

Innovative Care of the Older Person:

Geriatric Assessment Through E- Health

The Princess Alexandra Hospital GATE Project.

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Background.

- PAH is Tertiary referral hospital
- Number of beds 756 ~66,000 discharges
- ACAT QE-II offsite
- T/CARE QE-II offsite



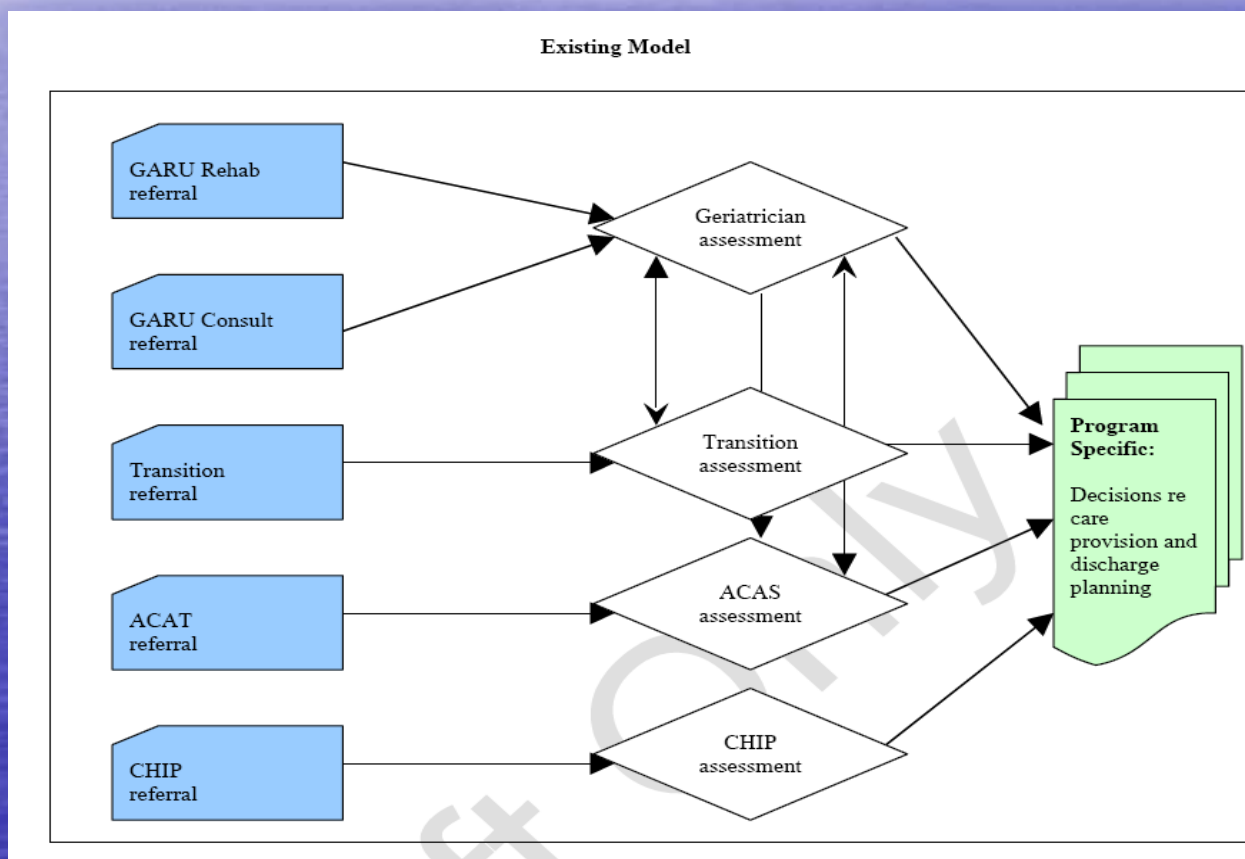
Rationale

- A significant proportion of elderly hospital inpatients who would benefit from Comprehensive Geriatric Assessment were not previously seen by the geriatric service.
- Current systems resulted in duplication of assessments.
- A structured and standardised assessment process is more efficient than current ad hoc approaches

