

Actively Building Capacity in Long-Term Care Facilities

THREE INITIATIVES:

*Recruitment & Retention of
Family Physicians, Nurse Practitioners
& Pharmacists*

Collaborative Service Delivery

*Interdisciplinary Collaborative
Curriculum*



A Collaborative Project of
McMaster University
Department of Family Medicine and
School of Nursing and Shalom Village
funded by
Ontario Ministry of Health and Long Term Care

SECTION I — EXECUTIVE SUMMARY

The Canadian population is aging in unprecedented numbers presenting unique challenges to the health care system. The largest expected increase will be persons over eighty years of age, many of whom will require residential care. To meet the predicted future need for long-term care, 20,000 beds are being added to this sector in Ontario.

In 2001, the Department of Family Medicine at McMaster University established a partnership with Shalom Village, a long-term care facility in Hamilton, and initiated a collaboration with the School of Nursing at McMaster University and the Faculty of Pharmacy at the University of Toronto. Together they submitted a proposal, *Actively Building Capacity in Long-Term Care* (ABC in LTC), to the Ontario Ministry of Health and Long-Term Care (MOHLTC) which was funded in November 2002 for completion in September 2003.

The project had three objectives:

1. To prepare a strategy document for recruitment and retention of family physicians, nurse practitioners and pharmacists in long-term care
2. To design a collaborative service delivery model for family physicians, nurse practitioners, and pharmacists in long-term care
3. To develop a collaborative curriculum for training family medicine residents, nurse practitioners and pharmacy students in the care of long-term care patients

CONSULTATIVE PROCESS TO INFORM RECOMMENDATIONS

This project examined literature, conducted community consultations, workshops and surveys to inform recommendations to the MOHLTC. The goal was to seek a better understanding of the issues, and to obtain expert advice and input on the three initiatives. The literature review found mostly descriptive, non-comparable observational studies. Community consultations were of three types: focus groups, teleconferences and key informant interviews. There were three stakeholder workshops with provincial representation from the three professions, and three curriculum surveys of long-term care content in family medicine residency programs, and nurse practitioner and pharmacy training programs.

RECRUITMENT AND RETENTION

In the literature, the models of recruitment of health providers are 1) affinity, 2) attraction, 3) economic-incentives and 4) comprehensive collaborative community strategies.

Affinity strategies capitalize on natural attraction arising from early personal experience with the elderly, enhanced with early positive educational exposure. Affinity studies are focused mostly on recruitment of students and selective admission policies. *Attraction strategies* focus on qualified professionals. Strategies include “perks,” “Magnet” worksites (high-quality work environments), return and re-entry programs, continuing professional development and speciality training. The prime *economic incentive* is indenture, a contract to pay for educational training in return for work commitment. It is used mostly to recruit to under-serviced, rural and remote areas. While indenture is shown to attract, the evidence for retention is poor. *Comprehensive collaborative programs* are coordinated provincial and regional actions with local community support. They are based on the premise that recruitment of health providers cannot be accomplished in isolation, but needs the combined efforts of government ministries of health, education and labour working in concert with universities and health care service organizations.



SECTION I — EXECUTIVE SUMMARY

In the literature, retention is deemed more important than recruitment. The best examples in the United States of recruitment and retention are “Magnet hospitals” and “Magnet nursing homes.” They provide quality work environments that include optimal patient /provider ratios, permanent positions, acceptable salaries and benefits, and career paths with professional support systems.

Community consultations (focus groups, interviews and workshops) report that the key incentive to work in long-term care is a strong affinity or “passion for elder care.” Described as a unique environment, incentives to work in long-term care include the opportunity to use clinical skills, the challenge of complex care, relationships to long-term care residents, and collaborative practice. The main barriers to working in long-term care are poor remuneration, low status and low prestige, lack of collaborative practice, heavy work loads, lack of on-call options, and “de-skilling” of allied staff—that is, hiring unskilled persons to perform duties that were formerly done by licensed practical nurses. De-skilling is reported to be occurring at the same time the complexity of care and acuity of illness of long-term care residents is rising.

In the workshop, the most frequently mentioned strategy for recruitment and retention is the development of academic teaching units in long-term care along with practice-based research to establish best-practice guidelines. Other recommendations to improve recruitment and retention in this sector include the following: linking service provision in long-term care with acute care, multiple career entry points, career paths in the sector, staff development programs, “up-skilling” of front-line staff—that is, hiring the most qualified health care providers at the appropriate level of training—and the provision of permanent full-time positions to ensure continuity of care.

Local, regional and provincial key strategies to promote recruitment and retention in long-term care are listed. (See Section 5, Table 5.4 Local, Regional, Provincial Strategies for Recruitment and Retention).

COLLABORATIVE SERVICE DELIVERY

The literature on collaborative practice identifies factors that enable, sustain, enhance and inhibit collaborative teams. The primary enabling factors are professional training in collaborative practice, and dedicated time to build and sustain collaborative teams. Recently expanded roles for nurses and pharmacists have created the potential for collaborative practice, but challenges exist within and between professions in terms of scope of practice, roles and remuneration. From the literature a list of core elements of collaborative service delivery in long-term care was developed. (See Section 6, Table 6.3 Core Elements of Collaborative Service Delivery Models)

In the stakeholder workshop on collaborative service delivery, the community infrastructure needed to implement collaborative service is explored. Essential factors include communication systems, information technology, and networks of providers to take call for 24/7 care. Functional collaborative teams need dedicated time, space and training to work effectively together. Local, regional, and provincial key strategies were identified that promote collaborative interdisciplinary team activity and service delivery in long-term care facilities. (See Section 6, Table 6.5 Local, Regional and Provincial Key Strategies to Promote Collaborative Interdisciplinary Practice).



SECTION I — EXECUTIVE SUMMARY

COLLABORATIVE CURRICULUM

Interdisciplinary education is based on the premise that when disciplines learn together using collaborative curricula, trust is created between disciplines. Trust enhances collaborative practice resulting in greater job satisfaction and improved patient care. Six basic requirements of interdisciplinary education are identified in the literature: 1) faculty trained in interdisciplinary education, 2) mutual understanding of the disciplines, 3) knowledge of roles and scopes of practice, 4) systems of accountability and responsibility, 5) experience of interdisciplinary learning, and 6) networking. Challenges to development of collaborative curricula include institutional support, recruitment of faculty, readiness of students and faculty, and organizational issues, such as timetabling and timing during training. (See Section 7, Table 7.1 Challenges in the Development of Collaborative Curricula).

Surveys of Ontario family medicine residency programs, nurse practitioner and pharmacy training programs report varying levels of training in elder care and geriatrics; but little, if any, specific content or focus on long-term care.

Participants at the curriculum workshop recognize that long-term care differs from acute care and geriatrics, and agree that there is a need for curriculum reform to include training in long-term care. Discussions of effective designs of collaborative long-term care curricula include the following key issues: 1) how to motivate altruism in providers, 2) didactic method—lectures versus case-based approaches, 3) content of material, 4) faculty rotations, 5) structure—mandatory or elective rotations, 6) inclusiveness of the collaborative service delivery team, 7) research focus and 8) continuing education. (See Section 7, Table 7.4 Issues in Effective Design of Collaborative Curricula).

DEVELOPING NETWORKS

One of the primary steps of the project was to develop a network of stakeholders, and a communication strategy to inform and to engage health care providers and educators across the province. (See Appendix 7 Database)



SUMMARY OF RECOMMENDATIONS

Embedded in the findings from the literature, community consultations and workshops are many strategies to address recruitment and retention, collaborative service delivery and collaborative interdisciplinary curriculum. The following list of recommendations are derived from these sources, and from the recommended local, regional and provincial strategies summarised at the end of sections 5, 6 and 7 (See also Appendix 6, Local, Regional and Provincial Strategies to Inform Recommendations)

1. Academic Teaching Units ¹

The MOHLTC fund academic teaching units in long-term care across the province

- To inform the process, the MOHLTC fund a demonstration pilot of academic teaching units in long-term care facilities

2. Recruitment and Retention Awareness

The MOHLTC fund development officers to assist in recruitment and retention of physicians into long-term care facilities in each region

3. “Magnet” Long-Term Care Facilities

The MOHLTC sponsors a process to develop standards for “Magnet” long-term care facilities across the province with the aim of linking standards to accreditation.

4. Long-term Care as a Focus in Education and Practice

The professional colleges and associations revise their policies and procedures to reflect long-term care as a priority focus in education and practice

5. Collaborative Practice Teams

The MOHLTC fund collaborative practice teams within long-term care facilities (family physician, nurse practitioner, pharmacists etc) as a model for patient care

- To inform the process the MOHLTC fund a demonstrate pilot to develop core competencies and training requirements for collaborative practice teams

6. Collaborative Service Delivery as the Standard

The regional office of MOHLTC facilitates the establishment of collaborative service delivery (on-call arrangements, inter-institutional co-operation, application of information technology, development of networks and committee structures of medical directors administrators and collaborative health care providers) as the standard within and across districts and geographic areas

- To inform the process the MOHLTC fund regional demonstration pilots of collaborative service delivery in long-term care

7. Palliative Care and End-of-Life Care Teams in Long-term Care

The Regional Geriatric Programs of Ontario, the Ontario Long-Term Care Physicians Association, the Ontario Palliative Care Association and the Section of Palliative Care at the Ontario Medical Association collaborate on the development and implementation of collaborative, palliative care and end-of-life teams in long-term care

- To inform the process the MOHLTC fund a demonstration pilot of a collaborative palliative care and end-of life team in long-term care

¹An academic teaching unit in long-term care is a recognised university training program which includes faculty members from family medicine, nursing, pharmacy and other disciplines who are responsible for development and implementation of curricula for the training of future care-givers to provide evidence-based quality clinical care that is responsive to the needs of long-term care residents. (For a complete description of academic teaching units, see page 31).



SUMMARY OF RECOMMENDATIONS

8. Mandatory Training in Long-term Care

The Council of Ontario Faculties of Medicine (COFM), Council of Ontario University Programs in Nursing (COUPN), and University of Toronto Faculty of Pharmacy explore mandatory student and family medicine resident rotations in long-term care facilities

9. Collaborative Curriculum

The Council of Ontario Faculties of Medicine (COFM), Council of Ontario University Programs in Nursing (COUPN), and Faculty of Pharmacy, University of Toronto collaborate on the development of an interdisciplinary curriculum in long-term care

- To inform the process the MOHLTC fund a pilot project to develop an interdisciplinary curriculum model
- To inform the process the MOHLTC fund an endowed chair in interdisciplinary education at each university in Ontario

10. Best Practices

The professional colleges, Ontario College of Family Physicians (OCFP), College of Nurses of Ontario (CNO), Ontario College of Pharmacists (OCP) collaborate with the Council of Ontario Faculties of Medicine (COFM), Council of Ontario University Programs in Nursing (COUPN), and University of Toronto Faculty of Pharmacy to establish evidence-based standards and guidelines for best practices in long-term care facilities

11. Research Capacity in Long-term Care

The MOHLTC fund an Ontario long-term care research strategy as a process to identify the priorities in long-term care research and to strengthen long-term care research capacity

12. Information Technology

The MOHLTC integrate long-term care facilities into the activities of primary care reform and the new initiatives in acute care information technology

13. Remuneration

Priority given to professional organizations negotiating with the MOHLTC for the purpose of improving remuneration policies so they reflect the realities of the long-term care sector and maximize recruitment and retention, collaborative service delivery and education in long-term care.



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SECTION 2 — INTRODUCTION

RATIONALE FOR THE PROJECT

The Canadian population is aging in unprecedented numbers presenting unique challenges to the health care system.(1)The number of person over eighty years of age will show the biggest increase, and many of these will require long-term care. To meet the predicted future need for long-term care, 20,000 beds are being added to this sector in Ontario.(2)

The Department of Family Medicine at McMaster University has a mandate to train future family physicians and a responsibility to ensure that future family physicians meet the geographic and demographic health needs of the Ontario population. The Department of Family Medicine has a number of divisions that address special needs. The Care of the Elderly Division (COED) within the Department of Family Medicine was established to address the special needs of the elderly population.

The Department undertook a planning process in March 2001 to address the training of future family physicians in the care of the elderly especially in long-term care. There were a number of evolving concerns in care of the elderly:

- The increasing shortage of family physicians interested in care of the elderly,
- Barriers to clinical practice outside the physician office,
- Lack of incentives to work in long-term care,
- Lack of training to work in long-term care,
- New relationships being forged with nurse practitioners, and
- Challenging complexities in prescribing and drug dispensing in long-term care facilities.

To begin to understand the scope of these concerns, and to formulate recommendations to begin to meet these challenges, the Department of Family Medicine established a partnership with Shalom Village, a long-term care facility in Hamilton, and initiated a collaboration with the School of Nursing at McMaster University and the Faculty of Pharmacy at the University of Toronto. A proposal was developed and submitted to the MOHLTC for this project, Actively Building Capacity in Long-Term Care (ABC in LTC), which was funded in November 2002 for completion in September 2003.

The project has three objectives:

1. To prepare a strategy document for recruitment and retention of family physicians, nurse practitioners and pharmacists in long-term care
2. To design a collaborative service delivery model for family physicians, nurse practitioners and pharmacists in long-term care
3. To develop a collaborative curriculum for training family practice residents, nurse practitioners and pharmacy students in the care of persons living in long-term care.



ONTARIO LONG-TERM CARE INITIATIVES

The shifting demographic profile of Canadians with an increased percentage of older persons in the population presents unique challenges to the health care system. The greatest demographic increases are in persons aged 80 years and over with an estimated 1.3 million by the year 2011. Advanced age generally brings a need for increases in health care services and long-term care. (1) (2)

To address the needs of Ontario's growing and aging population, in April 1998, the Government of Ontario announced a \$1.2 billion plan to build 20,000 new long-term care beds by 2006. This was the first expansion of long-term care beds in the province since 1988. In March 1999, the Government announced that the expansion of long-term care beds would be accelerated with the construction of the 20,000 new beds to be completed by 2004. As of September 02, 2003, 12,039 beds have been built, with another 8,222 under development.²⁽³⁾

NATURE OF THE LONG-TERM CARE SECTOR

Long-term care³ is the largest health care sector in Ontario. Long-term care facilities are designed for people who require the availability of 24-hour nursing care and supervision within a secure setting. In general, long-term care facilities offer higher levels of personal care and support than those typically offered by either retirement homes or supportive housing. Health care services in long-term care include 24-hour nursing care, personal care, and access to physicians and other health care providers.

Long-term care facilities in Ontario are owned and operated by various organizations:

- Nursing homes are usually operated by private corporations.
- Municipal homes for the aged are owned by municipal councils. Many municipalities are required to build a home for the aged in their area, either on their own or in partnership with a neighbouring municipality.
- Charitable homes are usually owned and operated by non-profit corporations, such as faith, community, ethnic or cultural group⁽⁴⁾

The MOHLTC licenses all long-term care facilities, and provides base level funding determined by the number of beds and the level of care provided. Co-payment fees paid by long-term care residents are for accommodation. Fee rates are set by the MOHLTC.

Long-term care facilities may choose to seek accreditation from the Canadian Council on Health Services Accreditation (CCHSA), an independent organization that reviews the services of facilities. Accreditation is given when the long-term care facility meets the national standards of CCHSA.

Entry of long-term care residents into facilities is coordinated through the provincial Community Care Access Centres (CCACs). Applications are assessed on the basis of individual care needs and social circumstances.

² Ontario Ministry of Health and Long-Term Care. Seniors' Care : Long-Term Care Facilities. http://www.health.gov.on.ca/english/public/program/ltc/15_facilities.html . 2003. 10-3-0030. Ref Type: Electronic Citation

³ In Ontario, long-term care refers to nursing homes, municipal homes for the aged and charitable homes for the aged.



