Final Recommendations

2011 Seniors Summit

Newfoundland & Labrador Medical Association

August, 2011

NEWFOUNDLAND AND LABRADOR
MEDICAL ASSOCIATION

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1. EXECUTIVE SUMMARY

The Government of Newfoundland and Labrador estimates that 20 per cent of the people of the province will be over 65 by 2017 (*Provincial Healthy Aging Policy Framework, 2007*). These changes will place increased strain on personal care homes, long-term and acute care facilities, and on the medical management and treatment of seniors. Physicians of Newfoundland and Labrador believe there is potential to meet the anticipated demands of the aging population and drastically improve the delivery of care to seniors by implementing a new, streamlined medical care model in the community and the acute care system.

In 2010, the Government of Newfoundland and Labrador held a series of public consultations on a new provincial long-term care and community support services strategy. On September 9, 2010, the Newfoundland and Labrador Medical Association (NLMA) presented its submission to government, which supported the need for a fully-resourced comprehensive model of care that reflects the full continuum of health and community services.

On March 30, 2011, the NLMA took the debate a step further by sponsoring a one-day Seniors Summit at the Holiday Inn in St. John's to develop policy recommendations for the medical treatment of the province's seniors. Unlike the public consultations in 2010, the Seniors Summit focused specifically on the medical model of health care delivery in the community and the acute care system. The event was attended by 30 physicians, nurses and social workers who collaborated to identify elements of a new medical model to address the issues and barriers experienced at the frontline service level in hospitals, nursing homes and in the community. Following the summit, a report titled *Summary Report: 2011 Seniors Summit* (see Appendix I) was prepared by Jane Helleur and Associates.

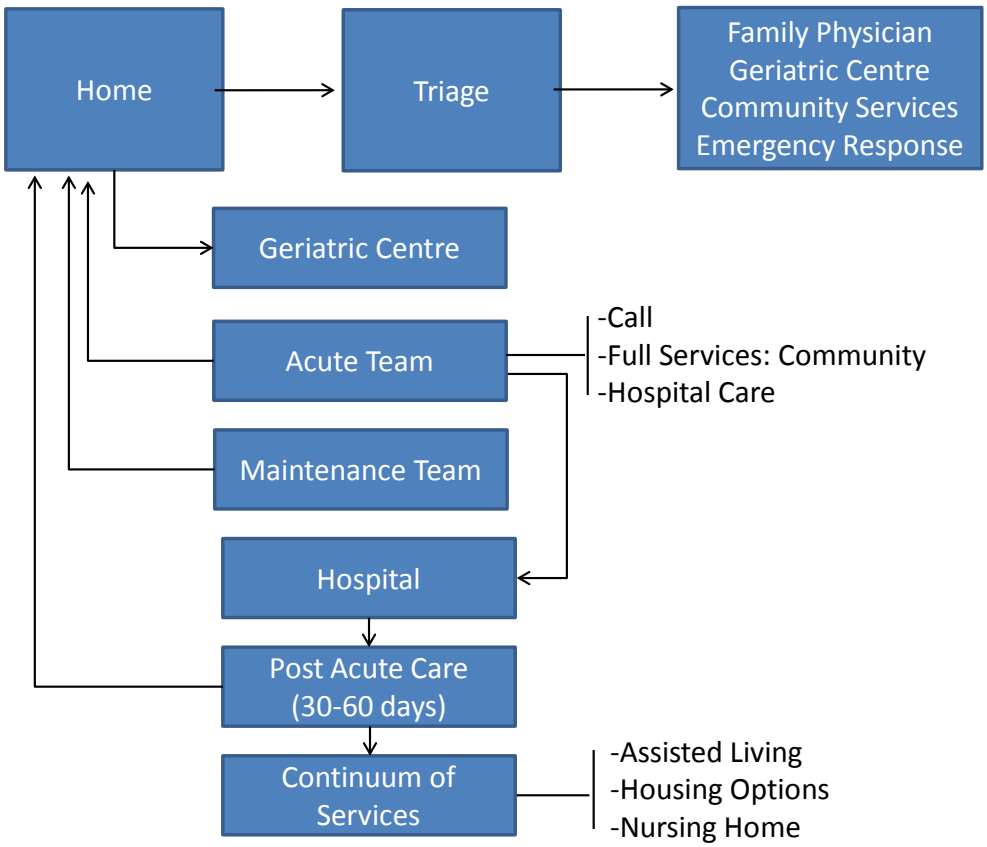
On May 17, 2011, the NLMA initiated an online discussion to give physicians and residents of the province an opportunity to provide additional input. The summary report and video presentations from the summit event were posted to the NLMA website and participants were asked to email suggestions to the NLMA for improving care for seniors. The report was also sent to affiliated medical organizations, which included the province's regional health authorities, private long-term care facilities, academic institutions, and not-for-profit health care organizations (for a list of report recipients who provided feedback see Appendix IV). Stakeholders were asked to review the report and describe changes they would like to see happen in the medical system by 2025.

Feedback from stakeholders and the public was consolidated and used to develop the 10 recommendations outlined in this report. The recommendations provide a clear plan for a more efficient and better coordinated medical care model that will improve the flow of patients through the acute care hospital and into the community or more appropriate bed. This will result in less bed blockages in acute hospitals, better use of home care and alternate level care beds, and more choices for seniors and their families. Many of the recommendations can be implemented with minimal additional costs by utilizing expertise, tools and processes that already exist in our health care system.