What wasn't working

- Lack of clear pathway referral
- Confusing and distressing for elderly patients trying to access appropriate service
- Confusing for the clinicians
- Inefficient use of clinician's time
- Duplication of assessment
- "Program based" rather than "patient centred"

Previous referral pathway



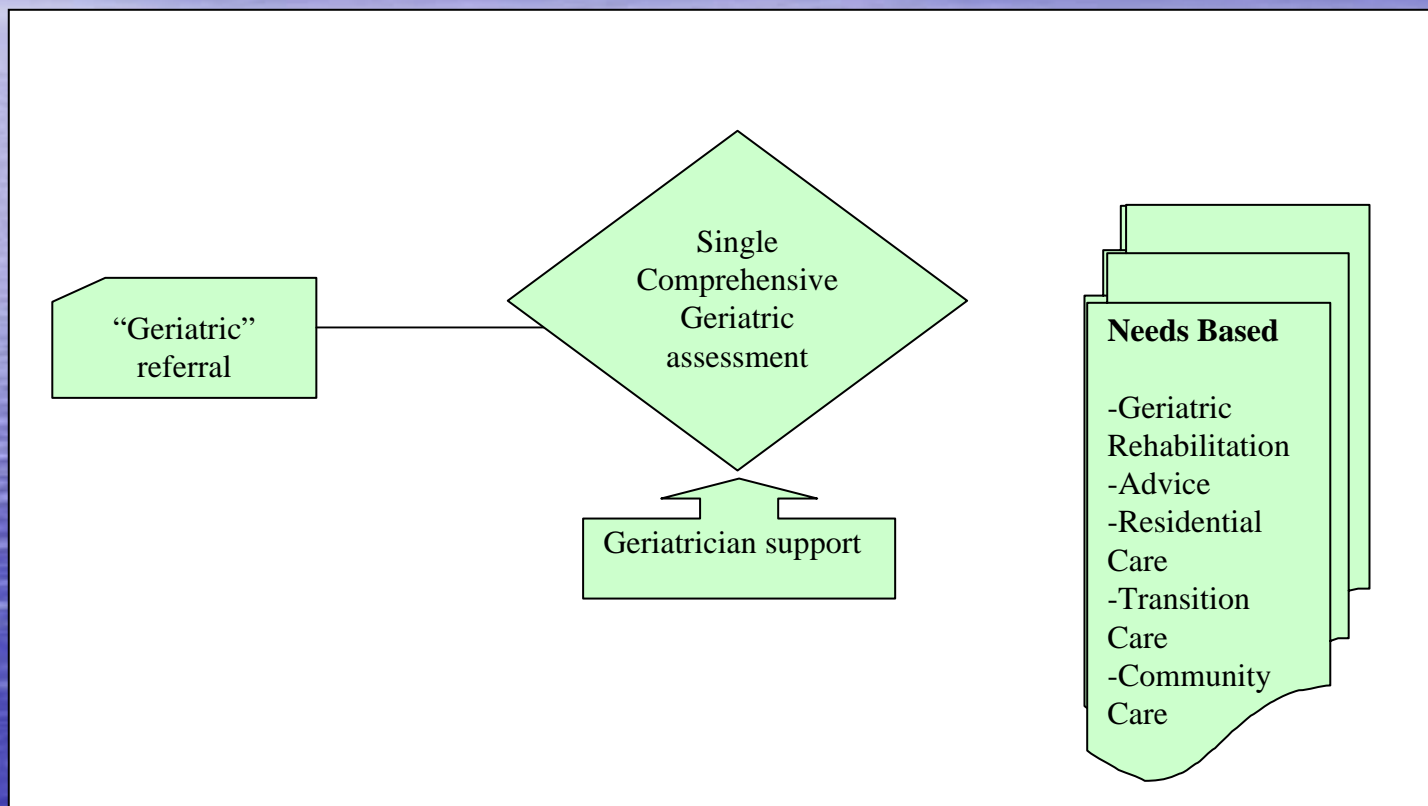
Objectives

- Simplify access to aged care services
- Create a single contact point for referrals
- CG-Assessment / inter *RAI* methodology
- Improve time to consultant review <24hrs
- Improve links between hospital & community services
- Improve the quality of documentation

Objectives - cont

- Formal geriatrician review for
 - any case referred for rehabilitation
 - Referred for residential care or transitional care
 - on a needs basis (dependent on case complexity).