SECTION 3 — BACKGROUND

ONTARIO LONG-TERM CARE POPULATION DATA

A 2001 project to examine the level of care required by Ontario long-term care residents was conducted by PricewaterhouseCoopers under the auspices of the Ontario Association of Non-profit Homes and Services for Seniors (OANHSS) and the Ontario Long-Term Care Association (OLTCA), and funded by the MOHLTC. It reports that three-quarters (76.6%) of residents in long-term care in Ontario are women with an average age of 82.1 years.⁴ Combined, Dementia and Alzheimer Disease are the most prevalent of all diagnoses (53%). The most prevalent physical care diagnoses are arthritis (30%), stroke (22%), congestive heart failure (11%), and diabetes (19%). Compared to eight other jurisdictions in Canada, US and Europe, Ontario's long-term care population has 1) a higher number with behavioural problems, 2) a similar number with cognitive impairment, 3) a similar proportion who are clinically complex, and 4) a higher number with reduced physical function. (5)

PROFESSIONAL HEALTH CARE SERVICES IN LONG-TERM CARE

Family Physicians

Traditionally, the provision of health care to long-term care residents has been the responsibility of family physicians working closely with registered nurses, health care assistants, clinical consulting pharmacists, and more recently, nurse practitioners, in a small number of facilities.

Shortages

Present shortages of family physicians in Canada present a unique challenge to the long-term care sector. Three recent studies, one by the College of Family Physicians of Canada (CPFC), and two provincial studies, Alberta and Ontario, (6) (7) (8) describe shortfalls in the number of family physicians. The CPFC estimate a present shortage of 3,000 family physicians across the country. None of the studies looked at the acute shortage of physicians in long-term care. In 2003, one-quarter of family physicians report working in long-term care, and as many of these are nearing retirement age, the shortage in this sector is likely to become more acute in the near future. (9)

The Ontario Long-Term Care Physicians Association (OLTCPA) undertook a study in 2001 with a focus on the ages of family physicians and number of long-term care residents per physician. Using a representative sample of long-term care medical directors, they found that family physicians in long-term care facilities are older and nearing retirement. Further, the older they are, the more residents they have in their practice; younger family physicians are hard to recruit into long-term care. (10)

Attending physicians

Long-term care residents may be former office patients of family physicians who work in long-term care facilities. More frequently, they are patients whose physicians are unable to continue to provide care after they relocate to a long-term care facility. Some family physicians refuse to see their patients once they move into long-term care, and some long-term care facilities do not desire family physicians working there because of lack of familiarity with facility policies and procedures.

Changing working conditions

Family physicians working in long-term care facilities report 10 to 15 years ago, their patients were healthier, in fact, some drove their own cars. Today, in contrast, long-term care residents need more complex care, have a greater acuity of illness and live for shorter periods of time. (10)

⁴ A number of young persons with chronic diseases, such as multiple sclerosis, also reside in long-term care facilities.



SECTION 3 — BACKGROUND

Nurse Practitioners

In Ontario, nurse practitioners are registered nurses with advanced knowledge and decision-making skills in assessment, diagnosis and health care management.(11) Advanced nursing practice has been defined by the MOHLTC as a registered nurse with additional nursing education to provide nursing services in all five areas of comprehensive health services (promotion, prevention, cure, rehabilitation and support) and at all levels in the health care system. Some services, like assessment, diagnosis and treatment can be safely and effectively provided by either a physician or a nurse practitioner. (12)

In 1999 the provincial government announced 20 pilot positions for nurse practitioners in long-term care facilities. (13) By 2003, 17 of the original 20 pilot facility placements had been filled, and more pilot positions had been announced.(14)

Pharmacy

Medications for long-term care residents are dispensed by pharmacists working with a contracted independent pharmacy or a contracted company that specializes in dispensing to long-term care facilities. Clinical consulting pharmacists conduct medication reviews. This may be done independently or in consultation with physicians, nurse practitioners and registered nurses. Pharmacists provide advice to allied health care providers to optimize medications regimes—an important service given the complexity of medication use in this population. Medication reviews by pharmacists include an assessment of the clinical situation with an eye to improved dosage, stopping medications or starting a new one.

At the time of writing, in Ontario there were 45 full-time clinical consultant pharmacists working in long-term care facilities. There are also community-based pharmacists who provide pharmaceutical consultations to long-term care facilities on a part-time basis. According to an industry leader, there is no shortage or problem with recruitment or retention of pharmacists because the positions are attractive and effort is made in hiring to achieve a good role fit. (15)



SECTION 4 — DESIGN OF THE PROJECT

PROFESSIONAL DISCIPLINES AND INITIATIVES

This multi-faceted report on long-term care focuses on three initiatives: 1) strategies for recruitment and retention, 2) collaborative service delivery model, and 3) a guide for collaborative curriculum. Our mandate was limited to family physicians, nurse practitioners and pharmacists with the full recognition that many allied professionals and health care workers are employed in long-term care. Information for the three initiatives was gathered through literature reviews, community consultations, stakeholder workshops, surveys, steering committee input and dissemination of the draft report for expert review.

LITERATURE REVIEWS

The literature includes both indexed and grey literature. Both are primarily descriptive and observational in content.

Search Strategy

Search strategies were developed for the literature using the computer and hand searches.

Indexed Literature

Computer searching

Key words were defined specific to the three objectives. The health science databases at McMaster University Library were used. (See Table 4.1) This includes EBM Review—Cochrane, DSR, ACP Journal Club, DARE from beginning to present (June 2003)—PREMEDLINE & MEDLINE, 1966 to June 2003, CINAHL, 1982 to Week 1, June 2003, and HealthSTAR, 1975 to June 2003.

TABLE 4.1: KEY WORDS FOR DATABASE SEARCHES

Recruitment and Retention	Collaborative Service Delivery Model	Collaborative Curriculum
recruitment	collaborative practice	learning
retention	interdisciplinary teams	education
job satisfaction	collaboration	curriculum
job dissatisfaction	shared care	<i>combined with</i>
<i>combined with</i>	integrated practice model nurse	interprofessional
family physician	managed care	multidisciplinary unidisciplinary
nurse practitioner	hierarchical model consultative	intradisciplinary transdisciplinary
pharmacist	model consortium model	<i>combined with</i>
<i>combined with</i>	<i>combined with</i>	family physician
long-term care	physician	nurse practitioner (s)
elder care	nurse/nurse practitioner	pharmacist
geriatrics	pharmacist	<i>combined with</i>
nursing home	<i>combined with</i>	geriatric curriculum
home for the aged	long-term care	long-term care curriculum
	elder care	senior care curriculum
	care of the elderly	care of the elderly
	geriatrics	
	nursing homes	
	home for the aged	
	<i>and</i>	
	interdisciplinary standards of	
	practice	



SECTION 4 — DESIGN OF THE PROJECT

Hand Searches

Journals with relevant articles from the past fifteen years were hand searched for additional papers and references. These journals included Primary Care, Canadian Family Physician, Family Medicine, Nurse Practitioner, American Academy of Nurse Practitioners, Pharmacy, Annals of Long-Term Care, Pharmacy Practice Management, Quarterly Pharmacist, Geriatrics and Gerontology, Medical Care.

Grey Literature

Grey literature searches on the Internet used “Google” as the search engine with the above lists of phrases in quotations. Official government web sites, both federal and provincial, were searched for content including Health Canada, Statistics Canada, the Ontario Ministry of Health and Long-Term Care, and the Romanow Commission on the Future of Health Care in Canada. Professional association websites were also searched: Canadian Medical Association, Canadian College of Family Physicians, Ontario Medical Association, Ontario College of Family Physicians, College of Physicians and Surgeons of Ontario, Canadian Nurses Association, Registered Nurses Association of Ontario, Nurse Practitioners Association of Ontario, Canadian Pharmacists Association, Ontario College of Pharmacists, Ontario Long Term Care Association and the five Faculty of Health Sciences and Schools of Medicine in Ontario. Also explored was the website of the Canadian Association of Retired Persons.

INCLUSION CRITERIA

For an article to be included in the review, it must have been relevant to one of the three topic areas: recruitment and retention, collaborative service delivery, and collaborative curriculum, and published or made public in the past fifteen years.

COMMUNITY CONSULTATIONS

Community consultations were set up to gather the wisdom of those with experience long-term care and those who have knowledge of the three initiatives. To ensure broad participation, we used focus groups, teleconferences and key informant interviews.

Purposive samples of family physicians, nurse practitioners and pharmacists were drawn from lists of persons identified by the medical and nursing consultant or steering committee members.

Inclusion criteria were experience in long-term care—present or past. The list of participants is confidential in keeping with focus group methodology. Participant assignment to venue was dependent upon availability and self-assignment. The option of an interview was offered for further privacy.

Four regional focus groups were completed: two with physicians—one local and one northern, one with nurse practitioners and one with pharmacists. A provincial teleconference with nurse practitioners was done, and key information interviews conducted with family physicians and pharmacists.

In total 46 health professionals were consulted. (Table 4.2)



SECTION 4 — DESIGN OF THE PROJECT

TABLE 4.2 NUMBER AND TYPE OF COMMUNITY CONSULTATIONS

Profession	Type of Consultation	Number
Family Physicians	Regional Focus Group	9
	Key Informant Interviews	4
	Northern Ontario Focus Group	10
Nurse Practitioners	Regional Focus Group	8
	Provincial Teleconference	10
Pharmacists	Regional Focus Group ⁵	3
	Key Informant Interviews	2
	Total	46

A generic discussion guide was drawn up with six major questions and probes adapted for each group.⁶ (See Appendix 1, Generic Discussion Guide) The main questions were as follows:

- 1) What are the barriers to working in long-term care?
- 2) What factors attract (physicians, nurse practitioners, pharmacists) to work in long-term care?
- 3) What are the unique professional practice issues for (physicians, nurse practitioners, pharmacists) in long-term care?
- 4) What are the personal rewards of working in long-term care?
- 5) What ideas do you have to address recruitment in long-term care?
- 6) What retention strategies do you think would be effective for (physicians, nurse practitioners, pharmacists) in long-term care?

Approval for the community consultation process was received from McMaster University Research Ethics Board with signed consent of participants for audio recording the sessions, and potential publication of the confidential information. Working from transcriptions the emergent themes were identified by team members with comparative analysis of repeated themes within and amongst groups as a measure of the “validity” of the findings. Emergent themes were prioritised in terms of meaningfulness and relevance to the topic at hand.

STAKEHOLDER WORKSHOPS

Three all-day workshops were set up for each initiative: 1) recruitment and retention strategies, 2) collaborative service delivery and 3) collaborative curriculum. The process for setting up the workshops was identical, but the invitees, format and content were specific to the initiative. Names of potential participants were suggested by the medical and nursing consultant and brought to the Steering Committee members for their recommendations and additional suggestions. Criteria for participation in the workshop were experience in long-term care or expert knowledge of the initiative.⁷ Prior to the recruitment and retention workshop, participants were presented with a summary of the literature and findings from the community consultations.

⁵ The numbers here are low due to a snow storm

⁶ These can be found in full detail in Appendix 1: Generic Discussion Guide

⁷ Because the SARS restrictions forced cancellation of the first date, a second listing was established of participants who met the criteria and were available on the slated date. For a listing of participants for all three workshops, See Section 8: Network Development: Workshop Participants



SECTION 4 — DESIGN OF THE PROJECT

Recruitment and retention

The workshop on recruitment and retention strategies had four objectives:

1. To identify the barriers and incentives for physicians, nurse practitioners, and pharmacists to work in long-term care
2. To generate strategies for recruitment and retention of these professions
3. To prioritize recruitment and retention strategies
4. To identify the implementation issues of prioritized recruitment and retention strategies

Collaborative service delivery

The workshop on collaborative service delivery had three major objectives:

1. To identify the challenges and opportunities for collaborative practice in long-term care
2. To explore infrastructure factors that influence collaborative practice
3. To explore collaborative practice in terms of service delivery in long-term care

Collaborative curriculum

The collaborative curriculum workshop had four major objectives:

1. To describe the present long-term care curricula in family medicine, nurse practitioner and pharmacist programmes
2. To identify curricular content specific to long-term care (knowledge, skills and attitudes)
3. To identify the issues for an effective interdisciplinary collaborative curriculum in long-term care
4. To propose next steps for future training in long-term care for family medicine, nurse practitioner and pharmacist programmes, and to make recommendations

SURVEYS

Three Ontario surveys were done of curricula in family medicine residency programs, the nurse practitioner program, and the Faculty of Pharmacy University of Toronto to determine what, if any, long-term care content is currently offered.

Family Medicine Residency Programmes in Ontario

A one-page email survey the five family medicine residency programmes in Ontario was sent to program directors for completion with input from Care of the Elderly programme directors. The aim was to explore the amount of formal long-term care curriculum content in each residency program.

Ontario Nurse Practitioner Programmes

The program director of the Ontario nurse practitioner program was contacted about course content in long-term care. The nursing websites were also searched for content: CNO, COUPN, NPAO.

University of Toronto, Faculty of Pharmacy

Course coordinators for the Bachelor of Science in Pharmacy (BSc. Pharm) and Doctorate in Pharmacy (Pharm.D) curricula were canvassed. Course syllabi and required readings (when available) were reviewed to determine the learning objectives and opportunities created to expose students to issues relevant to providing care in a long-term care setting. (See Appendix 2: Pharmacy Survey)



LIMITATIONS OF METHODS

This project was undertaken to seek advice, better understanding and expert input about current human resources, collaborative service models and training curriculum challenges for long-term care. This process has enabled the collaborating partners to make informed recommendations to the MOHLTC about how to address these challenges in the long-term care sector. We believe that we have effectively achieved this goal. However there are some limitations.

Given the nature of the initiatives explored it is not surprising that little, if any, confirmatory research exists. The majority of the indexed papers are descriptive, non-comparable observational studies. The grey literature is even less rigorous.

This project was designed to look at the literature and to gather additional information from community consultations, workshops and surveys. Time and funding was limited. It was not designed to be a formal research study, but rather a consultative process to gather information to inform recommendations made to the MOHLTC. Thus the community consultations have limitations. To reach saturation or repetition of themes—a measure of validity of the findings—the ideal number of groups and key informant interviews would have been up to six for each discipline in a variety of locations. We conducted seven different types of consultations, and found repetition of the major themes between groups. However, the data does not allow fully for explorations of possible within or between group differences. The workshops were also limited in that we conducted only a single workshop in each topic area. But they are broadly based with provincial representation of all three professions.

EXTERNAL REVIEW OF THE DRAFT REPORT

Family physicians, nurse practitioners and pharmacists knowledgeable about long-term care, and individuals informed by the perspectives of professional associations and relevant organizations were identified by the project team and steering committee members and asked to undertake a review of the draft report. A guideline for the external review process was developed with questions about the accuracy, comprehensiveness and possible omissions. Reviewers were asked to identify the top three strategies in each initiative that they thought should become recommendations. Nineteen persons agreed to the review process, and completed this task within a short time period. Their input was meaningful and strengthened our report. (See Appendix 3 for a list of external reviewers)

STEERING COMMITTEE RECOMMENDATIONS

Working with a penultimate draft, the steering committee met for a morning's review of the document and strategies. Using a brainstorming technique, each listed major strategies. These were grouped under the three initiatives, and assigned to level of responsibility, local, regional and provincial. (See Appendix 4: Steering Committee recommendations)



SECTION 4 — DESIGN OF THE PROJECT

DEVELOPMENT OF THE RECOMMENDATIONS

Strategies and recommendations emerged from three sources, the literature review, community consultations and workshops. In the literature, conclusions to studies were often easily translated into strategies. In the community consultations, participants were asked for their recommendations. Others emerged as common themes amongst the groups. A final segment of each workshop was devoted to eliciting strategies and recommendations for implementation. Strategies from these three sources were grouped in terms of the initiatives, analysed for major themes and assigned to level of responsibility, local, regional and provincial. Finally, at a half-day Steering Committee meeting, the 12 recommendations listed in the executive summary, were abstracted from the strategies.

SECTION 5 — STRATEGIES FOR RECRUITMENT AND RETENTION

INTRODUCTION

Recruitment and retention of health care providers for long-term care residents is a challenge as there are many barriers and few incentives. To understand the depth and breadth of the issues, a literature review, community consultation, workshop and draft report review were undertaken. This section summarizes the findings on recruitment and retention.

OBJECTIVE

To prepare a strategy document for recruitment and retention of family physicians, nurse practitioners and pharmacists in long-term care.