Seniors are vulnerable members of our society and they deserve to be treated with dignity and the highest level of care that can be provided. For this reason, the physicians of the province appeal to the Government of Newfoundland and Labrador to implement the 10 recommendations and proposed medical model. The NLMA is committed to working with government as we begin to collectively address our common challenges in this critical aspect of patient care.

Patrick M. O'Shea, MD, CCFP, FCFP
Past-President, NLMA

2. OVERVIEW: Relationship between Community and Acute-Care Hospital and Access to Service



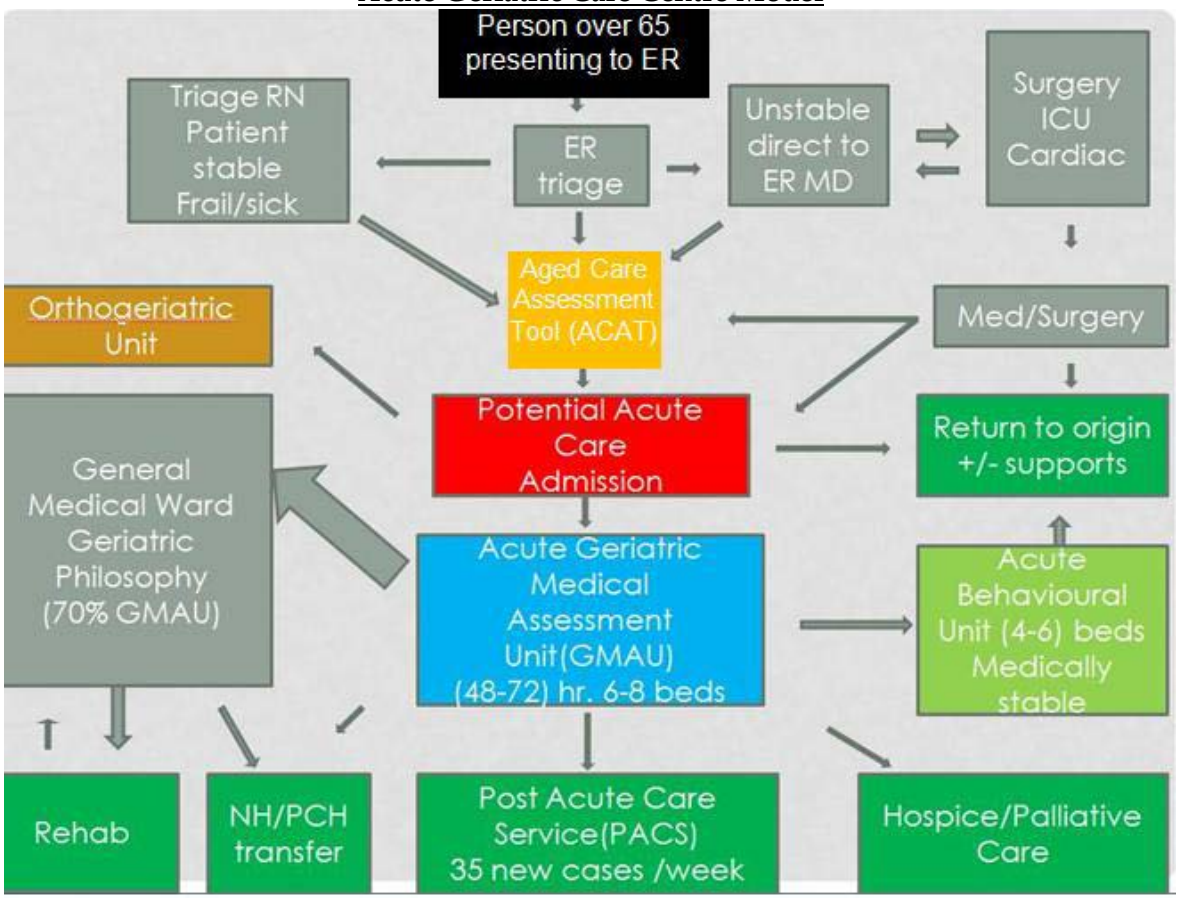
3. 2011 SENIORS SUMMIT: Final Recommendations

1. Acute Geriatric Care Centre

- **Establish an Acute Geriatric Care Centre within a designated hospital. The centre should be designed specifically for geriatric care and serve as the central intake for seniors with 24/7 access.**

- This Geriatric Care Centre can be initially done as a pilot project.
- Services should be provided using a multidisciplinary team approach.
- The Centre will have the ability to accept immediate transfers to an eight-bed Acute Geriatric Medical Assessment Unit for short stays of up to 72 hours. Such a unit has a higher staff ratio and priority access to investigations and consults.
- The Centre must have appropriate availability and access to acute, rehabilitation, convalescent and long-term care beds.
- The Centre must also have an Orthogeriatric Unit for pre-operative and 48-hour post-operative care of geriatric patients. The surgeon will then hand over care to a geriatrician for ongoing care with a focus on direct transfer to early rehabilitation, post-acute care service and/or discharge to the home with appropriate supports.

Acute Geriatric Care Centre Model



2. Home Support and Emergency Response Service

- **Establish a 24-hour home support and an emergency response service that can quickly respond to seniors' health care needs in the community (e.g., a 'geriatric rescue service', or home triage).**

- Members of the Home Support and Emergency Response Team should be comprised of health care professionals such as a family physician, a nurse practitioner, a registered nurse, a physiotherapist and a social worker, as well as homemakers and personal care attendants.
- This requires increased levels of emergency home support services, home support staff who are on retainers, and increases in the ceiling for the hours of care that can be provided.
- Establish a community-based geriatric respite team service to provide respite care in the home.

