Improving a System of Care for Elderly Persons in Rural Areas

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Older persons living in rural areas have access to fewer health services and service alternatives than urban dwellers (Christianson & Moscovice, 1993; Coward & Cutler, 1989; Krout, 1994; Nyman, Sen, Chan, & Commins, 1991). The development of specialized geriatric services is usually centralized within large urban centers with large numbers of frail older people. The provision of these services to a large, mostly rural, geographic area is a particular challenge when resources are both centralized and limited.

Southwestern Ontario is a largely rural 10-county area covering 16,000 square miles. The region includes 35 acute care hospitals of widely varying size (mostly small community hospitals), 105 long-term care institutions, a myriad of community-based provider agencies and an elderly (65+) population of approximately 200,000. Since 1992, the Southwestern Ontario Regional Geriatric Program (RGP) has been funded by the Ontario Ministry of Health to work with local and regional health and social support systems to improve care, test models of service delivery, and advocate for the most effective and appropriate care of the region’s frail elderly.

The RGP is a multidisciplinary program that consists of a small administrative staff, an acute care geriatric unit based in a teaching hospital, and an outreach program of 10 workers, made up of two social workers, two physiotherapists, two occupational therapists and four nurses, two with special expertise in incontinence management. The physician staffing is provided by the five geriatricians of the academic Division of Geriatric Medicine at the University of Western Ontario.

The RGP has faced increasing requests for referrals, consultation, and education. With budget restraints and an extensive mandate, the RGP realized that innovative strategies would be needed to affect the care of the elderly across such a large geographic region. As others have suggested (Caplan & Caplan, 1993; Connell et al., 1994; Karuza, Jr., Calkins, Duffey, & Feather, 1988; Minkler, 1991; Stolee, Kessler, & Le Clair, 1996), community-wide efforts are important in improving a system of care for elders.

This article reports on an initiative—known as the “Models Project”—in which the RGP worked with two communities to develop local resources and an improved model of assessment and care of the frail elderly adults in widespread rural areas. The primary goal of the project was to implement the proven methodology of the comprehensive geriatric assessment in areas where no one agency or institution had sufficient resources to achieve this alone, but where the combined resources of the community might do so.

Health System Context

Health care in Canada is a provincial responsibility with national standards governed by the federal Canada Health Act. Health services are largely funded through provincial health programs that provide insured hospital and physician services without charge. Provincially funded home care programs provide pro-
fessional and personal support care, on an individual service-plan basis, with goals of continued residence in the community, rehabilitation, and respite for caregivers. Other supportive services in the community may be received on a voluntary or private-pay basis, although these services may receive provincial subsidies. Long-term care residents pay a daily rate for accommodation, with professional and personal care supported by provincial funding. Eligibility for provincially funded services is determined on the basis of need. Many provinces, including Ontario, have begun a process of health care restructuring and rationalization, shifting the emphasis from hospital-based to community-based care, a process that emphasizes the need for improving the community-based system of health care in all areas. Physician remuneration is, for the great majority of services, provided by the province on a fee-for-service basis. The physician bills the province directly and there is no direct cost to the client. It is generally felt that the frail elderly client, who requires more detailed assessment and takes more time, fares less well in this type of system. The development of specially trained non-physician assessors could partly compensate for this, and may prove more cost effective.

Although most areas of Ontario were undergoing health care restructuring—including funding restraints and hospital closures—which in itself causes challenges, this also presented opportunities. The anxiety associated with such changes can also result in a readiness to learn and be connected to others (Bridges, 1991; Weisbord, 1987). Most communities had become reconciled to the idea that change was inevitable. Health care restructuring in Ontario has emphasized the development of integrated health delivery systems (Shortell, Gillies, Anderson, Mitchell, & Morgan, 1993); and communities were coming to accept that all segments of the system needed to work together toward greater integration and that more needed to be done with less. In this context, the RGP was in a better position to facilitate meetings of community leaders to explore mutual dilemmas regarding frail elders and to focus on making choices together to best to serve this population.

The Models Project

The RGP sought a level of service and system development equivalent to that of a well-functioning organization, and selected the principles and practices of organization development (OD) to guide the Models Project. For the purposes of the Models Project, the organization was considered to be the community of service provider organizations. The various agencies and institutions within the community would be analogous to departments within an organization. A project facilitator with experience and graduate-level training in organization development was hired. OD is an iterative process (French & Bell, 1995), and as applied to a system of geriatric care, the OD consultant would work alongside communities to assist them in discovering a view of the system as a whole, identifying their strengths and limitations in geriatric care, and identifying development opportunities for geriatric care across the system.

