GERIATRICS AMBULANT SERVICE

Counselling, assessment and orientation

« So what ? » or « What else ? »...
General context (1)

- Increased life expectancy in developed countries: «the geriatric tsunami»
  - Ageing baby-boomers
  - Progress in health care and medicine for prevention and treatment

- Impact on society

- Impact on hospital management and economic cost
1. Déficit des naissances dû à la guerre de 1914-1918 (classes creuses)
2. Passage des classes creuses à l'âge de fécondité
3. Déficit des naissances dû à la guerre de 1939-1945
4. Baby-boom
5. Fin du baby-boom

Source : Insee.
Most of elderly people live without disability

...But some of them can suffer:

- Results of physiological ageing on abilities.
- Results of acute medical problems and/or chronical diseases.

These accumulated facts may lead to FRAILTY
Definition of frailty concept:

- Woodhouse, 1988: neither « too good » nor « too bad »

- Campbell, 1997: multi-systemic reduction of remaining and reserving abilities
  ➔ Near symptomatic failures and risk of disability
LE « VIEILLARD FRAGILE »

Réserves fonctionnelles

vieillissement

insuffisance

50 100 ans
General context (4)

- Elderly people and hospital (1):
  - 50% of patients > 60 years old
  - Increased frequency of hospital admission
  - Increased length of hospital stay
  - Complexity of diagnosis because of polypathologic condition
  - Non-proficiency on all pathologies in « over-specialized » units
General context (5)

- Elderly people and hospital (2):
  - Increased risk of multiple organic complications
  - Increased risk of disability
  - Orientation difficulties:
    - Up to 25% of non-appropriate orientation after admission in emergency units
    - Insufficiency in social context assessment
Birth and growth of geriatric ambulant service (1)


- « Official » acknowledgement since 2002: « geriatric ambulant service may be useful »

- 2004-2007: creation of many teams on an « anarchic » way (sometimes without geriatric physician...)
Birth and growth of geriatric ambulant service (2)

- 225 geriatric ambulant teams in 2007, most of them created after 2003 (sultry summer)

- 2007-2012:
  - Geriatric ambulant service as necessary link
  - Definition of organisation
  - Definition of activity indicators
Enquête DHOS 2007 : Répartition régionale des EMG
Goals and missions (1)

- General idea: to provide non geriatric professionnals with an expert geriatric approach on geriatric topics:
  - Walk impairment and falls
  - Incontinence
  - Cognitive impairment (+++)
  - Pressure ulcers
  - Pain
  - Palliative care
  - Fonctionnal loss
  - Drugs use
  - Etc
Goals and missions (2)

- **Counselling for diagnosis, treatment and management of these kinds of problems**
- **Support for analysis of complex situations**
- **Information to medical and paramedical professionnals about geriatric syndroms and rules of conduct**
- **Keys for global assessment of the patient’s situation**
Goals and missions (3)

- Help for preventing complications and « collateral damages » of hospitalisation
- Support for building care plan and life project
- Help for final orientation of the patient (own residence, gerontology units,...)
- Keys for preventing further hospitalisations
Goals and missions (4)

- The « battlefield »:
  - In hospital:
    - Emergency unit
    - Medicine and surgery units
  - Out of the hospital:
    - All kind of care and cure sectors (clinics....)
    - Nursing homes
    - Patients’ own residence
Means

- A headquarter: a single office with a single telephone number

- A pluridisciplinary professionnal team with strong geriatric skill, ideally composed at least of:
  - Secretary
  - Geriatric physician
  - Nurse
  - Ergotherapeute
  - Psychologist
  - Social worker
Rules (1)

- Anyone can call, but the request must be known and accepted by the physician in responsibility of the patient.

- 2 professionnals of the team at least take part in the first assessment of each patient - If necessary, an other professionnel can be sent to complete the assessment.

- The assessment aims to answer the questions that are asked but keeps a global look on the patient’s situation.
Rules (2)

- Each assessment ends with a collective pluridisciplinary brainstorming

- A conclusion report is sent to the physicians in charge of the patient
  
  This report includes advices for management of the patient’s condition - The physicians can choose to apply them or not

- We shall not take part in the diligence of our advises (counselling but not directing)
Method: Comprehensive Geriatric Assessment (1)

- CGA and multidisciplinary intervention proved in several studies efficiency on:
  - Improving health outcomes of older people
  - Reducing morbidity and mortality
  - Reducing risk of admission to hospital
Method:
Comprehensive Geriatric Assessment (2)

- **CGA means:**
  - Acute investigation on patient’s medical history and way of life
  - Global and complete physical examination
  - Psychic and cognitive examination
  - Fonctionnal assessment for all kind of activities
Method: Comprehensive Geriatric Assessment (3)

- Using different kinds of tools and scales:
  - Get up and go test
  - Tinetti test
  - Mini Mental State Examination (Folstein)
  - Mini-Nutritional Assessment scale
  - Geriatric Depression Scale
  - Pain scales
  - Activities of Daily Life (Katz)
  - Instrumental Activities of Daily Living (Lawton)
  - Etc...
Benefits (1)

- For patients:
  - Global health and abilities check-up
  - Reduced morbidity and mortality by prevention

- For non-geriatric professionnals
  - Easy access to expert counselling
  - Improvement of patient’s management
  - Apprenticeship
Benefits (2)

■ For us:
  - Diversity of situations and action grounds
  - Improvement of experience
  - Interactivity on all levels
  - Global look on hospital’s organisation:
    what does work vs what doesn’t work?

■ For hospital and society: reducing hospitalisation’s costs?
Limits (1)

- **Long process:**
  - 2 hours/patient at least
  - 5 patients/day max

- **No absolute guarantee of major efficiency on severely impaired or very frail patients** (*CGA is not a « magical » process*)

- **Requires an hospital geriatric unit for better efficiency** (*classical hospitalisation, day hospitalisation, week hospitalisation, rehabilitation hospitalisation*)
Limits (2)

- Under-use: no geriatric assessment if the frailty elements are not detected by non geriatric professionnals

- Mis-use: geriatric assessment for « bed-blockers » management in hospital units

- Over-use? ... Not yet!
Geriatric ambulant service in the hospital of Mulhouse (1)

- Birth: 2006
- Location: geriatric unit
- Team:
  - 1 secretary
  - 2 physicians
  - 2 nurses
  - 1 ergotherapeute
  - 1 psychologist
  - 1 social worker

370 000 Euros/year
Geriatric ambulant service in the hospital of Mulhouse (2)

- **Intervention grounds:**
  - In hospital:
    - Emergency unit
    - All medicine and surgery units
  - Out of hospital:
    - All cure and care structures
    - Nursing homes
    - Residence of patients
Geriatric ambulant service in the hospital of Mulhouse (3)

- **Activity:**
  - 2006: 234 patients (middle age: 80)
  - 2007: 610 patients (middle age: 76)
  - 2008: up to 700 patients, real beginning of activity out of the hospital

- Only 50% of advices applied in medicine and surgery units

- More efficiency in the emergency unit
Conclusion (1)

- « So what? »
  - Problems for transmitting « geriatric culture »
  - Problems of under-use and mis-use
  - Real economic efficiency?

« Geriatric ambulant service will be a success as soon as it will not have to exist anymore »

Pascal COUTURIER, GRENOBLE
Conclusion (2)

- « What else ? »

- Useful process for patients and non geriatric professionnals

- Makes the dividing walls fall for better functionning at all levels

- Very interesting and enriching job for geriatric professionnals

- Possible part of bigger systems such as networks with lots of possible partners
Thank you, and...