

The RGP's of Ontario: Three Frequently Asked Questions

1. What is a comprehensive geriatric assessment?
2. What are specialized geriatric services?
3. What should be included in the ideal basket of specialized geriatric services?

Introduction

While most seniors live healthy and active lives, a small portion become frail and are at risk of avoidable hospitalization and avoidable or premature institutionalization. Based on a systematic review, the average prevalence of frail seniors in the community is estimated at 10.7% (Collard, et al., 2012). Frail seniors with complex health problems have unique needs and present specific challenges for accurate assessment, diagnosis, and treatment that cannot be met by specialties that focus on specific organs or a limited range of illnesses. A targeted approach is therefore required for the proportion of seniors with complex and/or multiple chronic conditions that cross traditional specialty boundaries. It is this subset of seniors, who are at risk of further losses of health and independence and higher use of health care resources that specialized geriatric services (SGS) are intended to serve. The goal of SGS is to reduce the burden of disability by detecting and treating reversible conditions, recommending optimal patient-centred care, and management of multiple co-existing chronic conditions. Outcomes of SGS include (Stuck et al., 1993; Wilding, 2015):

- Prevention of avoidable Emergency Department (ED) use, hospitalization, alternate level of care (ALC), and premature institutionalization
- Prevention of avoidable decline in high risk seniors with complex medical and psychosocial problems
- Increased functional ability, independence, and quality of life for seniors and their caregivers
- Improved clinical efficiencies in acute care
- Improved patient outcomes
- Enhanced capacity of health care providers to assess and treat frail complex high-risk seniors
- Enabler for care coordination

What is a Comprehensive Geriatric Assessment?

Comprehensive Geriatric Assessment (CGA) guides a multidimensional, specialized geriatric team approach to care that determines a frail older person's biomedical, psychosocial, functional, and environmental needs, and initiates an appropriate treatment and follow-up plan. CGA may be provided in various specialized geriatric inpatient, outpatient, and community settings. CGA is delivered in a patient-centred, interprofessional collaborative practice model. Teams that provide CGA integrate with primary care, specialists, and other providers to ensure a patient-centred approach. Integration of health and social care processes is critical to improved services and outcomes for older adults (Briggs & McElhaney, 2014).

There is evidence demonstrating that CGA improves diagnostic accuracy, optimizes care plans, improves patient and system outcomes, and assists clinicians in identifying the need for treatment change (Applegate, et al., 1990; Rubenstein, et al., 1991). The following diagram illustrates the various inter-related components of CGA.