3. Geriatric Assessment/Triage

- **Establish an intake triage system (whether initiated by phone-in or when presenting in the Emergency Room) that uses comprehensive geriatric assessment tools and makes referrals to appropriate services.**

- Telephone triage should be in place on a 24/7 basis.
- Seniors' triage in the Emergency Room requires a specific skill set. Increased resources and staff in Emergency Rooms will enable appropriate geriatric, palliative and psychiatric assessments, and identification of individuals at risk.
- Use InterRAI[1] as an assessment tool for frail, at-risk patients to determine level of care required.

4. Post-Acute Care Service

- **Implement a Post-Acute Care Service in the community for six weeks post-discharge with services offered by a fully-resourced Team of registered nurses, occupational therapists, a social worker, a physiotherapist and a physician**.

- Team will oversee the provision of enhanced in-home care for up to 60 days. This includes enhanced hours of personal care.
- Team will conduct continual assessment for long-term planning.
- Team will make referrals to appropriate service if unable to remain at home with supports.
- Team will ensure safe transitions from one level of service to another.
- Advanced health care directives should exist for everyone and be mandatory before admission to long-term care.

5. System Navigation

- **Improve the coordination of care by using "system navigators" to serve as seniors' advocates**.

- A navigator is necessary to support the client/family, and works to ensure client-centred care and services. A navigator will play an important role in directing patients to resources and appropriate services. Specially-trained social workers, nurses, or other professionals could be navigators.
- Seniors living in their own homes will also need a navigator to help direct them to the appropriate financial resources.

6. Information Technology

- **An electronic medical record (EMR) and electronic health record (EHR) must be implemented and fully accessible**.

- Such a system will enable timely communication and continual quality improvement and be a mechanism for data collection, analysis, and evaluation.
- Communication among all health care providers must be enhanced. At present, processes for information sharing are underdeveloped.

7. Funding Model

- **Develop and implement a funding model whereby funding is aligned with the individual client's needs and travels with the client rather than being linked to the institutional bed**.

- Funds that are associated with a client rather than an institution will enable more relevant and timely care, and a greater degree of patient decision-making autonomy.

- Patients' needs should be periodically reassessed to ensure they are matched with the appropriate level of funding.

8. **Payment Model**

- **A Collaborative Care Payment Model must be designed recognizing the importance of all team members providing care.**

- Such a remuneration system should provide reimbursement for care and services that enable and encourage the optimal delivery of care for seniors. For example, an alternative payment model that recognizes physicians' contributions to multidisciplinary teams is needed.
- Caregivers, both family and professional, need to be properly remunerated for the work they do.

9. Education

- **All health care professionals will need increased training in gerontology**.

- This process has started but needs to be enhanced to develop age sensitivity, and to address ageism. Ageism is defined as discrimination on the basis of age that makes assumptions about capacity; removes decision-making processes; ignores the older person's known wishes; and, treats the older adult as a child.
- Education of the public and caregivers will also have to focus on a person-centred approach that highlights the choices available in the continuum of care.

10. Geriatric Interest Consortium

- **Establish a Geriatric Interest Consortium of health care professionals to oversee the implementation of these recommendations**.

- This Consortium needs to be comprised of registered nurses, nurse practitioners, physiotherapists, occupational therapists, social workers, and physicians.
- This group would provide expert consultation and advice to government and the regional health authorities.

[1] InterRAI (www.interrai.org) stands for the international residential assessment instrument. The instrument was the first of many assessment tools for persons who are elderly, frail, or disabled that the interRAI collaborative network of researchers in over 30 countries have authored. Other evidence based clinical assessment tools include the Assessment Systems for nursing home and long-term care institutional settings; assisted living; acute hospital care; post-acute care; institutional mental health care; palliative care; and, care of persons with intellectual disabilities.

APPENDIX I: Summary Report: 2011 Seniors Summit

SUMMARY REPORT

2011 Seniors Summit

Newfoundland & Labrador Medical Association

March 30, 2011
Holiday Inn, St. John's, NL

NEWFOUNDLAND AND LABRADOR MEDICAL ASSOCIATION

JANE HELLEUR & ASSOCIATES INC.

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EXECUTIVE SUMMARY

On March 30th, 2011, the President of the Newfoundland and Labrador Medical Association, Dr. Patrick O'Shea, hosted a Summit on Seniors' Care at the Holiday Inn in St. John's for thirty frontline physicians, nurses and social workers. The summit was designed to gather input into a positively-focused policy and recommendations paper for seniors' medical treatment and support. The final report will be shared with the Department of Health and Community Services to support the province's development of its long-term care and community support services strategy.

There is a strong imperative to improve the medical treatment for seniors' care given demographic changes that will see 20 per cent of the population older than 65 by 2016, and rising to 25 per cent by 2025. These changes will place increased strain on personal care homes, long-term care and acute care beds, on diagnostic services capacity, and on medical treatment and management.

Participants identified a number of existing issues and barriers including: prevailing ageism within the health system; inadequate human resources for home support and diagnostic services; undeveloped processes for treatment and placement, information sharing, discharge planning, convalescence, and standardized patient assessments; geographic disparity that influences the level and type of care that can be accessed; and the lack of robust, evidence-based data collection to support system change in the medical care of seniors.