DELIVERABLES

This section on strategies for recruitment and retention includes four deliverables:

1. A summary of the literature on strategies for recruitment and retention
2. Findings of the community consultations on barriers and incentives
3. Findings of the stakeholder workshop including barriers and incentives, and recruitment and retention
4. Local, regional and provincial strategies to recruit and retain long-term care providers

1. A SUMMARY OF THE LITERATURE ON RECRUITMENT AND RETENTION

There are limited rigorous academic studies on recruitment and retention in the workplace, so our literature review goes beyond these to explore the business literature, government reports, professional organization reports, and Internet recruitment sites. (For details on the search strategy, see Section 4: Design of the Project) There is almost no literature on recruitment in long-term care. However, the literature on strategies for recruitment and retention in family medicine for rural practice provides insights to the long-term care sector.

Recruitment Literature

The main recruitment models in the literature are affinity, attraction, economic-incentives, and collaborative comprehensive community strategies. (Table 5.1)

Affinity models

Affinity is defined as a natural attraction to a medical specialty arising from personal characteristics and experience. This perspective has led to selective admission policies of students who state an “intent to practice” as a generalist, in a rural or under-serviced setting. (1) (2) Affinity is correlated with early, personal exposure (3) or early, positive educational exposure with mentoring, (4) role modeling, (5) and practice-based training in the setting. (6) Retrospective studies show evidence of some success. Selective admission that does not lead to choosing the special practice area upon graduation has been attributed to “negative school effects,” including negative student attitudes (7) (8) and negative clinical experience. (1) (9) (10) When academic teaching centres control for negative attitudes against older persons by providing early positive exposure, and positive role modelling by supervisors, affinity to the area can emerge. (5)

SECTION 5 — STRATEGIES FOR RECRUITMENT AND RETENTION

A systematic review of educational factors associated with recruitment and retention of primary care physicians in rural areas was done by Brooks et al (2002). (11) A total of six studies were found that analyzed pre-medical school factors, 15 that considered medical school factors, and six that analyzed residency factors related to rural recruitment and retention. Pre-medical school factors, such as rural upbringing and specialty preference, were most strongly correlated with recruitment of physicians to rural areas. Training factors such as commitment to rural curricula and rotations, particularly during residency, were most strongly correlated with retention in rural areas.

Attraction strategies

Attraction strategies are methods to attract professionals. These include “perks,” “Magnet” worksites, return and re-entry strategies, continuing professional development and specialty training.

“Perks”

“Perks,” such as exotic environments, signing bonuses, tuition reimbursement, and relocation fees are shown to attract, (12) (13) (14) but strong evidence for retention is absent.

“Magnet” nursing homes

In the US, “Magnet” hospitals and “Magnet” nursing homes have reputations as “good places to work.” (15) (16) (17) The corporate emphasis is on healthy working environments with policies and systems that allow employees to achieve personal, professional and organizational goals. Observational evidence shows “Magnet” hospitals are able to recruit and retain despite labour shortages. They score higher in quality of care compared to other hospitals, and feature decentralized decision-making with all registered nurse staff, autonomy and empowerment, professional development, and supportive professional environments. “Magnet” nursing homes are a recent development.

Return and re-entry strategies

Return and re-entry strategies have been developed for mature professionals who, in workforce surveys have expressed an interest in long-term care.⁸ In the UK, 49% of 166 physicians surveyed, who are presently not working as principal physicians in general practice, said they would be interested in a re-entry course to become a principal, if one were available.(18) In Australia, re-entry programs for mature nurses have shown success. (19) Groups of nursing homes (in the US) that collaborate to form their own nursing agency to hire and share staff also show evidence of ability to recruit and retain staff. (20)

Continuing professional development and specialty training

Continuing professional development in the UK shows success in recruiting young and established family physicians to work in inner city practices.(5) Development of specialty training programs, such as Geriatric Centres of Excellence, and academic teaching centres in long-term care facilities to enable early exposure, positive mentoring and role modelling, show success in attracting health professionals to train and work in the area. (21) Specialty training that defines a career path is also important. The American programs in geriatric nursing, (22) and the specialty program for nursing home physicians in the Netherlands have shown remarkable success in recruitment and retention.(23)

⁸ An Ontario survey of Canadian nurses in the US found nurses willing to return, but accomplishing this requires a comprehensive collaborative strategy. (39)



SECTION 5 — STRATEGIES FOR RECRUITMENT AND RETENTION

Economic Incentives

Economic incentives, such as indenture, are a special type of attraction strategy based on the assumption that professionals work where it is economically advantageous to do so. (24) Indenture is a contract made by a community to pay for educational training in return for a commitment to work in a specific setting for a fixed period of time. The main examples are from rural medicine. While indenture may attract physicians, evidence for long-term retention is absent.(25) In rural medicine, the top incentives for family physicians that both attract and retain are mostly quality of work life issues: on-call payment, fee for service differentials, a locum service, four weeks holiday, equity of pay across health care sectors and student loan forgiveness. (25) (26)

Comprehensive Collaborative Programs

Comprehensive collaborative programs are based on the premise that recruitment strategies cannot be developed in isolation for full community support is necessary to recruit and retain health care providers. Most Canadian provinces have developed and funded recruitment and retention strategies for rural practice. Three provinces, New Brunswick,(27) Alberta (28)and Saskatchewan (29) report coordinated action plans at many levels—provincial, regional, and local with buy-in from government ministries of health and education, professional associations, universities and health care facilities. Recruitment officers are hired to address recruitment inside and outside the country. Programs are developed to provide educational support, promote increasing enrolments, locum pools to enable time-off with salaried positions, wage competitiveness, benefits, re-training, financing continuing education, leave programs and technology supports. (30) Only descriptive studies of these community efforts are available. (28) Central to these collaborative strategies is the recognition that recruitment is the first step to achieving a strong, stable workforce. Retention is more important.

TABLE 5.1: RECRUITMENT STRATEGIES FROM THE LITERATURE

Recruitment Strategies

1. Attracting and training students to the field
 - a. Early, positive exposure to the field
 - b. Positive mentoring and role modelling
 - c. Increasing number of student places
 2. Attracting mature professionals
 - a. From other locations through development of “Magnet” workplaces
 - b. Through re-entry programs
 3. Developing specialty programs in the field
 - a. Identifying a career path
 - b. Practice-based research to define standards
 4. Economic incentives
 - a. Assistance with educational costs
 5. Comprehensive, collaborative programs
 - a. Provincial, regional, local plans that include all the above
 - b. Paid staff to coordinate and develop program
 - c. Websites to promote
-



Retention Literature

A British physician workforce study argues that recruitment and retention issues need to be separated to develop reasonable policies. (31) Other literature argues that retention is more important than recruitment. (32) (19) Retention literature includes studies of human resources, institutional culture, and personality inventories. Job retention concepts address achievement needs, affiliation needs, power relations, and job satisfaction. Known retention strategies are outlined in Table 5.2.

Job Dissatisfaction and Job Satisfaction

Job dissatisfaction studies argue that negatively disposed staff, and those experiencing a series of “job shocks” are more likely to leave. (33) For example, when nurses feel they invest more in their organisation than they receive in return, they burn out, and leave. (34) In contrast, job satisfaction studies of nursing look at quality of work issues, such as respect, adequate staffing, acceptable salaries, support from physicians and administrators, helping others, and political action to address issues of under-supply of staff and resources. (34) (35) (36) Identified barriers to job satisfaction are heavy workload with multiple responsibilities, lack of educational materials and supplies, lack of space and lack of cooperation.(37)

Issues critical for retention of family physicians

A British survey found that out-of-hours commitment was ranked as the most important factor of retention for general practitioners, followed by difficulty in combining work with family commitments.(18)

Issues critical for retention of nurse practitioners

Issues critical for retention of nurse practitioners in the US are good working conditions with supportive work environments, being able to work within the scope of practice, good salary and benefits, recognition from residents, challenging work, authority to judge resident care, primary responsibility for long-term care residents, positive interactions with other nurses, having a career path, improving education and training opportunities for nurses and caregivers, and establishing a research program in aged care nursing. (38) (19)

TABLE 5.2: RETENTION STRATEGIES IN THE LITERATURE

Retention Strategies

- “Magnet” workplaces with quality work environments that enable professionals to do what they have chosen to do and are trained to do to the best of their ability
 - Optimal patient/provider ratios
 - Permanent positions
 - Acceptable salaries and benefits
 - Career paths and professional support
-



2. FINDINGS OF THE COMMUNITY CONSULTATIONS ON BARRIERS AND INCENTIVES TO RECRUITMENT AND RETENTION. (FOCUS GROUPS, KEY INFORMANT INTERVIEWS AND TELECONFERENCES)

Barriers

In the community consultations, the main barriers to working in long-term care facilities were identified as lack of defined career paths, poor remuneration, lack of understanding of roles by others in the profession, low status and prestige, and heavy work loads. All three professions cited de-skilling of allied staff, at the same time as the complexity and acuity of patients is rising is a major barrier. De-skilling—hiring unskilled persons to perform duties that were formerly done by licensed practical nurses—is cited as a significant barrier to both recruitment and retention.

For physicians, lack of coverage by call groups was a major barrier.

Barriers specific to nurse practitioners are lack of equipment and resources, and lack of physician understanding of collaborative practice.

Pharmacists cited long-term care facilities as an ideal work setting, but reported feeling professionally isolated, as did nurse practitioners.

Incentives

“Passion for working with the elderly” is given as the main incentive to working in this sector. Long-term care is described as professionally challenging and rewarding in a number of areas: the opportunity to develop relationships with long-term care residents, chance to provide better continuity of care, and the focus on wellness and empowerment. All three professions cited the unique environment of long-term care that allows for greater reliance on clinical skills. Collaborative practice—the opportunity to work with other professionals in a relationship of equality—was seen by all three professions as a prime incentive to work in long-term care.

All three professions expressed the importance of establishing academic teaching units in long-term care with mandatory student rotations. This is seen as a way to develop the “passion” for long-term care. Professionals also called for an examination of roles within collaborative practice, to promote research to establish evidence-based best-practice guidelines for the sector and to explore parity with the acute care sector in terms of wages and working conditions. Importantly, they called for integration of long-term care with acute care. These actions, they stated, would be major incentives to recruitment and retention of health professionals in long-term care.

3. STAKEHOLDERS WORKSHOP ON RECRUITMENT AND RETENTION

Key Findings

Workshop participants identified the prime incentive for working in long-term care as “a passion for eldercare.” The main barriers are the negative value and image of this sector, the lack of educational preparation, and low levels of funding and remuneration. They recommended additional preparatory education and training for professionals to work in long-term care. This should include education on collaborative practice. They proposed a greater consumer focus, leadership from decision-makers, and a powerful lobby forum to improve the financing of long-term care and to raise the profile of this sector.



SECTION 5 — STRATEGIES FOR RECRUITMENT AND RETENTION

The most often mentioned strategy for recruitment and retention at the workshop is the development of academic teaching units in long-term care combined with practice-based research to establish best-practice guidelines. Other strategies for recruitment and retention include “re-visioning long-term care” to generate a climate of excitement, integration of long-term care with acute care to create a seamless system, and strengthening collaborative practice.

They recommended multiple career entry points and career paths in long-term care, staff development programs, enhancing the skills of front-line staff, and providing permanent positions to ensure continuity of care.

The major implementation strategy recommended by workshop participants is 1) integration of long-term care with educational institutions to bring “new blood” into the sector through the development of academic teaching units, and 2) integration with the acute care system.

SUMMARY OF RECRUITMENT AND RETENTION STRATEGIES FROM THE WORKSHOP

Table 5.3 is a summary of the recruitment and retention strategies from the workshop.

TABLE 5.3 WORKSHOP SUMMARY: BARRIERS AND INCENTIVES TO RECRUITMENT AND RETENTION IN LONG-TERM CARE FACILITIES

Barriers	Incentives
<ul style="list-style-type: none"> ■ lack of defined career paths ■ poor remuneration ■ lack of understanding of roles by others in the profession ■ low status and prestige ■ heavy work loads ■ lack of coverage by call groups ■ lack of equipment and resources ■ lack of physician understanding of collaborative practice ■ professional isolation ■ de-skilling of allied staff at the same time the complexity of care, and acuity of patients is rising 	<ul style="list-style-type: none"> ■ desire to work with elderly ■ professionally challenging ■ professionally rewarding ■ relationship with long-term care residents ■ continuity of care ■ focus on wellness and empowerment ■ unique environment ■ greater reliance on clinical skills ■ collaborative practice—the opportunity to work with other professionals in a relationship of equality ■ multiple points of entry ■ training programs for long-term care ■ integration of long-term care with acute care system

4. SUMMARY OF LOCAL, REGIONAL, PROVINCIAL STRATEGIES FOR RECRUITMENT AND RETENTION

The following summary, Table 5.4 on Local, Regional, Provincial Strategies for Recruitment and Retention is derived from the literature review, the community consultation, the workshop and the external review process.



SECTION 5 — STRATEGIES FOR RECRUITMENT AND RETENTION

TABLE 5.4 LOCAL, REGIONAL, PROVINCIAL STRATEGIES FOR RECRUITMENT AND RETENTION

Stakeholder	Strategies
University & Colleges	Set up Academic Training Units in long-term care <ul style="list-style-type: none"> ■ Develop long-term care curriculum ■ Develop continuing education programs ■ Set up collaborative interdisciplinary education programs ■ Define and develop training in collaborative practice ■ Provide students with early, positive exposure to long-term care ■ Set up positive mentoring and role modeling ■ Establish multiple career entry points for long-term care ■ Set up return & re-entry programs ■ Promote research to develop standards of care
Best Practices	Develop and implement standards of practice Develop evidence-based standards for admission Develop evidence-based care maps for management of common problems Obtain information technology for record keeping and monitoring patient care and therapeutics
Long-Term Care Facilities	Develop “Magnet Nursing Home” standards & make them the goal Provide staff development programs Provide permanent positions with benefits that are wage competitive Support re-training and continuing education Set up nursing agencies for long-term care Set up information technology for sector
Local	Set up network and database of long-term care medical directors Set up network and database of long-term care administrators Set up local committee on recruitment and retention Develop On-call system Establish physician locum pools Work with regional and provincial counterparts to develop a recruitment website Identify candidates for return & re-entry Integrate long-term care into the acute care sector
Regional	Fund and hire development officer to coordinate actions at all levels <ul style="list-style-type: none"> ■ Establish physician locum pools to enable time-off ■ Integrate long-term care into the health sector ■ Set up networks of providers and administrators ■ Set up Information technology for sector Fund and hire recruitment officers
Provincial	Fund development officers to coordinate activities Fund academic teaching units in long-term care Increase funding for nurse practitioners in long-term care Increase student enrolment with financial incentives for long-term care Fund information technology in sector Fund research in long-term care Address funding of health care in long-term care to ensure access and provision matches other sectors Address remuneration of providers



INTRODUCTION

Provision of health care in long-term care facilities presents many challenges. In this section, we explore the potential models of *collaborative practice* and collaborative service delivery. We define collaborative practice as teams comprised of family physicians, nurse practitioners and pharmacists working together to provide patient care within long-term care facilities. We define *collaborative service delivery* as the system framework in which care providers, facilities and institutions cooperate to provide clinical care across geographic areas. Our consideration is collaboration within and between disciplines to provide accessible and comprehensive care, and continuity of care.

The changing practice patterns of family physicians in long-term care, and the introduction of nurse practitioners to this sector bring unique challenges to service delivery. Working together may allow new patterns to emerge that could begin to ameliorate present deficiencies. The addition of clinical consultant pharmacists in the design and delivery of care will enhance the model. Allied health professionals such as registered nurses, health care assistants, geriatricians, psychiatrists, social workers, dietitians, laboratory technologists, occupational therapists, physiotherapists, and chaplains could potentially join the collaborative team to further enhance service delivery.