Proposed Model



Funding

- QH Strengthening aged care funding grant
- Yearly grant process commencing 2005 as part of implementation for aged care strategic plan
- Originally non-recurrent funding until July 2007
- Now obtained recurrent funding

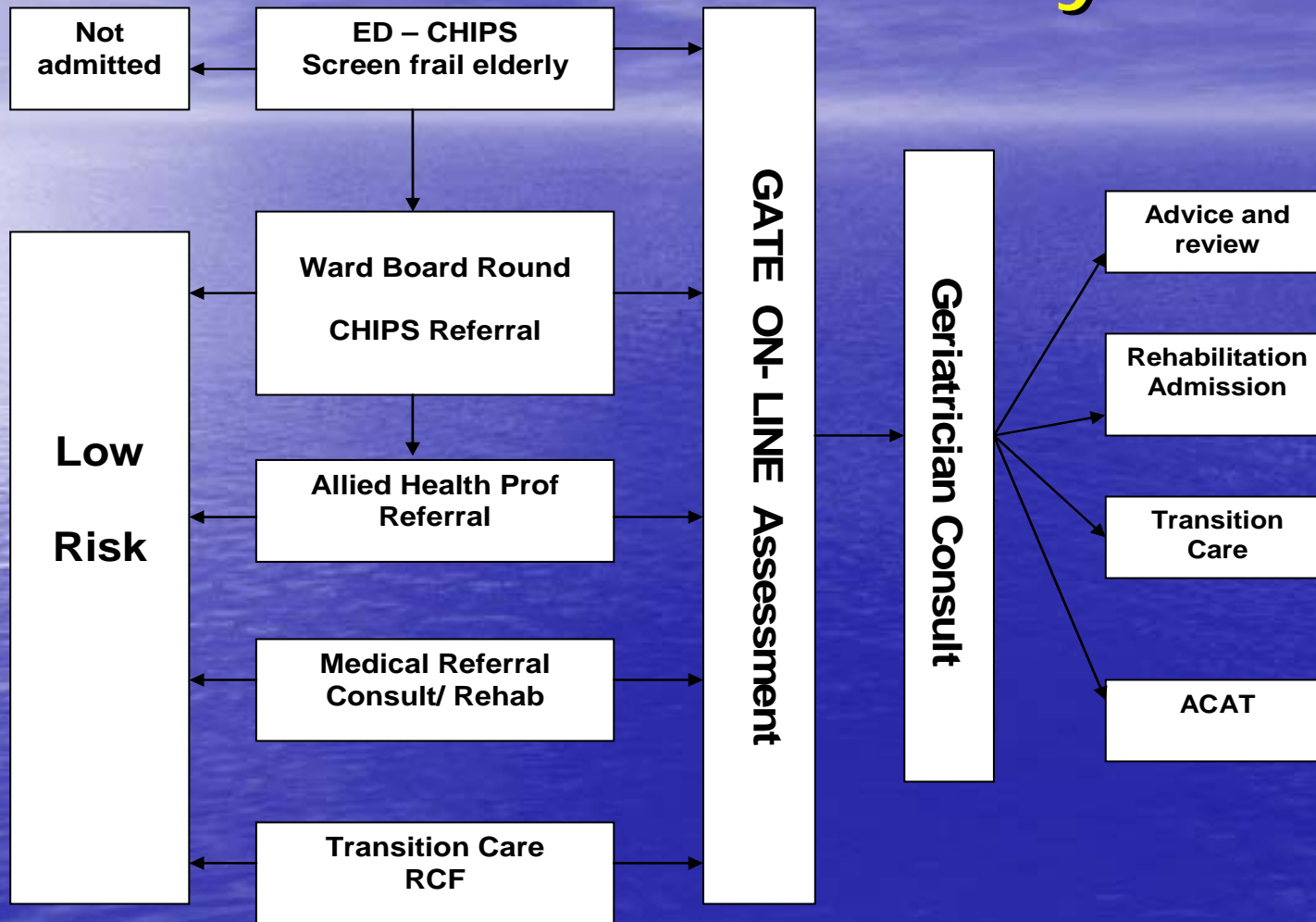
Types of Patients

- Frail elderly medical inpatients
- Frail elderly surgical inpatients
- Patients referred for geriatric rehabilitation or consult
- Patients referred for complex care needs post discharge
- Patients referred for residential care
- Patients suitable for transition care