The RGP’s OD approach had four overlapping stages: assess potential for action, get the whole system in the room, focus on the future, and structure tasks that people can do for themselves (Weisbord, 1987). As this was a new initiative, it was felt that the approach should be tested in two somewhat dissimilar sites prior to a more extensive application in the region as a whole.

Initial Assessment: Potential for Action

To learn about the aspirations and approaches to care of the frail elders in the region, the OD consultant began a process of information gathering across its 10-county area. The two-month process included informal telephone and on-site interviews with groups and individuals representing long-term care, acute care, and home service agencies as well as local planning bodies and the provincial Ministry of Health. This process provided information on issues in the current system of care for elders and on areas where improvement was seen as most needed. Providers were anxious to receive information and support on geriatric issues, and wanted to become more self-reliant in the care of the elderly. The focus of most clinical assessments in the community was on service provision rather than the identification of treatable or reversible conditions that would be the goal of a comprehensive geriatric assessment (Rubenstein, 1988). Many indicated a desire to improve “systems,” and talked about the need for a “seamless system.”

Information gained through the initial assessment was used to guide selection of the two pilot sites. Several communities were identified that were willing to invest in the development of local geriatric care with RGP support. Pilot site selection criteria included energized people with positive existing relations between service providers, leadership commitment, local interested physicians, current use of RGP resources, and the likelihood of having an impact on the care of elders. Four months into the project, sites in two rural counties were chosen as pilot locations.

Site 1 included three small towns and the surrounding area, in which 20.5% of the population was older than 65. The area presented challenges to elders including limited accessibility and affordability of transportation, resource requirements due to travel and time associated with in-home assessments, frequent winter travel problems, safety and isolation and decreased family availability for support. Site 2 was a town (population 32,000) and its surrounding area, in which almost 14% of the population was older than 65. (In Ontario 11.7% of the population is older than 65 [Sarkella, 1996].) This site was one of the RGP’s most intensively served areas, and enhancing this area’s capacity to care for elders could have a major impact on the RGP’s ability to serve other parts of its catchment region. Hospitals in the area were struggling with restructuring plans and relationships between stakeholders were strained.

Both sites shared similar ideas for developing their
systems of geriatric care: (a) to develop local geriatric assessment skills and the capacity for appropriate action (i.e., the ability to meet client needs and expectations, at the right time, with the right services, and in the most cost-effective way); (b) to develop resources for elderly persons with challenging behavior and geriatric mental health problems; (c) to increase interest and support from local physicians in geriatric care; (d) to increase awareness of services and support available to older adults and their families and caregivers; and (e) to develop strategies for transition between acute care, community care and long-term care; this included the concept of “alternatives to in-hospital stay.”

Getting the Whole System in the Room

Following site selection, forums were held at the two sites to promote a community-wide approach to the care of elders, to facilitate discussion between community leaders, and to reaffirm commitment to a project that would require long-term local management and ownership. There was a good representation of health service providers at the initial community meetings.

A Models Project steering committee was formed at both sites with representatives from acute care hospitals, private and non-profit long-term care facilities, and community agencies including home care, public health, and non-profit and private nursing services. Despite the provincial moves toward more integrated health delivery systems, this represented the first step for many to implement the principles of integration, which require cross-system thinking, acting, and funding. Although functioning without formal ties and in a fairly independent manner, the steering committees had some semblance of an organization management group; they spent considerable time creating a sense of unity around a shared vision, values, and purpose.

Focusing on the Future and Structuring Tasks That People Can Do for Themselves

The RGP continually assessed where and how the program could contribute, offering resources to communities in their search for ways to improve their local system of geriatric care.

Site 1 started their project work by using an assessment model (Kelley, Taylor, & Kirkpatrick, 1992) to identify existing resources that could meet the needs of elders during predictable phases of decline. Although some of the necessary resources existed within the system, they were fragmented and not easily accessible across the three communities. After much deliberation, the steering committee decided the future of their system of care would depend upon the continuous development of geriatric skills, knowledge and attitudes of their local people. Planning future delivery mechanisms and structures such as day hospital or assessment units should happen with help from those with new knowledge and experiences in geriatric care. The human resource development plan involved training a local resource team in comprehensive geriatric assessment; this team would in turn educate other health professionals in geriatric issues with RGP assistance when needed.

Early in the project, a survey of health professionals at Site 2 indicated that most service providers were looking for help and advice on complex geriatric cases within their own agencies; most believed their assessments for service provision were similar to the process of comprehensive geriatric assessment. In response, the RGP provided information to the steering committee on comprehensive geriatric assessment, interventions and systems approaches, encouraging a collective vision based on knowledge and principles of care of elders. The steering committee initially chose to focus their efforts on the development of day programs or other services that would support transitions between acute care, community care, and long-term care, and that would provide alternatives to in-hospital stay. After further discussions and a joint meeting of the steering committees of the two sites, however, they concluded that development of local expertise in geriatric assessment was the critical first step.

