Comprehensive Geriatric Assessments:

A Rural Ontario Area Case Study

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Résumé

Au fur et à mesure que les gens vieillissent, les problèmes médicaux se multiplient. Les systèmes de santé actuels de l'Ontario sont conçus pour mettre l'accent sur les soins actifs et épisodiques. Toutefois, les personnes âgées bénéficient de la prise en charge des maladies chroniques pour de multiples affections complexes. Comme le nombre de personnes âgées de plus de 65 ans devrait doubler d'ici 2041, il est évident que les systèmes de soins de santé doivent changer pour les populations actuelles et futures de personnes âgées fragiles. On s'entend généralement pour dire que l'évaluation et le soutien actuels des personnes âgées fragiles sont souvent incohérents ry fragmentés, ce qui rend les complexités de la fragilité plus difficiles à gérer adéquatement. La prestation de soins de santé en milieu rural peut être particulièrement difficile en raison des ressources locales limitées. Cet article décrit les méthodes d'amélioration des soins de santé pour les personnes âgées fragiles dans des régions essentiellement rurales. Un processus d'exploration des modèles existants de soins gériatriques et d'interaction avec les communautés locales a conduit à l'identification de considérations importantes pour améliorer les soins, car cela pourrait mener à des résultats plus positifs pour les personnes âgées fragiles. Les recommandations concernant les priorités de recherche futures seront également mises en évidence.

Abstract

As people age, it is well recognized that there is often an increase in their number of medical issues. Current health systems in Ontario are designed to focus on acute, episodic care. However, older adults benefit from chronic disease management for multiple complex conditions. As the number of individuals over the age of 65 years is expected to double by 2041, it is evident that health care systems need to change for current and future frail, older adult populations. There is general agreement that

existing assessment and support for frail older adults is often disjointed, fragmented and inconsistent, which makes the complexities of frailty more difficult to adequately manage. Provision of health care in rural areas can be especially difficult due to limited local resources. This article describes methods for improving health care for the frail elderly in largely rural areas. A process of exploration of existing models for geriatric care and interaction with local communities led to the identification of important considerations to improve care, as this could lead to more positive outcomes for frail older adults. Recommendations regarding future research priorities will also be highlighted.

Introduction

As people age, it is well-recognized that there is often an increase in medical issues. These problems can be cognitive or physical, or they may involve mental health. The medical community defines these increasing deficits as frailty. Frailty is described as a syndrome that encompasses a progressive multi-system decline that involves both the loss of physiologic reserve and an increased vulnerability to disease and death (Pioli, Davoli, Pellicciotti, Pignedoli, & Ferrari, 2011). Care for older adults is often complex due to co-existent medical, psychological, functional and social issues (Ellis, Whitehead, Robinson, O'Neill, & Langhome, 2011). Concurrent conditions can lead to atypical presentations for older adults, which increase the risk of misdiagnosis and/or inadequate treatment plans. Ellis et al. (2011) indicate that older adults require a different approach to care.

Current health systems in Ontario are designed to focus on acute care; however, older adults need chronic disease management (Prasad et al., 2014). Furthermore, Prasad et al. (2014) indicate that services for older adults are disjointed and are often described as "siloed", with little collaboration between agencies. This makes the complexities of frailty that much harder to adequately manage.

Older adults living in rural areas can be even more vulnerable.

Older adults living in rural areas can be even more vulnerable. A qualitative meta-synthesis of 12 studies from North America, Europe, Australia and New Zealand explored barriers to accessing health care for rural patients with chronic disease (Brundisini et al., 2013). The authors communicated three major hindrances: geographical distance (especially in poor weather), limited access to health care professionals, and potential feelings of vulnerability when leaving the culture of their rural community to seek out distant urban care. Crosato and Leipert (2006) noted that rural women caregivers across Canada identified the barriers of limited access to services due to geographical distances from regionalized centres and difficulty with accessing and affording transportation from rural communities.

