Evaluation of the Council of Australian Governments Long Stay Older Patients (COAG LSOP) Victorian Initiative

Final Report

April 2011

Australian Healthcare Associates

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Glossary

ACAS	Aged Care Assessment Service
ACE	Acute Care for the Elderly
AHA	Australian Healthcare Associates
AHMAC	Australian Health Ministers Advisory Committee
AMT4	Shortened version of AMTS
AMTS	Abbreviated Mental Test Score
AQoL	Assessment of Quality of Life
BCOP	Better Care for Older People
CAM	Confusion Assessment Method
CDM	Chronic Disease Management
COAG	Council of Australian Governments
COAWG	Care of Older Australians Working Group
CoP	Communities of Practice
COTA	Council on the Ageing
CPHI	Centre Promoting Health Independence
DH	Victorian Department of Health
DoHA	Department of Health and Ageing
ED	Emergency Department
GEM	Geriatric Evaluation and Management
GNP	Gerontology Nurse Practitioner
GRN	Geriatric Resource Nurse
GPs	General Practitioners
HARP	Hospital Admission Risk Program
HCOASC	Health Care of Older Australians Standing Committee
IC4OP	Improving care for older people
KPI	Key Performance Indicator
LOS	length of stay
LSOP	Long Stay Older People
MAPU	Medical Assessment and Planning Units
NARI	National Ageing Research Institute
RDNS	Royal District Nursing Service
TCP	Transition Care Program
the Department	The Victorian Department of Health
The toolkit	*Best care for older people everywhere - The toolkit*

1. Executive Summary

1 EXECUTIVE SUMMARY

1.1 *Introduction*

The Council of Australian Governments Long Stay Older Patients (COAG LSOP) Victorian initiatives began in July 2006.

In May 2010 the Victorian Department of Health contracted Australian Healthcare Associates (AHA) to complete the evaluation of the COAG LSOP Victorian initiatives. The objective of the project was to examine the performance of the COAG LSOP Victorian initiative against the set aims of the initiative, with a focus on measuring the effectiveness and efficacy against four key impact areas.

- strengthening attention to the needs of older people in the hospital and community
- improving consistency and integration of service delivery
- improving access to a range of 'age friendly', appropriate services and settings
- reducing the incidence of inappropriate hospital usage by older people.

The two components under the COAG LSOP umbrella that were the target for this evaluation were:

1. Improving Care for Older People (IC4OP)
2. Hospital Admission Risk Program Better Care for Older People (HARP BCOP).

These two major components have built upon and complemented a number of initiatives of the health and community sectors in the past decade.

The Victorian Department of Health (DH) funded 11 metropolitan and 25 rural or regional health services to participate in the IC4OP initiative and 13 rural or regional health services to participate in HARP BCOP.

A key output for the IC4OP - Minimising Functional Decline initiative was the development of an implementation resource; *Best care for older people everywhere - The toolkit (The toolkit*). This resource was for use in participating health services to support the translation of existing best practice guidance into practical improved care processes. *The toolkit* was designed to improve the capacity of health services across Victoria to address key factors that place older people at risk of functional decline while in hospital.

The toolkit was developed through collaboration between the DH, the National Ageing and Research Institute (NARI) and Victorian health services. The toolkit provides information and resources across 10 domains:

- Person-centred practice
- Assessment
- Mobility, vigour and self care
- Nutrition
- Delirium
- Dementia
- Depression

- Continence
- Medication
- Skin integrity.

There were three levels of implementation funded within the IC4OP initiative

Level 1 The *Person-centred care* and *Assessment* domains implemented in one acute ward at a minimum.

Level 2 All domains implemented in one acute care ward.

Level 3 All domains implemented in one acute care ward and the development of a care pathway(s) for older hospital patients across the care continuum from acute to the community.

1.2 *Evaluation Methodology*

A detailed implementation process was developed for the Victorian COAG LSOP project along with an Evaluation Framework. This framework, developed from the initial planning logic models, identified:

- four key strategy impact areas
- contributing project impacts
- outcome or output measure
- data sources
- data collection responsibilities.

Utilising the evaluation framework AHAs evaluation methodology included:

- conduct of a literature and horizon scan
- analysis of all data and reports submitted throughout the initiative by participating health services
- development of data collection tools
- visiting and interviewing key staff at each participating health services
- surveying care staff in target wards of participating health services
- analysis of findings against the evaluation framework.

1.3 *Summary of findings*

1.3.1 Improving Care for Older People

This program targeted acute inpatient care of older patients. It sought to enhance staff awareness and understanding of the complex care needs of older persons in acute hospitals and improve care of older patients in public hospitals and thus minimise their risk of functional decline. The initiative would thereby reduce the number of long-stays in hospital by older patients.

1. Executive Summary

The evaluation clearly demonstrates that the LSOP initiative has delivered significant achievements across the state in enhancing care for older patients in our public hospitals. Equally importantly, major changes in organisational and individual staff attitudes and approaches to the care of older persons have occurred within many participating health services. The cultural change widely accepted as a necessary prerequisite for optimal care for patients over 65 years of age is well underway.

Case studies, health service progress reports, Key Performance Indicator (KPI) data, sector consultation inputs and staff surveys all provide evidence of improved knowledge and awareness of the complex needs of older patients and of better care processes for older patients in the targeted clinical areas over the course of the initiative.

1.3.2 Hospital Admission Risk Program – Better Care for Older People (HARP-BCOP)

This extension of the existing HARP program into new rural and regional health services sought to improve the community care of older patients at risk of hospitalisation by virtue of chronic and complex ill-health and thereby reduce hospital presentations and admissions.

The evaluation clearly demonstrates that there have been significant achievements across the state within this program. There have been consistent improvements in the health and well-being of clients of the program and impressive reductions in hospital attendances, admissions and avoidable readmissions.

Case studies, health service progress reports, KPI's and the sector consultations inputs all provide evidence of improved care coordination for program clients in their community and improved client outcomes.

1.4 *Recommendations*

The following recommendations are based on the observations and learnings from this project and some are focused specifically for the COAG LSOP initiative while others have been made for the Department of Health generally to support health services in managing large multi site projects. Further discussions about the recommendations are seen in Chapter 8 of this report.

Recommendation 1 Executive sponsors

- **1.1** To be effective executive sponsors in health services need influence that cross not only disciplines but also program boundaries
- **1.2** For multi site projects regular meetings with executive sponsors should occur; these meetings should be regular and planned to be short and focused with alternative, times, venues and methods of attendance.

Recommendation 2 Funding

- **2.1** Funding surety needs to be established for life of projects
- **2.2** The DH should investigate ways to quarantine capital funding to respond to environmental audits.

1. Executive Summary

Recommendation 3 Project officers

3.1 To build health sector capacity DH should consider funding/supporting health services to offer scholarships (or similar) to complete appropriate project officer training. For example *BSBCMN 419A: Manage Projects* is a current unit of competency from the Australian Vocational Education and Training (VET) system *Business Services Training Package*.

3.2 For multi site projects regular project officer meetings/forums should occur; a number of the meetings should be statewide however, the majority should be regionally based meetings

Recommendation 4 Supporting minimising functional decline as an appropriate model of care for all health service users

4.1 It is recommended that DH support all health services to adopt minimising functional decline as an appropriate model of care for all health service users, across the continuum of care

Recommendation 5 Reform through existing structures

5.1 To support the transition of the IC4OP initiative from a project to long term model of care health services need to be supported to transition projects into existing processes, such as quality/clinical governance systems.

5.2 It is recommended that DH support health services to combine projects wherever possible.

Recommendation 6 *The toolkit*

6.1 It is recommended that *The toolkit* be marketed at educators, quality and clinical governance staff who can ensure appropriate health service protocols are met to introduce new tools/forms.

Recommendation 7 Clinical champions

7.1 DH continue to support health services to adopt clinical champions, utilising a model that bests suits the health service or the region.

Recommendation 8 Minimising functional decline training

8.1 DH should use its influence on key professional groups to encourage the concepts of minimising functional decline in the curricula of health professionals.

8.2 Health services should be supported to implement training in all domains that support minimising functional decline to all health professionals. Information should be included in all orientation programs and regular required training.

2 CONTEXT AND BACKGROUND

2.1 *Introduction*

This report is the Final Report of the Evaluation of the Council of Australian Governments Long Stay Older Patients (COAG LSOP) Victorian initiatives to the Evaluation Advisory Group.

Australian Healthcare Associates (AHA) were contracted to conduct the evaluation in June 2010 by the Victorian Department of Health (DH). As part of the implementation of the Victorian COAG LSOP initiative an Evaluation Framework was developed. AHA has utilised this framework in conducting the evaluation.