There was therefore agreement in both sites that the development of specialized geriatric services depended upon the initial development of locally based expertise in the care of elderly adults that would then help guide service planning and organization. Plans began to unfold at both sites for the development of geriatric resource teams that would perform comprehensive geriatric assessments. The local resource team—representing the primary service agencies across the pilot sites—would link to the RGP for clinical backup, education, consultation, and evaluation. Initially team members would serve as internal geriatric resources for their own organizations with the greater vision of becoming a resource team for the whole county.

The RGP made a commitment to cross-train a team from each site in comprehensive geriatric assessment. Individuals for the resource teams were selected by participating organizations and included social workers, physiotherapists, occupational therapists, and nurses. Not only did the teams represent several disciplines, but the team members came from various sectors of the health service system, including long-term care, community services, and acute care. This approach helps overcome the inability of small rural agencies or institutions to support both the depth and breadth of expertise needed for specialized geriatric assessment and management.

In keeping with the organization development approach, the RGP completed an assessment that identified where skills and knowledge of the resource team members in the care of elders could be enhanced; it also identified system problems that the steering committees needed to address through means other than training. The practicum could improve geriatric assessment and intervention skills and knowledge. The interagency nature of the teams could promote understanding of system strengths and barriers, but the development of local partnerships would be required to make the necessary system changes to enable the work of the resource teams.
The Practicum

The practicum focused on performance improvement (Robinson & Robinson, 1995; Rothwell, 1996) and its design promoted action learning and reflective practice (Argyris, 1993; Vella, 1995). The RGP also invested in training its own outreach team members in adult education principles (Brookfield, 1991; Knowles, 1990); the teams would be responsible for facilitating the training efforts at both sites and for ongoing support. The 15 training days were spread over four to five months and consisted of classroom work and clinical training experiences in their local communities and in the RGP geriatric assessment unit. To promote transfer of learning to the worksite, the practicum was followed by periodic case conferences and education sessions with the RGP. The first resource team began its training 15 months into the project. The participants completed reading assignments prior to the practicum and homework assignments during the training. The classroom component of the practicum was conducted mostly at the RGP offices, thus necessitating team members to leave their communities but also relieving them of their day-to-day duties and distractions. They were encouraged to stay in the same hotel to facilitate team-building.

The practicum included an overview of aging issues and changes related to aging; components of a comprehensive geriatric assessment, including mental status assessment, functional assessment, psychosocial assessment, and integration of information; medication issues in elders; and specific health conditions such as Alzheimer's disease, urinary incontinence, and hypertension. Many opportunities were available for clinical visits and debriefing. A day-by-day practicum schedule is available from the authors upon request.

Both sites committed to supporting the initial 15 days of training and development of their resource team with their existing resources; eventually the provincial Ministry of Health funded both sites for the 15 days of training. To cover the ongoing costs of the team education, case conferences, and ultimately the work of the team, Site 1 is seeking redirection of hospital restructuring funds and has submitted proposals to the provincial Ministry of Health and the District Health Council responsible for local health planning. At this time, Site 2 continues to support team development through their existing resources and has developed processes to ensure the equitable distribution of referrals across the team and their supporting agencies.

Each resource team member selected a "learning partner" in their organization. This was a professional, not necessarily from the same discipline, with whom the team member met on a regular basis to share the information and materials obtained from the practicum experience. By so doing the resource team member continues to learn by reviewing new skills and knowledge with their learning partner; together they can be an education resource to their organization. In addition, the learning partner should be able to replace the regular team member at case conferences throughout the year or permanently replace a team member in the event of restructuring, job relocations, or illness (this has occurred in one case).

The practicum education, particularly the clinical experiences, was rated highly by participants. Overall ratings (expressed as a percentage of the maximum possible score) for Site 1 participants were 81.6% for educational presentations and 92% for clinical experiences; the corresponding ratings for Site 2 were 82.7% and 83.9%, respectively. The following comments were typical: "more confident in the use of better physical, functional, and cognitive assessment tools" (Site 1); "more confident reviewing and speaking with physicians about medications" (Site 1); "it has provided the theory that I was hoping for and the tools for assessment" (Site 2). There was some evidence that resource team members were more confident in various aspects of geriatric assessment and management, particularly in Site 2. Before/after self-ratings of confidence in five areas are shown in Table 1 and analyzed using paired t tests. Confidence was significantly improved in all five areas in Site 2; resource team members in Site 1 reported significantly increased confidence in the use of assessment tools. The difference in results between the two sites relates in part to lower baseline scores for Site 2. Resource team members in Site 1 rated their confidence higher, and perhaps less realistically, at baseline. The follow-up scores for this team, although not significantly different from their baseline scores, may represent a more realistic assessment. Our experience in other similar but unrelated educational efforts has been consistent with work in industrial psychology (Muchinsky, 1993) in that an initial high level of self-rated confidence frequently reflected incomplete...
knowledge of what was required in, for example, a full geriatric assessment; as the learner became more aware of these requirements, confidence actually fell before increasing as skills were acquired.