It is evident that current systems need to change, both for the well-being of seniors accessing health care and to provide sustainable health care for future Ontarians as our population ages. The number of adults age 65 years and older in Ontario is projected to more than double from the current 2.2 million (16 % of the population) to over 4.5 million by 2041 (Ontario Ministry of Finance, n.d.). In response to the significance of this projection, the Ontario Ministry of Health and Long-Term Care introduced the Assess and Restore Guidelines in 2014 (Assess and Restore Guidelines, 2014) intended to inform the healthcare protocol for seniors going forward. The proposal that follows is based on these guidelines.

Implementation of this guideline is intended to

- extend the functional independence of community-dwelling frail seniors and other persons for as long as possible;
- reduce caregiver burden by improving psychosocial and health outcomes for community-dwelling frail seniors and other persons;
- facilitate the adoption of evidence-based clinical processes and interventions that have demonstrated efficacy in improving functional independence for community-dwelling seniors and other persons (Assess and Restore Guidelines, 2014, p. 1).

Sinha (2012) states that "despite older Ontarians being such large consumers of health care services in Ontario, there is a critical deficiency of geriatricians and physicians with expertise in caring for these older adults" (p. 145). The provision of geriatric services varies within and across different Local Health Integration Networks (LIHN) in Ontario, however, the majority of specialists practice in larger urban settings (Sinha, 2012). At the time of this research, the South West Local Health Integration Network (SW LHIN), responsible for the regional administration of public health care in southwestern Ontario, had not yet developed an overarching strategy to address comprehensive needs of frail older adults. Consequently, health care providers in many rural regions of the SW LHIN were, and are, compelled to adapt existing resources to meet the growing need. This often results in the provision of less than optimal services for frail older adults.

Focus for the current research encompassed Huron and Perth Counties, a sub-region of the SW LHIN. This area was selected by the SW LHIN to explore strategies for the improvement of health care for older adults (SW LHIN, 2016). These two counties, like all areas of Ontario, will be seeing significant increases in the number of older adults over the next few decades (University of Western Ontario, 2016). Statistics Canada (2011) indicates that just over 18 % of the population in Huron Perth is currently 65 or older; that number is expected to double by 2041, however (University of Western Ontario, 2016). Of the 22,000 seniors currently living in Huron Perth, almost 6,000 are complex patients with four or more chronic conditions (HealthForce Ontario, n.d.).

Providing health care in this area is logistically more challenging than in other areas of the SW LHIN due to the large geographical area that it covers and the fact that 62.3 % of the population lives in rural areas (University of Western Ontario, 2016). If accessible services to help manage the complexities of health care for older adults are not developed and implemented for the aging populations of these counties, pressure may subsequently increase on strained hospitals and long-term care home systems to provide care for these seniors who will often reach a point of crisis before receiving the comprehensive support they need.

Comprehensive geriatric assessments (CGA) can be the first step in improving outcomes for frail older adults. A CGA is "a multi-dimensional interdisciplinary diagnostic process to determine the medical, psychological and functional abilities of frail elderly people in order to develop and coordinate integrated plans for treatment and long-term follow-up" (Monteserin et al., 2010, p. 239). Pioli et al. (2011) indicate that CGAs are a two-stage process. In the initial stage of client engagement, this assessment identifies various medical, functional and psychosocial challenges. Then, based on this assessment, an interdisciplinary treatment plan is developed in the subsequent stage of client support. This helps to prioritize interventions, support unmet needs and then continue to provide ongoing care and follow-up. Evidence supports the use of CGAs to improve clinical outcomes and increase quality of life for frail older adults (Pioli et al., 2011). In addition, the use of CGAs has been shown to postpone or prevent acute care use and institutionalization, which keeps individuals at home in their communities longer (van Leeuwen et al., 2015).

Two key questions were investigated in this study.