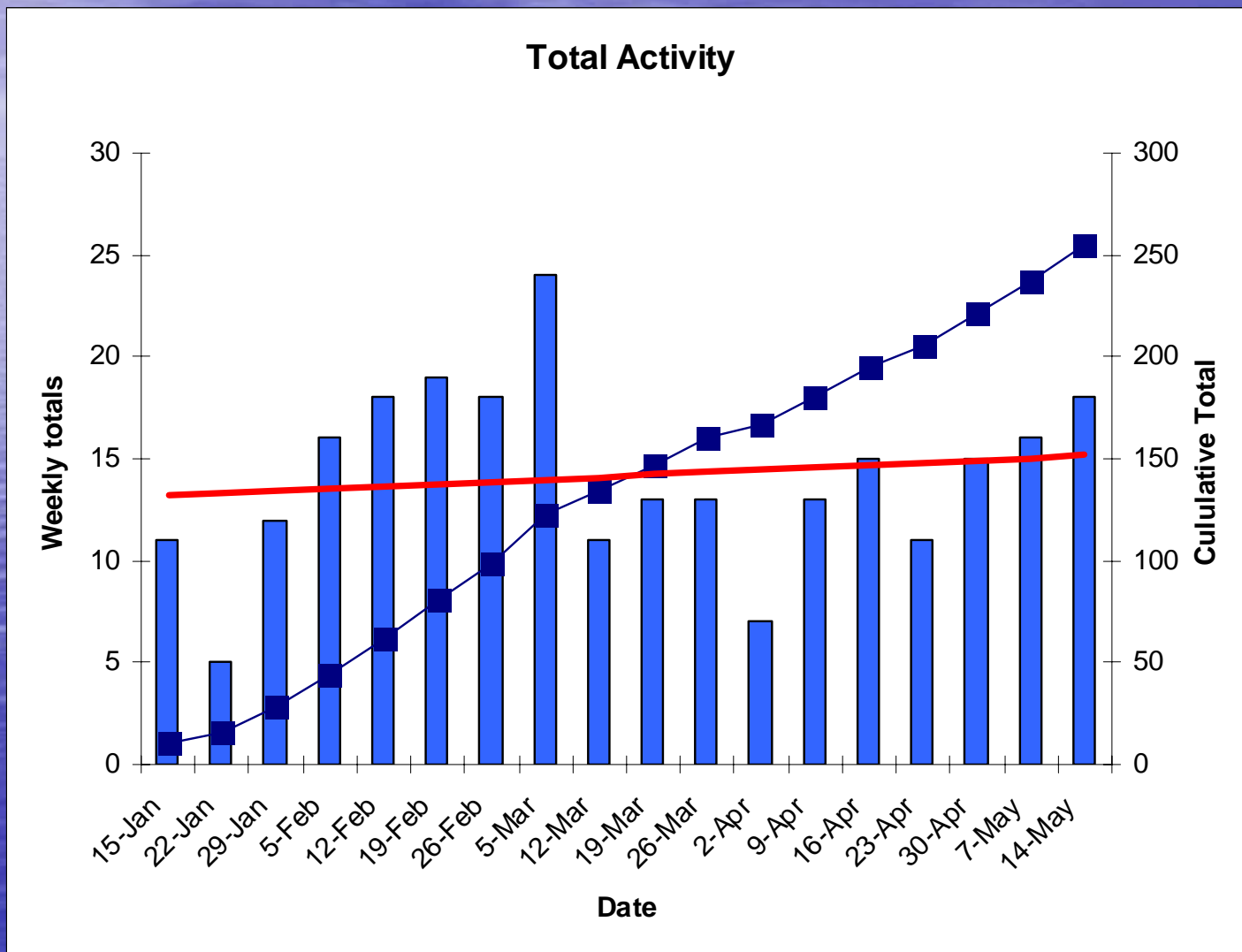
Referral sources

- Chip screen within 24 hrs post admission
- Ward board rounds
- Patients referred to GARU
 - Geriatric consult requests
 - Geriatric Rehab requests
- Orthogeriatric patients (#NOF project)
- Amputee & stroke patients different process

