Establishing a gerontology coordination centre to improve care for the elderly in Monaco

Overview

Like many European countries, Monaco faces emerging health challenges associated with an ageing population. Responding to changing trends, in 2006, the Ministry of Health and Social Affairs led an initiative to open a national Gerontology Coordination Centre. The Gerontology Coordination Centre now serves as the central coordinator for home support and care for the elderly, under the guidance of a multidisciplinary team composed of an administrative coordinator, a geriatrician, nurses, social workers and a psychologist. As part of the Centre's services, people aged 60 years or older are eligible to receive a comprehensive geriatric assessment designed to evaluate functional ability, physical and mental health and socioenvironmental circumstances. Assessments are conducted by the Centre's geriatrician, with annual reassessments led by nurses in home settings. Personalized care plans are developed by the multidisciplinary care team based on individual assessment results and are reviewed with patients in home settings. Care plans aim to promote good health and support independent living. Depending on the financial resources of patients, necessary care costs may be covered by the government. Since opening, the Centre has performed 4675 assessments and has attended to the needs of 2100 patients, delaying entry into institutionalized care by up to eight years. In addition to coordinating and delivering services directly to patients, the Centre also has important public health functions relating to the collection and evaluation of health data to help identify national health trends and emerging needs within the elderly population. This information can then be used by the Ministry of Health and Social Affairs to implement policies supportive of healthy ageing and to develop a more favourable environment for elderly citizens.

Problem definition

Similar to trends seen in other European countries, Monaco faces an increasing burden of chronicity in an ageing population. Changing population health trends have strained the ability of health and social services to effectively meet increasingly complex health needs within the growing elderly population (Box 1). While both health and social care sectors were well established, a lack of coordination and information sharing between these sectors hindered effectiveness. Furthermore, fragmentation across care levels obstructed smooth transitions between inpatient, outpatient and homecare services and compromised continuity of care.

Box 1

What problems did the initiative seek to address?

- Increasing chronicity in an ageing population.
- Lack of coordination between health and social sectors.
- Fragmentation across care levels.

Health services delivery transformations

Timeline of transformations

In 2005, understanding that effectively addressing the needs of an ageing population called for a more coordinated approach to health and social care, the Ministry of Health and Social Affairs worked with a multistakeholder group to analyse demographic data, define gerontology concepts and develop a new structure for the coordinated delivery of health and social care for elderly patients. In 2006, as a result of these efforts, the government opened the Gerontology Coordination Centre as a dedicated resource to support elderly people aged 60 years and over (Table 1). Today, the Centre continues to support health and social care needs of elderly people in Monaco.

Table 1
What were the chronological milestones for the initiative?

Early 2000s	Ministry of Health and Social Affairs begins discussions about how to respond to changing demographic pressures on the health and social care system.
July 2005	Gerontology Coordination Centre team assembled.
2005–2006	Preparatory activities to establish the Gerontology Coordination Centre.
September 2006	Gerontology Coordination Centre opens and begins providing care to the elderly population.
Present	Centre continues to provide care to the elderly population and respond to evolving health needs for this group.

Description of transformations

Selecting services. The Centre provides comprehensive gerontology assessments and personalized health and social care services for people aged 60 years and over. Patients receive general medical care with follow-up, health advice, and assistance arranging necessary social services and home support. Services focus on the early identification and management of conditions which compromise patients' autonomy and level of functioning and, consequently, home-support services are a key part of the proposed interventions. The Centre also runs a counselling service to support informal caregivers.

Designing care. All elderly residents aged 60 years and over are eligible for an annual, standardized comprehensive geriatric assessment. This tool is a composition of several internationally recognized tests designed to determine health status, physical functioning, social care needs and potential risks. Based on individuals' assessment results, a personalized care plan is developed for each patient by the multidisciplinary group of providers working within the Centre. Personalized care plans are reviewed and updated annually or if a patient experiences a change in status, such as onset of dementia or hospitalization.

Organizing providers. The Centre employs a geriatrician, nurses and social workers in full-time positions. In addition, a psychologist works one day per week. These providers work as a multidisciplinary team to coordinate and deliver care for patients. Comprehensive geriatric assessments are initially performed by the geriatrician, with reassessments typically led by nurses. Following each assessment, a social worker visits patients in their homes to complete a review of the home environment and discuss care options. A second social worker links with specialist providers if a patient enrolled in the Centre is hospitalized or requires other specialized services to ensure continuity of care. Additionally, several links and partnerships have been established between the Centre and other providers – such as general practitioners, hospital specialists and care homes – to improve coordination and organization of care for patients. A common language between health providers and social workers has developed as a result of working together as a team and a holistic approach to caring for elderly patients has been cultivated among health and social care professionals.