- What gaps or barriers prevent older adults from obtaining a CGA and follow-up care in Huron Perth?
- What key features are important to providing reliable and equitable access to a CGA and follow-up care for frail older adults living in Huron Perth?

The current proposal attempts to identify methods for improving access to comprehensive assessments for frail older adults in these counties. However, although the research presented below is specific to Huron Perth, it is believed that some findings may be generalizable to other rural areas and would warrant further investigation and research. It is hypothesized that this research could assist regional health service planners, social workers involved in direct geriatric care as well as geriatricians entering practice, and could also be used to improve service delivery for frail older adults in rural areas. Improved service delivery could have a direct positive impact on individuals and their caregivers, and in turn may lessen strain on hospital and long-term care services.

Methods

The method of study was a qualitative, phenomenological design, which consisted of in-depth individual and group interviews with clinicians, community agency representatives and individuals with lived experience. An open-ended interview format was utilized to identify key themes and to analyze and compare results across interviews. This research was completed in three phases spanning five months, from November 2016 to April 2017. This author joined the project in its second month, as a Master of Social Work intern, and for three succeeding months completed research for each of the three phases of the project. Method of sampling and data analysis will be explained within each phase below.

Phase I—Develop Critical Path and Research Key CGA Model Elements

The initial phase of the project involved the gathering of pertinent background information and the development of a critical path for the project by members of the SW LHIN. A steering committee of thirteen members was created, with representation from geriatric specialists and specialized geriatric services, geriatric community services, hospital and physician leads, and SW LHIN Team Leads. This group provided oversight and feedback to the Core Working Group. The Core Working Group consisted of seven members and was tasked with providing project direction.

Research for the initial phase focused on investigating several existing CGA models located both within and outside of the SW LHIN. Several specific features were explored and documented within each model of access, including referral processes, screening processes, assessment processes, treatment, system navigation and education, follow-up and continuing care, and collaborative support for frail older adults.

Seven models were explored through online research and telephone interviews. Common key model components were identified. Key components were summarized in a working document under the following categories: access and referral process, screening process, assessment, treatment, system navigation and support, follow-up and ongoing care, and collaboration.

Phase II—Research Current State in Huron Perth

Various stakeholders from diverse areas across the Huron Perth region were identified by members of the Core Working Group. These stakeholders included eight physicians and geriatric specialists, two groups of community service organization representatives, and one caregiver group. Stakeholders were engaged, through telephone interviews, in order to gain a basic understanding of existing pathways for CGA access for frail older adults within the Huron Perth sub-region. Perceived strengths and gaps in this region were also identified. Specific questions were explored in each interview to elicit information (Appendix A). Key responses and messages were summarized and synthesized into a working document. Similarities and differences were noted between physicians' responses and home and community care organization responses.

Phase III—Stakeholder Engagement and Feedback

Data analysis consisted of a comparative examination between consistent aspects of the explored CGA models and the perceived strengths and gaps in health care for frail older adults as identified by Huron Perth interviewees. A PowerPoint presentation was created to summarize information obtained from previous phases of the project and presented to key stakeholder groups through webinars and on-site presentations. Eight stakeholder groups were identified by the Core Working Group and these included representation from specialized geriatric programs, geriatric health care providers, long-term care organizations, and patient and family representatives. Group members included Huron Perth providers and also extended into other areas of the SW LHIN. Information and feedback obtained through these presentations was then integrated into a stakeholder engagement summary.

The identified key CGA model features, the current state for CGA access in Huron Perth, and the strengths and gaps in specialized care for frail older adults were then combined to create a final document. This final document provided key model components contrasted with current Huron Perth experiences. This allowed for deeper analysis and encouraged consideration of important CGA components for future development of programs and strategies. These components may help to address the healthcare needs of frail older adults going forward in Huron Perth and possibly other areas as well.