The evaluation used a variety of methods to inform the descriptions of the initiative, assessments of its impact and recommendations regarding future potential endeavours to improve care of older persons in Victorian public hospitals.

These included a review of extensive DH documentation regarding the initiative, a comprehensive consultation with the sector and a literature review and horizon scan. The literature review and horizon scan is at Appendix 1.

The evaluation methodology is described in detail at Appendix 2.

Over 35% of all hospital admissions and 47% of occupied bed days are for people aged 65 years and over.

Inpatients aged 65 years and over averaged 8.6 days per hospital stay. Those aged over 85 years averaged 10.6 days.

Six per cent of all current public hospital admissions for people aged 65 years and over are for subacute care, such as rehabilitation and geriatric evaluation and management.

In 2005–06, people aged 65 years and over represented 13.2% of Australia's population.

This proportion is expected to increase to 25% by 2047. Given the current ways we provide acute care for older persons, this demographic change is expected to raise *Government expenditure on hospitals and health services by 80% in real terms by 2047.*

2.2 *Context – Demography*

Shifting demographics and increasing life expectancy are having a growing and incontrovertible impact on hospitals[1, 2]. Currently, more than one-third of all people admitted to our hospitals are over 65 years of age and people in this age group account for over 50% of inpatient hospital days. The ageing of the population will particularly quicken from 2010 when the bulk of the post-war *baby boom generation* begins passing 65 years of age.

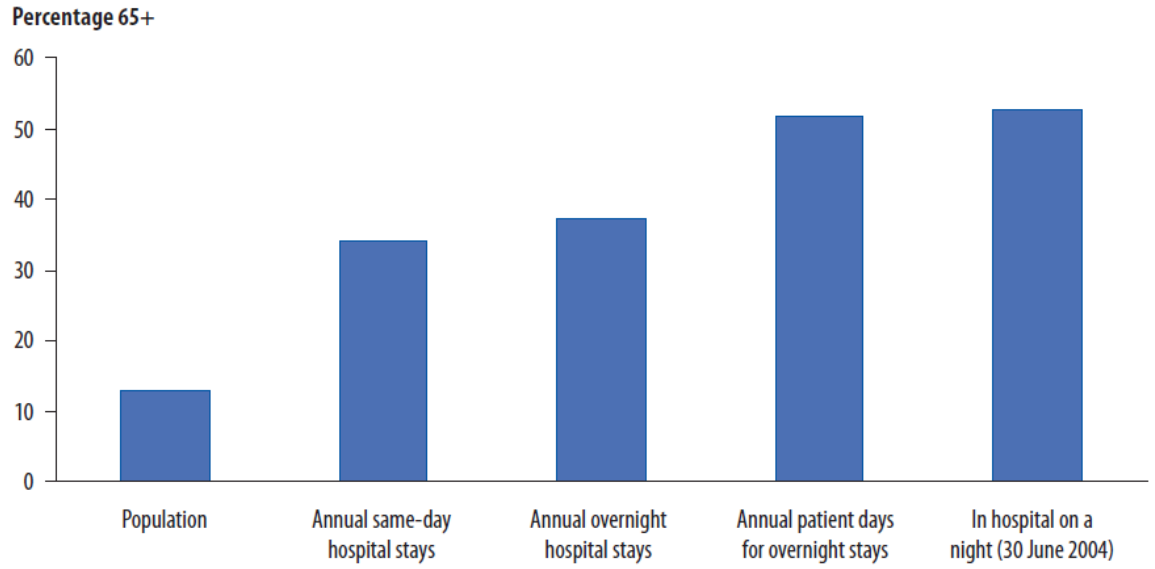
In 2005–06, people aged 65 years and over, represented 13.2% of Australia's population[1, 2]. This proportion is expected to increase to 25% by 2047. These changes will see an increasing proportion of hospital activity and expenditure focused on acute care of older Australians.

An intergenerational report (IGR) is produced by the Australian Government every five years to assess the sustainability of government policies over the next 40 years. The second report (IGR2), released in 2007, forecasts that Australia's population will grow to 28.5 million by 2047 and 25% of the population will be over 65 years of age. This will partly be a result of the average life expectancy increasing by seven years for men (to 86 years) and women (to 90 years). The report also states that Australian Government health expenditure will almost double over the next 40 years.

2. Context and Background

As depicted in *Figure 2-1* the percentage of patients 65 years and older already constitute a large volume of care that hospitals and health systems provide, especially when compared to the percentage of over 65 years in the population[1-3]. Increasingly, care of older adults needs to be seen to be the central business of these facilities. Acute health services need the tools to manage this changing patient population mix effectively and the vision to see the opportunities to improve both the quality of their care and the value delivered to the community.

Figure 2-1: Population and hospital use: people aged 65 and over as percent of total, 2004-05



Source: AIHW. Older Australians in Hospital. Bulletin 53. August 2007.

Older Australians have a higher rate of admission to hospitals than the general population. They are admitted for a different mix of reasons and their stay in hospital is generally longer. The acute hospital usage rate increases with age across the over 65+ years of age cohort, with very significant acute bed utilisation by persons over 85 years of age.

As shown in *Table 2-1*, in 2005-06 overnight stay patients aged 65 years and over had longer hospital stays than patients less than 65 years. Those aged over 85 years had even longer average hospital stays. People 65 years and over staying overnight in hospital had an average stay of 8.6 days, compared with an average of 6.2 days for all Australians. The average length of stay was even higher in oldest age groups, being more than 10.6 days for people aged 85 years or more.

Table 2-1: Average length of stay (overnight patients) by age group, Australia, 2005-06

	0-64 yrs	65-74 yrs	75-84 yrs	85 yrs and over	65 yrs and over	All ages
Private hospitals (days)	4.1	5.6	7.7	9.9	7.4	5.4
Public hospitals (days)	5.2	7.7	9.5	11.0	9.2	6.6
Total	**4.8**	**7.0**	**8.8**	**10.6**	**8.6**	**6.2**

Source: Australian Government Department of Health and Ageing Annual Report 2008

The reasons for increasing length of stay for older people include a greater likelihood of carrying co-morbidities or health problems other than the one for which they were admitted and a slower recovery

from treatment because of a decline in a number of body functions. The average length of stay for all overnight stay patients is decreasing in hospitals across Australia, as shown in *Table 2-2*.

Table 2-2 Average length of stay, excluding same-day separations, Australia, 204 -2009

						Change (percent)	
	2004–05	2005–06	2006–07	2007–08	2008–09	Ave since 2004–05	Since 2007–08
Public hospitals (days)	6.7	6.6	6.5	6.5	6.3	–1.3	–2.3
Private hospitals (days)	5.4	5.4	5.4	5.4	5.3	–0.6	–1.4
Total	6.3	6.2	6.2	6.2	6	–1.1	–2.0

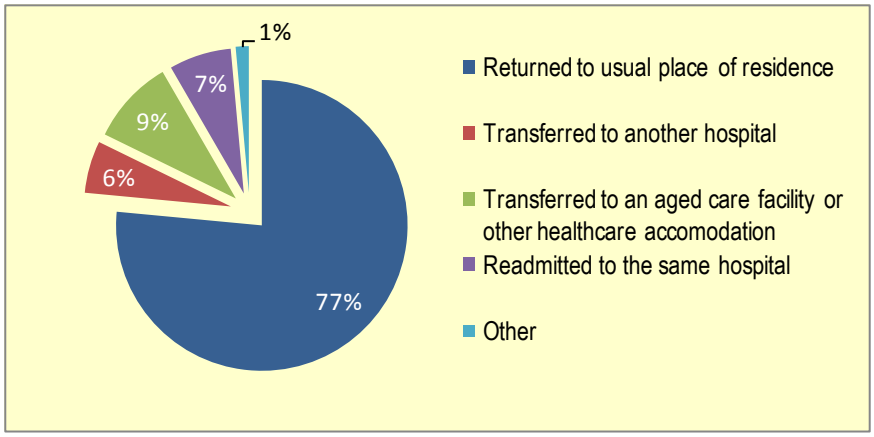
Source: Australian Institute of Health and Welfare 2010. Australian hospital statistics 2008–09.

The percentage of patient days utilised by people over 65 in public hospitals across Australia has remained at 47% of all days, from 2004-05 to 2008-09. In 2008-09 in Victoria the percentage of patient days for people over 65 years was 49%[1].

In 2005-06 a significant percentage (5-10%) of all Australian public hospital admissions for people aged 65 years and over was for subacute care, including rehabilitation and geriatric evaluation management. In 2008-09 in Victoria this percentage was 14-15%[2].

