Geriatric Assessment Program and Integrated Care

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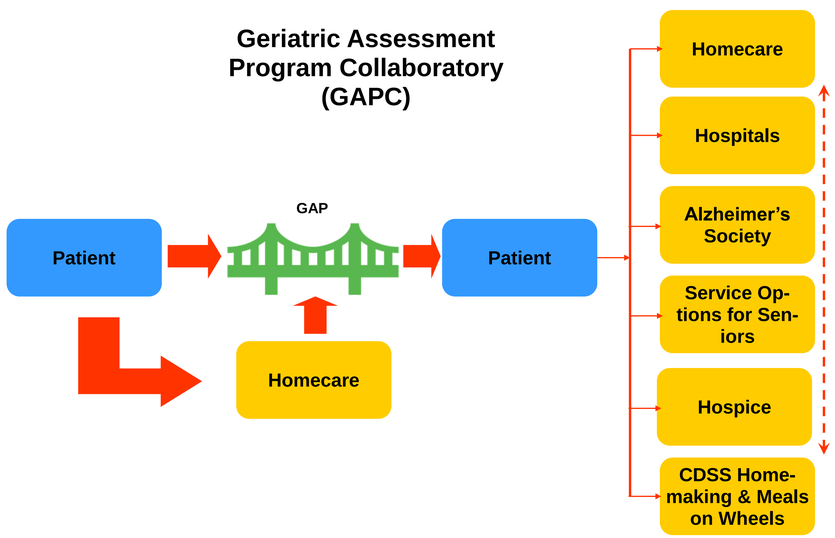
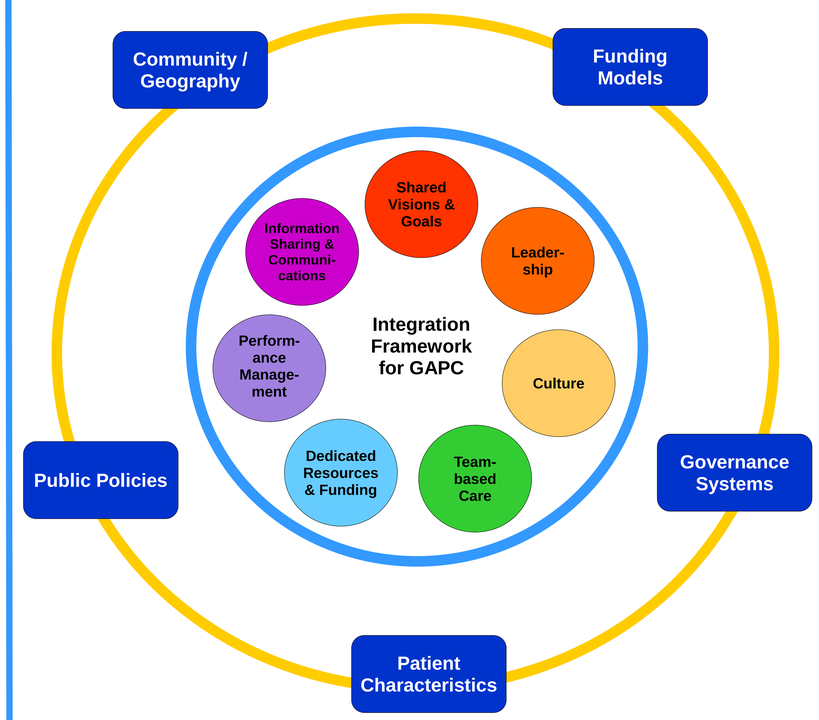
WHAT?



The Geriatric Assessment Program (GAP) is a program of the Camrose Primary Care Network (PCN). It is a PCN program designed to meet the needs of an aging population in Camrose and its surrounding areas in Alberta. The GAP has partnered up with community-based health and social care partners: Seniors Mental Health Outreach Team, Homecare, Homemaking and Meals on Wheels (CDSS), financial support services (Service Options for Seniors), hospitals and the Alzheimer's Society, to name a few. This collective of organizations (GAPC) has created an integrated network to ensure that vulnerable elderly patients and caregivers are better supported in the community through enhanced coordinated services delivery. The collaborative offers patient assessments, referrals among partners, patient and caregiver education, and health and social services navigation and provision.

HOW?



This integration framework illustrates the factors that are identified as contributing towards services integration among the GAPC organizational partners. Of the seven critical success factors, dedicated resources/funding, shared vision and goals, and communication and information sharing were identified as the most important integration enabling factors. Governance systems and the small community setting were identified as important external influencing integration factors.

SO WHAT?

PROVIDER OUTCOMES

- Greater awareness of service partners
- Relationships developed
- Enhanced community-based supports for GPs
- Increased patient referrals
- Greater collaboration
- Enhanced communication
- Sharing resources

PATIENT OUTCOMES

- Enhanced health and social services navigation
- Reduced acute care utilization
- Greater caregiver/family support & trust
- Enhanced quality of life
- Better services coordination
- More comprehensive care
- Greater access to services (Healthcare & Social care)
- Crisis reduced
- Reduced inappropriate medication utilization
- More appropriate care
- Better client/patient needs identification
- Less isolation
- More comprehensive care
- Stay at home longer

Several perceived outcomes were identified by GAPC partnering organizations as a result of their integration efforts. These outcomes can be grouped into two categories: provider-related outcomes, and patient-related outcome. For the former, greater awareness of service partners was the most commonly perceived provider-related outcome. For the latter, greater services coordination was the most commonly perceived patient-related outcome.

Lessons #1 Context matters

Contextual issues for GAPC include rurality, sense of community, Alberta's healthcare and social services governance systems, and Camrose & district's aging population.

Lessons #2 Champions are critical

Individuals in the GAPC who act as champions were critical in ensuring GAPC's success and sustainability.

Lessons #3 Technology was not essential

Despite the lack of a common information technology platform or EMR, integration was still possible.

Lessons #4 Complexity influences coordination

Highly complex patients require greater services coordination.

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