Results

Seven features of CGA delivery models were analysed: access, screening, assessment, treatment, education and support, follow-up, and collaboration. Common key features for each were identified. Most models were defined as full CGA. Subsequent interviews with providers, community agencies and caregivers within the Huron Perth sub-region identified perceived strengths and gaps in geriatric assessment and ongoing care for this region. Feedback obtained from these findings produced suggestions and considerations for system change moving forward in the care of frail elderly clients.

Key aspects of the models researched were found to include

- specialized geriatric-trained interdisciplinary teams, with variances in the number of disciplines represented;
- timely single-point access to CGA, which allows for triaged screening processes;
- preliminary tests completed prior to full assessment by trained assessors who are determined to be best suited for specific needs of individual clients;
- primary care physicians engaged in all aspects of care; geriatric specialists involved or consulted as needed; and

- assessment, follow-up and ongoing care offered locally or in-home as needed.

In most models, one professional functioned in a case management role to provide ongoing support and education, and to facilitate system navigation for clients and families. Models promoted regular, planned and flexible follow-up assessments and ongoing care planning. High value was placed on collaboration and communication between inter-professional team members. Regular patient care reviews were scheduled in larger team models, and frequent collaboration with geriatric community agencies was highly valued.

Interviewees from Huron Perth area consistently identified that current system access to CGA is inconsistent, inequitable, limited and difficult to navigate for providers, agencies, clients and caregivers. There appears to be a lack of clarity regarding what constitutes a CGA and who provides the assessments. No formal screening tool reportedly exists to identify whether a CGA would be beneficial. Although identified as valuable, access to inter-disciplinary teams appears to be inconsistent, and professionals on these teams appear to have minimal or no specialized geriatric training. When multiple providers are involved in care, access to records and test results is limited, often prompting duplication of assessments. This was described as very frustrating for clients and caregivers. Systems were consistently described as "siloed". Limited access to geriatric specialists creates long wait times for assessment which causes physicians to refer only most urgent cases or to not refer at all. Providers and caregivers identified travelling to larger centres as a significant barrier. Distance and unfamiliarity of location discouraged attendance at assessment appointments. No consistent case manager role to ensure follow up and ongoing care for individuals was identified during interviews. Many clients and caregivers doubted the value of assessments because results often did not equate to changes in levels of support or care. As a result, they often chose not to attend initial appointments or reassessments. Providers indicated that they would value more opportunities to consult with geriatric specialists regarding the ongoing care of frail elderly, as this was described as limited or non-existent in their current situations.

Feedback upon presentation of the above results to Huron Perth stakeholders provided general support of initial findings. It was agreed that there are currently some good geriatric initiatives and programs available in Huron Perth, although those initiatives and programs have been described as "siloed", inconsistent, inequitable and often fragmented. In response to the information presented, stakeholders suggested that there might be a benefit in integrating, linking and merging current initiatives. Several additional considerations were identified. Stakeholders felt that Huron Perth would benefit from an overarching geriatric strategy that would provide more equitable and timely access to health services for frail, elderly patients, incorporate the use of a standardized assessment tool, and provide centralized intake processes. They identified the benefit of client and

THEY IDENTIFIED THE BENEFIT OF CLIENT AND CAREGIVER ACCESS TO LOCAL, SPECIALIZED INTER-DISCIPLINARY TEAMS AND CASE MANAGERS FOR SYSTEM NAVIGATION AND SUPPORT.

caregiver access to local, specialized inter-disciplinary teams and case managers for system navigation and support. The importance of providing initial and ongoing CGA assessment training for interdisciplinary teams was stressed, as well as education to providers and service organizations concerning CGAs and the potential benefits of assessment.

DISCUSSION

What Was Learned from Huron Perth

Qualitative data obtained in this research through open-ended interviews with providers, community agency representatives and caregivers produced consistent messages that would be important to consider when developing or reconstructing comprehensive care for frail older adults. There is no consistent understanding of what a CGA is, who is trained to complete it, and where or how to refer patients who would benefit from one. This confusion is compounded by current systems that provide inequitable and inconsistent access to a CGA and supportive follow-up care. Some individuals are referred to memory clinics, some to specialized geriatric services, others to Behavioural Supports Ontario, and still others to internists. If frail older adults do not require any of these supports, they tend to "fall through the cracks".