Older Australians are significantly more likely to be transferred to other healthcare facilities at the end of any particular episode of care in acute hospitals. As highlighted in *Figure 2-2,* following a subacute admission, 77% return to their usual residence, and 9% of people are transferred to residential aged care or other healthcare accommodation. For those under 65 years, 89% return to their usual accommodation.

Figure 2-2: People over 65 years, separations from subacute care (rehabilitation and geriatric evaluation management), by mode of separation, all hospitals, Australia 2008–09



Source: Australian Institute of Health and Welfare 2010. Australian hospital statistics 2008–09.

[1] Australian Institute of Health and Welfare 2010. Australian hospital statistics 2008–09. Health services series no. 17. Cat. no. HSE 84. Canberra: AIHW.
[2] IBID

2. Context and Background

Why are older Australians admitted to public hospitals?

Renal dialysis, cardiology, respiratory medicine and orthopaedics are the most common reasons that older people are admitted to public hospitals. People aged over 65 years also represent a particularly high proportion of patients admitted for ophthalmology, which commonly involves surgical lens procedures for cataract treatment.

Older Australians and elective surgery

People over the age of 65 comprised 28% of public hospital admissions for emergency surgery and 28% for elective surgery in 2005–06. The median waiting time for all elective surgery in public hospitals was higher in the 65–84 years age groups than for the general population. This is influenced by the relatively long waits for joint replacement and cataract treatment that are commonly required by older people.

Older Australians and emergency departments

Older Australians have a higher overall rate of presentation to emergency departments than other age groups. They also require more urgent attention than other age groups, being over 30% of people in the two highest triage categories (Resuscitation and Emergency). As shown in *Table 2-3,* more than 50% of the older people presenting to an emergency department are admitted to the same hospital, or referred to another, compared with 23% of people less than 65 years of age.

Table 2-3: Emergency Departments - presentations by departure status, by age group, Australia, 2005-06

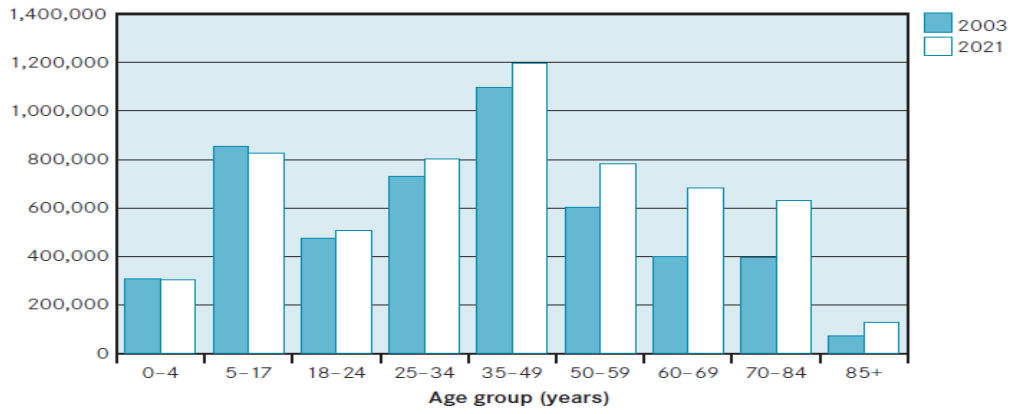
	Admitted or referred	Not admitted	Did not wait or left at own risk
0-64 yrs (%)	23	70	7
65-74 yrs (%)	51	46	3
75-84 yrs (%)	62	36	2
85 yrs and over (%)	67	32	1
All ages	29	65	6

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

Victoria's public hospitals continue to treat a growing number of patients. They are currently on target to admit over 1.4 million patients this year, compared to one million in 1999-2000.

2. Context and Background

Figure 2-3: Victorian population structure projections 2003-2021

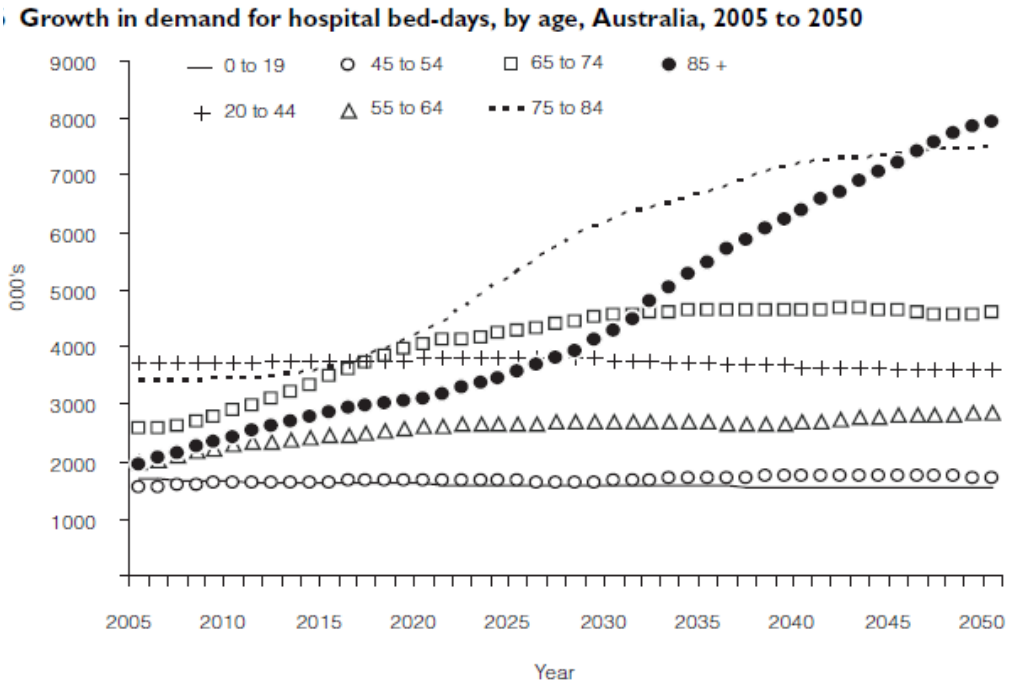


Source: Department of Sustainability and Environment, 2003

Older people are significant users of acute health services in Victoria, with people over the age of 65 using around half of all multiday stays. As the population ages Victoria's health services, like those in all jurisdictions across Australia, will experience a steep rise in the percentage of older people requiring acute hospital treatment and care. The projections for ageing in Victoria are shown in *Figure 2-3*.

The predicted growth in demand is shown in *Figure 2-4*.

Figure 2-4: Growth in demand for hospital bed days, by age, Australia, 2005 to 2050



Source: Australian Health Review November 2006 Vol 30 No 4

2. Context and Background

2.3 *Context – Policy*

2.3.1 National Policy Initiatives

Over the past decade the Australian and state and territory governments have had a strong focus on collaborating on initiatives to improve the care of long-stay older patients in public hospitals and their access to appropriate long-term care options.

In 2001 Australian Health Ministers Advisory Committee (AHMAC) established the Care of Older Australians Working Group (COAWG), now known as the Health Care of Older Australians Standing Committee (HCOASC). They commissioned a number of studies[1] including:

- *Service Provision for Older People in the Acute – Aged Care System* (The National Ageing Research Institute and the Centre for Applied Gerontology) 2002
- *Stock take of Models of Care at the Acute – Aged Care Interface* (Howe, Rosewarne and Opie) 2002
- *Examination of Length of Stay for Older Persons in Acute and Sub-Acute Sectors* (Aged Care Evaluation and Management Advisors) 2003
- *Review of Assessment and Transition Practices for Older People in Acute Public Hospitals* (University of South Australia) 2003
- *Feasibility Study on Linking Hospital Morbidity and Residential Aged Care Data to Examine the Interface between the Two Sectors* (AIHW) 2002
- *Unnecessary and Avoidable Hospital Admissions for Older People* (Siggins Miller) 2003.

In 2004, HCOASC released a key framework document '*Age-friendly principles and practices: Managing older people in the health service environment'.* This established an overarching national framework for health services in managing older people's health care needs. This document outlined seven principles and associated practices to inform service development for older people.

HCOASC followed the release of *the age-friendly principles* with a number of resources to assist health services in implementing better care for older patients. These included:

- a National Action Plan for improving the care of older people across the acute-aged care continuum, 2004–2008 ('Hospital to home')
- Best Practice Approaches to Minimise Functional Decline in the Older Person Across Acute, Subacute and Residential Aged Care Settings
- The 'how to' guide. Turning knowledge into practice in the care of older people
- A Guide for Assessing Older People in Hospitals
- Clinical Practice Guidelines for the Management of Delirium in Older People
- Stroke Care Pathway.

