Author's response to reviews

Title: Short-term Geriatric Assessment Units: 30 years later

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Reviewer's report:

Title: Short-term Geriatric Assessment Units: 30 years later
Version: 1 Date: 28 March 2010
Reviewer: Thierry Chevalley

Minor Essential Revisions

1. In the introduction, the authors compared GAU (created to offer total and integrated health care to frail elderly who were hospitalized with acute problems) to the American GEMU with similar organizational and operational characteristics. On the other hand, they mentioned on page 3 that GEMU concerned patients in their sub-acute phase. Could the authors give us some comment about this apparent difference.

In the 4th paragraph of the discussion, we compared the Quebec GAU with the British and American GEMU which admit patients in need of sub-acute care. After we did the study, we could conclude that this situation was true for only 81% of Quebec GAU. Therefore we removed this point from the introduction.

Results section

2. In the text on page 10, the authors mentioned that 54% of the GAU have a mixed care profile and this percentage is 58% in Table 1.

It was true that 58% should have appeared in the text instead of 54% and the correction was made (page 9).

3. The comments of the last part of Table 1 regarding the composition of medical staff should be given earlier in the text (page 10 instead of page 13).
We changed the placement of the comments as suggested (page 9).

4. The title of Table 2 is confusing, it could be: “Characteristics of clientele hospitalized in 60 GAU”. Therefore GAU (n = 60) have to be removed from the Table 2.

We agreed that the title and first line of the table were not clear. First of all, we modified the title of table 2 following the suggestion but, we did not add the “n = 60” in the title because we changed the sub-titles. We drew attention to the fact that the first column of the table provided the average values for the 15,575 individualized hospitalizations that occurred in all 60 GAU in Quebec. In the second column, we indicated the minimum and the maximum average values obtained for the individualized hospitalizations for each GAU. The column titles were altered to make it clearer.

5. Regarding other health care professionals, there is some discrepancy that the authors need to comment between the text on page 14: “we observe a constant ratio in the total number of nursing staff per bed with a median value of 4.8, 2.8 and 1.8 par 15 beds during the day, evening, and night shifts respectively” and the ratio given in Table 3 showing a clear drop according to the increase in the size of the GAU, at least for the physiotherapists and occupational therapists.

We found that there was not a discrepancy between the text and the table but concluded that it was not clearly presented. So we added some additions to the text to make it easier to follow. (page 13) The sentence about “a constant ratio in the total number of nursing staff per bed with a median value of...” is correct but the results about this are not mentioned in the table. Instead the table gives the results regarding other health care professionals than regular nursing staff. Perhaps the confusion arises because the liaison nurses shown in the table were considered separately from the regular nursing staff not mentioned in the table. Given this, the observation of the reviewer about the “clear drop according to the increase in the size of the GAU” is accurate.

6. On pages 15-16, the authors mentioned that plans for inter-professional intervention are systematically executed in 95% of the GAU, but only 23% archive them in a file after hospitalization and that the medical discharge summary is transmitted to the family doctor in 41%. Since these last percentages could be of importance to improve home care, it could be of interest to know if these percentages are different according to the composition of medical staff, the affiliation to university and to the size of the GAU.

The reviewer pointed out an interesting issue. Taken together, the plans for inter-professional intervention were archived after hospitalization in 23% of the GAU. We had already compared the percentages according to the composition of medical staff, the affiliation of the university and to the size of GAU, and found that there was no statistical difference in these cases. We added a sentence to the text to mention this.(pages 14-15) For the interest of the reviewer, here are the principal tendencies on this question: The university GAU (38% vs. 18%), the
GAU with only geriatricians as medical staff (43% vs. general practitioners only: 23%; general practitioners and geriatricians: none) and the GAU with a large number of beds (43% vs. 4-9 beds: 21%; 10-15 beds: 14%; 16-20 beds: 15%).

Altogether, the medical discharge summary was transmitted to the family doctor in 41% of cases. We added to the text the mention that: “it is more frequently transmitted by university GAU (63% vs. 32%, p # 0.05) and those having 16-20 beds (71% vs. 4-9 beds: 20%; 10-15 beds: 40%; 21-40 beds: 43%, p # 0.05)”.