OBJECTIVE

To design a collaborative service delivery model for family physicians, nurse practitioners and pharmacists in long-term care

DELIVERABLES

This collaborative service delivery section has three deliverables:

1. A summary of the literature on collaborative practice identifying factors that enable, sustain, enhance and inhibit teamwork, and a description of disciplinary scope, core competencies and overlaps of practice. As well, a summary of the literature on the core elements of collaborative service delivery models
2. Key findings of the stakeholder workshop, and strategies for collaborative practice implementation
3. Local, regional and provincial key strategies promote collaborative interdisciplinary practice

1. A SUMMARY OF THE LITERATURE ON COLLABORATIVE PRACTICE

The literature review explored factors that enable, sustain, enhance and inhibit collaborative practice; descriptions of disciplinary scope; core competencies and overlaps in practice; and core elements of collaborative service delivery models.

Primary Care Renewal and Interdisciplinary Teams

In 2000 in Canada, the College of Family Physicians of Canada (CFPC) proposed a renewed model of primary care practice networks where family physicians, nurse practitioners, nurses, midwives and allied health professionals work together in interdisciplinary integrated teams.⁽¹⁾ While supporting collaborative practice in principle, they cautioned against adopting a single model. They argue that each individual professional in the collaborative team needs to work at making it function competently. The American 1998 Pew Health



SECTION 6 — COLLABORATIVE SERVICE DELIVERY

Professions Commission Report, *Creating Health Professional Practice for a New Century*, refers to this as interdisciplinary competence, and calls for awareness of the core competencies that help to promote interdisciplinary competence in all health professions.(2) Collaborative practice is defined as integrated care to clients through shared goal setting, shared decision-making and mutual respect. (3)

Factors That Enable, Sustain And Enhance Collaborative Practice

From a review of the literature supported by focus groups findings, University of Ottawa researchers, Way, Jones, et al (2003), identified seven essential elements of structured collaborative practice between family physicians and nurses: (4)

1. Responsibility and accountability— independent and shared
2. Co-ordination following from joint decision-making to ensure right provider and right time
3. Communication with information presented in a manner that is relevant, concise, and timely
4. Co-operation—acknowledging and respecting other disciplines' professional opinions
5. Assertiveness—support perspectives of their own profession with confidence, and assured of the value of one's own contribution
6. Autonomy— independent decision-making based on professional standards
7. Mutual trust and respect—attitudes that bind together the previous elements in unique and synergetic actions

In long-term care in the US, Ryan (1999) offers the following strategies (Table 6.1) for team-building to establish collaborative practice, and strategies to nurture collaborative practice. (5)

TABLE 6.1 STRATEGIES TO ESTABLISH AND NURTURE COLLABORATIVE PRACTICE

Strategies for *Team-Building* to Establish Collaborative Practice

- Learn about each other's philosophy of care, communication style, behaviour under stress, areas of strength, and areas where support will be needed
- Discuss the scope of practice of the nurse practitioner and how it will be implemented
- Establish mechanisms that enable urgent and routine communication with each other.

Strategies to *Nurture* Collaborative Practice in Long-term Care

- Discuss positive and negative clinical outcomes so that future decisions are based on common understandings about what has happened
 - Remain faithful to the designated time for sharing clinical data. The amount of time needed may decrease, but do not let increased comfort and familiarity with each other reduce communication.
 - Do not assume allied health care workers and other clinicians are familiar with how collaboration works or what a nurse practitioner does. Hold discussions with staff on working with the nurse practitioner, on expected value to clinical care and outcomes.
 - Keep reading and learning. Stay current and share new approaches and ideas with each other.
-

Factors that Inhibit Collaborative Practice

Lack of understanding and training in collaborative practice

Ryan (1999) explains that few physicians and nurse practitioners are trained to be competent in collaborative practice.(5) Thus, confusions may arise about the meaning of autonomy and the equating it with independence instead of interdependence. The difference between the two is significant. For this reason, nurse practitioners who expect to be independent in managing the health care of the frail elderly are not the best candidates for teamwork in long-term care. Neither are nurse practitioners that prefer dependent relationships with physicians. The same holds true for physicians who have philosophical and professional biases against collaboration with nurse practitioners.(6)

Remuneration

Ryan argues that in the US, the fee-for-service system of physician remuneration does not support collaborative practice. It does not remunerate physicians for team-building or team nurturing. And it creates competition for patients.(5)

In Ontario, there are three different systems for paying family physicians, nurse practitioners and pharmacists that were identified in the community consultations and workshops as a barrier to collaborative service delivery.

Physicians

Historically, there have been few incentives for family physicians to work in long-term care. Present physician remuneration does not reflect the changing demands of increasingly complex care. Issues identified are the limits on the number of physician visits each month, and fee-for-service billings that do not account for mileage, parking or on-call time. Neither does the present remuneration model fit the requirements of the work, which by nature is preventive, relational (family meetings and telephone consultations) and episodic. Similarly, it does not support collaborative team activity, as it does not remunerate physicians for nurse practitioner consultations, care-planning meetings or time to enable sustain and enhance collaborative practice. Nor does it support meetings with pharmacists. The Ontario Long-Term Care Physicians Association (OLTCPA) has proposed a new comprehensive funding model to the MOHLTC. (9)

In the UK, a pilot study to improve recruitment and retention of physicians found salaried contracts were an incentive to practice in under serviced areas. (8)

Nurse Practitioners

The 1999 MOHLTC pilot project provided nurse practitioners with limited contract salaries. As a recruitment strategy, the additional 2003 pilot projects have been funded with a higher salary range, but the disparity presents a retention challenge for the earlier pilots.

Pharmacists

Pharmacists are hired by pharmacies with long-term care facility contracts, and paid from the dispensing fee from the Ontario Drug Benefits Program. The fee does not cover all expenses for clinical consultant pharmacists. The American model provides separate coverage for medications and consulting.(10)

SUMMARY OF FACTORS THAT INHIBIT COLLABORATIVE PRACTICE

Table 6.2 summarizes the factors that inhibit collaborative practice

TABLE 6.2 FACTORS THAT INHIBIT COLLABORATIVE PRACTICE

Factors that inhibit collaborative practice (7)

- Lack of knowledge of collaboration
 - Lack of experience with collaboration
 - Differing philosophies of collaboration
 - Lack of choice of work settings
 - Problems of clinical competence
 - Issues in scope of practice
 - Differing systems of remuneration
-

Disciplinary Scope of Practice, Core Competencies and Overlaps of Practice

A collaborative service model builds on the strengths of each discipline. Discipline scopes of practice have undergone changes in the last decade in Ontario, and have been the subject of debate between professional organizations. New professional specialities, extended class nurses and Doctors of Pharmacy, have emerged and new models of collaboration are being explored.

Scope of Practice and Core Competencies

Physicians and Pharmacists

In a joint statement in 1996, The Canadian Medical Association (CMA) and the Canadian Pharmaceutical Association (CPA) addressed the scope of practice of pharmacists and core competencies that interface with physicians.(11) Physician scope of practice and key competencies are outlined in a report of the Royal College of Physicians and Surgeons of Canada, and are broadly defined as medical expert, communicator, collaborator, manager health advocate scholar and professional. (12)

In existing collaborative models in Ontario, the physician selects the appropriate therapy and duration while the pharmacist manages the drug therapy according to protocols outlining the responsibilities of the pharmacist (including patient and family education), the parameters of patient monitoring, and drug therapy modifications. (13) Pharmacists also conduct individual patient assessments and provide recommendations to physicians on how to optimize drug therapy.

Nurses and Physicians

In Ontario the nurse practitioner role is evolving. Nurses note that their professional boundaries are defined functionally, philosophically and politically. Together, nursing and medical associations have developed standards and guidelines for the delegation of medical acts. Although some members argue it should be possible to determine whether a function is a nursing or a medical act, definitions of scope of practice are shared, so delineation is difficult. (14)

Overlaps in Scope of Practice

Physician and Nurse Practitioner

Attitudes to the relationship between physicians and nurse practitioners have been addressed in a national study of the extended/expanded role of nurses in Canada. (15) On the positive side, physicians note that the introduction of nurse practitioners has the potential for increased accessibility to health care services. Nurses express concern about having necessary supports in place to ensure full-implementation and acceptance of their role. They identify barriers in service delivery relevant to long-term care. These are 1) decreased ability to provide comprehensive health care services due to skill/knowledge limitations, 2) decreased effectiveness due to restrictions imposed on scope of practice (e.g., prescriptive authority, ease of access to referrals and diagnostic services), 3) delayed acceptance of roles due to lack of public/professional awareness; 4) restricted opportunities for nurses due to the heavy reliance on a fee-for-service system, and the absence of alternative funding mechanisms, 5) role strain and delayed confidence-building due to unsupportive physicians, and 6) resistance from physicians, especially those compensated by fee-for-service.

Physicians identified their barriers to acceptance of nurse practitioners as arising from the negative impact on their fee-for-service income, restricted prescriptive authority of nurses, absence of relationships to speciality physicians for referral and the potential for continuity of care problems when ordering diagnostic tests independent of physicians, inadequate nurse supervision with possible poorer quality of care to patients, and responsibility and liability concerns for attending physicians when nurses see patients independently.

Family Physician and Pharmacist

There is literature on the potential for collaborative relationships between physicians and pharmacists in the expanded role of clinical consulting (16) (17) working models (18) randomized controlled trials with elderly patients, (19) (20) (21) (22) (23) (24) (25) (26) (27) and a Cochrane systematic review of the expanded role of pharmacists. (28) Generally, these studies report that clinical pharmacists providing medication reviews or pharmaceutical care reduce inappropriate prescribing and possible adverse drug effects and improve healthcare resource utilization without adversely affecting health-related quality of life. (22) Further, that physicians are receptive to recommendations to resolve drug-related problems. (21)

Nurse Practitioner and Pharmacist

There is scant literature on the relationship between nurse practitioners and pharmacists. In the US, pharmacists are supportive of prescriptive authority of nurses, but they claim to lack information about the legal ramifications of nurse prescribing. (29) Identified barriers are restrictive state provisions governing the scope of practice and prescriptive authority. (30) In Britain, pharmacists questioned the educational preparation of nurse prescribers, and recommended they work with pharmacists in a collaborative practice relationship. (31) The American Society of Consultant Pharmacists (ASCP) supports collaborative practice agreements between pharmacists and those who prescribe, (32) and the Ontario College of Pharmacists recognizes the prescriptive authority of the nurse practitioner for a predefined list of medications.



SECTION 6 — COLLABORATIVE SERVICE DELIVERY

ELEMENTS OF COLLABORATIVE SERVICE DELIVERY MODELS

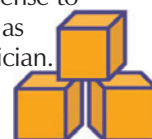
The literature describes core elements of collaborative service delivery and some theoretical and practical models, but cautions that there is not one established ideal model for family physicians and nurse practitioners in long-term care.⁹ This is because collaborative service delivery models are dependent upon the specific client population and the services required. (4) What needs to be done, who does what, who has power to do it, who prefers doing it, what the patient wants, who is available, who will lead, and who will provide support are important questions. (33) Table 6.3 lists core elements of collaborative service delivery described in the literature.

TABLE 6.3 CORE ELEMENTS OF COLLABORATIVE SERVICE DELIVERY MODELS

Elements	Description
Accountability	Define system of accountability (34) (35)
Administration	Determine and clarify administrative roles of collaborative professionals (33)
Agreements	A collaborative practice agreement is a voluntary, written agreement between a pharmacist and those who prescribe that permits expanded authority for the pharmacist and may include protocols, practice guidelines, care plans and formulary systems (32)
Care delivery process	Determine optimal care ratios, standards of care, accountability and quality improvement activities (35) (36)
Communication	Establish system of regular communication with allied professionals, eg, interdisciplinary rounds (37) (38) (39) for patients & families and emergency contact (35)
Clinical guidelines	Develop clinical guidelines, protocols, interdisciplinary standards, evidenced-based practice and clinical outcomes continuously monitored across all sectors of care (36)
Clinical governance	Adopt quality improvement system with clear lines of accountability for clinical quality systems and effective processes for identifying and managing risk and addressing performance of team members (40)
Client roles	Determine model of client-provider interaction (41)
Conflict resolution	Methods for conflict resolution (41)
Credentialing ¹⁰	Establish a system of credentialing, qualification and license to practice (42)
Decision-making	Define decision-making process: (5) expectations, member contribution, executive roles or consensus format and task variations dependent upon scope of practice and problem at hand (41)

⁹ There is one report of an American managed care demonstration project with nurse practitioners (NPs) in six “nursing home” sites. (53) All six sites have the same corporate model of care. A cluster of 10 NPs has a supervisor or clinical leader. Each site office has a clinical supervisor nurse responsible for all clinical activities and a part-time medical director (20-50% of time) who provides consultation, deals with contracted attending physicians, and helps to set policy. Case managers authorize non-medical services (eg physiotherapy, etc). Case managers work closely with NPs to determine if medical services are warranted. NPs provide an oversight to care of each patient, and the amount of autonomy arises from policy and decisions made with the most responsible physician. NPs responsible for one to two nursing homes, visit several times a week. They notify the attending physician when there is a change in status. NPs are in the homes frequently enough to establish relationships with the staff and patients. They provide formal and informal training to staff. Some NPs take night calls.

¹⁰ *Credentialing.* In Ontario, there is tremendous variability in the way long-term care facilities handle credentialing. Many long-term care facilities integrate their physician credentialing process with that of the local hospitals. Physicians with a license to practice medicine are asked to provide proof of hospital privileges, which is accepted by the long-term care facilities as basic qualification to work within the facility. A signed “letter of agreement” outlines service expectations of the physician. Some locations use the hospital credentialing system described above, while some have their own unique, independent process. There are a growing number of long-term care facilities that do not have any formal



SECTION 6 — COLLABORATIVE SERVICE DELIVERY

Elements	Description
Documentation & medical records	Establish system documentation, determine where it resides, who is responsible for it and “ownership” of medical record (43) (42)
Equipment	Determine what is needed, accessibility, quality, and maintenance (35)
External response system	Develop response system to external demands, such as labour relations, legislative and regulatory systems (35)
Focus of efforts	Consensus on types and amount of intervention appropriate (41)
Information access, support & resources	Develop system of information access, support & resources—these are predictive of degree of job strain and indicator of retention (44)
Information technology ¹¹	Establish information technology infrastructure, integrate with the workflow (42)
Knowledge of collaborative practice	Establish training for collaboration & awareness of the scope of practice of other disciplines (5)
Leadership	Define participation in decision-making, power, management style (35) (45)
Legal, regulatory roles	Clarify legal, regulatory and administrative roles of collaborative professionals (33)
Liabilities	Resolve malpractice insurance issues for disciplines (43)
Management style	Develop consensus on management styles (35)
Model for team function	Establish set of beliefs about collaborative practice (46)
On-call	Establish agreement on on-call system and back-up (43)
Organizational supports	Create mission, vision and philosophy of the organization plus standards that govern professional practice and accountability (35)
Practice-based research	Establish practice-based research to determine interdisciplinary standards of practice (46) (47) (48) (49)
Replacement	Establish system for members to enter team, leave or change responsibilities (5)
Roles and responsibilities	Define roles and responsibilities (43) (41)
Prescriptive authority	Establish system of consultation for new prescriptions (50) and interdisciplinary medication reviews (51)
Performance management	Develop performance management criteria (35)
Professional development	Develop orientation program for new members, preceptorship, mentorship, continuing education activities, promote a learning environment and performance management (35)
Referrals to specialists	Address system of referral to specialists (43)
Structure of relationship	Develop consensus on structure and process. Is it collaboration or consultation? Request or a referral? (33) (52) (34) (43) Define process, types, guidelines. (34) (43) Set up system and evaluate
Team meetings	Develop consensus on timing, frequency, length and agenda (41)
Timelines for response	Determine response timelines for acute and chronic problems (41)

¹⁰ credentialing process. It is believed this is because of the difficulties finding physicians to work within long-term care. In these settings, if a physician, with a license to practice medicine in Ontario expresses an interest in working in a long-term care facility, the offer will be accepted. (42)

¹¹ A McMaster University team developed an Evidence-based Assessment Record for delivering best-practice guidelines to clinicians in this field, but implementation is not yet possible due to lack of common information technology infrastructure in the long-term care sector. (42)



2. KEY FINDINGS OF THE STAKEHOLDER WORKSHOP AND STRATEGIES FOR COLLABORATIVE PRACTICE IMPLEMENTATION

The primary findings for this section of the report are based on the stakeholder workshop combined with the community consultations. In the focus groups, teleconferences, and key informant interviews, participants also spoke to issues of collaborative practice. For details on the design see Section 4, Design of the Project.

