relationship.

Personal Weekly Schedule

Remuneration: For twenty hours per week, free of overhead, I am paid at an hourly rate from the CHOICE program and my fee for service billing is for service outside of CHOICE. {Comprehensive Home Option, Integrated Care of the Elderly}

Monday	Tuesday	Wednesday	Thursday	Friday
Teaching U of A appointment	CHOICE 4 hours	Lodge work	CHOICE 4 hours	CHOICE 4 hours
Visit long term care patients Half one week, half the next.	CHOICE 4 hours	_____	CHOICE 4 hours	½ day in colleague's office. C.P's and counseling

Summary

'Thinking outside the box' presents a great opportunity to provide a high quality of service for frail seniors in our province. We can promote a system, which bodes well for the future challenges we face in healthcare. In my opinion, experienced family physicians that may be ready for change, could be actively recruited to this work, however governments must provide the necessary incentives for this to occur.

The work in Broda-style teams in lodge settings could be a first step in changing patterns of delivering primary care to seniors. Not all patients in lodge settings are to the point of frailty that would demand a Broda style approach.

I believe that working with teams to improve the quality of care of frail seniors can indeed remind us of the meaning of our work. This patient group has to be the most appreciative for the service we provide, they are worthy of the best, and I strive to contribute to this end.

Appendix 6

Editorial. "Health-Care of the Elderly and Family Practice Involvement",
Geriatrics Today: Journal of the Canadian Geriatrics May 2002,5, p.61

By: Dr. Jean A.C. Triscott, Chair: Health -Care of the Elderly Committee, CFPC
Associate Professor of Family Medicine, University of Alberta

The older population, those 65 of age and older, have increased and is projected to increase from 12% of the Canadian population in 2000 to 23% in 2041. The increase in the proportion of the population aged 85 and over, those with the greatest need for health care and social support services, will be even greater.¹ Seniors often become frail from multiple chronic diseases, which cause physical and functional limitations. Home care is the fastest growing sector of health care in Canada with reported annual growth of 11%.³ Statistics confirm that the downsizing of the hospital sector has been dramatic and ongoing. Other factors driving growth in home care are consumer demand,² government cost containment, changing attitudes towards institutionalization and new advances in technology, less intrusive surgical techniques and new drugs have driven the growth of home care. Patients are going home from hospital sicker and often in need of more complex medical care than in the past.³ As a result the complexity of care needs have increased in the community. There have been major obstacles for primary care physicians in keeping these frail complex elderly in the community e.g. increasing time commitment to manage these complex elderly patients, decreasing remuneration, decrease communication to primary care physicians, lack of coordination of services, lack of continuity, poor integration of team resources.³

As a result of the shift from hospital to home and the increasing aging population, there is a need for the Primary Family Physician to be involved in ongoing management of these patients. Another factor adding to an increasingly important role for primary care physicians in the care of the frail elderly is the small number of specialists in Geriatric Medicine who often have preferences for urban academic settings, which facilitate research. The Care of the Elderly Fellowship has been officially recognized by the College of Family Physicians of Canada (CFPC) since 1989. It represents elective supplementary training in Care of the elderly of 6 or 12 months duration available after the 2-year core Family Medicine Residency.⁴ The program is also available to primary care physicians who are already in practice. Graduates of the care of the elderly Programs can develop a primary care geriatric practice, but they can also perform functions typically done by consultants. This consulting role for family physicians with appropriate training and/or experience exists and will continue to exist in Canada because of the insufficient number of RCPSC-trained specialists in geriatric medicine. This is particularly true for rural areas, towns and smaller cities. These qualified individuals have made very sizable contribution to many university-based training programs across the country. While this add-on training for family physicians was greeted with some opposition, family physicians with additional training in care of older adults and RCPSC-trained specialists in geriatric medicine have collaborated closely on both clinical and academic levels.⁵

There is a great need to develop new models of health care delivery to seniors. Seniors need a system that is community-based, preventive, health promotion -oriented, continuous, seamless, flexible accessible, client-oriented, caregiver friendly, comprehensive quality-based and cost-effective. Seniors and their families need a one-stop approach to their multiple complex medical and functional needs. This model should include primary, secondary and tertiary levels and needs to work in both urban and rural settings in Canada. The Primary Care Physicians, Care of the Elderly Family Physicians and Internal Medicine Geriatricians need to cooperate and work together in advancing clinical, education and research in the Care of the Elderly. As there is increasing collaboration, there will be a bigger voice to Government, Universities and Funding agencies in advancing the cause of the Care of the Elderly in Canada.