7. If there are some interesting differences among GAU regarding the screening or preventive protocols as well as the intervention’s protocols mentioned on page 17, I suggest showing them in a new Table according to the type of GAU (composition of medical staff, university affiliation and/or its size)

We compiled the number of screening or preventive protocols implemented in the GAU as well as the intervention’s protocols that were used. We found that the university affiliated GAU “have completed more often a higher number (# 8) of protocols about these ten problem issues (37% vs. 13%, p # 0.01)”. However, there was not a significant difference for the other types of GAU. Instead of introducing a new table about this we preferred to simply mention it in the appropriate section of the text. (pages 16-17)

Level of interest: An article whose findings are important to those with closely related research interests
Quality of written English: Acceptable
Statistical review: No, the manuscript does not need to be seen by a statistician.
Declaration of competing interests: I declare that I have no competing interests

Reviewer's report
Title: Short-term Geriatric Assessment Units: 30 years later
Version: 1 Date: 11 March 2010
Reviewer: Nathalie Salles
Reviewer’s report:

Major Compulsory Revisions

1. It should be very interesting here to have information about the geriatric organization in included centres, i.e., presence or not of geriatric rehabilitation care, geriatric mobile team in different Emergency Department, geriatric day hospital, presence of Post Emergency Geriatric Unit, support home care organization...It should help authors to explain differences in elderly patients admission procedures.

We agree with the reviewer about the usefulness of information about the geriatric organization in included centres. We have already given information about the other geriatric programs (page 16). In order to make it better, we made
modifications and additions in the background and discussion sections to explain differences in elderly patient’s admission procedures. (pages 4, 18-19) We also added a mention that “Day hospitals (90% vs. 42%, p < 0.001), geriatric out-patient clinics (63% vs. 29%, p < 0.05), and psycho-geriatric out-patient clinics (58% vs. 13%, p < 0.001) are more available in university GAU. Day hospitals (93% vs. 30% to 79%, p < 0.001) and geriatric out-patient clinics (73% vs. 25% to 43%, p < 0.01) are statistically more available within GAU having 21-40 beds.” (page 16)

2. Even if the study included a large number of GAU (71), results do not, in my view, impact geriatric practices, and do not give important practical implications for geriatrics. It would have been interesting to detail the results, i.e., to compare the number of beds of the different GAU included in terms of duration of stay and geriatric assessment for example. But also to identify subgroups, for example GAU of University hospitals, GAU with better ratio of health care professionals… In my opinion, the study only describes different not readily comparable GAU distributed in Quebec.

As the reviewer pointed out, the aim of this article is, above all, descriptive in nature, given the scarcity of literature on this subject. In our view, it was pertinent to do it, in part, because since the implementation of this structure in Quebec in the ‘80s, there has never been any study produced on that matter even though the GAU are implicitly accepted as a homogeneous entity.

Our prime objective was to identify the extent of diversity of structures and processes existing within the GAU program. The article wished to pave the way for further analysis, notably the impact of this diversity on the quality of care as we mentioned in the introduction: « … we would expect to observe a great diversity both at the level of the resources used in each unit and clinical activities offered. This variety could underline and expose elderly unmet needs. »

In the same way, and to respond at the same time to the comments 6 and 7 made by the first reviewer, we compared the results according to different GAU groups (geographical location of GAU, their size or number of beds, their university academic affiliation, the composition of their medical staff, and their clinical care profile) and added pertinent information in numerous places within the text. This was the major modification that we made to the text.

3. The Method part of the paper should be more detailed, for example, it should have been interesting to describe different index employed: Index of clinical severity and Index of risk of mortality; which scales were employed (geriatric standardized evaluation) in the different included GAU, …

The index of clinical severity and index of mortality presented on pages 6-7 of the article are generalized in all hospitals in Quebec as clinico-administrative data computed by the governmental Ministry of Health. A reference to this was already given in the text. The standardized evaluation was accomplished by a professional systematic evaluation rather than by specific tools. This lack of standardization of evaluation by geriatric scales or other tools (MMSE, Barthel,
Lawton, etc.) has been described in our published article entitled “Quality of care assessment in geriatric evaluation and management units: construction of a chart review tool for a tracer condition” (BMC Geriatr 2009, 9:34). It was not discussed again in this specific article because it was beyond its purpose.

4. In conclusion, reported results are only descriptive without real answer to a well defined question.

As we have already mentioned, the nature of this article is descriptive, with a detailed response to the explicitly made objective “to describe the operation of the Quebec GAU and their resources and to discuss their specific role in face of the increasing needs of the vulnerable elderly.” (page 5)

Level of interest: An article of limited interest
Quality of written English: Needs some language corrections before being published
Statistical review: No, the manuscript does not need to be seen by a statistician.