The workshop on collaborative service delivery had three major objectives:

1. To identify the challenges and opportunities for collaborative practice in long-term care
2. To explore infrastructure factors that influence collaborative practice
3. To explore collaborative practice in terms of service delivery in long-term care

Key Findings of the Workshop

Collaborative Service Delivery

There is consensus among the physicians, nurse practitioners and pharmacists that working together in a collaborative service delivery model (within and between professions) is the vision for long-term care. They advise it should include other health providers whose numbers and skill-levels need to be increased to meet the needs of long-term care residents—increased acuity and complexity of care.

Needs-based Model

It was agreed that the structure of collaborative practice is dependent upon specific population health needs.

Education about Collaborative Team Service

Workshop participants recognize that collaborative service delivery will not just happen. It needs to be created through collaborative practice education and team-building. The latter may result from practice, but it needs to be resourced and structured with regular meetings and with reference to the skills, competencies and interests of the team members.

Funding

The funding system and remuneration of independent practitioners in the long-term care sector need to be reformed, as the present remuneration system inhibits rather than facilitates collaborative service delivery.

Best Practice

Professional practice issues that need to be addressed to achieve best practice standards:

- recognition that medical management in acute care differs from long-term care
- recognition that long-term care includes end of life care
- there must be clarification of new professional developments for all team members
- it is imperative to establish evidence-based standards of practice through practice-based research in long-term care.

Governance

Repeatedly in community consultations and workshops, participants called for integration of the long-term care sector with acute care. This is needed at a number of levels. Networks of administrators and care providers must be established at the local and regional levels. Partnering must occur between long-term care facilities and edu-

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cational institutions to recognize long-term care as a special needs area for training of health care providers. New systems need to be established to integrate the long-term care and acute care sector, such as information technology and referral systems for consultations.

STRATEGIES FOR IMPLEMENTATION OF COLLABORATIVE SERVICE DELIVERY MODELS

In the workshop, strategies for implementation of collaborative service delivery models were defined. See Table 6.4 Strategies for Implementation of Collaborative Service Delivery Models

TABLE 6.4 STRATEGIES FOR IMPLEMENTATION OF COLLABORATIVE SERVICE DELIVERY MODELS

Strategies	Implementation
Renewed Vision	<ul style="list-style-type: none"> ■ Recognise existing resources and capitalize on them by building strengths into the system ■ Recognise unique qualities of long-term care and the passion of caring for the elderly ■ Create a renewed vision for long-term care ■ Identify all stakeholder needs, desires and vision to promote “life care” in long-term care ■ Recognise that buy-in of long-term care administrations is essential for collaborative practice to succeed
Education	<ul style="list-style-type: none"> ■ Establish academic teaching units in long-term care facilities that provide a systematic approach to training and professional development ■ Create links with all educational institutions and investigate how to incorporate a long-term care component in their training programs ■ Identify mentors and role models, passionate about long-term care to teach and train ■ Create training models for collaborative competence ■ Provide dedicated space for learners
Work Setting	<ul style="list-style-type: none"> ■ Provide workable environment with trained, permanent allied staff ■ Provide clinical support in form of geriatric consultation teams ■ Provide administrative leadership and support to build an understanding of the nurse practitioner role ■ Create appropriate, supportive environment for collaborative practice ■ Provide dedicated space for team activity ■ Provide dedicated time for family physicians, nurse practitioners, nurses and pharmacists to meet
Best Practices/ Standards of Care	<ul style="list-style-type: none"> ■ Determine optimal care ratios ■ Create evidence-based standards of care ■ Create evidence-based standards of collaborative practice ■ Establish practice-based research ■ Develop quality of care indicators for collaborative practice teams ■ Collaboratively develop long-term care protocols ■ Develop advanced care directives appropriate to long-term care ■ Develop collaborative practice teams to share responsibility for care, not to off-load problems
Evaluation	<ul style="list-style-type: none"> ■ Develop quality indicators for evaluation of collaborative practice ■ Develop quality indicators for evaluation of quality of care



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Strategies	Implementation
Communications & Networks	<ul style="list-style-type: none"> ■ Bring information technology into long-term care to support collaborative practice ■ Promote discipline-specific networks for support and professional development
24/7 Care	<ul style="list-style-type: none"> ■ Set up after-hours on-call network of physicians experienced in long-term care with call levels to support nurse practitioners taking call when issues beyond scope of practice ■ Provide attractive remuneration package for 24/7 coverage ■ Address liability issue and inadequacy of insurance for nurse practitioners should be similar to physician coverage ■ Establish professional consultant support systems and improved access to diagnostics, such as X-rays and laboratory tests
Funding	<ul style="list-style-type: none"> ■ Change funding model for long-term care—it requires a paradigm shift for pharmacy from dispensing fee salaries to funding for clinical consulting ■ For physicians the present transactional model of fee-for-service should be changed to maintenance remuneration to support relational life care ■ Medical Director remuneration should be competitive ■ Nurse practitioner salaries should be competitive ■ All three disciplines need funding and protected time for collaborative practice team building and support for a collaborative service delivery model

3. LOCAL, REGIONAL AND PROVINCIAL KEY STRATEGIES FOR COLLABORATIVE INTERDISCIPLINARY PRACTICE

The literature and workshop are the sources for Table 6.5 that summarizes local, regional and provincial strategies to promote collaborative interdisciplinary practice.

TABLE 6.5 LOCAL, REGIONAL AND PROVINCIAL KEY STRATEGIES TO PROMOTE COLLABORATIVE INTERDISCIPLINARY PRACTICE

Stakeholder	Strategies
University & Colleges	<ul style="list-style-type: none"> Set up Academic Training Units in long-term care ■ Develop long-term care curricula ■ Develop continuing education programs ■ Set up collaborative interdisciplinary education programs ■ Define and develop training in collaborative practice ■ Provide students with early, positive exposure to long-term ■ Set up positive mentoring and role modeling ■ Establish multiple career entry points for long-term care ■ Promote research to develop standards of care & best-practice



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Stakeholder	Strategies
Professions	<p>Set up and support long-term care continuing education programs</p> <ul style="list-style-type: none"> ■ For family physicians, nurse practitioners and pharmacists <p><i>Nurse practitioners</i></p> <ul style="list-style-type: none"> ■ Examine scope of practice in relation to needs of long-term care ■ Determine needs for on-call system and support network <p><i>Pharmacists</i></p> <ul style="list-style-type: none"> ■ Examine scope of practice in relation to the needs of long-term care facilities ■ Establish credentialing for long-term care pharmacy
Long-Term Care Administrators	<p>Work towards “Magnet” Nursing Home standards</p> <ul style="list-style-type: none"> ■ Set up information technology for sector ■ Negotiate access to timely diagnostic tests
Local	<ul style="list-style-type: none"> ■ Set up network of family physicians working in long-term care ■ Develop on-call system ■ Establish physician locum pools of those with experience in sector ■ Negotiate with consultants to establish system of referrals for physicians and nurse practitioners ■ Set up integrated information technology to enable use of web-based assessment and record-keeping
Regional	<ul style="list-style-type: none"> ■ Set up networks of providers and administrators ■ Set up information technology for sector
Provincial	<ul style="list-style-type: none"> ■ Fund academic teaching units in long-term care ■ Increase funding for nurse practitioners in long-term care ■ Increase enrolment with financial incentives for long-term care ■ Fund information technology in sector ■ Fund research in long-term care ■ Address funding of primary care in long-term care to ensure access and provision matches other sectors ■ Address remuneration of providers in terms of type and amount



INTRODUCTION

Long-term care requires an interdisciplinary and collaborative approach to the provision of health care. In light of this, and the need for training in collaborative service delivery, this project examined curriculum development for long-term care. Our focus is on interdisciplinary education using collaborative curricula under the direction of an academic teaching unit. It is held that learning in a collaborative environment will lead to more effective team relationships in clinical practice.

OBJECTIVE

To develop a collaborative curriculum for interdisciplinary training in long-term care for family medicine residents, nurse practitioners and pharmacists.

DELIVERABLES

1. A summary of the literature on collaborative curricula including requirements and challenges facing collaborative curriculum planning, and descriptions of collaborative curricula models and academic teaching units
2. A review of curricula in Ontario—survey findings
3. Key findings of the stakeholder workshop on collaborative curriculum in long-term care
4. Local, regional and provincial key strategies for implementation

1. A SUMMARY OF THE LITERATURE ON COLLABORATIVE CURRICULA

Introduction

Thirty years ago, the World Health Organization (WHO) initiated a worldwide movement in interprofessional education¹² stating that it would improve job satisfaction, encourage a holistic response to patient needs, (1) and improve patient outcomes. (2) (3) They argue that learning together using collaborative curricula will increase trust levels among the disciplines, (2) (4) will develop interdisciplinary competence in the health professions, (5) and will enable the implementation of interdisciplinary collaborative practice.

Interprofessional education with collaborative curricula is being introduced in medicine, dentistry, physiotherapy, occupational therapy, (6) nursing, pharmacy, (7) social work, (8) psychology (9), and public health (10) in Australia, the UK, (1) (11) the US, (8) (9) (10) (12) (13) and Canada. (14)

Readiness is an issue. In England, (6) and New Zealand (7) studies report students recognize the need to share knowledge and skills to understand clinical problems and service delivery. This is especially true for the multi-faceted health problems of the elderly which require coordinated, interdisciplinary care (9) (15) and clinicians who need interdisciplinary team training. (16)

Requirements for Interdisciplinary Education and Collaborative Practice

Six requirements for interdisciplinary education and collaborative practice are identified as follows:

1. Mutual understanding (17)
2. Knowledge and understanding of future roles/responsibilities of other health professionals in various settings (18)

¹² A multiplicity of terms is used to describe collaborative curricula. (40) (41) (42) These include the following: interdisciplinary, (42) (43) (41) (12) (44) (17) (9) intradisciplinary, multidisciplinary, (12) (17) (44) (9) transdisciplinary, (17) (44) interprofessional, (7) (11) and service learning. (9) (18)



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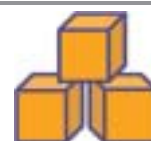
3. Respecting the roles of different disciplines, learning to work as a team member, and developing an understanding of collaboration, accountability and responsibility (18)
4. Training faculty in interdisciplinary education (18)
5. Experiencing interdisciplinary learning, and (18)
6. Networking to further knowledge and understanding. (18)

Challenges in Collaborative Education for Care of the Elderly

There is a shortage of qualified practitioners in geriatrics to work in interdisciplinary teams that has led to the use of interdisciplinary/collaborative teams without specific interdisciplinary education. (19) Table 7.1 identifies challenges in the development of collaborative curricula.

TABLE 7.1 CHALLENGES IN THE DEVELOPMENT OF COLLABORATIVE CURRICULA

Challenges	Issue
Institutional support	Institutional support is essential (20) (21)
Funding and reimbursement	In the US, the Medicare program provides no incentives for interdisciplinary education, and restricts reimbursement for community based training to medical residents (22)
Faculty	Faculty need to be trained in interdisciplinary education, particularly interdisciplinary service learning (20) (23) (21)
Recruitment & retention of students & faculty	Need faculty, but also need students willing to study in an interdisciplinary model directed towards collaborative practice (24) (25)
Readiness of students for interdisciplinary education	Lack of readiness of students may lie with professional role perceptions and traditional status differences (26) (27) (28)
Timing during educational program	Should interdisciplinary training be early in program or later when students are secure in their own discipline? (20) (27)
Timetables and schedules	Timetables and schedules can pose problems of coordination for several disciplines (24) (29) (21) (23) (30) (31)
Different goals, values and discipline dominance	Different professional goals and values can lead to difficulties in interdisciplinary teams, as can professional dominance (32) (31) (33) (34)
Differences in educational models	The majority of curricula are not set up to teach interdisciplinary thinking and skills. Challenge is where to begin (35) (36) (37)
Program assessment	May be problematic when programs of different length, entry-level requirements, and systems of evaluation are combined (30) (29)
Patient's readiness for interdisciplinary delivery model	Patients may expect physicians to be the professional decision maker (36)



Collaborative Curricula

Nine indexed reports were found on interdisciplinary or collaborative curricula for the health sciences,¹³ and eight reports of geriatric interdisciplinary curricula.¹⁴ (See Appendix 5: Table 7.2 and Table 7.3). Evaluations are either formative—to introduce changes to improve the process—or pre and post attitude studies. Two studies report that research is needed to begin to understand what to teach and how to teach it. (38) (18)

Academic Teaching Units in Long-term Care

An academic teaching unit in long-term care is a recognised university training program, which includes faculty members from family medicine, nursing, pharmacy and other disciplines who are responsible for development and implementation of curricula for training future care-givers to provide evidence-based quality clinical care that is responsive to the needs of long-term care residents.

Objectives of Academic Teaching Units

- Develop and implement curricula to prepare family physicians, nurse practitioners and pharmacists to work with long-term care residents
- Develop and implement curriculum on core competencies in collaborative practice
- Develop and implement curriculum in ‘end of life’ in long-term care
- Undertake research in best practices in long-term care
- Promote scholarship in long-term care
- Meet accreditation standards for educating care providers

Human resources

- Director, respected academic clinician, with faculty appointment, to oversee the program
- Assistant Directors – family medicine, nurse practitioner, pharmacist
- Project Manager – Director’s assistant with Masters in health field or equivalent
- Research Associate – with PhD or equivalent in health field and geriatrics
- Secretary – clerical support
- Faculty preceptors and supervisors in family medicine, nurse practitioner and pharmacists

Faculty

The Academic Teaching Unit will ideally be a program within the Faculty of Health Sciences with faculty members having appointments in the Department of Family Medicine and/or School of Nursing.

Students

- Medical students
- Family medicine residents
- Nurse practitioner students
- Pharmacist students
- Graduate students with a research interest in long-term care

Teaching model

We envisage that the best model for teaching this new program will be problem-based learning model.

Teaching about clinical care will be based on a collaborative practice model using collaborative service delivery.

¹³ One report a process evaluation, four report pre and post evaluation, but data is not comparable. Appendix 5: Table 7.2

¹⁴ Three report evaluations, but data is not comparable (see Appendix 5: Table 7.3)

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It will take place within the disciplines of family medicine, nurse practitioner and pharmacists and between these disciplines.

The Program will develop student and resident rotations in collaborating long-term care facilities and will promote collaborative practice teams.

Physical Space

The Academic Teaching Unit will require space for human resources, program management, research offices, student and resident offices, meeting rooms, lecture and tutorial rooms, educational resources and for a library of relevant material.

Community Partners

Long-term care facilities in the community will be invited to partner in the program. Collaborating long-term care facilities will be designated as “teaching” or “university affiliated” long-term care facilities

Evaluation

Program evaluation with periodic monitoring to maintain and enhance academic standards. Evaluation will include formative evaluation of students, residents and faculty and an annual report summative evaluation.

2. A REVIEW OF CURRICULA IN ONTARIO—SURVEY FINDINGS

Three Ontario surveys of existing curricula were undertaken: 1) family medicine residency programs, 2) Ontario nurse practitioner programs, and 3) the University of Toronto Faculty of Pharmacy¹⁵ to determine, what, if any, long-term care content is currently offered. (Descriptions of the survey designs are in Section 4). The following summarizes the findings for each professional group.