Over the past 10 years or more there have been a number of other national policy initiatives that have sought to deliver improved care of older Australians in acute hospitals including:

- ***Phase 4 of the National Demonstration Hospitals Project*** (NDHP4) focused on improving acute care of the older patient in hospitals

- ***The Pathways Home Program***, that provided funding to the states and territories to improve their rehabilitation and step-down services; and more recently
- ***The Transition Care Program (TCP)***. This was an initiative of the Australian and state and territory governments seeking to help older Australians return home after their hospital stay. The program was announced in the 2004/05 Australian Government Budget and was jointly funded by the Australian Government and the state and territory governments.

  The TCP was designed to help older people leaving hospital to return home rather than inappropriately enter residential care.

  This program provides older people with a package of services that includes low-intensity therapy (such as physiotherapy, occupational therapy and social work), case management, as well as nursing support, personal care or both. It helps older people complete their recovery and optimise their functional capacity, while they or their family or carer consider long-term care arrangements.

  An evaluation of the TCP concluded that the program provided additional treatment and care options following hospitalization that were highly valued by patients and their families. Functional improvements occurred. When compared with similar groups of frail older people discharged from hospital during the same time period, those who received TCP had fewer readmissions to hospital and were less likely to move into permanent residential aged care.

2.3.2 Victorian Policy Initiatives

Within the Victorian policy context *'Improving care for older people: a policy for health services* (IC4OP policy)' was released in 2003. This highlighted the need for health services to change the way they care for older patients in response to the shifting demographics in the Victorian population.

The IC4OP policy focused on improving the care provided for older people by health services and better integration of care across settings to ensure that people receive the right care in the right place at the right time.

Three fundamental drivers were identified to stimulate improvements in the care of older people. These were the need to:

1. adopt a strong person-centred approach to the provision of care and services
2. better understand the complexity of older people's health care needs
3. improve integration within health services' community-based programs, and between health services and ongoing support services available in the broader community.

The IC4OP policy was underpinned by 12 principles that informed the practice and process changes required.

2. Context and Background

The IC4OP principles:

1. Health services apply practice based on best evidence to the care of older people, including specific attention to the risk of malnutrition, decreased functional mobility, loss of skin integrity, incontinence, falls, the development of delirium, problems with medication, poor self-care and depression.
2. Health services take clinical governance responsibility for the care of older people.
3. Treatment and care provided by health services places the person at the centre of their own care and considers the needs of the older person's carers.
4. Health services identify older people at risk of adverse health outcomes and/or having existing or potential supportive care requirements.
5. Treatment and care provided for older people with a positive risk screen includes a comprehensive assessment.
6. Treatment and care provided for older people includes interdisciplinary care planning that is founded on evidence-based care pathways.
7. Treatment and care provided for older people is coordinated to achieve integrated care across settings.
8. Older people receive treatment and care in the setting that best meets their needs and preferences where it is safe and cost effective to do so.
9. Health services integrate their community-based programs to provide the appropriate treatment, therapy and supportive care to meet the needs of older people.
10. Robust protocols and agreements developed between health services and ongoing community support providers ensure that older people continue to receive the care they require in a coordinated and integrated manner.
11. An adequate level of support for people awaiting long-term care options is provided in the setting that best meets their needs.
12. All people across Victoria have access to *Centres Promoting Health Independence*.

The implementation of this policy required a multifaceted, incremental approach. A key aspect of this was state-wide collaborative partnerships with key stakeholders. In addition to working with health services, the Department developed partnerships with the Commonwealth Department of Health and Ageing (DoHA), consumers, peak organisations, professional bodies and tertiary institutions.

This involved partnerships and strategies such as:

- incorporating consumers onto advisory committees
- engaging the National Ageing Research Institute (NARI) to undertake resource development projects
- engaging the Council on the Ageing (COTA) and Northern Health in rolling out a training program to support service development
- working with Latrobe University in evaluation processes.

2. Context and Background

Such partnerships and strategies helped to support and resource health services to deliver service developments against their agreed plans.

The Department funded four state-wide projects, to support health services improve the way care is delivered to older people with complex care needs. These projects aimed to ensure a foundation of evidence based practice and education for person-centred care, support the development of cognition management and assist in identifying and planning for environmental improvements.

These projects included:

- Best Practice in Person-centred Health Care
- Enhancing Practice Program
- Improving the environment for older people in Health Services: An audit tool
- Dementia Management in Hospitals Program.

A summary of key results of IC4OP was published in 2008. This report demonstrated that participating health services had achieved significant practice changes, including:

- a refocusing of culture towards person-centred care
- all health services strove to minimise functional decline in the areas of nutrition, functional mobility, skin integrity, continence, falls, medication management, dementia, delirium, depression and self-care. This work highlighted the need to have evidence-based resources available to support the systems change required
- application of the environmental audit tool and subsequent physical improvements had a profound impact on accessibility for older people in hospital settings, on staff morale and awareness of the needs of older people, and on the morale of patients and carers.

When acutely ill elderly patients have an illness that requires hospitalization, they frequently experience functional decline

Elements of hospitalization, including iatrogenic illnesses, bed-rest and immobility can contribute to a poor result, leading to prolonged hospital stays, nursing home placement, and death.

Too often, this decline is accepted as an inevitable outcome of hospitalization.

The Victorian Department of Health policy direction is focused on aligning and integrating community-based programs to support discharge from inpatient services and prevent or substitute for hospitalisation. The relevant state policies and planning frameworks include:

- *Improving care for older people: a policy for health services (2003):* A policy framework for the effective care of older people by health services, which focus on integrating care across settings to ensure people have the appropriate care in the appropriate place. www.health.vic.gov.au/older/improvingcare.pdf
- *Directions for your health system: Metropolitan Health Strategy (2003):* A policy and planning framework for providing health care services across metropolitan Melbourne, including an expanded role for ambulatory care services as a cornerstone in the configuration of health care services www.health.vic.gov.au/metrohealthstrategy/index.htm

2. Context and Background

- *Rural directions for a stronger healthier Victoria (2009):* A policy and planning framework that is an update of; *Rural directions for a better state of health*. It provides an opportunity to build on what has already been achieved, outlines the next phase of continuing service development, and acknowledges the major support all health services provide for their rural communities. The framework contains three broad directions, with a revised focus to update development priorities. The three directions are; improving the health of rural Victorians, supporting a contemporary health system and strengthening and sustaining rural health services. www.health.vic.gov.au/ruralhealth
- *Care in your community: A planning framework for integrated ambulatory health care (2006):* The framework encompasses all community-based ambulatory care services. The vision is for a modern, integrated and person-centred health system aimed to meet the future needs and expectations of communities and individual users of health care services, and to provide integrated and accessible services in local communities www.health.vic.gov.au/ambulatorycare/downloads/care_in_your_community.pdf
- *Improving care: Hospital Admission Risk Program public report (2006)*: This report is an independent evaluation of HARP that outlines the characteristics of HARP projects and the integration into ongoing services. It identifies key outcomes of HARP and provides direction for further development of HARP services www.health.vic.gov.au/harp-cdm/improvingcare.pdf
- *Victorian services coordination practice manual (2007):* This manual defines the practices, processes, protocols and systems that support service coordination across Victoria. www.health.vic.gov.au/pcps/downloads/sc_pracmanual.pdf .

3 THE VICTORIAN COAG LSOP INITIATIVE

3.1 *Introduction*

Under the current national policy initiative in this arena *Improving Care for Older Patients in Public Hospitals*, the Australian Government provided a total of $150 million to the states and territories to implement a range of initiatives in 2006-2010 that complemented existing older patient care improvement programs in each jurisdiction. The initiative focuses on reducing unnecessary admissions, improving admitted patient services, and improving the transition to appropriate long-term care in metropolitan and rural areas. There was a focus on improving the flexibility and capacity of rural hospitals to provide more age-friendly services.

The COAG LSOP initiative began in Victoria in July 2006 and ran for four years (2006/07 to 2009/10). The Victorian COAG LSOP initiative focused on improving the capacity of health services to provide more appropriate care for long-stay older patients in public hospitals and reducing avoidable or premature admission of older people to hospitals, particularly in rural areas.

By building on existing initiatives, Victoria sought to prevent avoidable hospital admissions for older people. In the event that people do require a hospital stay the focus was on improving the care older people receive to minimise their risk of functional decline. Together these initiatives sought to prevent older people experiencing long stays in hospital and avert the potential requirement for residential aged care placement.

In metropolitan areas the initiatives focused on providing more appropriate care for long-stay older patients in public hospitals. In rural and regional areas the initiatives focused on providing more appropriate care for long-stay older patients and reducing avoidable or premature admission of older people to public hospitals.

Following the success of the IC4OP initiative, the then Victorian Department of Human Services took the opportunity provided by the COAG LSOP initiative to further embed the implementation of *Improving care for older people* within Victoria's public hospital system.