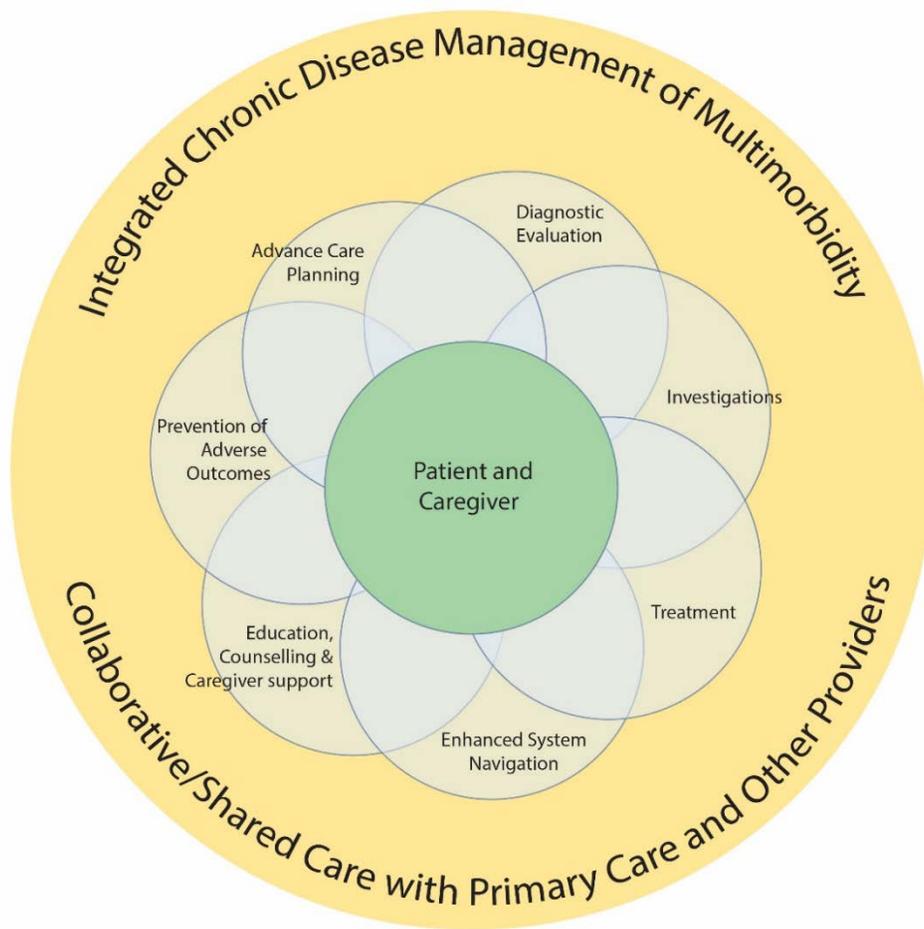


Figure 1: Inter-related components of CGA

CGA Components

- **Diagnostic Evaluation:** specialized geriatric assessment of high risk seniors by qualified geriatric teams using a combination of standardized screening, diagnostic assessment, and clinical expertise to inform appropriate plan of care
- **Investigations:** laboratory testing, diagnostic imaging, etc.
- **Treatment:** delivery of evidence-informed treatments that are aligned with patient-focused goals, priorities and prognosis; treatment plans take into account the interacting effects of multiple co-existing chronic diseases (crossing traditional specialty boundaries to provide integrated chronic disease management)
- **Enhanced System Navigation:** efficient navigation and care coordination of assessed seniors to/with the most-appropriate provider(s), setting(s), and type(s) of intervention(s)
- **Education, Counselling, & Caregiver Support:** improving capacity of patients and caregivers to self-manage disease, and to prevent crises that lead to avoidable unnecessary use of acute care services
- **Prevention of Adverse Outcomes:** optimizing the environment and supports (e.g. environmental modification, devices, human resources, etc.) to prevent traumatic and adverse events (e.g. motor vehicle crashes, medication errors, falls, or burns that lead to prolonged hospitalizations), and to reduce the burden of other chronic diseases (e.g. CHF, Diabetes) that also lead to avoidable hospitalization when poorly managed

- **Advance Care Planning:** patient-centered goals of care to prevent unnecessary investigations and treatment that carry unacceptable cost and risk to patients while offering little to no benefit to the patients
- **Integrated Chronic Disease Management of Multimorbidity:** supports *Mind, Mobility, and Medications in the Multimorbidity (M4)* experience of older people (crossing the traditional disease-specific specialty boundaries – e.g. managing DM, CHF, COPD in the face of dementia, mental health issues, or social determinants of health)
- **Collaborative/Shared Care:** integration and linkages with primary and community care providers and caregivers to support care plans; to ensure gains made are retained and chronic conditions can be managed to avoid crisis situations in the future (e.g. to prevent avoidable ED use, avoidable hospitalizations, avoidable ALC, or avoidable institutionalization)

What are Specialized Geriatric Services?

Specialized Geriatric Services (SGS) are a spectrum of hospital and community-based health care services that deliver CGA. They diagnose, treat, and rehabilitate frail older persons with complex medical, functional, and psychosocial problems. SGS are delivered by interprofessional teams of geriatric and geriatric mental health care providers specifically trained to recognize and treat frail seniors with multiple and complex needs. Teams may comprise the following: physician, nurse, social worker, physiotherapist, occupational therapist, dietician, pharmacist, and other health professions.

