

# Health Equity and Geriatric Care in a Rural Practice

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## Introduction

1. Consider the widespread use of a geriatric screening tool to more quickly identify seniors at risk, offer interventions and determine optimal program expansions.
2. Examine the challenges and rewards during development of a complex program within a rural Family Health Team.
3. Consider the use of the Health Equity Impact Assessment (HEIA) Workbook, at a micro level, to identify gaps and unintended consequences in program development.

## Aims

In 2013, the newly established Strategic Planning Committee began to formally evaluate our programs. "Behaviour change interventions, including screening and information provision/awareness raising, may be more effective in better-off populations and may actually exacerbate health inequalities." (Goyder et al 2010). Therefore we have chosen to use the Health Equity Impact Assessment (HEIA) Workbook to mitigate such unintended consequences during program development and review.

## Materials and Methods

The program lead and administration have assessed outcomes using a Logic Model Design (McMaster Business Consultants) to evaluate the efficiency and effectiveness of the program structure. Members of the Strategic Planning Committee (SPC) have assessed the program using the Health Equity Impact Assessment (HEIA) Workbook Version 2.0. Committee members considered the tool either individually or in teams of two. Their feedback was collated and further discussed to identify future directions.

## Literature Cited

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Geriatrics, Interprofessional Practice and Interorganizational Collaboration, Regional Geriatric Program of Toronto, <http://giic.rgps.on.ca/>

## Results

HEIA - identified barriers to questionnaire completion include:

- Disability – visual impairment; mobility impairment (receiving home visits); intellectual disability.
- Aboriginal Peoples – receiving care predominately at the M'Chigeeng Health Centre; under-identified within the EMR.
- Linguistic – low literacy, form unavailable in French and Anishnawbe.

*Challenges* related to the process of completing the HEIA tool: "ambiguous", "time-consuming", "difficult", "labour intensive".

*Rewards* related to the process of completing the HEIA tool:

"helps us focus on a common goal", "makes the team stronger" "powerful in how it ... (allows) us to examine the direction of our programming", "it does evaluate things that aren't seen with the logic model", "It has highlighted areas where we can improve EMR documentation", "it has identified several barriers to accessing the Geriatric screening form", "team members have a better understanding of our patients".

**Conclusions:** Patient-centred screening tools may expedite referrals to FHT providers while being iterative to the patients themselves. This also offers a realistic way for FHT personnel to initiate complex programs. Working through the HEIA tool has provided a greater depth of understanding of our program and our patient population, as well as identifying steps that need to be taken to avoid increasing health inequity. The use of the HEIA tool appears complementary to the use of a Logic Model Design. The Strategic Planning Committee will continue to utilize the HEIA tool to enhance equity of access to our FHT programs, alongside the use of the Logic Model for efficiency and efficacy.

Specific plans include:

1. Response to identified barriers to accessing the Geriatric screening tool:
  - Disability: Distribution of the screening tool as large print versions, and at home visits for those who are mobility impaired.
  - Aboriginal peoples: distribution of the screening tool at the M'Chigeeng Health Centre, including at Elders' luncheons; better EMR documentation to identify our FN people.
  - Linguistic communities: staff available to help those with low literacy. No plans yet for translation of the tool into other languages. Other: (Non-FHT funded) staff have been assisting a variety of seniors to complete the tool: we will now track the numbers of patients requiring assistance.
2. Strategic Planning Committee processes: Members will review the free 2-hour e-learning course about the HEIA tool, created by the CAMH Health Equity Office and Education Services to enhance our ability to evaluate our other FHT programs. Subsequent programs will be reviewed first using the Logic Model, and following approval by the SPC will be reviewed using the HEIA tool, but as a group discussion.
3. Geriatric Program expansion: to adopt an inter-professional, shared-care, geriatric model to enhance care for the frail elderly, utilizing the Stonechurch/McMaster model (Moore et al, 2012). We will start with patients >80 years old who have not yet completed our GPHE form.

## Geriatric Form Completion Rates

	Total Rostered	Forms Completed	% Forms completed/ Eligible to complete
Population > 64	889	173	19.40%
Females > 64	441	95	21.50%
Population >79	185	40	21.60%
Identified as First Nations within EMR > 65	66	6	10%

## Background

Manitoulin Central Family Health Team (MCFHT) provides primary care services within a rural community. Approximately 25% of our practice is aged 65 and over (compared to 14.2% of Ontario population in 2011). Approximately 40% of the Island population is Aboriginal, but we lack accurate data for our practice to identify the proportion of First Nations over 65. Determinants of health (such as income/ social status, and culture) are central to priorities in program development, as are considerations of our limited human resources.

MCFHT was approved in 2009 to join an existing interprofessional clinic in Mindemoya. Providers included 1 FTE RN(EC), 1 FTE SW, 1 FTE RN, 0.5 FTE Health Promoter, 0.1 FTE Pharmacist. As we developed our initial programs we wanted to create multiple ways for our patients to access the providers that did not depend upon a referral from a physician or RN(EC), and to be particularly efficient with our resources. We also considered the need to educate our patient practice about the new healthcare providers.

We utilized the Geriatric Periodic Health Exam – Patient Form (GIC, 2011), to support patients of the MCFHT who are ≥ 65 by providing a self-reflective questionnaire to increase patient awareness and autonomy over their healthcare while identifying health risks. 173 patients have thus far completed the screening tool at the Manitoulin Central Family Health Team located in Mindemoya, while presenting for other health interventions.

Issues of concern identified by the tool have been addressed through group teaching sessions, appointments with FHT professionals and clinic physicians or RN(EC), referrals to community resources and through organization of three seniors' conferences.

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## Further information

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