The other key existing initiative that the Victorian COAG LSOP built on was the *Hospital Admission Risk Program (HARP).*

The state-wide Hospital Admission Risk Program had proven that the provision of more integrated service delivery reduced the demand on hospital services and improved patients' health and well being. In the HARP initiative, groups of acute and community-based health care providers formed consortia to implement a range of specific projects specifically designed to enhance care coordination for older clients in their specific local context.

Each of these projects aimed to provide an integrated system of care through the use of care coordinators, who ensured that patients were linked to all the existing acute and community services they required. They also facilitated the coordination between these services through ensuring effective communication and exchange of relevant information.

The model produced reductions in the demand for acute hospital services without increasing overall costs to the system. Central to success, at a systems level was the active involvement of key stakeholders throughout the planning, implementation and ongoing review stages of the project. At an individual patient level, the employment of personal care facilitators, who assisted the patients in

understanding their health condition, accessed the required services and promoted self-management, was of prime importance.

The data from HARP indicated that for older patients with a history of frequent emergency department presentations and/or at risk of frequent presentation, with complex health care needs, an integrated care facilitation model that is patient-focused, links and coordinates services, and delivers a continuum of care through the acute and community health sectors reduces utilisation of acute health care facilities. Given that the HARP initiative was broadly successful, HARP programs have subsequently been mainstreamed into Victoria's health care system.

The Victorian COAG LSOP also included the provision of one-off funding for two categories of service improvements:

- improving the environment for older people in hospital
- information management structure.

3.2 *Improving Care for Older People*

This LSOP initiative was implemented at 36 health services across the state. This saw 19 new health services join with the 17 agencies involved in the previous IC4OP initiative to focus on improving care for older patients and the prevention of functional decline. The list of participating health services are in *Table 3-1* and *Table 3-2*.

Table 3-1: IC4OP minimising functional decline implementation sites Metropolitan

Metropolitan / Urban Areas	Existing	New
Alfred Health	✓	
Austin Health	✓	
Calvary Healthcare Bethlehem		✓
Eastern Health	✓	
Melbourne Health	✓	
Northern Health	✓	
Peninsula Health	✓	
Southern Health	✓	
St Vincent's Health	✓	
Western Health	✓	
Werribee Mercy		✓

Table 3-2: IC4OP minimising function decline implementation sites Rural and Regional

Rural and Regional Areas	Existing	New
Barwon Southwest Region		
Barwon Health	✓	
South West Healthcare		✓
Western District Health Service (Hamilton)		✓
Colac Area Health		✓
Portland District Health		✓
Gippsland Region		
Latrobe Regional Hospital	✓	
Bairnsdale Regional Health Service		✓
Central Gippsland Health Service		✓
West Gippsland Healthcare Group		✓
Bass Coast Health Service		✓
Loddon Mallee Region		
Bendigo Health Care Group	✓	
Mildura Base Hospital		✓
Echuca Regional Health		✓
Swan Hill District Health		✓
Castlemaine Health		✓
Maryborough District Health Service		✓
Hume Region		
Goulburn Valley Health	✓	
Wodonga Regional Health Service	✓	
Northeast Health Wangaratta	✓	
Benalla & District Memorial Hospital		✓
Seymour & District Hospital	✓	
Grampians Region		
Ballarat Health Service	✓	
Wimmera Health Care Group		✓
East Grampians Health Service (Ararat)		✓
Stawell District Hospital		✓

3. The Victorian COAG LSOP Initiative

This initiative focused on addressing the key factors that place older people at risk of functional decline and other adverse events while in hospital, and sought to develop a more coordinated and comprehensive approach. Minimising the risk of functional decline for older people in hospitals in turn should reduce the number of people experiencing excessively long hospital stays.

The guidelines *Best practice approaches to minimise functional decline in the older person across the acute, sub-acute and residential aged care settings* commissioned by the HCOASC was used as a platform for the development and implementation of a functional decline prevention program.

3.2.1 The Toolkit

A key output for the IC4OP - Minimising Functional Decline initiative was the development of an implementation resource, *Best care for older people everywhere - The toolkit (The toolkit*) for use in participating health services that would support the translation of existing best practice guidance into practical improved care processes. *The toolkit* was designed to improve the capacity of health services across Victoria to address key factors that place older people at risk of functional decline while in hospital.

Ten key areas addressing functional decline were identified for incorporation into *The toolkit*. Leadership for development of content for each domain for *The toolkit* was assigned to one health service. Each of the health services, who had participated in the prior IC4OP initiative, partnered with two to three other health services and a regional partner in content development. The list of participating health services is at *Table 3-3*

Table 3-3: Health services involved in Toolkit development

Domain	Lead agency	Partner agency	Regional partner
Assessment	Western Health	Bayside Health Northern Health	Loddon Mallee
Skin Integrity	Eastern Health	Austin Health Bayside Health	Loddon Mallee
Mobility	Peninsula Health	Austin Health Eastern Health	Gippsland
Nutrition	Bayside Health	Peninsula Health Melbourne Health	Gippsland
Delirium	Melbourne Health	St Vincent's Health Western Health	Barwon South Western
Dementia	Ballarat Health	Barwon Health St Vincent's Health Western Health	Barwon South Western

Domain	Lead agency	Partner agency	Regional partner
Depression	Southern Health	Calvary Bethlehem Healthcare	Grampians
Medication	St Vincent's Health	Melbourne Health Peninsula Health Northern Health	Grampians
Continence	Austin Health	Eastern Health Southern Health	Hume
Person-centred practice	Northern Health	Southern Health Latrobe Regional Hospital	Hume

The development of content for each key area (or domain) thus involved a number of participating health services, either as the Lead Agency for a domain or as partner agencies in *The toolkit* development process. These domain teams performed literature reviews, identified relevant resources, field-tested these resources and submitted preferred content to the National Ageing Research Institute (NARI).

NARI developed a framework for the domains to ensure that an integrated resource kit was produced and provided ongoing support for *The toolkit* development and editorial oversight of compilation of *The toolkit.*

There were three levels of implementation envisaged for this resource:

Level 1 The *Person-centred care* and *Assessment* domains implemented in one acute ward.

Level 2 All domains implemented in one acute care ward.

Level 3 All domains implemented in one acute care ward and the development of a care pathway(s) for older hospital patients across the care continuum from acute to the community.

3.3 *Hospital Admission Risk Program Better Care for Older People*

The aim of Hospital Admission Risk Program Better Care for Older People (HARP BCOP) was to further develop prevention and self-management strategies for older people with chronic or complex conditions, in rural and regional Victoria, by providing new approaches to care on presentation to hospital, and more targeted support on discharge. Expected outcomes included reductions in hospital use and improved health and functional status for older people.

The COAG LSOP initiative funded 13 HARP BCOP sites, see *Table 3-4*. Of the 22 established state-wide HARP services, 11 were located in regional areas. These existing HARP services had a role in supporting the development of the HARP-BCOP projects.

Table 3-4: Hospital Admission Risk Program Better Care for Older People implementation sites

Rural and Regional Areas	Existing HARP service	New HARP BCOP project
Barwon Southwest Region		
Barwon Health	✓	
South West Healthcare	✓	
Western District Health Service		✓
Portland District Health		✓
Gippsland Region		
Latrobe Regional Hospital	✓	
Bairnsdale Regional Health Service	✓	
Central Gippsland Health Service		✓
West Gippsland Healthcare Group		✓
Bass Coast Health Service		✓
Loddon Mallee Region		
Bendigo Health Care Group	✓	
Mildura Base Hospital	✓	
Echuca Regional Health		✓
Swan Hill District Health		✓
Castlemaine Health		✓
Maryborough District Health Service		✓
Hume Region		
Goulburn Valley Health	✓	
Wodonga Regional Health Service	✓	
Northeast Health Wangaratta	✓	
Benalla & District Memorial Hospital		✓
Seymour & District Hospital		✓
Grampians Region		
Ballarat Health Service	✓	
Wimmera Health Care Group	✓	
East Grampians Health Service		✓
Stawell District Hospital		✓

3.4 *Improving the environment for older people in hospitals*

Improving the environment for older people in Health Services: An audit tool, had been developed as part of the initial IC4OP initiative. It identified the key principles underpinning age-friendly physical environments and provided health services with an audit tool to assist them to improve their environments to better cater for needs of older people. Health services performed environmental audits and developed action plans for improving the physical environment for older people accessing their services.

The development of a hospital environment that values older people and promotes their health must consider the physical surroundings as well as the relationship between service providers and older people. Creating older person friendly environments capitalises on an older person's strengths and abilities, protects them against harm, takes account of the needs of staff charged with their care and fosters a safer, more accessible and comfortable environment for everyone.

