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Novel Approach to Community-Based Geriatric Care: Experience from Developing Country - A Brief Report

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ABSTRACT

This Report evaluates a community-based geriatric care program based at Kondavil Family Health Center, Sri Lanka, involving community-based screening, institutional care, and home visits. Initiated in June 2021, it addressed health issues in the ageing population of a medical officer of health area in Jaffna Sri Lanka with a significant focus on community engagement. Over the period of two years, the program conducted 130 informatic sessions and screened 1739 elderly, and provided home-based care for 13 needy patients. It achieved substantial success in identifying health issues and facilitated the access to healthcare through 800 referrals among them. The program's integration of home visits offered insights into unique challenges faced by elderly that permitted to effectively combine clinical support with psychosocial care for them. It demonstrated how trained community health workers can be employed for the purpose of bridging the gap between the community and primary care specially in the resource poor settings. Specifically, this method was beneficial for rural residents, leveraging young locals.

Keywords: Geriatric care, Cancer screening, Home visits, Health workers training

INTRODUCTION

This Report offers a detailed analysis of a community-based geriatric care program implemented at the Family Health Center, Kondavil, Jaffna, Sri Lanka. The program addressed the increasing health challenges confronting the ageing population residing in the Nallur Medical officers of health (MOH) area. Its focused screening on common geriatric problems and highly prevalent non-communicable diseases (NCDs) operating through three main components: community-based screening, institutional care, and follow-up home visits when it was necessary. The objectives of this community health program were to provide general health education, identify common health issues and providing necessary referrals for further medical evaluation, and assessing the living standard and well-being of selected elderly Patients through home visits. Community health workers were selected and trained by the department of Community and Family medicine, Faculty of Medicine, University of Jaffna. The training program was coordinated by a consultant Family Physician and experts from different specialties contributed in the training of community workers. The training program for the first year spanned over three weeks on daily basis and repeated every year. The training encompassed various areas including effective communication with the public, specialized nutritional knowledge for the geriatric population, and an emphasis on the program's goals and confidentiality. A special emphasized was given to geriatric care and organization screening programs, coordination of home visits, and supporting medical officers and allied health professionals the program was decided in accordance with the guidelines