Family Physicians

A brief survey of Ontario’s five family medicine residency explored the amount of formal long-term care curriculum content in the basic residency programs. The educational formats are lectures, seminars, academic half-days, and clinical exposure to long-term care settings through core family medicine rotations and mandatory geriatric rotations. There also differences in perceptions of what constitutes formal curriculum in long-term care as opposed to care of the elderly, geriatrics or family medicine. It is difficult to quantify the formal long-term care curriculum in the family medicine residency programs. Most family medicine residents are exposed to long-term care through their full-time core rotations, but this is not standardized. At McMaster University, family medicine residents complete a two-year residency to acquire the core competencies for licensure as family physicians or mandatory. A third year of training (or part) is available for those who want to enhance their skills in the care of the elderly. During this 3rd year, core curriculum in long-term care is a requirement for meeting national standards. There are, however, no mandatory accreditation requirements nationally for long-term care exposure for family medicine residents during their two-year basic training.¹⁶

¹⁵ There is only one school of pharmacy in Ontario

¹⁶ The College of Family Physicians of Canada has the following explanation in its 2002 *Red Book: Standards for Accreditation of Residency Training Programs* for the 2 year basic residency training: (http://www.cfpc.ca/local/files/Education/Red_Book_new.pdf#page=18)

Care of the Elderly

Residents **must** learn the special skills, knowledge, and attitudes related to care of the elderly. Residents **must** be able to do a comprehensive functional and clinical assessment of the frail elderly, including assessment of mental function. They **must** also be familiar with the atypical presentation of illness and with the management of common geriatric and psychogeriatric problems, both physical and psychological, in hospital, institutional, and community settings.



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The majority of the family medicine residency programs report plans to increase the amount of curriculum content and education about long-term care in the future

Nurse Practitioners

The Primary Health Care Nurse Practitioner Program is offered at Ontario universities that share a nurse practitioner curriculum organized by a consortium, the Council of Ontario University Programs in Nursing (COUPN).⁽³⁹⁾ This includes Lakehead University, Laurentian University, McMaster University, Queen's University, Ryerson University, University of Ottawa, University of Toronto, University of Western Ontario, University of Windsor and York University. The course content is not specific to long-term care.

The Ontario Primary Health Care Nurse Practitioner Program began in September 1995 and is a 12-month post-baccalaureate certificate offered in both English and French to experienced degree nurses. There is an option for experienced diploma nurses to obtain their nurse practitioner qualifications and baccalaureate degree in an integrated program. The core curriculum can be delivered *via* distance education on a full-time or part-time basis. The program prepares nurse practitioners as generalists for comprehensive and continuous care to clients across the health continuum and throughout the life span. The client is defined as individual, family and community. Comprehensive primary health care services have five components: promotion, prevention, cure, rehabilitation and support within an extended scope of nursing practice. Full-time students who are in a combined Baccalaureate/Nurse Practitioner program attend classes and participate in clinical placements for 24 consecutive months. Full-time certificate nurse practitioner students attend classes and participate in clinical placements for 12 consecutive months. When core nurse practitioner courses are started, the five courses must be completed within three calendar years.

Five core courses related to care of the elderly include the following: Pathophysiology for Nurse Practitioners, Advanced Health Assessment and Diagnosis, Therapeutics for Nurse Practitioners, Roles and Responsibilities, and an Integrative Practicum. There is a total of 15 hours of class time devoted to care of the elderly, but clinical placement in a long-term care facility is not mandatory.

Pharmacists

It is recognized that for pharmacy students to acquire the requisite knowledge and skills to provide care effectively to the growing population of long-term care residents, they must be exposed to relevant issues in geriatrics and long-term care during their university education. Course coordinators for the Bachelor of Science in Pharmacy (B.Sc. Pharm) and Doctorate in Pharmacy (Pharm.D.) curricula at University of Toronto were canvassed. (See Appendix 2, Pharmacy Survey)

Geriatric and long-term care issues are a minimal part of the overall curricular content. None of the courses specifically use the words elderly, long-term care, or geriatrics in course objectives. Many of the general health science courses (e.g. physiology, medicinal chemistry, biochemistry, etc.) review disease states and drug therapies that are relevant to care of the elderly (i.e. disease states such as Parkinson's, Alzheimer's disease, stroke, which are more likely to affect the elderly) however, the concepts are broadly applicable. Issues pertaining to the elderly may be addressed (as an extension of the general discussion), but these discussions are not mandated by the course objectives. The most "common" geriatric / long-term care theme integrated into teaching during the first two years of the curriculum covers communication (e.g. communicating with hearing impaired elderly). Aging

¹⁶ Residents should learn to be effective team members by participating in a multidisciplinary geriatric team. A variety of resources, including family medicine and specialty faculty with expertise and training in care of the elderly, should be available to residents. It is expected that family practice block time will include an opportunity for residents to care for ambulatory elderly patients in the home and the office. In order to meet these objectives, programs should make use of ambulatory clinics, long-term care programs, and hospital rotations, as well as family practice settings.



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issues, discussed in a limited way, include informed consent in the cognitively impaired, cultural barriers to care of elderly immigrants, and dealing with caregivers. The amount of time spent reviewing these issues is restricted, as they are usually part of more general discussion.

Therapeutics and professional practice labs integrate teaching cases with care of the elderly, usually in the final two years of the undergraduate B.Sc. curriculum. Therapeutic cases deal specifically with pharmacological management of disease. Cases may involve elderly patients, but the learning objectives are treatment of the specific diseases. Cases created by tutors are the most common way geriatric issues are reviewed in the Pharm.D curriculum, but learning objectives tend to be general. There are opportunities for independent study in a small number of non-mandated courses. In a limited number of rotations, students are exposed to care of the elderly, and they may request these, but availability is an issue. A number of specialty courses are offered in the undergraduate curriculum, but one that covers care in the elderly has not yet been designed. Overall, little opportunity exists in the present pharmacy curricula to integrate issues in geriatrics and gerontology.

3. KEY FINDINGS OF STAKEHOLDER WORKSHOP ON COLLABORATIVE CURRICULUM

Four key factors emerged in the stakeholder workshop on collaborative curriculum in long-term care. (Design of the workshop is described in Section 4, Design of the Project).

Long-term Care Differs from Acute Care

Participants at the workshop agree that long-term care is different from acute care, and that it requires a collaborative team approach.

Collaborative Practice Must Be Taught

Collaborative practice is learned. If students gain their core competencies in collaborative teams, in practice they may be able to avoid creating dysfunctional teams. Interdisciplinary education and collaborative practice should be introduced early in the educational programs.

Need For Curricula Reform

Participants in pharmacy and family medicine raised discipline-specific questions. For pharmacy, the issue is whether long-term care should be added to the present curriculum or whether there should be a specific course or an internship of six to 12 months. For family medicine, the issue is that all family medicine residents should have clinical training in long-term care, and that this should be mandatory. To achieve this, what is needed is professional agreement, appropriate resources, willing partners to act as academic teaching sites, and committed and competent teachers.



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Need For Mentoring

Mentors with knowledge and experience in long-term care will be needed in all three disciplines

ISSUES FOR EFFECTIVE DESIGN OF COLLABORATIVE CURRICULA

Participants brain-stormed to produce a list of issues that need to be addressed in the effective design of collaborative curricula. See Table 7.4.

TABLE 7.4 ISSUES FOR EFFECTIVE DESIGN OF COLLABORATIVE CURRICULA

Lectures versus case-based approaches	Lecture formats could have an interdisciplinary session followed by discipline-specific sessions to address discipline-specific content Focused case-based approach can bring out interdisciplinary issues, and foster an understanding of the role and scope of practice of each discipline
Content	Need a fair amount of overlap between the disciplines, yet, at the same time, provision for uniqueness of content has to be addressed
Faculty	Should rotate between the disciplines.
Academic teaching units in long-term care	Rotations and internships should be in facilities where there are existing collaborative models amongst the three disciplines
Collaborative service delivery team	The whole range of allied health care workers—registered nurses, registered nursing assistants, personal support workers, dieticians, physiotherapists, occupational therapists, speech therapists, social workers, recreation therapists, chaplain and information broker (to assist with issues in evidence-based practice)
Rotations and internships in long-term care	No consensus whether they should be optional or mandatory as the goals are different for each discipline
Interdisciplinary research	Research is needed to determine the structure of the collaborative model and delivery of care. It should be able to determine which educational model makes a difference in training and subsequent practice
Research questions	Is interdisciplinary learning an effective learning format? Does learning together help with working together in the field? Do collaborative practice teams provide better care? If you learn with one team, can this translate to working with another team?
Questions raised about long-term care	How do you promote altruism in health care providers? How do you encourage students to take on responsibility in under-serviced areas?



CURRICULUM CONTENT SPECIFIC TO LONG-TERM CARE

Table 7.5 summarizes common curriculum objectives for family physicians, nurse practitioners, and pharmacists that were developed at the workshop. Participants were challenged to identify knowledge, skills and attitudes unique to long-term care.

TABLE 7.5 CURRICULUM CONTENT SPECIFIC TO LONG-TERM CARE

Knowledge

- Dementia, including behavioural issues
- Delirium
- Depression
- Urinary incontinence
- Falls, restraints
- Functional decline
- Infectious diseases (e.g. pneumonia, sepsis, influenza, nosocomial)
- Constipation
- Appropriate medication use
- Pain management
- Skin/wound care
- Foot disorders/care
- Chronic disease management (e.g. osteoarthritis, hypertension, diabetes)
- Nutrition (malnutrition, dehydration, parenteral feeding)
- Rehabilitation

Skills

- Communication skills
- Interdisciplinary collaboration and teamwork skills
- Establishing goals of care and facilitating decision-making
- Comprehensive health assessment – including use of standardized instruments
- Advocacy

Attitudes

1. An understanding of the long-term care setting in terms of
 - Health care delivery system and continuum of care
 - Resources
 - Legislation
 - Standards of Care
 - Population health – common health problems
 - Epidemiology – incidence of disease, co-morbidity, disability
 - Quality of Life issues
 - End-of-life care – promotion of therapeutic optimism and realistic expectations for change and functioning



Attitudes

2. A relationship-centred approach with the following characteristics
 - Ethical
 - Compassionate
 - Individualized
 - Context specific
 - Evidence based
 - Holistic
 - Culturally competent
 3. The concept of the long-term care neighbourhood as a community of individuals requiring
 - Responsiveness
 - Consideration of the collective as well as the individual
 - Risk assessment
 - Nurturing of a healthy and spirited neighbourhood
 - Wellness, health promotion
 4. The value of teamwork, interdisciplinary collaboration, communication, and leadership
-

OBJECTIVES FOR DISCIPLINE-SPECIFIC CURRICULA

Tables 7.6, 7.7 and 7.8 below describe long-term care, discipline-specific curricula for family physicians, nurse practitioners and pharmacists.

TABLE 7.6 FAMILY PHYSICIAN LONG-TERM CARE DISCIPLINE-SPECIFIC CURRICULUM

- Judicious use of medical technology to avoid iatrogenic problems
 - Establishing medical policy in the long-term care (e.g. preventive measures, drug use guidelines, discharge policies)
 - Incorporating long-term care patient management into the running of a family practice
 - Telephone management of patient care problems
 - Coordination of care between settings, especially acute care and LTC
-

SECTION 7 — COLLABORATIVE CURRICULUM IN LONG-TERM CARE FACILITIES

TABLE 7.7 NURSE PRACTITIONER LONG-TERM CARE DISCIPLINE-SPECIFIC CURRICULUM

- Cardiology (e.g. congestive heart failure, angina, atrial fibrillation)
 - Atypical presentations of disease
 - Certification of death
 - Advanced clinical assessment skills
 - Teaching-coaching skills
 - Technical skills including
 - Hypodermoclysis
 - Wound management
 - Venipuncture
 - Suprapubic catheter management
 - Dealing with cognitive impairment in terms of provision of personal care (bathing, toileting, eating)
-

TABLE 7.8 PHARMACISTS LONG-TERM CARE DISCIPLINE-SPECIFIC CURRICULUM

- Homeostatic mechanisms, age-related physiologic changes
 - Adverse drug reactions
 - Drug-drug interactions
 - Polypharmacy
 - Drug compliance
 - Drug administration
 - Selection of drug therapy goals focusing on function and quality of life
 - Management of specific delegated drug therapies (e.g. Warfarin dosing, insulin/oral hypoglycemic agents, analgesics)
 - Psychotropic medications
-



4. LOCAL, REGIONAL AND PROVINCIAL KEY STRATEGIES TO PROMOTE COLLABORATIVE INTERDISCIPLINARY CURRICULUM

The following strategies for implementation of long-term care curriculum arose from the workshop. They include local, regional and provincial strategies. (See Table 7.9)

TABLE 7.9 LOCAL, REGIONAL AND PROVINCIAL KEY STRATEGIES TO PROMOTE COLLABORATIVE INTERDISCIPLINARY CURRICULA

Stakeholder	Strategies
University & Colleges	<p><i>Long-term care education</i></p> <ul style="list-style-type: none"> ■ Develop long term care curriculum for each professional group ■ Integrate curricula into undergraduate programs in each professional group ■ Make long-term care clinical experience a requirement in family medicine residency, nurse practitioner training and pharmacy training. <p><i>Interdisciplinary Education</i></p> <ul style="list-style-type: none"> ■ Develop collaborative curricula and core competencies ■ Disciplines should derive their own concept of interdisciplinary care and establish common goals ■ Determine common content areas & discipline specific areas ■ Tutors can rotate between the disciplines ■ Use case-based modules ■ Develop incentives and rewards for interdisciplinary opportunities, e.g. “collaborative long-term care learning team of the year”, funding tied to interdisciplinary learning activities <p><i>Identify potential interdisciplinary teaching sites</i></p> <ul style="list-style-type: none"> ■ Prepare terms of reference for academic teaching sites <p><i>Establish research in long-term care to explore collaborative practice and collaborative education</i></p> <ul style="list-style-type: none"> ■ Identify centres of excellence and organizational models ■ Establish evaluation systems to determine research competency
Professions	<p>Derive concept of interdisciplinary care and establish common goals with allied professions</p> <p>Establish collaborative interdisciplinary partnerships</p> <p><i>Develop continuing education curriculum format for long-term care</i></p> <ul style="list-style-type: none"> ■ Add collaborative practice to content areas ■ Evaluate effectiveness of continuing education
Local	<p>Establish partnerships between universities and colleges with long-term care facilities</p> <p>Link up with networks of long-term care medical directors and administrators</p> <p>Link up with networks of long-term care collaborative practice teams</p>
Regional	<p>Link up with networks of long-term care medical directors and administrators</p>
Provincial	<p>Working with ABC in LTC team—circulate report to education curriculum decision-makers in each profession</p> <p>Fund centres of excellence in collaborative practice</p> <ul style="list-style-type: none"> ■ Fund demonstration pilot of an academic health science centres of excellence for collaborative team work in long-term care <p>Fund collaborative education teaching sites in long-term care</p> <ul style="list-style-type: none"> ■ Fund pilot to inform



SECTION 8 — NETWORK DEVELOPMENT

INTRODUCTION

One of the first steps of the project was to develop a database of stakeholders to enable a communication strategy to inform and to engage health care providers and educators across the province. (See Appendix 6, Data base) Names of potential participants were suggested by the medical and nursing consultants and brought to the Steering Committee for further recommendations. Criteria included experience in long-term care or family medicine, expert knowledge of the initiative and “out of the box thinkers.” A listing of the workshop participants is below.