Foundational elements of a medical model for care of seniors must directly respond to these issues and barriers. A new system of care must also include:

- Facilities designed specifically for geriatric care
- A client-centred philosophy
- A balanced continuum of care with increased access to 24-hour home support and emergency response (e.g., a 'geriatric rescue service', home triage) and a community-based geriatric respite team service
- Appropriate availability of acute, rehabilitation and long-term care beds
- Adequate supply of health professionals, both for seniors' acute care and for community-based family health teams
- Systems that allow appropriate and timely transfers and placements
- Robust resources and staff in Emergency Rooms to enable appropriate geriatric, palliative and psychiatric assessments, and identification of individuals at risk

- Information sharing systems
- A focus on professionals' education and training (e.g., capacity assessments)
- A funding model as well as an alternative payment model that recognizes physicians' contributions to multidisciplinary teams
- Navigation and advocacy support to support seniors system access and decision-making
- Enhanced funding and resources in the community to allow seniors to be cared for in their own homes for as long as possible

The summit resulted in four possible models for seniors' medical treatment and support that animated how the foundational elements could be operationalized. Short-term and long-term initiatives were also identified. The significant initiatives highlight the need for:

- A vision and strategy for senior's care, utilizing the great deal of expertise that already exists in the province
- Public discussion regarding the needs and expectations for seniors' care and focused efforts to eliminate ageism
- Leveraging tools and processes that already exist through development of protocols and increased resource support
- Developing a triage process for seniors in Emergency Rooms using appropriate tools
- Developing an appropriate physician funding model
- A funding system whereby funding travels with the individual client, versus with the institutional bed

A great deal of optimism was expressed for the ability to make significant system change, especially in light of long-term system savings that could accrue through a streamlined medical model of seniors' medical treatment. Participants expressed their desire to be part of designing this system change.

1. INTRODUCTION

On March 30th, 2011, the President of the Newfoundland and Labrador Medical Association, Dr. Patrick O'Shea, hosted a Summit on Seniors' Care at the Holiday Inn in St. John's. The summit was designed to gather input into a positively-focused policy and recommendations paper for seniors' medical treatment and support. The Summit was also designed to support the province's development of its long-term care and community support services strategy.

A total of thirty individuals attended the Summit, representing frontline physicians, nurses and social workers

This report provides a summary of the Summit's discussion highlights and outcomes. In brief, the agenda for the day entailed:

- Opening remarks and presentations
- Identification of issues and barriers
- Identification of foundational elements of a medical model of seniors' care
- Small group work focused on developing a model for medical care of seniors
- Presentation and debrief of small groups' models
- Concluding observations and comments

The agenda is attached as Appendix II.

2. OVERVIEW OF OPENING PRESENTATIONS

Dr. Patrick O'Shea opened the Summit by describing the imperative to improve the medical treatment for seniors' care given demographic changes that will see 20 per cent of the population older than 65 by 2016, and rising to 25 per cent by 2025. These demographic changes will place increased strain on personal care homes, long-term care and acute care beds, on diagnostic services capacity, and on medical treatment and management. He noted that maintaining the status quo for medical care of seniors is not an option, given the demands on the provincial health care budget that stands at approximately $2.2 billion for 2010/11.

Dr. Roger Butler, Associate Professor-Family Medicine, MUN Faculty of Medicine and Chair of Family Medicine Geriatric Rotation, followed Dr. O'Shea's opening remarks and presented one approach to care of seniors in acute care settings. This approach was based upon his experience in three acute care hospitals in Australia. The hallmarks of this approach are:

- Emergency room triage supported by a comprehensive acute care assessment tool
- Ability to immediately transfer seniors to a six to eight-bed Acute Geriatric Medical Assessment Unit for short stays of 48-72 hours. Such a unit has a higher staff ratio and priority access to investigations and consults
- A four to six-bed Acute Behavioural Unit for medically stable patients. The unit is run by a geriatric psychiatrist
- An Orthogeriatric Ward for pre-operative and 48-hour post-operative care. Weekly team rounds occur, with a focus on direct transfer to early rehabilitation, post-acute care service and/or discharge to home with appropriate supports
- A Post-Acute Care Service in the community for six weeks post-discharge with services offered by a fully-resourced team of registered nurses, occupational therapists, a social worker, a physiotherapist and a physician

Dr. Mehrul Hasnain, Clinical Associate Professor of Psychiatry and Geriatric Psychiatrist (Waterford Hospital), presented strategies to improve geriatric care in community and non-acute care settings. He noted that there are multiple problems for older adults ranging from chronic diseases, cognitive deficits, the effects of multiple medications and depression. Such multiple problems are often under-recognized, delayed in their recognition and/or under-treated. This results in unavoidable suffering, burden, inappropriate placement and increased cost.

Polypharmacy and the targeted conditions of pain, dementia, depression, and delirium were highlighted in terms of their significant burden to affected individuals and the health system. Without action, this burden will escalate considerably.