The target population for SGS is frail seniors whose health, dignity, and independence are at risk due to:

- multiple complex medical and psycho-social problems
- a recent unexplained decline in health and/or level of function
- loss of capacity for independent living

These risks, in turn, place frail seniors at risk for avoidable ED visits, avoidable hospitalization, avoidable ALC, and premature LTC placement. SGS prevents such undesirable and costly outcomes by addressing the following common conditions:

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|---------------------------------|----------------------|
| • cognitive impairment/dementia | • functional decline |
| • delirium | • poly-pharmacy |
| • depression/mood disorder | • substance misuse |
| • responsive behaviours | • malnutrition |
| • falls/mobility | • pain |
| • incontinence | • caregiver burden |
| | • elder abuse |

Types of Specialized Geriatric Services (Basket of Services)

The following core specialized geriatric services (SGS) deliver comprehensive geriatric assessment (CGA) that optimizes the function and independence of frail seniors, preventing avoidable ED visits, avoidable hospitalization, avoidable ALC, and premature LTC placement, thereby supporting aging in place in the community. Collaborating with community and primary care, these services are delivered in a variety of settings.

Outreach Teams

Comprehensive assessments in the older person's place of residence are conducted by one or more health care professionals. These 'eyes on the ground' are critical to understanding the social determinants of health within the home setting that can lead to loss of control of other diseases and ED use/hospitalizations. These teams collaborate with community and primary care and provide system navigation to keep at-risk seniors at home and out of hospital.

Outpatient Geriatric Clinics

Clinics are used to assess, diagnose, treat, monitor, and follow older persons in a clinic setting.

Geriatric Day Hospitals

These ambulatory programs provide diagnostic, rehabilitative, or therapeutic services to persons living in the community who require more care than a Geriatric Clinic can provide.

Geriatric Emergency Management (GEM)

Consultation by a specialized geriatric health professional in the emergency room providing: assessment, diagnosis, identification of "at risk" older persons, initiation of appropriate treatment, and linkages with community and primary care.

Inpatient Consultation Teams

Interprofessional teams provide inpatient consultation, assessment and treatment of patients with complex needs and/or geriatric syndromes.

Acute Geriatric Units/Acute Care of the Elderly Units

Inpatient hospital units in an acute care setting for complex frail older persons with multiple comorbidities who require short-term diagnostic investigation and treatment.

Geriatric Assessment and Treatment Units/Geriatric Rehabilitation Units

Inpatient units for frail older persons with complex medical conditions who, following an episode of surgery/illness/injury, require an individualized assessment, treatment, and rehabilitation program.

Geriatric Mental Health Services

Geriatric mental health professionals provide assessment and treatment for those older persons who may have psychiatric, behavioural, addiction, or psychosocial issues. Although not one of the funded core SGS, geriatric mental health services are an important part of the continuum of service for frail seniors. At many sites, geriatric mental health services are provided in an integrated or collaborative model with SGS.

Selecting from the Basket of Specialized Geriatric Services

CGA performed by SGS can take place in a variety of settings. The RGPs advocate that CGA should be available across the continuum of health care services in community, emergency, inpatient, and long-term care settings, and delivered by an interprofessional, specialized geriatric team.

There are a number of contextual factors that influence the composition of the ideal basket of SGS. These contextual factors include the availability of interprofessional geriatric specialists; access to community services (CCAC and CSS); access to primary care; transportation; physical space; organizational readiness; bed availability; and residential care availability. Planning for specialized geriatric services must be guided by an assessment of population and regional needs, as well as available resources.

There is no one-size-fits-all basket of SGS for any given region. An individualized, strategically-tailored approach needs to be considered for every region. To support such an approach, the RGPs of Ontario are prepared to serve as consultants to the MOHLTC and LHINs as SGS Networks are considered for each region (i.e., to provide expert advice on the optimal basket of services for that particular region).

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