The implementation of the audit tool was a key component of the IC4OP initiative. All health services that participated in the LSOP were eligible for one-off funding for required environmental improvements. Each health service undertook an environmental audit using the established tool to identify priority infrastructure improvements. A report was provided that identified areas for action and associated costings. Following review and prioritisation, funds were provided to health services during 2006-07 and 2007-08 to implement priority actions. These funds addressed around 70% of identified need in 2007 and 50% of identified need in 2008.

3.5 *Information Management Structure improvements.*

Initiatives were identified that would build capacity and infrastructure to support streamlined care management and placement processes for older patients leaving hospital and those waiting in the community who require residential or community care. These initiatives focused on investment in the infrastructure necessary for effective collaboration between service providers at the acute/aged care interface.

Areas of investment included:

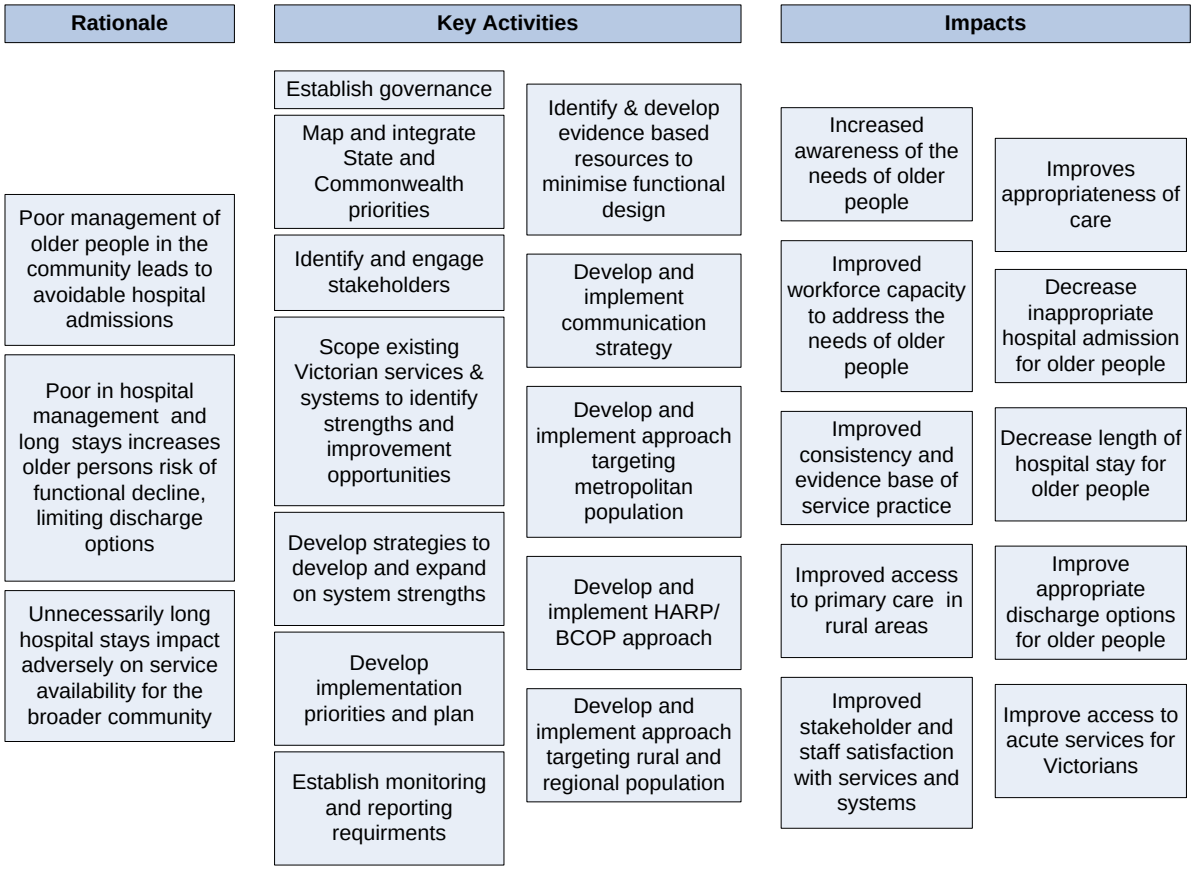
- *Information Management Infrastructure:* Information Technology can facilitate electronic referrals, data collection and improved communication between service providers while Aged Care Assessment Service (ACAS) are moving steadily into an electronic environment, appropriate and adequate equipment was required to support this change. The COAG LSOP funding supported the 18 Victorian ACAS teams to introduce mobile computers and initiate efficiency gains. The funding supported greater computer access and computing literacy in general.
- *The TREAT project* (Telemedicine in Residential aged care facilities to Enhance Assessment and Treatment) was a trial, run at the Northern Hospital, of the use of telemedicine to enhance geriatrician assessments in residential care facilities.

4 IMPLEMENTATION AND EVALUATION OF VICTORIAN INITIATIVES

4.1 *Implementation of State-wide programs*

A comprehensive and detailed planning process underpinned the implementation of the LSOP initiative in Victorian public hospitals. An outline of the overarching Long Stay Older Patient Implementation Strategy is presented in *Figure 4-1*.

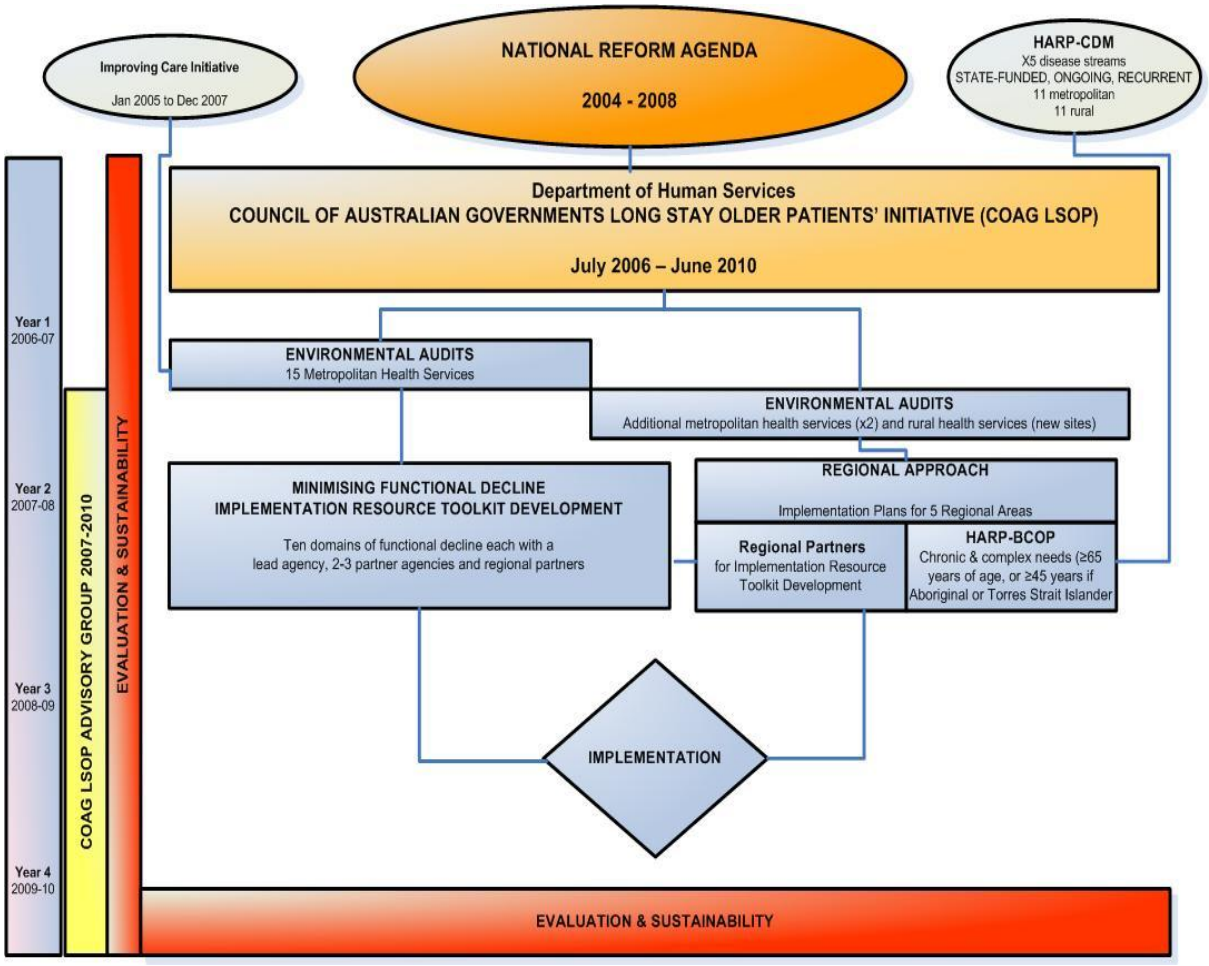
Figure 4-1: Victorian COAG LSOP Overall Strategy



Detailed outlines were also developed for key implementation activities delegated to working groups to support the achievement of high level impacts by the LSOP initiative and optimise desired outcomes. These outlines are at Appendix 3.