Dr. Hasnain proposed a process, perhaps through a pilot approach, that would enable timely and appropriate recognition and treatment of these conditions. This process would entail:

- A multidisciplinary approach led by individuals with a professional interest and motivation in geriatric care
- The establishment of baseline measures that include clinical outcomes, service utilization, cost-effectiveness and satisfaction
- Professional education and skills training, supported by the provision of appropriate tools
- Modifications in the approach based upon follow-up measures and outcomes
- Changes in education and training of health professionals to enable timely and appropriate recognition and treatment of the multiple problems experienced by older adults

3. ISSUES AND BARRIERS

As a full group, building upon the opening presentations, participants identified the issues and barriers related to the effective care of seniors. Based upon their own experiences the identified issues and barriers fall into the following themes:

Attitude: Ageism is prevalent in the health care system resulting in seniors' health conditions being normalized and, consequently, under-treated. Geriatric care is undervalued as a practice focus for many health professionals, with evidence of prejudice being prevalent. Older adults have not garnered political power and their needs are not widely recognized.

Resources: Woefully inadequate human resources, home support and other services exist to support appropriate diagnosis, treatment and placement. Resource constraints serve to propel ageism attitudes and practices among health professionals.

Process: Processes such as information sharing, discharge planning, convalescence, and standardized patient assessments are underdeveloped.

Geography: Where seniors live can significantly influence the level and type of care and treatment that they can access and receive.

Evidence: The lack of robust, evidence-based data is not currently available to support a 'business' case for system change in the medical care of seniors. Positive outcomes of such system change take a long time to fully realize.

4. FOUNDATIONAL ELEMENTS OF A MEDICAL MODEL FOR CARE OF SENIORS

As a full group, participants identified the foundational elements of a medical model for care of seniors. The identified elements resulted in the following:

Change Management: A significant focus must be on achieving philosophical and cultural change at all levels of society and the health care system regarding geriatric care. A focus must be upon geriatric care education and training of health professionals. As well, public education and patient education in the areas of advance health care directives and palliative care is required.

An additional component of change management is creating the business case for system change as it relates to care for seniors. The status quo is not an option. The business case should include a model that accounts for changing demographics and the increasing demand on our provincial health system (that is already burdened). A coalition of health care professionals delivering the same message and who are united around a business case may be necessary.

Quality: A process and mechanisms for robust data collection, analysis and evaluation must be available. Such a system enables continual quality improvement. Evidence-based tools for identifying individuals' needs are also necessary as are best practice approaches.

System of Care: A medical model must include:

- Facilities designed specifically for geriatric care
- A client-centred philosophy
- A balanced continuum of care with increased access to 24-hour home support and emergency response (e.g., a 'geriatric rescue service', home triage) and a community-based geriatric respite team service
- Appropriate availability of acute, rehabilitation and long-term care beds
- Adequate supply of health professionals, both for seniors' acute care and for community-based family health teams
- Systems that allow appropriate and timely transfers and placements
- Robust resources and staff in Emergency Rooms to enable appropriate geriatric, palliative and psychiatric assessments, and identification of individuals at risk
- Information sharing systems
- A focus on professionals' education and training (e.g., capacity assessments)

Funding: This includes adequate and increased funding and a funding model. Each component of the funding model for the medical treatment of seniors must be honoured, including an increased level of home support and other community support services. It must also achieve greater transparency for determining health expenditure priorities. An alternative payment model that recognizes the value of physicians' contributions to multidisciplinary teams will also be necessary.

Navigation and Advocacy: System navigation and advocacy support is required to improve seniors access to necessary services and their decision-making process.

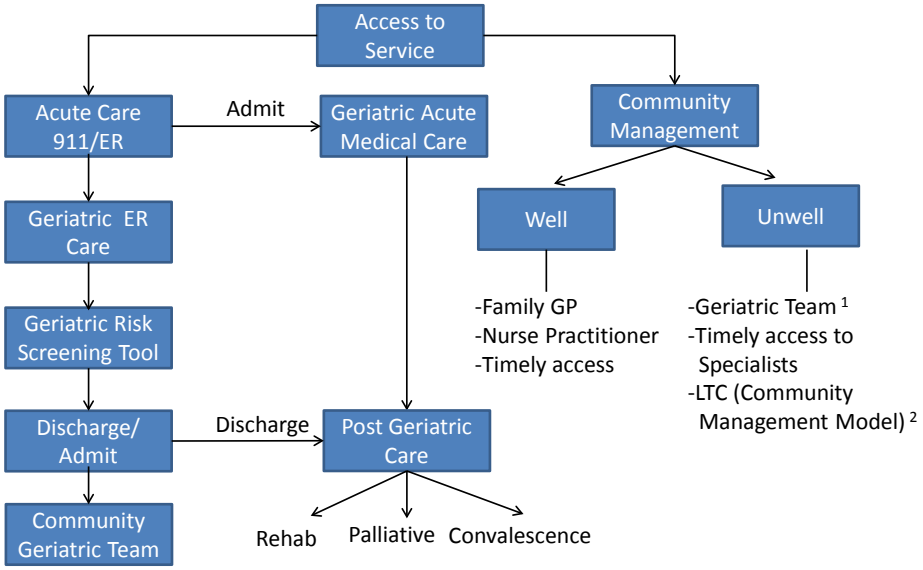
5. BUILDING A MODEL

In four small groups, participants focused on developing a medical model that would meet the health care needs of seniors. A synopsis of each of the models follows:

Model One

The focus of this group's work was in achieving client/family-centred care across the continuum. This included the components of:

- An educated public regarding what is available, how to access services and system navigation support
- Educated geriatric care professionals and a significant culture change and attitude shift toward care and treatment of seniors
- Chronic disease management through interdisciplinary teams
- The critical role of an information sharing system
- A funding model that supports the medical model, including an alternate payment system for physicians and a funding mechanism whereby funding is aligned with the individual client rather than the institutional bed



