



*European Academy for Medicine of Ageing
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**Management of a Geriatric
Team / Ward / Network**

**Evidence based
medicine in geriatric
services**

Francesco Landi

*Centro Medicina dell'Invecchiamento
Cattedra di Medicina Interna e Geriatria
Università Cattolica del Sacro Cuore, Rome*

Mary's history

Mrs. Mary, 85 yrs old widow, lives alone in a third floor apartment without elevator. Her two daughters live hundreds miles far with their families and children. She has diabetes and hypertension, a small venous ulcer on right leg and takes several pills for diabetes and hypertension. Her primary care physician is in charge of her and a home care organization provides wound toileting twice a week. After John's (the husband) death (one month ago) she becomes depressed, she doesn't eat regularly, the blood pressure isn't any more checked by her doctor and in the pharmacy when needed, and the venous ulcer enlarges despite the home care agency visits.

**Her neighbor smells gas odor in the
landing a Monday afternoon !**

What happens to Mary ?

Most likely ...

- Neighbor calls 118 (emergency ambulance support)
- Ambulance brings her to hospital
- Hospital ER assesses her medical conditions: if no acute medical conditions (i.e. not septic), sends home (always ?)

Important issues:

Her primary care MD will not find out

Nutrition, skin wound etc. will not be addressed

Daughter not called and involved

... we can do some hypotheses about the future !

What happens if Mrs. Mary is diagnosed just a reactive depression and the need of being pharmacologically treated ?

Most likely ...

- Primary care physician will have to detect it
- Probability to be treated 50/50 or less
- She is likely not to adhere and no one will check, no care management

What happens if Mary is demented ?

Most likely ...

- Treated for acute problems
TC, MRI scan
- Discharged to a nursing home or Alzheimer's Unit (?)
- If she is able to move to daughter, she may live at home with home health care

What happens if she is found, because of the gas odor, with a broken hip in the bathroom?

Most likely ...

- Admitted to hospital for hip surgery (probably venous ulcer continues to worsen, diet may not be addressed)
- Discharged to post-acute rehabilitation unit (5-10 days if good rehab potential)
- Discharged to nursing home if rehab tolerance or progression in hospital is slow
- Discharged to home
- Two day later, Mary “isn’t feel right” (blood pressure ?, diabetes ?)

Overall Problems with Care

- **Mrs. Mary falls between primary and secondary health care and social services; as a consequence she is at risk of being “forgotten”.**
- **Inadequate assessment and education**
- **Absence of long-term care management**