The overall design of the LSOP initiative in Victoria is depicted in *Figure 4-2.*

Figure 4-2: Victorian COAG LSOP Overall Design



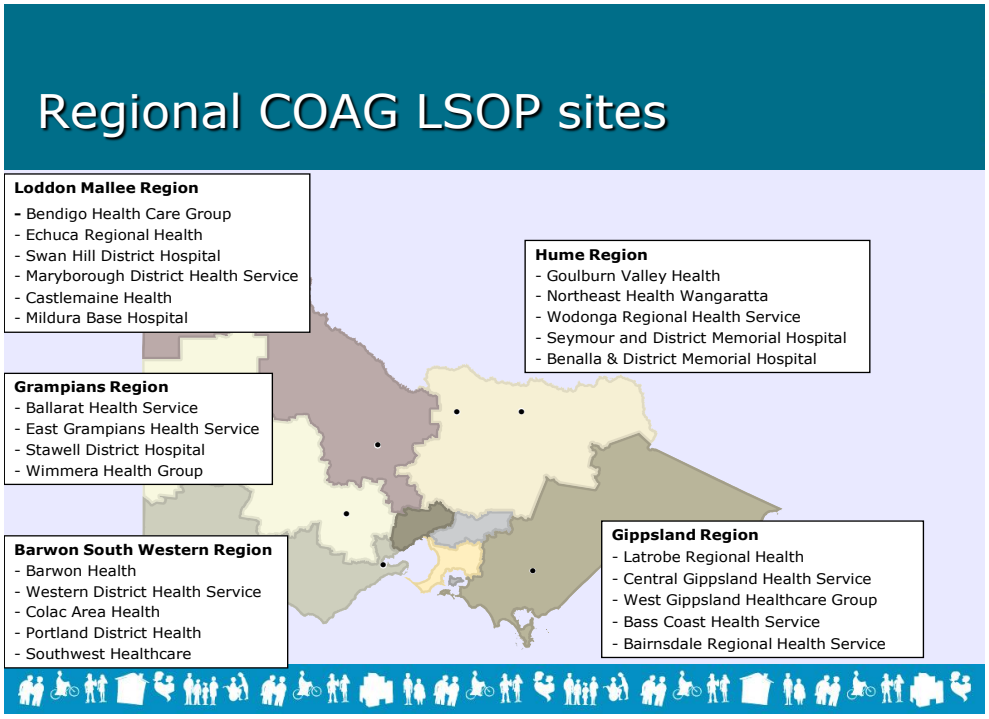
Victoria's plan for the state-wide implementation of the COAG LSOP initiative was based on an incremental approach. The rollout of the two principle elements of the initiative was staged over the first two years to optimise the chances of successful uptake within health services.

As noted previously the IC4OP initiative was implemented at 36 health services across the state, and HARP BCOP in 13 rural services.

4.2 *Regional Implementation*

The development of regional consortia was identified as the most effective model for implementing the IC4OP initiative across regional Victoria. Where possible the lead agency for each consortium was the nominated Centre Promoting Health Independence (CPHI) for the region. The health services involved in each region are detailed in *Figure 4-3*.

Figure 4-3: Victorian COAG LSOP Regional Health Services



Each regional consortia was required to establish a steering committee comprised of the executive sponsors and key implementation contacts. An implementation plan was required for each regional consortium.

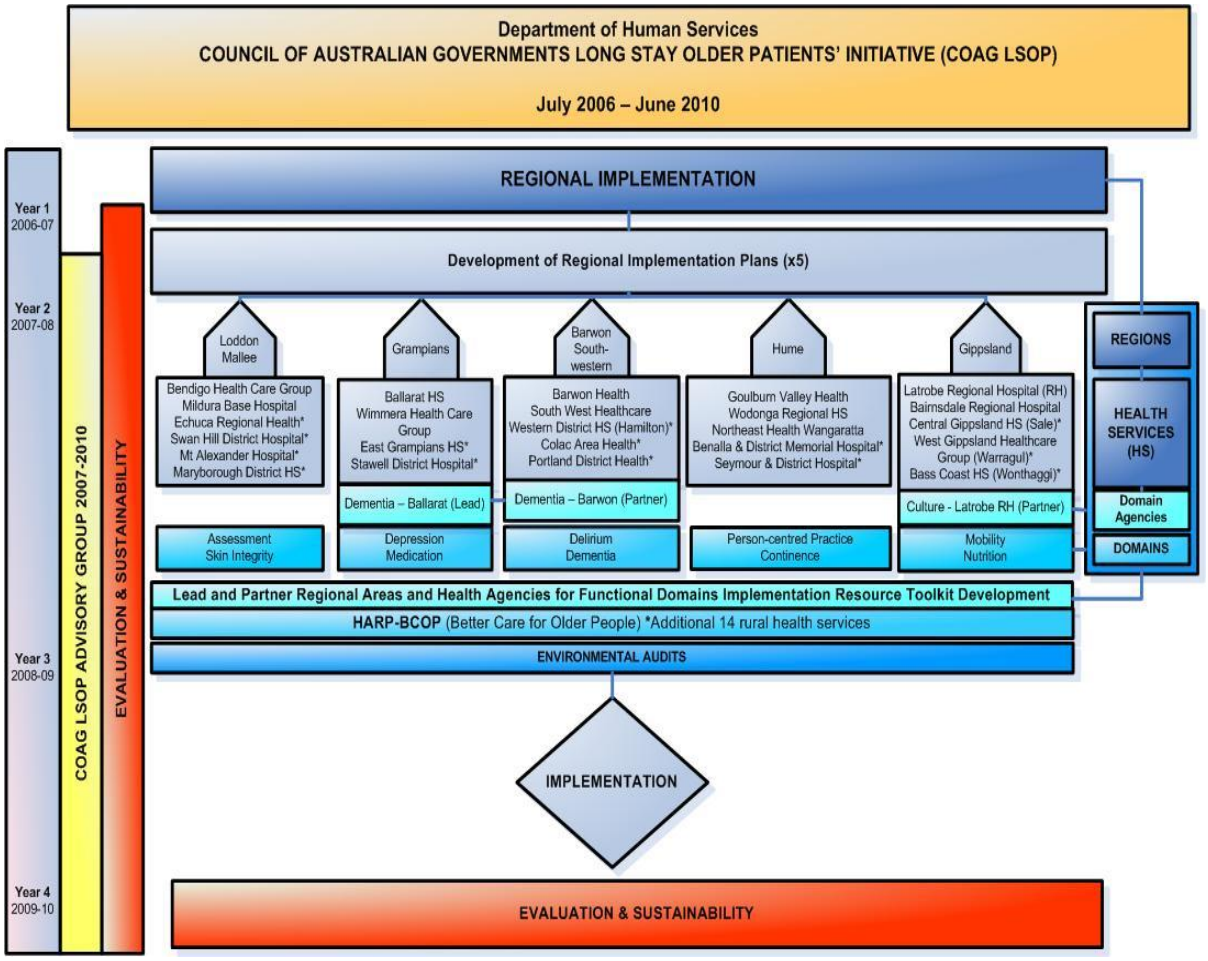
In addition to their focus on minimising functional decline, rural health services worked together to facilitate health care system integration. A DH project officer was appointed in each region to facilitate and manage regional coordination, including the development of an implementation plan outlining key priority areas and the identification of activities that will improve the care of older people in their region.

The pre-existent Victorian HARP CDM initiative was used as a platform to expand coordinated care to the additional rural centres identified. Each new site was required to nominate an Executive Sponsor and Key Implementation Contact for this initiative.

The HARP CDM guidelines provided the basis for implementation. Each new site was partnered with an existing rural HARP CDM service provider in their region. An implementation plan was required from each health service. The HARP CDM Community of Practice provided invaluable support and mentoring to new service providers.

A diagrammatic representation of the COAG LSOP regional implementation is at *Figure 4-4*.

Figure 4-4: Victorian COAG LSOP Regional Implementation



The rural and regional health services in LSOP were further grouped into regional consortia that used the existing Victorian HARP as a platform to expand the program of chronic and complex care for older people, via the HARP BCOP projects into the 13 new rural centres.