Notes:

1. Team consists of RN, MD. OT, PT, NP and SW
2. Those in LTC must have same access to services as well elderly to ensure equitable service delivery

Model Two

Essential components of this model are as follows:

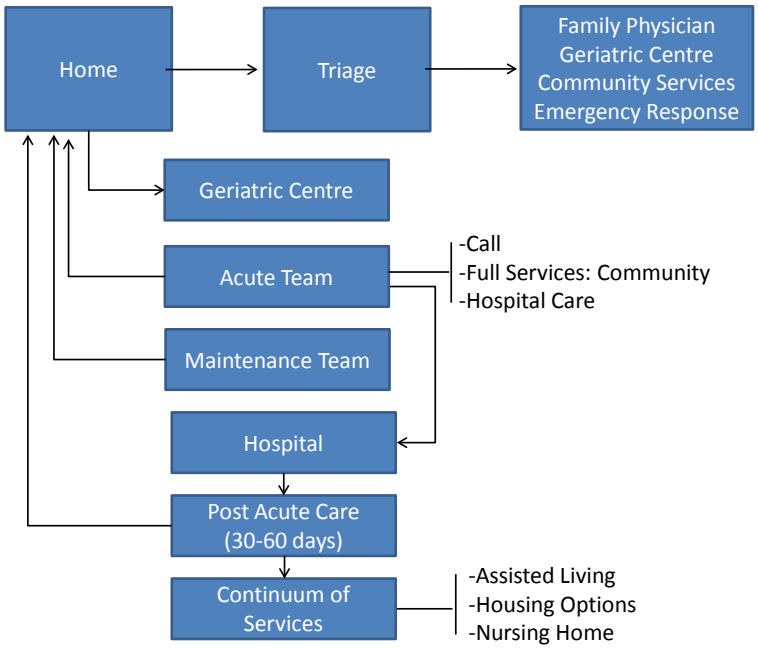
- As a starting point, the group utilized the elements of the model presented by Dr. Butler earlier in the day. This includes geriatric triage (possibly conducted by a geriatric nurse) with the aid of an assessment tool. Telephone triage on a 24/7 basis should also be in place
- A navigator/liaison nurse plays an important role in directing patients to resources
- Provision of appropriate levels of service based upon needs, and recognizing that needs can change
- Discharge planning from nursing home to the client's home is possible if heath status improves. This requires increased levels of emergency home support services, home support staff who are on retainers, and increases in the ceiling for the hours of care that can be provided
- Safe transitions from one level of service to another (and back) is necessary
- Nursing home protocols should exist for dehydration, pneumonia, advanced health care directives and urinary tract infections
- Advanced health care directives should exist for everyone
- Respite and convalescent care services are required
- Use of nurse practitioners as important health care team members

Model Three

Essential components of this model are as follows:

- Key Principles
  - Funding follows the client not the bed
  - Flexibility
  - Philosophy of independent living
  - Services aligned with philosophy
  - A developed continuum of services that provide choice
- Community Intake Triage (whether initiated by phone-in or presenting in the Emergency Room)
  - 911
  - Information technology links and support
  - Primary triage enabled by lists of services and contact nurses
- Geriatric Centre (24/7 access)
  - Designated hospital
  - Acute team (inpatient and outpatient)
  - Maintenance team (pre-hospital and post-hospital)

  - Call system teams
  - Home visits
- Family Medicine Teams
- Assessment Tools
- Emergency
  - Assessment (triage) tool that is attached to services
  - Designated geriatric area (in emergency/acute care)
  - Multidisciplinary team – priority access to investigations/specialists
  - Post-acute care service to ensure minimum hospital time
- Post-Acute Care
  - Teams that provide in-home care (60 days)
  - Continued assessment for long-term planning
  - Referral to appropriate service if unable to remain at home with supports



Model Four

The following are the hallmark features of the fourth medical model of care for seniors presented:

- Communication among health care providers represents a foundational element. Interaction must be enabled between family physicians, specialists and personnel in rehabilitation, home support, palliative care, personal care home and long-term care settings
- Seniors' triage is necessary in the Emergency Room and requires a specific skill set
- A navigator is necessary to support the client/family, and works to ensure client-centred care and services
- A focus on community services is necessary as this is where patients reside. It is important that anyone from a community-based team can make a referral to a central intake team. Members of the community-based team include professionals such as a family physician, a nurse practitioner, a registered nurse, a physiotherapist and a social worker
- The central intake team uses comprehensive assessment tools, makes referrals to appropriate services and assigns a case manager
- The scope and nature of community-based home support services must be increased such that a community-based rehabilitation team is equipped to conduct assessments and provide oversight for nursing homes within their region
- A feedback loop is also necessary to enable all team members to assess their interventions and reflect on whether or not the interventions worked
- It will also be necessary to assess inefficiencies in the current system of care as there are many tasks that detract from patient care that could be better designed
- Attention must also be paid to family physicians to ensure they are equipped/supported to take on tasks for after-hours support

6. SHORT-TERM AND LONG-TERM OPPORTUNITIES

Small groups were also asked to identify those actions which could be pursued in the short term (next 5 years) and long term (15 years). The following opportunities were identified and are not presented in any particular order:

Short Term

- Establish a Geriatric Interest Consortium
- Establish a vision for what seniors' care should look like for the province
- Initiate public discussion regarding the needs and expectations for seniors' care
- Use tools already in place and incorporate Beers criteria in Emergency Rooms, admissions and nursing homes
- Ensure a discharge liaison nurse is in place at each acute care facility
- Use InterRAI as an assessment tool for frail, at-risk patients
- Establish and implement a delirium protocol
- Establish navigators for seniors' care
- Increase the number of volunteers in hospitals
- Conduct education/training regarding geriatric care philosophy, commencing with Orthopedics and Neurology
- Develop and implement a Geriatric Assessment tool for Emergency Room assessment
- Develop a triage system/process
- Increase resources in nursing and allied health professions
- Develop an appropriate physician funding model
- Develop and implement a funding system whereby funding travels with the client
- Require completion of advanced health care directives prior to admission to long-term care

Medium Term

- Implement information technology solutions
- Establish a mobile SWAT team that can quickly respond to seniors' health care needs
- Increase number of convalescent beds
- Ensure availability of recreation therapy personnel for the 4 pm to 9 pm timeframe

Long Term

- Establish a Geriatric Centre/Urgent Care Centre
- Develop continuum of care options, including more Level 2 and 3 long-term care beds, more dementia daycare beds, and night and respite beds

7. PRIORITY AREAS OF FOCUS

Through a full group discussion, participants collectively identified the priority areas of focus. In doing so, there was a shared and strong sentiment that the status quo is not an option. However, it was also noted that there is a great deal of seniors' care expertise already in the province, that national benchmarking already exists, and that the screening, assessment, monitoring and evaluation tools required are readily available. Indeed, a great deal can be accomplished through realignment of resources to address the extremely high vulnerability of this patient population and to achieve greater system efficiency.

Nonetheless, to ensure appropriate care for seniors requires cultural change and political will and commitment. Sound change management practices are required, as the models of care discussed by participants all represent a significant departure from current practice. For example, funds that are associated with a client rather than a bed, will enable more relevant and timely care and a greater degree of patient decision-making autonomy. However, it also compels system change and a measured degree of risk that is inherent in any system change. Similarly, a commitment to discharge from an acute care bed to other settings within 30 to 60 days of admission requires a robust continuum of care and changes in current mindsets and practices.

A significant emphasis must be placed on developing a strong consumer-driven (client-focused) approach. Additionally, there is a strong imperative to ensure education of professionals at all levels occurs to remedy attitudinal problems being experienced in the delivery of care to seniors. Geriatric care must be instilled as core medical school curriculum.

A fully-resourced continuum of care must be pursued to achieve a comprehensive, multidisciplinary geriatric service. In developing this service continuum, diligence is required to ensure there are safe transitions from one form of care to another, as well as an environment of continuous reassessment to ensure individuals are receiving the right care, at the right time and in the right place.

Finally, it was noted that as a priority, physician remuneration for geriatric care must be redesigned. Such a remuneration system should provide reimbursement for care and services that enable the optimal delivery of the continuum of care for seniors.

8. SUMMARY OF PARTICIPANT FEEDBACK

Participants completed an open-ended feedback form. The following are representative comments made about the 2011 Seniors Summit.

What Went Well

- A great day with great ideas; excellent exchange of information; first rate; invigorating
- Opportunity for networking with colleagues; cross services interaction
- Great presentations; relevant to my practice
- A very good process; well organized and conducted
- Interesting and informative day
- Group work summarized the key initiatives to address
- Excellent interaction
- A first step in transformation of geriatric health care
- Pleased with the passion expressed
- Focused, positive discussion
- New ideas and approaches discussed

Actions Required to Build on Summit Outcomes

- Hoping to see a model I can work with
- We need to continue the momentum
- Our ideas should not be shelved as we do not want to be at the same place in 10 to 15 years' time
- More community resources are necessary to decrease slope of curve of increasing health care costs
- We need a concrete business case and care model for seniors' care
- We need to move fast to transform the ideas into action
- I already have ideas to move forward with positive changes
- We have the expertise here in the province and now we need to act upon it
- Would like to see a centralized intake team for timely screening and direction to appropriate resources
- We need a follow-up meeting to develop strategy and action plan. Ensure public and non-governmental agencies also involved in future planning
- Need cultural changes regarding issues of ageism
- Start small and build upon our successes
- Focus on the immediate/short-term wins, including for 24/7 access for patients for appropriate triage

APPENDIX II: Seniors' Summit Participant Listing: March 30th, 2011

Dr. Paul Bonisteel
Family Medicine
New Harbour Medical Clinic

Dr. Roger Butler
Family Medicine
Dr. Leonard A. Miller Centre

Ms. Pam Carter
Resident Care Manager
Glenbrook Lodge & Villa

Ms. Michelle Clarke, RN
Division Manager
St. Clare's Emergency

Ms. Glenda Compton
Regional Director
Long-term Care, Eastern Health

Mr. Bruce Cooper
Deputy Minister
Department of Health and Community Services

Mr. Darryl Cooze, RN, BN
Division Manager HSC Emergency
Emergency and Paramedicine Program

Ms. Deborah Ronayne Craig
Community Mental Health Nurse
Geriatric Psychiatry

Dr. Percy Crocker
Family Practice
Newfoundland Drive Family Practice

Ms. Kelly Deering
E.R. Social Worker
Health Sciences Emergency Dept

Ms. Susanne Harris
Regional Manager, Placement Services
Long Term Care, Eastern Health
St. Patrick's Mercy Home