There appear to be many helpful existing services and initiatives within Huron Perth, but they are described as very siloed by individuals, providers and community service agencies. Most expressed tremendous frustration at the need to duplicate lengthy assessments. When referred to specialized geriatric services, individuals or caregivers will sometimes decline the referral because of long travel distances and wait times, and they often doubt that the CGA will produce health benefits or added ongoing support. Because of high demands for geriatric services, physicians often refer only urgent cases, and long waits may mean health-related decisions are often made before a full assessment can be completed.

Promising CGA Practices

Common CGA practices were identified across many of the models examined in this research. Many of these practices would appear to address the issues that were consistently reiterated during interviews with Huron Perth health care providers, geriatric community agency representatives and caregivers. In the development of a model of care for the frail elderly, it would be important to consider the key features presented below.

Models consisted of professionals from various disciplines who were trained to be geriatric assessors. It is suggested that specialized interdisciplinary teams be utilized. Assessors

would receive advanced training to be able to complete core components of a CGA. Geriatric specialists would designate regular times to be available on site or by teleconference to assess complex cases, consult or provide education as needed. This would optimize the limited availability of geriatric expertise. Assessors would also function as case managers for individuals and their families. Beyond initial assessments, assessors can assist with system navigation and become a consistent point of access for clients for care planning and reassessment as needed. Crisis response as well as proactive follow-up may prevent or delay hospitalization and residential placement.

CRISIS RESPONSE AS WELL AS PROACTIVE FOLLOW-UP MAY PREVENT OR DELAY HOSPITALIZATION AND RESIDENTIAL PLACEMENT.

To improve access to CGA support for frail older adults, several features from the models examined could be effectively engaged.

- First, creation and implementation of a common screening tool would help identify when a CGA would be appropriate and helpful. This would make referral criteria clear and could ensure that individuals are triaged to the most appropriate interdisciplinary assessor, based on identified needs.
- Second, identifying a single point of access for a CGA would reduce confusion regarding where clients who require this assessment should be referred. However, it will be important that many providers and agencies have the ability to make referrals, as the first contact point for frail older adults may be hospitals, health care providers, home care or other geriatric community agencies.
- A third important feature emphasizes the need for access to geriatric services locally, either in communities nearby or in seniors homes, if necessary. Multiple satellite locations would be beneficial in addressing the identified barrier of distance.
- Lastly, access needs to be timely. It is suggested that increased CGA training among multiple interdisciplinary professions will decrease wait times for specialized geriatric services. Timely access is helpful as both a preventative measure and a means of addressing immediate needs that often bring frail older adults to seek support or medical care.

Collaboration has been identified as an important feature in geriatric care. The importance of involving primary care physicians at all points of care, including assessment, treatment and follow-up cannot be overstated. Similarly, regularly scheduled face-to-face collaboration with the CGA interdisciplinary team and area service providers, such as the local Alzheimer Society, Home and Community Care, and Behavioural Supports Ontario, is imperative. This

would both minimize duplication of assessments and ensure that appropriate supports are offered to individuals and their families. Information sharing is vital to providing comprehensive care for frail older adults.

Implications

It is suggested that establishing a rural geriatric model of care in Huron Perth that incorporates the identified components from this study would help ensure wrap-around care, provide equitable access and minimize barriers to treatment for frail, elderly patients living in this area. It would promote early intervention, minimize risk and reduce caregiver burden and stress for both frail elderly patients and their caregivers. Services would be delivered in-home or within communities and would ensure that clients and caregivers are active participants in the development of care plans and ongoing support. Increased access to CGAs and ongoing follow-up may allow frail, elderly patients to remain in their communities and homes and possibly prevent many hospital visits.