GERIATRIC SERVICES



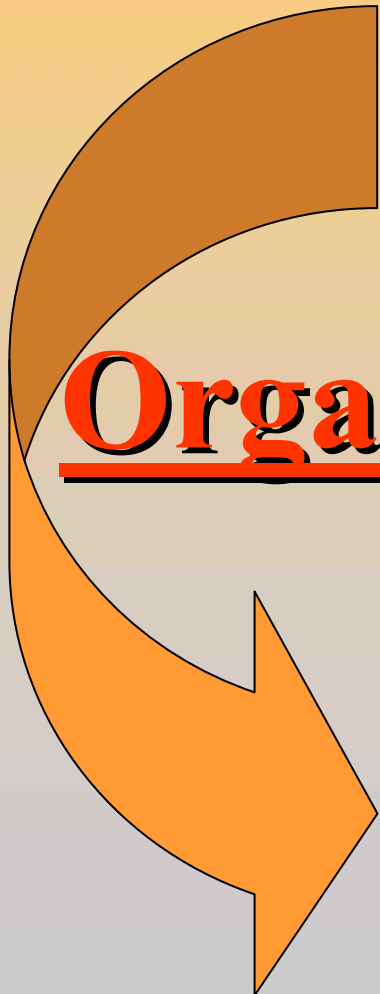
HOSPITAL

Organization

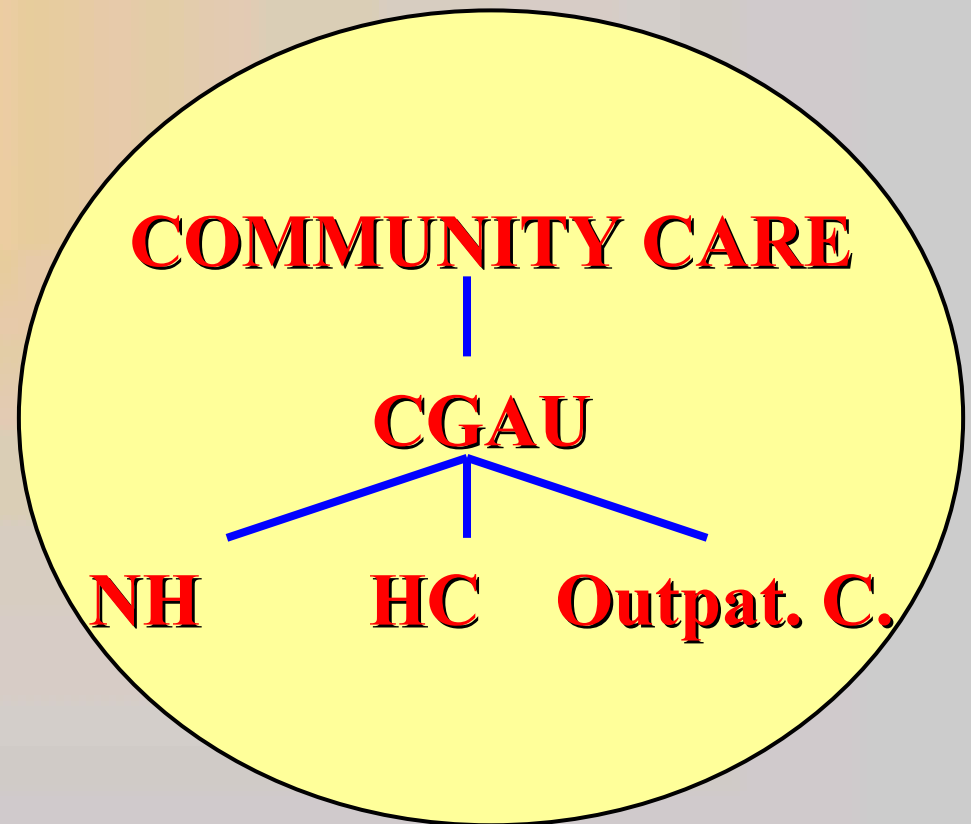
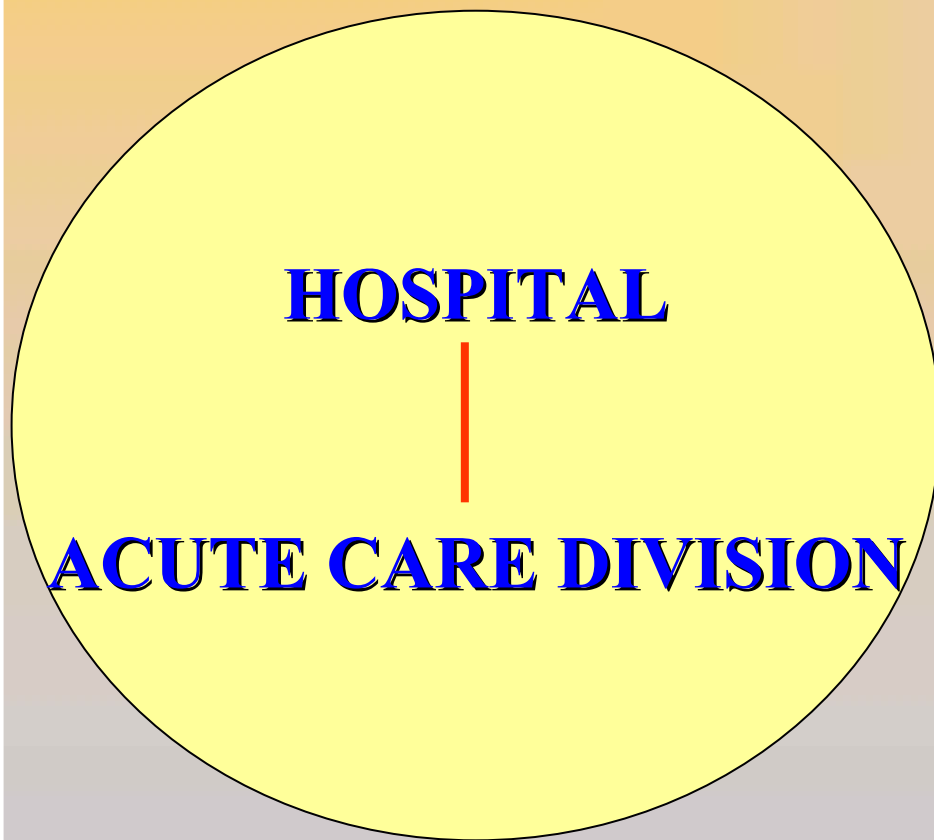
CGA