Managing services. The Centre is overseen by the Ministry of Health and managed by an administrative coordinator. Weekly team meetings with all providers are convened by the Centre's coordinator and serve as an opportunity to review progress and set weekly objectives.

Improving performance. Health providers have received training on how to conduct comprehensive geriatric assessments. Additional trainings on the management of patients with dementia and Alzheimer's disease have also been organized for health providers, social workers and caregivers.

Health system enabling factors

Two government orders enacted between 2006 and 2007 provided the necessary legislative framework for the Gerontology Coordination Centre by formalizing its status as an organization and allowing benefits to be allocated to elderly patients for health and social services (Table 3). The Ministry of Health and Social Affairs developed a central information bank to collect data on Centre patients, which can be used to help guide wider system planning decisions by, for example, identifying additional transportation networks for elderly people or supporting implementation of further legislation to protect elderly citizens' rights.

Outcomes

Since opening, the Gerontology Coordination Centre has performed 4675 comprehensive gerontology assessments and followed 2100 patients. Closer follow-up of elderly patients as a result of the Centre has been reported to delay institutionalization of elderly patients by up to eight years.

Table 2
How was the delivery of health services transformed through the initiative?

Before	After
Selecting services	
Services largely reactive and focused on acute care; health and social care services for elderly patients lack coordination.	Personalized health and social services are provided to elderly people aged 60 and over; home care, counselling, health promotion and disease prevention services expanded.
Designing care	
No standardized, systematic assessment of elderly patients' health and social care needs.	Standardized comprehensive geriatric assessment tool used to assess elderly patients; personalized care plans developed for each patient based on individual assessment results.
Organizing providers	
Strong primary care system in place with general practitioners acting as gatekeepers to specialist services; fragmentation exists among the various providers caring for elderly patients; limited cooperation between health providers and social workers.	Gerontology Coordination Centre employs a multidisciplinary team composed of a geriatrician, nurses, social workers and a part-time psychologist; the geriatrician and nurses lead assessments for patients; social workers review care plans with patients and link with other providers to ensure coordinated care.
Managing services	
Not applicable in this case.	Centre overseen by the Ministry of Health and managed by an administrative coordinator; weekly team meetings held between Centre staff.
Improving performance	
Not applicable in this case.	Providers received training on performing comprehensive geriatric assessments; additional training on dementia offered to health providers, social workers and caregivers.

Table 3
How has the health system supported transformations in health services delivery?

System enablers	Example
Accountability	• Government orders enacted to formalize the opening of the Gerontology Coordination Centre and provide funding for activities.
Incentives	• Government benefits allocated to elderly patients according to the degree of loss of autonomy to encourage use of services by those most in need.
Information	• Software developed to collect patient data in a centralized database for evaluation; information accessible by government for planning purposes. • Data collected by Centre used to annually evaluate changing health needs in the elderly population.

Change management

Key actors

Development and implementation of the initiative was led by the Ministry of Health and Social Affairs. A new multidisciplinary team was established to oversee the running of the Gerontology Coordination Centre. Led by the Centre coordinator, this team is composed of a secretary, geriatrician, nurses, social workers and a psychologist. Under supervision from the Ministry, this team continues to manage the Centre and provide care for the elderly population in Monaco.

Initiating change

The Ministry of Health and Social Affairs led the development of the Gerontology Coordination Centre in response to anticipated demographic pressures compounded by the fragmentation of health and social services. Preparations for opening the Centre took approximately one year. During this time demographic data was analysed and research examining relevant literature carried out, the Centre team was recruited and trained, budgets for the Centre were drafted and new assessment tools and technical software were developed.

Implementation

The Gerontology Coordination Centre opened in 2006 and has since established itself at the heart of the gerontology network in Monaco, acting as the central coordinator for all gerontology services under the guidance of its dedicated team. Partnerships with other actors, such as general practitioners, hospital specialists and care homes, ensure the Centre is connected to all key players. Weekly team meetings between Centre staff facilitate smooth running of the Centre and serve as an opportunity to discuss emerging needs and set future objectives.

Moving forward

The Centre continues to serve the elderly population in Monaco and advise the government on health and social care needs for this population.

Highlights

- Monaco's small geographic and population size lent itself to a centralized approach, whereby the initiative created a hub for the coordination of elderly people's care.
- Centralizing information collected on elderly patients provided data on emerging population needs, allowing data-driven responses at the political level.
- Services offered are holistic, integrated and tailored to patients' individual needs and place strong emphasis on supporting patients to remain independent.