The Geriatrics Today: Journal of the Canadian Geriatrics Society is a peer-reviewed Journal, which encourages original geriatric research, evidence-based articles, and Clinical Guidelines. The Editorial Board has representative from both Geriatric Medicine and Care of the Elderly, Family Physicians and other specialties. Due to the increasing multicultural population of Canada an International representation adds to the quality of the Editorial Board. The aim of the important Geriatric Journal is to foster geriatrics as an important field in Canada, to increase the number of practitioners who care for the seniors and to have a voice for Canadians. The Journal is indexed in Excerpta Medica EMBASE. We would like to continue to encourage quality articles in the Journal

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Appendix 7

CORRESPONDENCE - Health-Care of the Elderly and Family Practice Involvement **GERIATRICS Today: J CAN GERIATR SOC 2 September 2002**

To the Co-editor:

I work with a group of general practitioners who practice in the Eastern region of Quebec. We read with interest your editorial, which appeared in "GERIATRICS Today".¹ As a group, we are favourable to the position that you have taken.

I am a 1994 graduate of the program of Family Medicine at the University of Laval, Quebec. In 1995, I completed a one-year fellowship in "Care of the Elderly" as an added qualification in the area of care to older persons. While in practice over this time, I can confirm that there is a lot of ambivalence related to the perception and the status given for a physician having these added qualifications; some regard us only as general practitioners ("GP"), while others regard us as general practitioners with added qualification (GP+). Furthermore, there are others who view us as "hybrid specialists" who do the work of a geriatrician without RCPSC. The work that we are able to do for the aged often depends on the recognition or not of this "Fellowship" and also on the perceptions embedded in our own medical profession.

I am startled to find out that the College of Family Medicine of Canada (CFPC) officially recognizes this training program since 1989, while at the same time not recognizing a Canadian certification in this field. Some of my colleagues believe that the recognition by the Royal College of Physicians ("FRCPC: geriatric medicine") perhaps constitutes the only solution in North America.

In my opinion, the College of Family Medicine of Canada, considering the aging of the population and as a consequence of the incredible task, which, will rest upon us as a profession in the health network, should make sure in the upcoming years, of better visibility in the medical make-up of our country. There exists indeed the necessity for a better union between the different physicians who practice and will devote themselves to the field of care for aged persons, with different types of training. I hope that these doctors will practice their profession together, in light of their competence and hence of their legitimacy. I am one of those who believe that aged persons deserve to have quality care in our health system, irrespective of professional training background.

Jean B. Martin, MD, CCFP

Chef du Service de g riatrie, Centre hospitalier r gional de Rimouski, Rimouski, QC

1. Triscott JAC. Health-care of the elderly and family practice involvement, (Editorial). GERIATR Today JCGS 2002; 5:61.

Correspondence - REPLY:

Thank you for your excellent letter in response to Health Care of the Elderly and Family Practice Involvement (Editorial) GERIATR Today JCGS 2002; 5:61. Your comments in regards to training with added qualifications in Care of the Elderly are most relevant. Professionals with extra skills in Care of the Elderly will increasingly be needed to provide aging Canadians with a quality healthcare system. All physicians, both Family Physicians / Care of the Elderly and Internal Medicine/Geriatricians need to work together and be leaders in developing new interdisciplinary models of Primary Care Reform, to accommodate the chronic complex frail elderly patient in the communities of Canada, whether rural or urban. Physicians with a special interest in Geriatrics need to collaborate in order to help the development of new models of Primary Care delivery to this special aging population. The present fee for service models may not be serving this particular population and alternative funding or sessional forms of remuneration may need to develop for changes to evolve. Professional collaboration will advance clinical, education and research in care of the elderly; thus, there will be a larger voice to Government, Universities and Funding Agencies to advance geriatric care.

Jean A.C. Triscott, MD, CCFP, Co-Editor

Associate Professor of Family Medicine, Edmonton; Chair, Health-Care of the Elderly Committee, CFPC