WORKSHOP PARTICIPANTS

Recruitment and Retention

Family Physicians

James Edney
Family Physician/ Medical Director – Homes for the Aged, Metro Hall, Toronto
Kanwal Shankardass
Family Physician/ Former Medical Director, St. Peter’s Hospital, Hamilton

Nurse Practitioners

Dave Farr
Nurse Practitioner – Shalom Village, Hamilton
Nancy Griffiths
Nurse Practitioner – Extendicare, London

Pharmacists

Elaine Akers
Regional Director Operations, Medical Pharmacies Group Inc., Pickering
Tom Paton
Director of Pharmacy – Sunnybrook & Women’s Hospitals. Toronto

Other Participants

Karin Fairchild
Senior Policy Analyst, Ontario Ministry of Health & Long Term Care, Toronto
John Flick
Administrator – Grey Gables Nursing Home, Markdale
Tim Glover
CEO – Outside the Box Consulting, Hamilton

SECTION 8 — NETWORK DEVELOPMENT

Collaborative Service Delivery

Family Physicians

Norm Flett

Medical Director – St. Joseph’s Villa / OLTC Physician – Dundas Family Medical Group
Past President – OLTCPA

Fred Fraser

Family Physician / Medical Director – Heritage Green

Joe Khera

Family Physician / Medical Director – Macassa Lodge

Nurse Practitioners

Michelle Clifford-Middel

Nurse Practitioner – Barrie, Ontario

Lorraine Johnston

Nurse Practitioner – Avalon Care Centre, Orangeville

Lynn Lawson

Nurse Practitioner – St. Joseph’s Health Centre, Guelph

Jan Marie Morgan

Nurse Practitioner – St. Joseph’s Hospital, Hamilton

Dona Ree

Nurse Practitioner – Pinewood Court Nursing Home, Thunder Bay

Pharmacists

Glenda Campbell

Charlton Pharmacy / Medical Pharmacies Group, Hamilton

Barb Farrell

Clinical Research Coordinator, Pharmacy Dept. – SCO Health Service, Ottawa

Norine Graham-Robinson

Manager, Long Term Care Services – Medical Pharmacies Group, Pickering

Denis O’Donnell

Medical Pharmacies Inc., Stouffville

Joan Pollari

Pharmacist – Guelph, Ontario

Other Participants

Sharon Gilmour

COO – Outside the Box Consulting, Hamilton

Sheri-Lynn Kane

Geriatrician – St. Joseph’s Hospital & Home, Guelph

Jeanette O’Leary

Director of Resident Care – Shalom Village, Hamilton

Michael Rachlis

Private Consultant – Health Policy Analysis, Toronto



SECTION 8 — NETWORK DEVELOPMENT

Collaborative Curriculum

Family Physicians

Nancy Fowler
Family Physician / former Director Postgraduate Residency Program,
Family Medicine, McMaster University, Hamilton

Lyla Graham
OLTC Physician / Care of the Elderly, Family Medicine,
University of Ottawa, Ottawa

Bob James
Family Physician / Medical Director – Wentworth Lodge/St. Joseph’s Villa, Dundas

Chris Ragonetti
Family Physician / Medical Director – Brant Centre, Burlington

Liz Shaw
Family Physician / Director Postgraduate Residency Program
Family Medicine, McMaster University, Hamilton

Irene Tuttle
Family Physician / Medical Director – Extendicare, Hamilton

Nurse Practitioners

Betty Delmore
Nurse Practitioner – Family Medicine, McMaster University, Hamilton

Faith Donald
Nurse Practitioner Program, Ryerson University, Toronto

Suzanne Doucette
Regional Coordinator – University of Ottawa, Health Sciences, Ottawa

Dot Hammond
Consultant – Hammond Associates, Toronto

Anne Pizzacalla
Nurse Practitioner – McMaster University, Hamilton

Pharmacists

Karen Cameron
Pharmacist – Ontario Pharmacists’ Association, Toronto

Larry Jackson
Pharmacist – Sunnybrook & Women’s College, Toronto

Debbie Kwan
Pharmacist – Dept. of Pharmacy, Toronto Western Hospital, Toronto

Rose Pavlakovic
Pharmacist / Manager Community Professional Programs
Shoppers Drug Mart, North York

Lalitha Raman-Wilmns
Pharmacist – University of Toronto, Faculty of Pharmacy, Toronto



SECTION 8 — NETWORK DEVELOPMENT

Other Participants

Anna Emili

Family Medicine Fellow – McMaster University, Hamilton

Michael Rachlis

Private Consultant – Health Policy Analysis, Toronto

Lori Schindel-Martin

Founding Director, Ruth Sherman Centre for Education & Research,
Shalom Village, Hamilton



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APPENDIX 1: GENERIC DISCUSSION GUIDE

GUIDELINE FOR INTERVIEWS AND FOCUS GROUP DISCUSSIONS: BARRIERS AND INCENTIVES FOR PHYSICIANS, NURSE PRACTITIONERS, AND PHARMACISTS

1. What are the barriers to working in long-term care?

probe

- Cultural perceptions/ Personal attitudes/Training
- Quality of the work setting
- Organization of work
- Competing interests (office & long-term care)
- Call system/ Establishing network
- Information management
- Office management (information technology)

2. What factors attract physicians to work in LTC?

probe

- Early exposure
- Work setting
- Type of patients

3. What are the unique Professional Practice Issues in long-term care?

probe

- Training
- Challenge of complexity of cases
- Interdisciplinary practice
- Continuing education focus
- Relationship to tertiary care & referral system
- Need for Academic Teaching Unit

4. What are the Personal rewards?

probe

- Remuneration (system & amount)
- Time off & benefits
- Personal Legacy

5. What “out-of-the-box”, innovative ideas do you have to address recruitment and retention issues for physicians in LTC?

6. What retention strategies do you think would be effective for LTC?

7. What “out-of-the-box”, innovative ideas do you have to address recruitment and retention issues for physicians in LTC?

SUMMARY OF GERIATRIC, AGING AND LONG-TERM CARE CONTENT IN THE PHARMACY CURRICULUM AT THE UNIVERSITY OF TORONTO

According to the 2001 census, the elderly account for the most rapidly growing segment of the Canadian population (based on age). Seniors aged 65 years or older currently comprise 12% of the population - this figure is expected to increase to 15% by the year 2011. Given this fact along with the knowledge that restrictions in activities of daily living and admissions to long-term care facilities rise after the age of 75-85 years, the implications on the health care system extensive. In order to provide care effectively to this growing population of patients, pharmacists must be exposed to relevant issues (to geriatrics and long-term care) during their university education in order to acquire the requisite knowledge and skills. Accordingly, course coordinators for the B.Sc. and Pharm.D. curricula were canvassed and course syllabi and required readings (when available) were reviewed to glean what learning objectives and opportunities have been created to expose students to issues relevant to providing care in a long-term setting.

The findings of this review are summarized as follows:

- Geriatric and long-term care issues comprise a minimal proportion of the overall B.Sc. and Pharm.D. curricular content.
- No course specifically includes the words elderly, long-term care, or geriatrics in their course objectives
- Many of the general health science courses (e.g. physiology, medicinal chemistry, biochemistry, etc.) review disease states and drug therapies that are more relevant to care of the elderly (i.e. disease states such as Parkinson's, Alzheimer's, stroke, etc. which are more likely to affect the elderly), however the concepts taught are usually broadly applicable; issues pertaining to the elderly may be addressed (as an extension of the general discussion) but these discussions are not mandated by the course objectives
- The most "common" geriatric / long-term care theme integrated into teaching during the first two years of the curriculum deals mainly with issues of communication (e.g. communicating with hearing impaired elderly)
- Aging issues discussed in a limited fashion include informed consent in the cognitively impaired, cultural barriers to care of elderly immigrants, and dealing with caregivers; time spent reviewing these issues is restricted as they are usually introduced as part of more general discussion
- Therapeutics and professional practice labs integrate teaching cases involving care of the elderly most frequently in the final two years of the undergraduate B.Sc. curriculum. Therapeutics cases deal more specifically with pharmacological management of disease and do not necessarily incorporate psychosocial issues extensively into the discussion
- Pharmacy practice labs afford students some opportunity to integrate therapeutic knowledge with communication skills to deal with both medical and psychosocial issues. Cases may involve elderly patients but the learning objectives tend to be general for the treatment of the specific disease (vs. elderly population); tutors may guide discussions to ensure that specific issues pertinent to elderly patients are discussed. Cases created by tutors in therapeutics are the most common vehicle by which geriatric issues are reviewed in the Pharm.D. curriculum; although the cases involve elderly patients, thereby lending themselves to discussions regarding special issues in caring for this population, the learning objectives tend to be general



APPENDIX 2: PHARMACY SURVEY

- Opportunities for independent study are available in a small number of courses. These opportunities are dependent on student interest and not mandated by the course objectives (e.g. self-generated learning objectives in a problem-based therapeutics environment; pharmacy practice research proposals investigating provision of care to the elderly; Pharm.D. seminar presentations)
- Students are exposed to various therapeutic and psychosocial issues pertaining to care of elderly patients in a limited number of rotations (where the focus of practice is on providing care to the elderly). Students may request these rotations, however preceptor/rotation availability may change yearly
- Although specialty courses such as pediatrics, aboriginal issues in health, obstetrics and gynecology and complimentary medicine are offered in the undergraduate curriculum, a course specifically dealing with issues surrounding the provision of care in the elderly has not been designed

Conclusion Little opportunity exists to integrate geriatrics and gerontology issues in the present pharmacy curriculum

APPENDIX 3: LIST OF EXTERNAL REVIEWERS OF THE DRAFT REPORT, AUGUST 2003

First Name	Last Name	Title
Theresa	Agnew	Chair, Nurse Practitioner Association of Ontario (NPAO)
Bill	Dillaine	COO, Central Park Lodge, Canada
Faith	Donald	Assistant Professor, Nurse Practitioner Program, Ryerson University
Karin	Fairchild	Senior Policy Analyst, Ontario Ministry of Health & Long Term Care
Barbara	Farrell	Clinical/Research Coordinator, Pharmacy Department SCO Health Service
Norm	Flett	Medical Director – St. Joseph’s Villa /Past President - OLTCPA
Lyla	Graham	Program Director, Care of the Elderly, Family Medicine, University of Ottawa
Nancy	Griffiths	Nurse Practitioner – Extendicare, London
Dot	Hammond	Health Systems Consultant
Jan	Kasperski	Executive Director & CEO, College of Family Physicians of Canada
Sue	Matthews	Provincial Chief Nursing Officer, MOHLTC, Toronto
Joan	Marshman	Chair, University of Toronto Curriculum committee, Faculty of pharmacy
Carrie	McAiney	Assistant Professor, Geriatric Psychiatry, McMaster University
Margaret	Ringland	Director of Member Relations and Professional Services
Anitta	Robertson	RNAO, Program Development Manager, Recruitment & Retention Projects
Karen	Sullivan	Executive Director, Ontario Long Term Care Association (OLTCA)
Greg	Ujiye	Manager, Pharmacy Practice, Ontario College of Pharmacists
Kris	Wichman	Ontario Pharmacists’ Association



APPENDIX 4: STEERING COMMITTEE RECOMMENDATIONS, JULY 31, 2003

Recruitment & Retention	Collaborative Service Delivery	Interdisciplinary Curriculum	Other
1. Develop regional networks of medical directors, administrators, nurse practitioners & pharmacists	Develop continuing education for community physicians in collaborative practice	Develop High School programs to attract students to sector	Fund time for team meetings
2. Develop provincial marketing campaign for sector as a vibrant, progressive workplace	Establish demonstration pilots in collaborative practice & evaluate	Establish positive exposure for undergraduates	Increase funding & consider alternate funding plan for physicians
3. Change the language to terms like long term living	Showcase collaborative service delivery		Fund incentives for after hour coverage
4. Develop evidence-based guidelines for sector	Set up regional mechanism for communication in collaboration	Evaluate collaborative education model	Fund information technology for long-term care sector
5. Develop academic teaching units in long-term care facilities	Identify model of collaborative practice teams across the province	Set up collaborative interdisciplinary physician training	Offer continuing education incentives to nurses, physicians and pharmacists
6. Create guide to being magnet hospital	Integrate long-term care with acute care system to create a seamless system of care	Create interdisciplinary curriculum task force	Change funding formulae for patient care & provider remuneration
7. Develop re-entry training for nurses and physicians	Establish provincial best practice resource centres	Set up mentorships for sector	Set up geographic full-time funding for physicians, nurse practitioners & pharmacists
8. Hold provincial conferences on recruitment in retention in long-term care in 2004	Create awards for best functional teams	Set up on-line library of literature for sector	Determine & provide adequate remuneration
9. Establish standards of practice <i>via</i> task forces or consensus conferences	Identify evaluation outcomes of 'success'		Develop economic incentives for sector
10. Recruitment Officer/Office in regions for long-term care	Determine most effective mix ratios of practitioners		Fund patient medical reviews
11. Develop sector strategy for physician recruitment and retention	Provide permanent space for collaborative teams		Fund sector to meet "Magnet" facility standards & best practice
12. Develop collaborative co-ordinated approach to recruitment & retention	Change accreditation standards to include standards of collaboration		Integrate facilities within their communities
13. Establish comprehensive collaborative provincial recruitment program that benefits regions and local faculties	Set up demonstration projects on new delivery models for the interdisciplinary practice		
14. Develop "Magnet" long-term care facilities	Develop horizontal and vertical curriculum units on collaborative practice		
15. Evaluate recruitment & retention strategies delivery model			



APPENDIX 5: TABLE 7.2 GENERAL INTERDISCIPLINARY CURRICULA

Where	Disciplines	Approach	Curricula	Evaluation
University of Alberta (1)	Canada's first interdisciplinary health sciences courses pharmacy & medicine	6-8 hours per week small groups of 8-10 one facilitator per group	Team building & ethics	
Victoria, Australia (2)	"Rural Interprofessional Education" (RIPE) project a 3-year pilot in nursing and medicine with a regional tutor, co-facilitated by a nurse and a physician	1st year two-week rural placement for mixed pairs of 3rd year nurses and medical students in different clinical sites in four regions	Rural Clinical practice	Pre and post-placement survey assessment of own knowledge, attitudes and perceived skills in interprofessional practice, and those of others
University of South Florida (3)	Develop a model to guide education in medicine, nursing, public health, and social work	Clinical practice	Rural Clinical practice	Cultural sensitivity as members of an interdisciplinary team in a rural setting
Georgetown University, in Washington, D.C. (4)		Interdisciplinary curriculum in clinical ethics	10 two-hour sessions, first hour traditional style lectures, second small group discussion Facilitation by faculty, community professionals, philosophy graduate students specializing in bioethics, medical residents and clergy working in pastoral care	Process evaluations: 3 new required sections. 10 hrs of classroom presentation & discussion, 10 two-hour segments of one lecture hour followed by one hour of small group discussions, third was on interdisciplinary collaborative nature of clinical and ethical decision-making.
Georgetown University Medical Centre (5)	Five 1st year nursing students and five medical students	Collaborative teams of student partnerships in community development programs	Four outreach projects, 2 with teenage girls & boys Outreach to the Elderly, health educational to 25-30 older adults in a Catholic parish.	

APPENDIX 5: TABLE 7.2 GENERAL INTERDISCIPLINARY CURRICULA

Where	Disciplines	Approach	Curricula	Evaluation
Wichita State University's College of Health Professions (6)	Students in dental hygiene, physical therapy and physician assistants	Four phases use problem based learning with simulated patient scenarios and active patient studies	1) discipline-specific information, team concepts and problem-based learning 2) students work in multidisciplinary teams with simulated patient cases in the problem-based learning format; 3) small inter-disciplinary groups seeing real patients, & performing periodontal examinations; 4) problem-oriented physical exam, and a neuromuscular assessment	Pre and post-test evaluation of each phase showed no difference in knowledge among the three disciplines. All felt problem-based learning was a good way of presenting multidisciplinary material, 93% felt their problem-solving skills improved, 98% felt their group working skills improved, and 98% felt they had learned more about the other two disciplines.
Minnesota state wide interdisciplinary community (7)	Public health nurses, registered nurses, social workers, protection workers, women's advocates, corrections staff, family support workers, and paraprofessionals	Full day of learning activities		Pre and post-evaluations. State-wide training led to increased awareness and knowledge of violence issues, skills and interventions, and development of community partnerships amongst practitioners
East Carolina University (8)	Marriage and family therapy, nursing, psychiatry, psychology and social work	Team taught by faculty members 1) class exercises on interdisciplinary collaboration 2) systems of care, philosophy & practice, with an overview of clinical material	Interdisciplinary practice: Services for children with serious emotional disorders	Pre and post-evaluations. Participants became more community minded, had more sophisticated, in depth and detailed accounts of interdisciplinary collaboration
East Tennessee State University (9)	Medical, nursing, and public health	Team building activities: community road rally, community cross word puzzles, scavenger hunts and community resources and contributions. Used to develop relationships and increase knowledge between disciplines and the community.	Common curricula areas: communication skills, community organization, assessment, Biostatistics, epidemiology, group process and problem solving, health assessment, health promotion for community and individuals and health intervention strategies	Post test no negative feedback was given.