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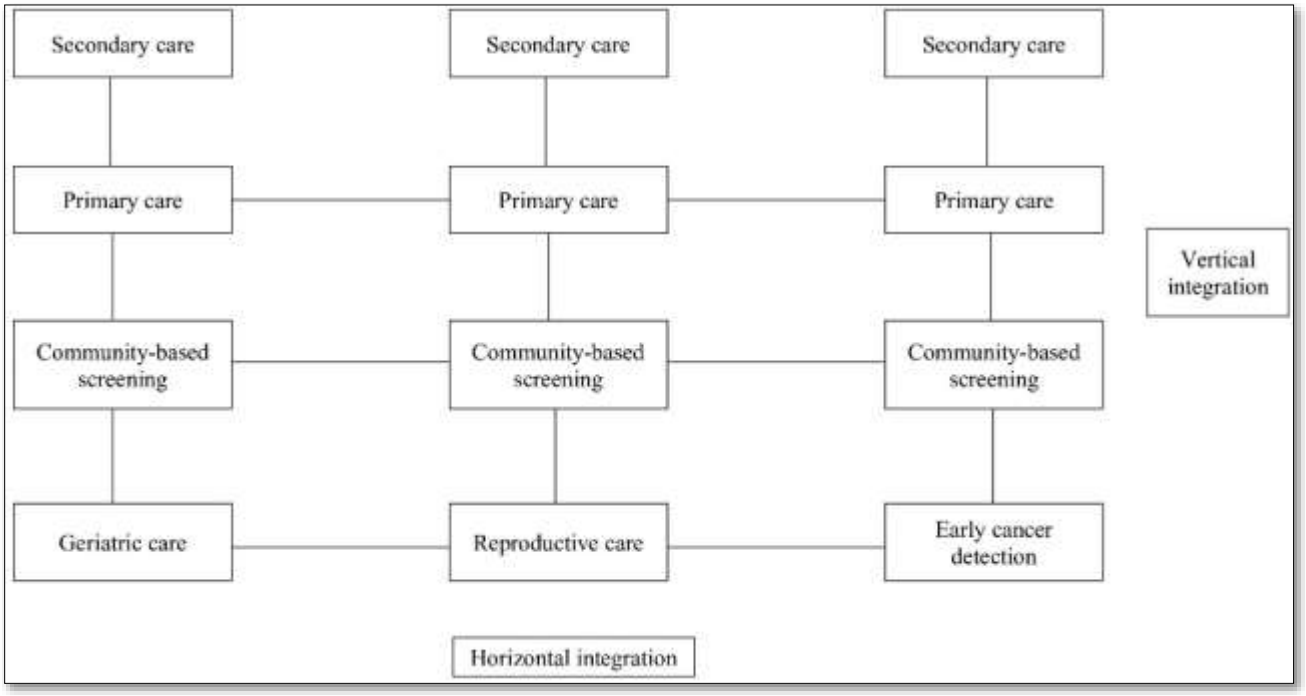
of ministry of health's noncommunicable diseases [1]. All the community centers functioning within the limits of MOH area Nallur were included in the study and necessary permission and approvals were obtained from relevant authorities. These centers functioned as hubs for coordinating geriatric services three days a week for the whole duration of program. One community health worker coordinated with the authorities of those centers to facilitate the program. Activities at these centers were diverse, ranging from meetings with the elders and performing relaxation exercises like laughter therapy and yoga. The participants were encouraged to share their life experiences through which their age-related priorities were identified. Since the commencement of our community-based geriatric care program in June 2021 130 informative sessions were successfully conducted. Over two years, the program witnessed a significant increase in attendance. In the first year, we screened a total of 739 elderly participants, and this number rose to 1000 in the subsequent year, culminating in a total of 1739 screened individuals. The monthly attendance varied, with notably higher numbers in the later months of 2023, reflecting the wider acceptance of this program community. The following health indicators were screened: blood pressure (BP), random blood sugar (RBS), and handgrip strength. In addition, height and weight were measured, and Body mass Index (BMI) was calculated. Referrals for identified needs were made to the Family Health Centre Kondavil from where further referrals were made to appropriate specialties in the Professorial unit Teaching Hospital Jaffna as required [2,3]. The home visits had given an opportunity to assess living standards, caregiver support, and tailored treatments. The task force for home visits included medical officers, pre-intern medical graduates, nursing officers, nutritionists, and trained community health workers. Our task force provided basic knowledge and training for the most dependent patients on self-care practices as related to physiotherapy, environmental adaptations, symptom evaluation, chronic illness management, and wound care. It introduced basic training to caregivers to handle the most dependent patients [4]. Further, telehealth services were established to enhance the continuity of care. Additionally, younger elders in the community were trained to assist in elder care, fostering an inclusive and supportive community engagement. During these whole two years,800 referrals were made from community centers to FHC Kondavil. Among them 550 patients were referred to the professorial unit THJ This underscores the program's effectiveness in identifying elderly individuals who needed additional medical care, particularly those with chronic conditions. The referrals were crucial in facilitating access to necessary treatment and support. Comprehensive home-based care was provided to 13 elderly needy patients. This care, encompasses clinical support, physiotherapy, counselling, and emotional support, considering deeper insights into patients' living conditions, adherence to medical advice, and overall well-being. The home visits proved invaluable in understanding the unique challenges faced by elderly individuals when it comes to managing their health conditions within their home environments. Community centers were cooperative, in arranging the gathering of people and providing spaces for events. The feedback from patients and community centers has been overwhelmingly positive, with an appreciation for the home visits, particularly on home-based BP and RBS checks. There were also requests for the inclusion of cancer screening and reproductive health-related issues. Which were Included later part of the screening program according to primary care screening guidelines [5-7]. The satisfaction extended to the community health workers, who have demonstrated their capability to work seamlessly with community centers and expressed contentment with their roles. The staff at the Family Health Centre were also pleased, as they could focus on the patients in need. Overall, patients had expressed satisfaction with the personalized care that they had receive. Over its two-year span, the program has achieved notable success in identifying common health issues among the elderly, providing immediate health education, and facilitating necessary medical referrals. Its structured approach, from the establishment of community care centers to the integration of home-based patient care, has allowed for adaptive and responsive care tailored to the evolving needs of the elderly population. The marked increase in participant attendance and the successful follow-up on referrals highlight the program's feasibility in raising awareness and improving access to healthcare services. Particularly significant is the integration of home visits, which have offered invaluable insights into the unique challenges faced by the elderly in their own environments. These visits have been instrumental not only in providing clinical support but also in addressing the psychosocial aspects of elder care, thus enhancing the overall well-being of the participants. This project encountered key challenges in data management and analyzing dropout cases. Manually maintaining data restricted quick access and time-consuming for analysis. Not all the individuals referred from the community centers visited the family health center. Notably, there is no system in place to follow up with patients referred from community health centers.

RECOMMENDATION AND FUTURE PLAN

This program has proven to be acceptable, appropriate, and feasible for a community-based geriatric care program in a developing country like Sri Lanka. The above approach has cultivated community engagement which in turn helps for future scalability and sustainability. Implementing digital data systems could enhance effective data management and analysis in dropout cases. Horizontal integration of other community-based healthcare programs will support effective resource management. Such integration will enhance patient care by implementing a more unified healthcare system. Furthermore, it is recommended to do home-based care out

of hours, which has demonstrated greater effectiveness in providing accessible and cost-effective care. The adoption of these strategies is likely to yield improved patient outcomes and more efficient utilization of healthcare resources. This delivery model could demonstrate an improvement in the quality of life, especially in resource-limited settings. Our plan is focused on implementing a vertical and horizontal integration model, aimed at enhancing sustainability and cost-effectiveness in healthcare delivery. This process allows us to identify patients who are then referred to the Family Health Centre in Kondavil from community centers for further assessment and care. Depending on their medical needs, patients may receive additional referrals, those with general medical issues will consult with a General Physician, while the VOG addresses reproductive health concerns for those who are detected from early-stage cancer detection, patients are referred to Consultant oncological surgeon [5-8]. Our future strategy encompasses horizontal integration, where community health workers shall be utilized for additional roles especially cancer screening and reproductive health management for better resource management. Rather than assigning distinct staff for each project, we plan to deploy the same set of workers for diverse responsibilities, including community-based screening and duties at institutional-based clinics. This method not only centralizes our efforts but also optimizes the utilization of our human resources [9]. An integral part of this plan is staffing efficiency and compensation. By employing an integrated model, we aim to reduce the overall headcount, thereby ensuring competitive salaries for the staff. Moreover, we plan to offer out-of-hours home-based care, with our staff receiving overtime payments. For example, suppose two out of three community health workers provide home care from 4 PM to 7 PM. In that case, they will be compensated at an overtime. This approach, which combines overtime with regular salaries, is designed to ensure a fair and satisfactory income for our staff, as opposed to the less favorable financial conditions under a system with a separate staff for each service category.



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