Dr. Merhrul Hasnain, DABPN
Clinical Associate Professor of Psychiatry
Geriatric Psychiatrist, Waterford Hospital

Dr. Cathy Hickey
Psychiatry
Dr. Leonard A. Miller Centre

Dr. Bruce Hollett
General Practice
Waterford Hospital

Dr. Vaughan Jackson
Family Medicine
East End Medical Clinic

Mr. Larry Kelly, RN, MScR
Program Director
Rehabilitation and Continuing Care

Ms. Alice Kennedy
Regional Vice President
Long Term Care, Rehabilitation, Community Support Programs, Continuing and Palliative Care

Ms. Elizabeth Kennedy
Regional Director Clinical Efficiency
Eastern Health

Dr. Jason McCarthy
Family Medicine, Dr. Leonard A. Miller Centre; Clinical Chief, Rehabilitation & Continuing Care

Dr. Aaron McKim
Family Medicine
East End Medical Clinic

Ms. Debbie Morris
Director (A) Long-Term Care and
Community Support Services
Department of Health and Community Services, GNL

Ms. Terri Jean Murray
Social Work Manager
Clinical Efficiency
Eastern Health

Ms. Judy O'Keefe
Regional Director, Long Term Care Program,
Placentia Health Centre, Eastern Health

Dr. Pat O'Shea
Family Medicine
Newfoundland Drive Family Practice

Dr. Vinod Patel
General Practice, Emergency Medicine
Patel Medical Centre

Dr. Ann Sclater
Geriatric Medicine, Dr. Leonard A. Miller
Centre; Professor of Medicine, Internal Medicine and Geriatric Medicine, MUN

Ms. Trudy Smith
Community Health Nurse
Eastern Health

Ms. Carol Snelgove
Social Worker
Community Health and Nursing Services
St. John's Region, Eastern Health

Ms. Linda Turner
Geriatric Psychiatry Program
Eastern Health

Ms. Brenda Wakeham
Geriatric Psychiatry Referral Coordinator
Eastern Health

Appendix III: Agenda for 2011 Seniors Summit

2001 SENIORS SUMMIT
Holiday Inn, St. John's
08:30 to 16:00 - March 30th, 2011

About the Summit

This summit is expected to result in a positively-focused policy and recommendations paper that focuses on the medical treatment and support required to ensure the province's health system is well-positioned to meet the current and future medical care needs of an aging population. The Summit will serve as an important focus on medical treatment that can support the province's development of its long term care strategy.

Agenda

08:30 Welcome and Introductions
Jane Helleur, Summit Facilitator

08:40 Setting the Stage: Why Focus on Seniors' Care?
Dr. Patrick O'Shea, NLMA President

09:00 Strategies to Improve Seniors' Care

Acute Care Settings
Dr. Roger Butler: Associate Professor-Family Medicine, MUN Faculty of Medicine and Chair of Family Medicine Geriatric Rotation

Community and Non-Acute Care Settings
Dr. Mehrul Hasnain: Clinical Associate Professor of Psychiatry, MUN Faculty of Medicine and Geriatric Psychiatrist, Eastern Health

10:00 Refreshment Break

10:20 Foundational Elements of a Medical Model of Care for Seniors
Full Group Discussion

- What are the issues and barriers being experienced at the frontline service level?
- From this morning's presentations, what elements could be incorporated into a medical model of senior's care?
- What other core elements of a model are required?

12:00 Lunch

12:40 Developing a Working Model

APPENDIX IV: Summary Report Feedback Participant Listing

- Eastern Health (Ms. Alice Kennedy, Long-Term Care, Community Support Services, Rehabilitation, Continuing and Palliative Care)
- Western Health (Ms. Kelli O'Brien, Chief Operating Officer, Long-Term Care and Rural Health)
- Labrador Grenfell Health (Dr. Michael Jong, VP Medical Services)
- Faculty of Medicine, Memorial University
- School of Social Work, Memorial University
- Association of Registered Nurses of Newfoundland & Labrador (ARNNL)
- Newfoundland & Labrador Nurses' Union (NLNU)
- Newfoundland and Labrador Association of Social Workers
- Seniors Resource Centre of Newfoundland & Labrador
- Alzheimer Society of Newfoundland & Labrador, Inc.
- Anglican Homes Inc./Saint Luke's Homes
- Newfoundland & Labrador Association of Public and Private Employees (NAPE)
- Ms. Pat Card
- Ms. Doris Gushue
- Ms. Margaret Howe, retired Nurse, Corner Brook
- Ms. Della Kelly, Torbay
- Ms. Elizabeth Kennedy, Regional Director Clinical Efficiency, Eastern Health
- Ms. Connie King, St. John's
- Ms. Daphne Lush, NP
- Mr. Ken Maynard, Stephenville
- Ms. Margie McFarlane
- Ms. Terri Jean Murray, Social Work Manager Clinical Efficiency, Eastern Health
- Dr. Trudy O'Keefe, St. Anthony
- Dr. Catherine Penney, St. Anthony
- Ms. Mandy Poole, Stephenville Crossing
- Dr. Peter Seviour, St. John's
- Dr. Ian Simpson, Corner Brook
- Dr. Gabriel Woollam, Happy Valley-Goose Bay

Newfoundland and Labrador Medical Association

Providing leadership in the promotion of good health and the provision of quality health care to the people of the province

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