APPENDIX 5: TABLE 7.2 GENERAL INTERDISCIPLINARY CURRICULA

REFERENCES TABLE 7.2 GENERAL INTERDISCIPLINARY CURRICULA

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APPENDIX 5: TABLE 7.3 GERIATRIC INTERDISCIPLINARY CURRICULA

Where	Disciplines	Approach	Curricula	Evaluation
Columbia University the Program for Organizing Interdisciplinary Self Education (POISE) (1)	Durable, cost effective method of linking and coordinating mental health services within an institutional	Assume that staff already have the technical skills	1. team development 2. management--systematic problem solving in geriatric assessment and in the development of the treatment decision guide. 3. maintenance—critiquing team process	(POISE) aids in development of almost all interdisciplinary teams except for acute care and short stay hospitals
Rhode Island Geriatric Education Centre (RIGEC) (2)	Nurses, social workers, psychologists/counselors, physicians and allied health care workers (3)	5 core workshops and 2 advanced practice seminars background information on teamwork, conflict resolution & leadership	1. healthy, functional older adults 2. older adults with chronic illnesses and some functional impairment 3. older adults with multiple co-morbidities & physical & cognitive impairment	Workshop evaluations were rated very positively Specific changes were implemented which resulted in a more specific content and attention paid to the application of theory to practice
American Geriatrics Society education committee (4)	Internal medicine and family practice residents as a component of the geriatrics curriculum	Specific learner objectives for provision of effective geriatric interdisciplinary care	3 main sections, focusing on attitudes, knowledge and skills	
Palliative Care Program, McMaster University (5)	First offered to medical school students, then expanded to include all health sciences students	Case based approach	Roles & interdisciplinary teamwork/ issues of patients & families/pain management & symptom control/thoughts, feelings/ issues in grieving & bereavement/importance of selfcare/ spirituality/ethical decision-making/ communication/ cultural aspects/ intimacy during serious illness	Each year the program is evaluated and 99% of the time has had a positive response
University of Hawaii, School of Social Work (6)			Interdisciplinary team work and cultural competence Standardized learning objectives Research on best practice issues.	

APPENDIX 5: TABLE 7.3 GERIATRIC INTERDISCIPLINARY CURRICULA

Where	Disciplines	Approach	Curricula	Evaluation
American Medical Association and the American Society of Consultant Pharmacists (7) (8)	Consultant pharmacists, medical directors, attending physicians and other health professionals foster collaborations between consultant pharmacists, medical directors, attending physicians and other health professionals in long term care	Web based focus on medication-related problems in nursing facility residents	Multidisciplinary Medications Management (M3) program Medication management in long term care with guidelines for practitioners and team members in long-term care, identification of adverse drug reactions/suggested reporting systems and strategies for response	
Medical College of Ohio's (MCOs) Rural Elderly Assessment Program (REAP) (9)	Physical therapy, nursing, family medicine, and occupational therapy	Interdisciplinary education module	Developmental seminars in interdisciplinary team building, geriatric health assessment, and curriculum design, implementation and evaluation	
Sioux Valley Hospital and the University of South Dakota School of Medicine(10)	Nursing, medicine, pharmacy, social work or gerontology and allied health disciplines	6 week training course didactic workshops, clinical experiences and dissemination of training materials	To establish didactic and clinical education in rural areas	Post program

APPENDIX 5: TABLE 7.3 GERIATRIC INTERDISCIPLINARY CURRICULA

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APPENDIX 6: LOCAL, REGIONAL AND PROVINCIAL STRATEGIES TO INFORM THE RECOMMENDATIONS

Action	Strategies		
	Local	Regional	Provincial
INITIATIVE ON RECRUITMENT & RETENTION			
Recruit students into long-term care (LTC)	Develop training programs in LTC Create policies for selective admission criteria for LTC	Increase number of student places in health sciences	Expand policy of economic incentives for health care providers to work in LTC
Create entry strategies for LTC for qualified professions	Create fellowships in LTC Create innovative re-entry course for older practitioners Create career paths	Hire recruitment officers to develop & coordinate comprehensive, collaborative recruitment strategy	Establish comprehensive, collaborative recruitment strategy Fund recruitment officers to develop comprehensive, collaborative recruitment strategy
Make “Magnet nursing homes” the standard for LTC	Adapt Ontario standards to local LTC facilities	Set up regional committee to establish Ontario standards for “magnet LTC homes”	Set up provincial committee to assist regional groups to establish networks



APPENDIX 6: LOCAL, REGIONAL AND PROVINCIAL STRATEGIES TO INFORM THE RECOMMENDATIONS

Action	Strategies		
	Local	Regional	Provincial
INITIATIVE ON COLLABORATIVE SERVICE DELIVERY			
Establish interdisciplinary academic teaching units in LTC	Universities & LTC facilities to set up committees to establish academic teaching units	Develop network of academic teaching units	Fund academic teaching units in long-term care
Establish collaborative teams	Provide protected time for team building and maintenance Fund research in long-term care to develop standards of practice & collaboration	Develop network of collaborative teams for information sharing Develop indicators for evaluation	Create nurse practitioner positions with across-the-board funding for LTC Professional associations to address liability issue of collaborative practice Change provincial funding model for long-term care to enable collaborative service delivery
Establish community infrastructure to support collaborative service delivery teams	Set up network of health providers for 24/7 coverage Adopt integrated information technology Establish professional consultant support systems Integrate LTC with acute care—to improve access to diagnostics	Create networks of LTC medical directors, administrators & health providers Assess Information technology needs for sector	Fund information technology in LTC
INITIATIVE ON COLLABORATIVE CURRICULUM RECOMMENDATIONS			
Establish academic teaching units in LTC	Establish demonstration pilot Recruit & train faculty in interdisciplinary education	Identify interdisciplinary teaching sites Establish regional network of to support teaching sites	Mandate province-wide network of LTC academic teaching units
Establish collaborative interdisciplinary curriculum	Develop curriculum for each professional group Evaluation interdisciplinary curriculum competence, effectiveness & costs of academic teaching site	Prepare proposed academic service model and human resource requirements Facilitate collaborative practice team learning in rural and urban settings	Fund demonstration pilot of academic teaching units in LTC



APPENDIX 7: DATA BASE

ABC IN LTC DATABASE

(Alphabetically sorted by Last Name)

First Name	Last Name	Title	Organization
Theresa	Agnew	Chair	Nurse Practitioner Association of Ontario, Toronto
Elaine	Akers	Pharmacist	Medical Pharmacies Group Inc., Pickering
Angelo	Arciero	Pharmacist	MediSystem Technologies Inc., Toronto
Jean	Benton	Nurse Practitioner	Miramichi Lodge, Pembroke
Manon	Bouchard	Nurse Practitioner	Residence Saint-Louis, Orleans
Glenda	Campbell	Pharmacist	Medical Pharmacies Group, Pickering
Dr. Larry	Chambers	President & Chief Scientist	University of Ottawa Institute on Health of the Elderly associated with SCO Health Service, Ottawa
Gary	Chin	Chief Executive Officer	MediSystem Technologies Inc., Toronto
Michelle	Clifford-Middel	Nurse Practitioner	Barrie
Nancy	Cooper	Director of Policy & Professional Development	Ontario Long Term Care Association, Markham
Cathy	Crane	Project Coordinator	Ontario Ministry of Health and Long-Term Care, London
Praveen	Daptardar	Pharmacist	Mississauga
Betty	Delmore	Nurse Practitioner	McMaster Family Practice West End Clinic, Hamilton
Dr. Alba	DiCenso	Professor	School of Nursing, McMaster University, Hamilton
Bill	Dillaine	Chief Operating Officer	Central Park Lodges Canada, Toronto
Dr. Lisa	Dolovich	Assistant Professor	Faculty of Pharmacy, University of Toronto, Toronto Department of Family Medicine, McMaster University, Hamilton
Faith	Donald	Assistant Professor	Nurse Practitioner Program, Ryerson University, Toronto
Suzanne	Doucette	Regional Coordinator	Council of Ontario University Programs in Nursing, University of Ottawa, Ottawa
Lena	Dutton	Nurse Practitioner	Macassa Lodge, Hamilton
Dr. James	Edney	Medical Director	Homes for the Aged Metro Hall, Toronto
Dr. Anna	Emili	Care of the Elderly Fellow	McMaster University, Hamilton
Dr. Ralph	Epstein	Family Physician	Hamilton
Karin	Fairchild	Senior Policy Analyst	LTC Facilities Branch, Community Health Division, Ontario Ministry of Health and Long-Term Care, Toronto
Dave	Farr	Nurse Practitioner	Shalom Village, Hamilton Long Term Care/ Nurse Practitioner Project, Hamilton



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First Name	Last Name	Title	Organization
Barbara	Farrell	Clinical/Research Coordinator	Pharmacy Department, SCO Health Service, Ottawa
Dr. Norman	Flett	Medical Director	St. Joseph's Villa, Hamilton
John	Flick	Administrator	Grey Gables, Markdale
Dr. Nancy	Fowler	Family Medicine Residency Program Director (Past)	McMaster University, Hamilton
Dr. Christopher	Frank	Care of the Elderly Program Director	Queen's University, Kingston
Dr. Fred	Fraser	Medical Director	Heritage Green, Stoney Creek
Sharon	Gilmour	Consultant	Outside the Box Consulting, Dundas
Tim	Glover	Chief Executive Officer	Outside the Box Consulting, Dundas
Dr. Lyla	Graham	Care of the Elderly Program Director	University of Ottawa, Ottawa
Norine	Graham-Robinson	Manager, Long Term Care Services	Medical Pharmacies Group, Pickering
Nancy	Griffiths	Nurse Practitioner	Chateau Gardens, London
Dot	Hammond	Health Systems Consultant	Hammond Associates, Toronto
Eileen	Hanna	Special Projects	Department of Family Medicine, McMaster University, Hamilton
Maureen	Harmer	Chair	Continuing Gerontologic Education Cooperative, Hamilton
Dilys	Haughton	Team Leader	Shalom Village, Hamilton Long Term Care/ Nurse Practitioner Project, Hamilton
Phyllis	Hiltz-Bontje	Compliance Advisor	Ontario Ministry of Health and Long-Term Care, Toronto
Betty	Ho	Acting Department Manager	Department of Family Medicine, McMaster University, Hamilton
Carol	Hobbs	Nurse Practitioner	Millbrook
Erin	Hughes	MOHLTC Liaison	Ontario Ministry of Health and Long-Term Care Toronto
Larry	Jackson	Pharmacist	Sunnybrook & Women's College Health Sciences Centre, Toronto
Dr. Robert	James	Medical Director	Wentworth Lodge, Hamilton
Michael	Janjic	Administrator	Clarion Nursing Home, Stoney Creek
Jane	Jennings	Nurse Practitioner	Shalom Village, Hamilton LTC/ Nurse Practitioner Program, Hamilton



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First Name	Last Name	Title	Organization
Dr. Phyllis	Jensen	Research Associate Assistant Professor	Department of Family Medicine Hamilton Health Sciences and McMaster University, Hamilton
Ernie	Jodoin	Senior Health Planner	Hamilton District Health Council Hamilton
Lorraine	Johnston	Nurse Practitioner	Avalon Retirement Centre, Orangeville
Dr. Sheri Lynn	Kane	Geriatrician	St. Joseph's Hospital & Home, Guelph
Jan	Kasperski	Executive Director & CEO	Ontario College of Family Physicians Toronto
Dr. Joginder	Khera	Medical Director	Macassa Lodge, Hamilton
Dr. Oded	Klinghofer	Medical Director	Parkview Nursing Centre, Hamilton
Debbie	Kwan	Pharmacist	Department of Pharmacy, Toronto Western Hospital Toronto
Lynn	Lawson	Nurse Practitioner	St. Joseph's Health Centre, Guelph
Dr. Cheryl	Levitt	Professor & Chair	Department of Family Medicine, McMaster University, Hamilton
Dr. Joan	Marshman	Chair, Curriculum Committee	Leslie Dan Faculty of Pharmacy, University of Toronto, Toronto
Sue	Matthews	Provincial Chief Nursing Officer	Nursing Secretariat, Ontario Ministry of Health and Long-Term Care, Toronto
Wendy	Matthews	Home Care Services Manager	Marchese Pharmacy Hamilton
Dr. Carrie	McAiney	Assistant Professor	Division of Geriatric Psychiatry, McMaster University Hamilton St. Joseph's Healthcare Hamilton, CMHS
Barbara	McCoy	Alzheimer's Society Psychogeriatric Consultant	Hamilton Health Sciences Hamilton
Patricia	Morden	Chief Executive Officer	Shalom Village Hamilton
Jan Marie	Morgan	Nurse Practitioner	St. Joseph's Hospital, Hamilton
Dr. Donald	Noad	Medical Director	Idlewyld Manor, Hamilton
Denis	O'Donnell	Pharmacist	Medical Pharmacies Group Inc., Pickering
Jeanette	O'Leary	Director of Resident Care	Shalom Village Hamilton
Dr. Anthony	Opie	Medical Director	Queen's Garden, Hamilton
Dr. Alexandra	Papaioannou	Associate Professor	Division of Geriatric Medicine, McMaster University Co-Director, McLaughlin Centre for Research and Education in Aging & Health, Hamilton
Tom	Paton	Director of Pharmacy	Sunnybrook & Women's College Health Sciences Centre, Toronto



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First Name	Last Name	Title	Organization
Rose	Pavlakovic	Manager, Community Professional Programs	Shoppers Drug Mart North York
Jacqueline	Pearson	Project Assistant	ABC in LTC Project, Hamilton
Anne	Pizzacalla	Nurse Practitioner	Seniors Health and Rehabilitation Program Hamilton Health Sciences, Hamilton
Joan	Pollari	Pharmacist	Guelph
Zagorka	Popovski	Pharmacist	Medical Pharmacies Group Inc., Pickering
Dr. Kiran	Rabheru	Associate Professor	Division of Geriatric Pyschiatry University of Western Ontario, London
Dr. Michael	Rachlis	Private Consultant and Health Policy Analysist	Toronto
Dr. Chris	Ragonetti	Medical Director	Brant Centre, Burlington
Lalitha	Raman-Wilms	Assistant Professor	Leslie Dan Faculty of Pharmacy, University of Toronto, Toronto
Karen	Rawn	Nurse Practitioner	Durham
Dona	Ree	Nurse Practitioner	Pinewood Court Nursing Home, Thunder Bay
Margaret	Ringland	Director of Member Relations and Professional Services	Ontario Association of Non-Profit Homes and Services for Seniors Woodbridge
Donna	Rubin	Chief Executive Officer	Ontario Association of Non-Profit Homes & Services for Seniors, Woodbridge
Lori	Schindel-Martin	Founding Director, Ruth Sherman Centre for Education & Research	Shalom Village Hamilton
Dr. Kanwal	Shankardass	Family Physician	Dundas
Dr. Elizabeth	Shaw	Family Medicine Residency Program Director	McMaster University, Hamilton
John	Skirving	Chief Executive Officer	Canadian Tire Hamilton
Eric	Staples	Regional Coordinator	Ontario Primary Health Care Nurse Practitioner Program, Hamilton
Dr. Michael	Stephenson	Medical Director	The Wellington, Hamilton
Karen	Sullivan	Executive Director	Ontario Long Term Care Association, Markham
Dr. Alan	Taniguchi	Medical Director	Shalom Village, Hamilton
Dr. Irene	Tuttle	Medical Director	Extendicare Hamilton, Hamilton



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First Name	Last Name	Title	Organization
Greg	Ujiye	Manager, Pharmacy Practice	Ontario College of Pharmacists Toronto
Horacio	Waisgluss	Pharmacist	Mississauga
Yvonne	Walton	Compliance Advisor	Ontario Ministry of Health and Long-Term Care South Central Region
Kris	Wichman	Pharmacist	Ontario Pharmacists' Association, Toronto
Lynne	Withers	Nurse Practitioner	Sarnia
Luisse	Wood	Nurse Practitioner	Etobicoke
Ana	Yurgan-Rotella	Nurse Practitioner	John Noble Home, Brantford