A more tangible outcome is the operation of the interdisciplinary resource teams at both sites. The team at Site 1 was established with 10 members, representing seven community agencies and facilities. The team at Site 2 has 12 members representing nine community agencies and facilities. Team members remain in their usual positions but devote two days a month to the resource team, with support from their sponsoring agencies. Both teams are guided by local steering committees with participation as necessary from the RGP. In each community, subcommittees have been formed to pursue the development of policies and procedures, fund-raising and marketing activities, and evaluation. Referral procedures and mechanisms have been established for each team. Resource team members typically participate in the assessment of one or two frail elderly clients each month. Resource team members have provided education within their organizations and have also had ongoing education themselves. The next stage in resource team development at both sites will be to gain additional clinical experience and credibility, and begin determining for themselves the most valuable outcome measures. Major concerns relate to time pressures on resource team members and ongoing financial support: “limited time and competing roles and demands remain an issue” (Site 1).

Steering committee members have commented on the benefits of the overall process: “The Models Project has been a helpful process for three communities to come together in planning for the future which involves planning and working with the elderly” (Site 1); “The project has prompted us to think beyond the walls of the organization, something at which we have not had a great deal of experience” (Site 2); “The Models Project has forced the community to sit down together to discuss how we might work better together” (Site 2).

The geriatric resource teams continue to have an educational relationship with the RGP, including occasional case conferences and telephone consultation. The cross-learning of the resource team has promoted the required holistic approach to geriatric assessment. Performance guidelines developed by the RGP and the learners are helping team members to focus on clinical improvements and necessary skills. Team members are taking steps to become their organization’s geriatric resource, and are heightening awareness of the need for early recognition of decline and of the value of comprehensive assessment.

Next Steps

The team members form a core of expertise from which knowledge and skills can be devolved to other members of their communities. It is hoped that this new knowledge will guide the development of services to meet the needs of the elderly population in a way that recognizes the specific circumstances of the communities and supports necessary system-wide coordination. The expertise of the resource teams will be valuable to the local steering committees as they further develop their systems of health care for the elderly.

Discussion

The core of the Models Project has been the local development of human resources with expertise in comprehensive geriatric assessment. In and of itself, however, a training program is only a partial solution to improving care for elders. The steering committees and sponsoring organizations must take responsibility for removing barriers that hinder the transfer of skills and knowledge to their worksites. They must develop ongoing strategies to support the newly trained assessors, including sufficient time for the transition to a new way of doing their work and recognition of performance improvements (Broad, 1997; Ford & Weissbein, 1997). To promote sustainability of the training effort they should aggressively seek opportunities to remove systemic barriers to effective geriatric care.

Although programs to address the health care needs of rural elders have often worked to address resource constraints and accessibility issues such as transportation, the need for improved coordination and service networks has also been recognized (Christianson & Moscovice, 1993; Hicks & Bopp, 1996; Krout, 1994). The potential for rural areas of strategies such as case management has been explored (Bushy, 1997; Parker et al., 1992; Urv-Wong & McDowell, 1994), but these approaches are unlikely to address service coordination challenges at a system level, or provide the human resource development necessary to provide comprehensive assessments that can identify reversible problems in addition to service needs.

Anderson and colleagues (1994) have also reported on the development of interdisciplinary geriatric teams in smaller communities. Our experience has been consistent with their findings of the importance of funding issues and the support and commitment of sponsoring agencies, physicians, and communities. Our approach differed in its goal of community collaboration and coordination through the development of interagency teams. This may make the maintenance of local agency support an even greater challenge, but provides greater potential for enhanced service networks and system coordination.

In future projects, there would be advantages in requiring the project sites to more clearly define their commitment and expectations and to negotiate their desired relationship with the RGP (Schwar, 1994). For example, a “request for proposal” to participate in the Models Project could start project sites off with a higher level of commitment if they are required to define as a group their own potential for action, their preferred future, their resources, and their partnership configurations.

The OD approach has helped the RGP move from a traditional expert model to working with others to learn new collaborative, consultative approaches. The model brings the appropriate people together to
share a valued purpose, focus on a desired future for geriatric care, and encourages patience to do what is doable as people are able (Jaques & Cason, 1994; Weisbord, 1987). New challenges will be faced as the province moves toward more integrated health systems. As a result of the organization development work of the Models Project, these communities should be in a better position to meet these challenges.

References

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