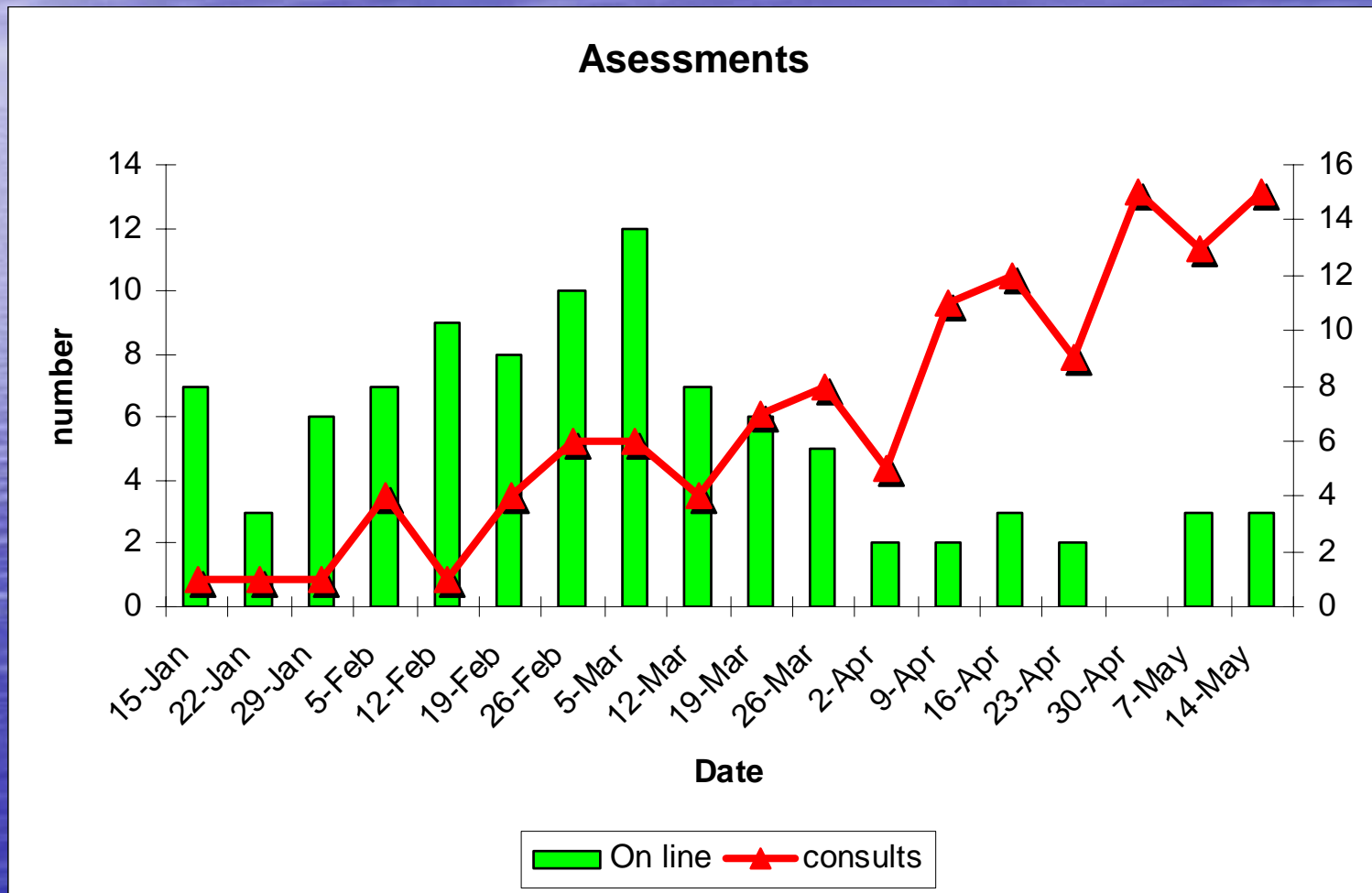
GATE Referral Pathway



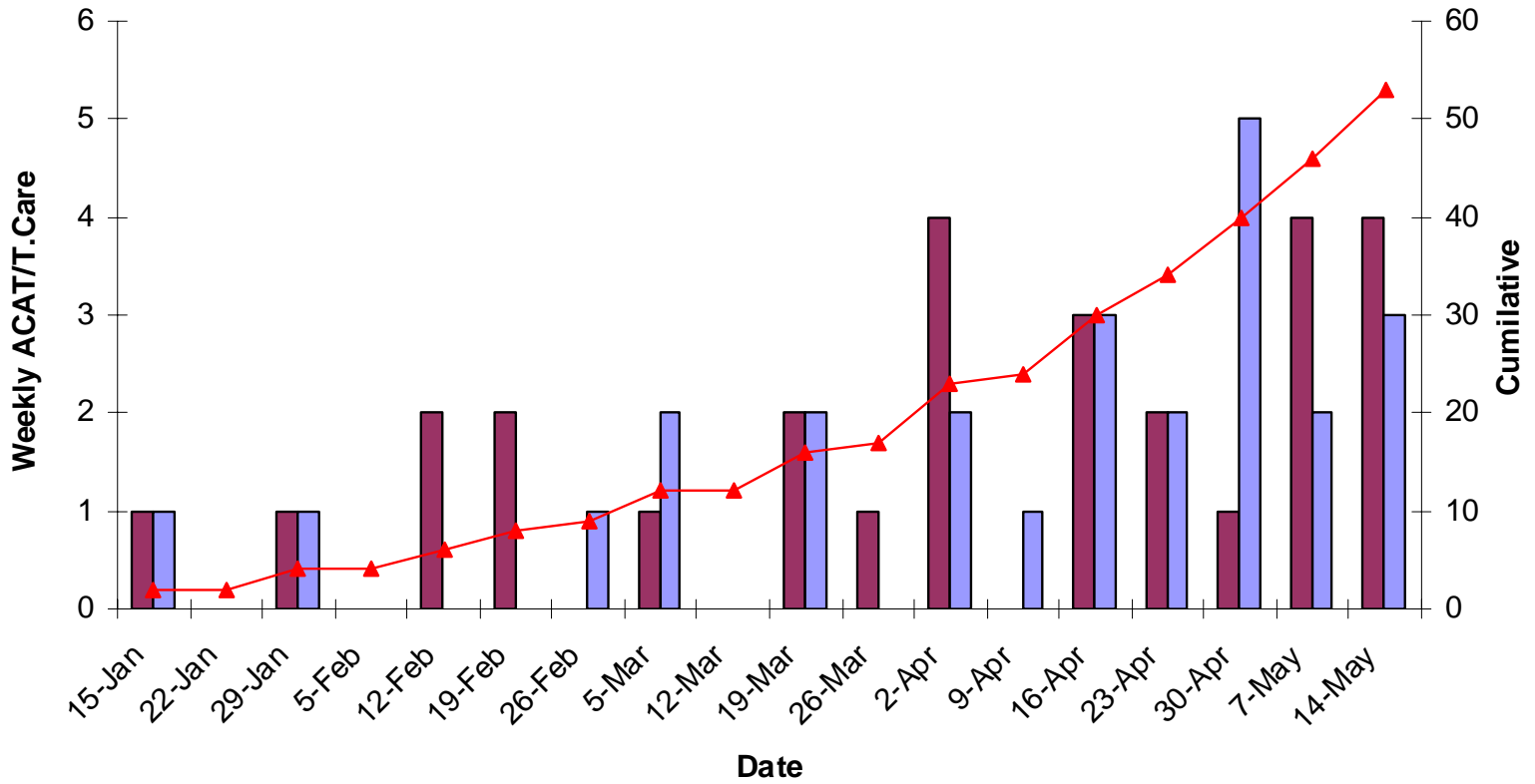
Total numbers



Type of Assessments



ACAT/T.Care



ACAT T.CARE Cumulative

Process I

- Based on observations from assessors, staff and relatives (what does the patient do)
- Multiple observation periods
 - Pre-morbid (3 days prior to acute illness)
 - Admission (initial 24 hour period)
 - Review assessments (for longer stay patients or when sudden change of status occurs)
 - Includes consultations if patient already assessed at admission
 - Discharge (last 24 hours of episode)

Process II

- A single assessment system
- Conducted at time of referral and repeated at critical points during admission and at discharge
- Applied only to selected patients who are “frail”
- Designed to support, problem identification, referral and discharge planning
- Enabling technologies
 - 1. Web based software with messaging functions
 - 2. Robust assessment instruments – the interRAI Acute Care

Process III

- Assessor's interim report available immediately at completion of data collection
- Geriatrician auto-notified by e-mail of assessment pending
- Clinical data and provisional report reviewed
- Report written
- Auto-dispatched to service coordinator
- Available immediately online

Summary report

- Provide a summary profile of the person
- Incorporates
 - Background and commentary
 - Major problems
 - Key observations
 - Screeners
 - Scales
 - cognition
 - IADL
 - ADL
 - Pain
 - BMI
 - Priority areas for action