Instrument

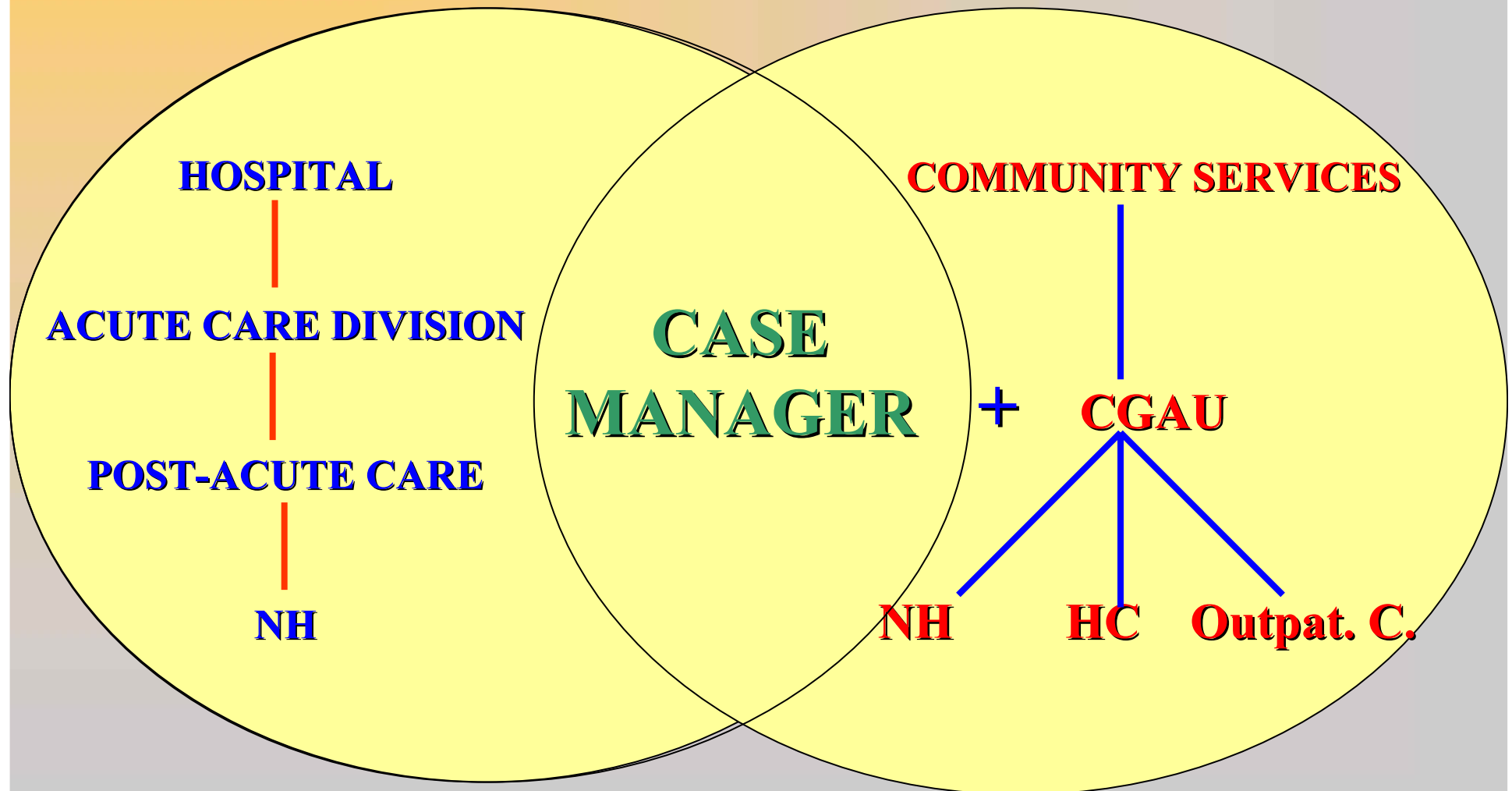
COMMUNITY CARE



Geriatric Services for frail elderly: today ...



... in the future



Take Home Messages (I)

Some features of the best practices may explain these results.

The role of Case Manager - ability to design care plans and co-ordinate all available services, so assuring integrated care.

Single entry point - in our model the community geriatric evaluation unit represented the gatekeeper to health services. This provided a unique community-based setting to refer patients, regardless of specific needs.

Take Home Messages (II)

Case Manager into a multidisciplinary team - the close collaboration between case managers, community geriatric evaluation unit and general practitioners was critical to the success of the intervention; this may determine the effectiveness of any community-based programs.

New assessment “system” (MDS-HC) - yields better results in terms of physical functioning and costs savings as compared with traditional geriatric assessment.

Take Home Messages (III)

- *The evidence shows that the development of cost-effective, integrated systems of care for frail elderly are possible.*
- *Despite positive results, none of the experimental models to date have been successfully generalized on a large scale !!!*