Latham and Ackroyd-Stolarz (2014) indicate that adults over 75 years of age account for over 70 % of emergency room visits in the United States. In Ontario, in 2014/15, the proportion of visits to emergency rooms among people aged 65 and older grew faster than any other age group, with about 60 visits per 100 people of this age group (Health Quality Ontario, 2016). The duration of visits is longer for elderly patients, and individuals from this age group are more likely to be admitted than their younger counterparts. As our population continues to age, it is expected to produce increased strain on a system that is already feeling overburdened (Heckman, Molnar, & Lee, 2013; Latham & Ackroyd-Stolarz, 2014). CGAs provided in hospital have been shown to increase the chances that elderly patients can continue to live independently in their own homes after an emergency admission (Ellis et al. , 2011). When frail older adults receive a CGA proactively and in a timely manner, it might reduce the chance that they will need an emergency room visit or hospital admission. Long-term care residential placement might also be postponed. The presumption would be that there would be reduced utilization of hospital beds for frail older adults waiting for long term care beds, as is currently often the case (Dakin & Crowe, 2012). In addition, this may reduce wait lists for long-term care homes if health can be maintained or improved.

This study highlights important considerations for systemic change in the way older adults with complex conditions are cared for within the health system.

This study highlights important considerations for systemic change in the way older adults with complex conditions are cared for within the health system. Identified components from this research demonstrate best practices for the development of geriatric care strategies for the frail elderly in Huron Perth. The direct

and positive impact of improving care for frail older adults is unmistakable for individuals and caregivers. These findings may also have implications for the rest of Ontario and all of Canada. More research and attention is required to distinguish whether findings can be replicated in other rural areas. Identifying consistent key best practices will be important, as these best practices could be then modified and developed to best suit specific regions with varying resources. It is possible to envision favourable outcomes at the community and systemic levels as we anticipate increased need and significant pressure on existing health systems.

Limitations

The information gained through current research is limited as it represents a specific, rural location and, therefore, may not be generalizable to other rural areas without additional research. Current findings are meant to provide a basis for additional research and to identify key components to consider when providing geriatric care. This research was time- and resource-limited and involved only a cross-section of representatives who work with frail elderly clients. Although key themes were consistently identified, it would be beneficial to engage additional groups and providers. It may also be beneficial to explore additional CGA models in depth.

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Appendix A

Stakeholder Focus Questions

1. What do you see as current key strengths in the care of older adults with complex chronic conditions in your community (frail elderly)?
    - Do patients/clients currently have care through a multi-disciplinary team (i.e. SW, OT, NP, etc)?
        - Is there any practitioner who functions as a Care of the Elderly physician?

- Which of the services listed above (on stakeholder engagement) are available?
- Which are missing?

2. What areas of care for older adults do you feel need improvement?
3. Who completes CGA+ for patients/clients in your area?
   - How do patients/clients currently obtain a CGA+ (what is the path)?
     - At what point in a client's journey are referrals made to geriatrician or SGS?
     - What tells you that you need more assistance?
       * Are patients screened first, how (tools used?), and by who?
     - If you have made referrals, what has been your experience (amount of time, where needs met, what was the outcome)?
   - If patients receive a CGA+, who develops a care plan?
     - Is there regular on-going follow-up care planning, if so by who?
   - Who assists with system navigation and education/support for illnesses for patient/client and caregivers?
4. What would you see as critical priorities to address in specialized geriatric services:
   - Within next 1-2 years
   - Over the next 3-5 years
5. What benefits would you see in having a connection to a local geriatrician (how would you utilize this access)?
6. Due to the complex needs of the frail elderly, geriatric services appear to best function using an integrated approach:
   - What do you see as key priorities for partnership and collaboration in the care of older persons with complex chronic conditions?
   - What would you need to get out of an integrated model?
   - What would be the barriers?
   - What could you contribute?
7. Are there any other issues or opportunities that are important to the development of specialized geriatrics in your community that we have not yet discussed?

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