Assessment Summary () generated at 07:41 on 17-Jul-2007

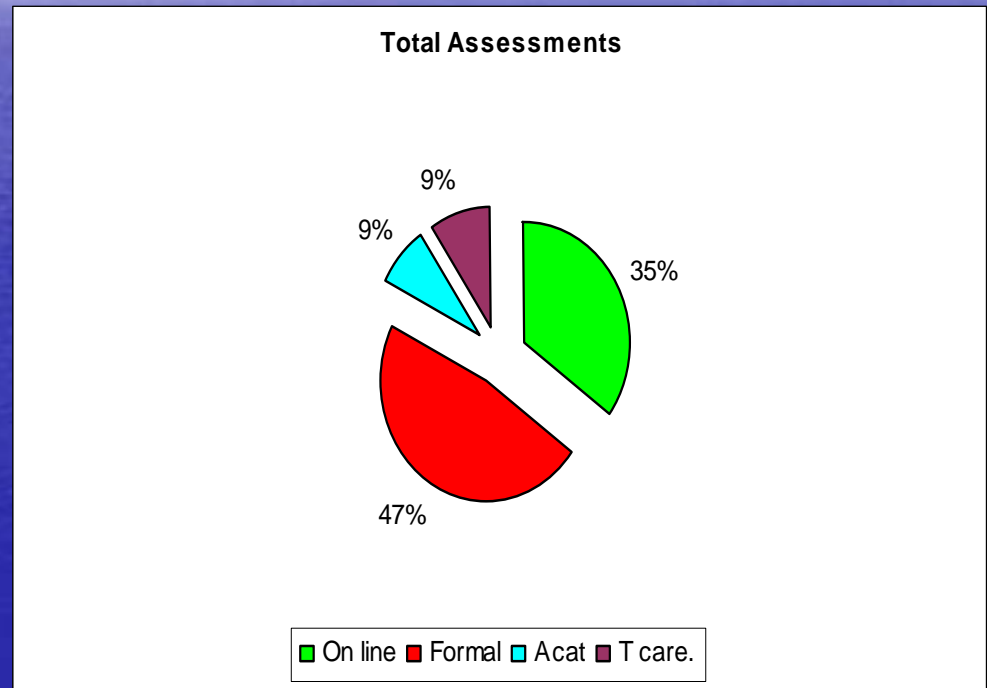
Aged Care Assessment		Scales	
Consultation Report Summary			
Acute Care Setting			
Name: Mr Joe X	Gender: Male	Cognitive performance /6	P 2 A 2
Age: 88 years	Treating doctor: Bob Hope UR number: zzzzzz	Communication /8	1 2
Hospital: Test Hospital	Admitted: 19-Jul-2005 Ward: 5A	Short ADL /16	0 8
Date of this report: 17-Jul-2007		Instrumental ADL /48	42 na
		Pain /4	0 0
Assessment dates		Recommended Areas for Intervention	
P		Prevention (of decline or occurrence)	
A : 20-Jul-2005 (0 days)	Key P=Premorbid A=Admission R=Review D=Discharge	Activities of daily living Delirium Falls - high risk Falls - medium risk Institutional care	
Nurse Assessor Commentary		Treatment	
At Admission: This gentleman appears very confused, even though his heart failure is settling down. At times he resists care, particularly at night. He is unsafe, because his balance is poor and his judgement impaired. His wife is reasonably well, but she struggles at times. She would be willing to accept more assistance at discharge. Children do not live nearby. Low set house.		Delirium Behaviour Cognition Nutrition Urinary incontinence	
Rochelle Vincent (20-Jul-2005)		Consultant Geriatrician Summary ()	
		There is evidence that this gentleman has developed delirium in association with heart failure. Other causes should be carefully excluded. It appears that this has occurred on a background of dementia. This in turn was interfering with his self care abilities even before he became unwell. In hospital, his self care capacity has deteriorated further. It can be anticipated that as his medical problems resolve, so to will his cognitive function and independence. Careful attention to maintaining mobility will be required. Additional support services may be appropriate at discharge.	
