

## **Geriatric Access and Integration Network Consultation on Specialized Geriatric Services**

### **Background**

The Geriatric Access and Integration Network (GAIN) has been asked by the Hamilton Niagara Haldimand Brant Local Health Integration Network (HNHB LHIN) Board to assist them with establishing priorities for Specialized Geriatric Services (SGS) in this region. This information will be used to assist them with their Year 2 and 3 plans for the Aging At Home strategy funds and to assist them in making decisions regarding proposals for SGS. To this end, GAIN is aiming to develop an overall framework/model for SGS in this region that could be used to facilitate the development of SGS priorities and inform decision making by the LHIN Board.

### **Focus Group Consultation with Key Stakeholders**

The first step in this process involves focus groups with providers and clients across the HNHB LHIN. The goal of the focus groups is to begin to identify some of the gaps that currently exist within SGS, and to start to develop an overall model/framework for SGS.

Specialized geriatric services (SGS) include specialized geriatric assessment, consultation, short term treatment, rehabilitation, and short-term specialty case management. SGS uses interdisciplinary teams with expertise in care of the elderly. These services are one part of a larger health system for older adults. To assist the focus group participants, we have pulled together a summary of the SGS currently in place (see attached tables). This information has been taken from the Regional Geriatric Program – Central (RGPC) website. Since the time this information has been posted, there have been changes to some of the services. We have tried to provide a summary that is as accurate as possible, but some of the details may still need to be updated. We will ask for your feedback on this summary during the focus groups.

### **Integrated Systems of Care for the Elderly**

The Canadian health care system for the elderly has been described as fragmented, with negative incentives, lack of accountability, and inappropriate and costly use of the acute and long-term care.<sup>1</sup> Traditional health systems have been criticized for their inability to meet the complex medical and social needs of the elderly.<sup>2</sup> Services are often not coordinated, some overlap, and some leave needs unmet. Specifically, current problems associated with the health care of the elderly include: multiple entry points, service delivery influenced by resource contacted rather than patient need, redundant evaluations and minimal use of standardized tools, inappropriate use of costly services, long waiting times for services, inadequate transmission of information, and piecemeal response to needs.<sup>3</sup>

Integrated health systems were developed in response to problems with current health systems. Integrated service delivery models that provide comprehensive community-based medical and social services have been developed in an attempt to improve continuity of care for the elderly, as well as to

---

<sup>1</sup> Bergman, H., Béland, F., Lebel, P., et al. (1997). Care for Canada's frail elderly population: Fragmentation or Integration? *Canadian Medical Association Journal*, 157, 1116- 1121.

<sup>2</sup> Johri, M., Beland, F., & Bergman, H. (2003). International experiments in integrated care for the elderly. *International Journal of Geriatric Psychiatry*, 18, 222-235.

<sup>3</sup> Hebert, R., Durand, P.J., Dubuc, N., & Tourigny, A. (2003). Frail elderly patients. New model for integrated service delivery. *Canadian Family Physician*, 49, 992-997.

increase the efficiency and cost-effectiveness of health care and social services. Some programs attempt to improve coordination between services such as between hospital and home care. Others provide fully integrated services within one organizational structure, and others are designed around home care services.

### **Common Features of Effective Integrated Systems of Care:**

Various models or systems of integrated care for the elderly have been developed such as SIPA (Canada); PRISMA (Canada); PACE (USA) and CHOICE (Canada); of particular interest is the ASSIST model developed by the Regional Geriatric Advisory Task Force for Mississauga Halton. These models of care are described in Appendix A. There are a few common features of these models:

**Case management:** Integration is primarily achieved by case management. Case managers in most programs are embedded into the interdisciplinary team, so that teams are responsible for managing cases as well as providing (dispensing) services, which promotes coordination and continuity of services. This also promotes clinical responsibility and financial responsibility. On most teams, the case manager links geriatric evaluation with long-term management.

**Community-based care:** Integrated health systems provide primary and preventive services within the community as a substitute for institution care.

**Single Entry Point:** A single entry point system guarantees a sufficient client volume for financial stability and efficient operation and helps to ensure that resources are targeted on the basis of medical/psychiatric need.

**Multidisciplinary Teams:** Most integrated programs have a multi-disciplinary team, at minimum consisting of geriatricians/geriatric psychiatrists and nurses. Those integrated with social services also include a social worker.

**Standardized measures:** Some of these programs use standardized measures to identify needs (e.g., Minimum Data Set (MDS) and measures of functional autonomy such as the SMAF (Functional Autonomy Measurement System - Systeme de mesure de l'autonomie fonctionnelle).

### **Reflecting on Key/ Guiding Principles**

In developing a framework for SGS it is useful to reflect on the principles that underlie optimal care programs for the elderly. In our review of documents we found a variety of articulated guiding principles:

- Provision of person-centered care
- Commitment to enhancing quality of life and caregiver support
- Promotion of older person's health and independence
- Provision of services around person's needs
- Provision of services which support independence and help older person's to stay healthy
- Provision of evidence-based approaches to care
- Equal and timely access to services
- Early identification and intervention
- Flexibility in responsiveness to community and population needs
- Coordinated system of services across the continuum of care
- Respect for Diversity and Inclusiveness
- Ethical Principle of "Do No Harm"
- Accountability
- Aging in Place

## **Continuum of Care**

To further inform thinking about SGS within the continuum of care we have attached a document developed by the Ministry of Health and Long-Term Care for your review (See Appendix B).