		*** Signature file missing for geriatrician 72 ***	
Primary Diagnoses at Admission		Geriatrician	
Cardiac failure			
Living Arrangement and Support			
Admitted from: Private residence - owned/purchasing			
Marital status: Married			
Living arrangement: With spouse/partner only			
Support person available: Yes			
Housing available: Yes			
Problem List			
Cognition and mood		P	A
Communication		☒	☒
Mobility, balance and endurance		☐	☒
Continence		☐	☒
Activities of daily living		☒	☒
Instrumental ADLs		☒	☒
Nutrition		☒	☒
Pressure ulcer		☐	☐
Pain		☐	☐
Community services used		☒	☒

Obstacles.

- Resistance to change
- Change involved several services
- Large number of stakeholders
- Some worried that positions would be eroded
- Lack of knowledge and confidence of assessment tool.

Who was seen

- 274 total
 - 173 referrals
 - 30 ACAT
 - 30 Transition Care
 - Others screen positive/ negative



Achievements

- Patients assessed & interim report in chart within 24 hours
- Geriatrician review within 2 days of referral
- Geriatrician review for ACAT referrals
- Reduced wasted ACAT visits
- Some ACAT referrals offered rehab
- Geriatric services offer a consultant ward round three times a week
- Ongoing weekly reviews

Benefits to Patients

- Reduced duplication of assessment
- Attention to geriatric syndromes
- Full exploration of rehab potential
- Greater access to geriatric opinion & rehabilitation
- All patients referred for Res Care get a geriatric unit assessment

Where to from here.

- New model consolidated into hospital and community aged care services
- ACAT assessment functions to be integrated into the model
- New inter *RAI* / ACCR software implemented and operating to support ACAT assessment
- Use of this model in other sites
- Telemedicine potential

Long Term Plan