The regional implementation framework envisaged Regional project officers supporting regional networks, the development of Communities of Practice, consortia and the organisation of regional symposia.

4.3 *Implementation of IC4OP Health Service projects*

Participating health services developed local IC4OP implementation plans that were specific to their local care system and context. These detailed implementation plans were reviewed by Departmental staff and incrementally revised over time to adjust for changes in project aims and focus and/or contextual changes within health services. Progress against each plan was monitored by LSOP project staff within the Department. Participating health services regularly reported against the suite of clinical indicators and KPIs in both elements of the initiative.

Each health service modelled their local programs taking account of the proposed implementation levels (Levels 1-3). Health service programs were greatly influenced by health service composition, casemix,

executive priorities, staff capacities and the physical lay-out of wards. The majority of health services modelled their program for Level 1 implementation (Patient Centred Care and Assessment domains in one target acute ward area), although many of these subsequently also did work on implementing process changes in other domains. Four health services that initially modelled for Level 2 implementation (all domains in one target acute care ward area) were later encouraged to also undertake Level 3 implementation within their health service.

The LSOP initiative stressed the need for implementing sustainable approaches to change from its inception. There was a strong emphasis that this was not merely a 'project', but rather the commencement of a long-term change process to enable sustained practice improvements.

By the end of the LSOP initiative virtually all health services had set out to change care processes in more than the mandated two domains. Most of the changes in care processes within the initiative have occurred within one acute ward, however some health services have worked across two or more co-located/contiguous ward areas. A few health services, who were not Level 3 health services, have tackled whole of hospital programs. The majority of participating health services focused on the prevention of functional decline under the auspices of the LSOP initiative in targeted clinical areas. These target wards have effectively been *demonstration projects* for Health Services, providing an opportunity for *proof of principle* for desired changes in care.

4.4 *Evaluation of the Victorian COAG LSOP Initiatives*

As noted previously, a detailed implementation process was developed for the Victorian COAG LSOP project along with an Evaluation Framework. This framework developed from the initial planning logic models, identifies the:

- four key strategy impact areas
- contributing project impacts
- outcome or output measure
- data sources
- data collection responsibilities.

In May 2010 Department of Health contracted Australian Healthcare Associates (AHA) to complete the evaluation of the Victorian COAG LSOP. The objective of the project was to examine the performance of the COAG LSOP Victorian initiative against set aims of the initiative, with a focus on measuring the effectiveness and efficacy against four key impact areas.

- strengthening attention to the needs of older people in the hospital and community
- improving consistency and integration of service delivery
- improving access to a range of 'age friendly', appropriate services and settings
- reducing the incidence of inappropriate hospital usage by older people.

The two components under the LSOP umbrella that were the target for this evaluation were:

1. Improving Care for Older People
2. Hospital Admission Risk Program Better Care for Older People.

4. Implementation and Evaluation of Victorian Initiatives

In developing the final methodology for the evaluation AHA utilised the existing evaluation framework. The full evaluation methodology is at Appendix 2. In summary, a four phase methodology was used:

- Phase 1
  A. initial project briefing
  B. finalise project plan, stakeholder list
  C. develop evaluation framework and methodology
  D. establish consultation strategy
  E. complete a literature scan and document review.

- Phase 2
  A. analysis of available data
  B. development of consultation instruments
  C. consultation with stakeholders
  D. collection of case studies.

- Phase 3
  A. individual program level assessments
  B. higher level LSOP initiative assessment.

- Phase 4
  A. interim reports
  B. submission of draft evaluation report
  C. submission and acceptance of final evaluation report.

The following chapters summarise and then discuss the findings of the evaluation.

5 PROJECT PROCESSES

5.1 *Introduction*

The LSOP initiative was recognised as being the continuation of a cultural change process within Victorian public hospitals that commenced with the launch of the IC4OP policy initiative in 2003. The LSOP initiative had therefore from its inception always stressed the need for implementing sustainable approaches to change. There was a strong emphasis that this was not merely a 'project', but rather a part of a long-term change process to enable sustained practice improvements.

To support and facilitate the required changes, the Department implemented a number of structural supports for the initiative. These included requirements that health services:

- have an executive sponsor for the initiative
- contribute to the communities of practice, including attending regular meetings and activities
- prepare an annual plan against each of the key impact areas and report on agreed outcomes on a six-monthly basis
- implement a governance structure within their organisation to oversee all project development, implementation and evaluation.

The LSOP initiative has been supported through two key forums, the Improving Care Community of Practice and the Improving Care Advisory Group. These structures helped engage executive sponsors and project workers and supported the delivery of this initiative across the state. The forums were designed to address the complex issues that were anticipated to arise relating to implementing significant changes to work practices and in attitudes and approaches to the care of older people. The list of members of the Advisory Committee is at Appendix 5.

In addition to working with health services, the Department partnered with the Commonwealth Department of Health and Ageing, consumers, peak organisations, professional bodies and tertiary institutions. These partnerships helped to support and resource health services to deliver service development against their agreed plans.

Following the analysis of the reports submitted comments highlighted a number of key project processes that either had worked very well or had had a negative impact on individual health service projects. These project processes were explored further during the consultations. The following is a summary of the analysis of project reports and the consultations regarding:

- the planning and implementation processes of the initiative
- governance of initiative
- engagement of stakeholders
- health service project officer role
- Department of Health staff roles
- state wide forums
- *The toolkit*
- KPIs.

5.2 *The planning and implementation processes for the initiative*

5.2.1 IC4OP

- The rural and regional health service Project Officers universally found the regional Project Officer forums to be extremely valuable as a mechanism to share information and develop practical implementation strategies suitable for their respective health services.
- Fewer metropolitan Project Officers reported finding significant value from their Project Officer forums. These forums varied significantly in style, apparently in relation to the preference of the incumbent DH Project Manager. They were described as too formal and not sufficiently focused on addressing the coal-face implementation issues that the health service Project Officers faced.
- Several health services commented that forums aimed at executive sponsors were often too long and did not take into account the demands on executive sponsors' time.
- Some health services found the collaborative management style of the project challenging, reporting a perception that there was a lack of apparent structure and direction for the IC4OP aspect of the LSOP initiative, especially during the first years of the project. However, others found this process useful because it allowed flexibility and opportunities for services to learn from others to improve their own processes or avoid mistakes made by others.
- Most participating health services reported that a number of changes in direction and focus occurred during the project and that the rationale for these changes was not clearly communicated to the field. Some appreciated the changes in the reporting as they reflected a more qualitative approach, while others failed to identify or understand some changes.
- Many rural and regional health services felt that the funding available to support the IC4OP initiative was inadequate, especially given the required deliverables (in terms of plans, reports, travel and KPI's) and also understanding the size of the task to change culture within a health service.
- A small number of health services reported that the state-wide support initiatives focusing on aspects of improving care of older patients (e.g. Best Practice in Person-Centred Health Care, Enhancing Practice Program, and Dementia Care in Hospitals) were perceived to have resulted in competition for staff time and organisational resources and were said to have impeded their local progress in their IC4OP and functional decline prevention initiative.

5.2.2 HARP BCOP

- Health services reported having sufficient time to adequately plan care programs, recruit and train staff and build necessary foundation relationships within their communities prior to accepting their first clients.
- The overwhelming majority of stakeholders interviewed describe the HARP-BCOP project as well planned, well thought through and well executed.
- The project is typically described as having very clear, well articulated, practical goals.
- The ability to tailor the project to local community needs has received universal acclaim from the sector.
- A number of those interviewed expressed the view that the planning and implementation processes had included the provision of exemplars for required documents (e.g. program plans,

implementation reports, case studies etc) rather than requiring staff to develop such documents, which was a positive for the program. However, these exemplars then underwent serial revision as they were not compliant with the Departments project management requirements, which reflected badly on the project.

5.3 *Governance of initiative*

5.3.1 IC4OP

- The required governance framework within health services by-and-large worked very well in metropolitan hospitals and the larger regional hospitals.
- The required governance framework within health services by-and-large was deemed to be too cumbersome and excessive by smaller rural health services, who quickly refashioned the oversight to:
  - combine IC4OP and HARP BCOP projects
  - align with their existing Clinical Governance frameworks.
- Regional Alliances only worked effectively in those regions that as a matter of course meet collectively to review and oversight clinical projects and programs. In those regions where such collective mechanisms for project oversight were not already established and active, the LSOP Alliances appeared much less effective.
- Several regions that experienced difficulty in establishing effective governance oversight expressed the view that there should have been clearer guidance from the Department regarding the proposed mode of operation of the Regional Alliances.

5.3.2 HARP BCOP

- Most health services regarded the required governance structures as beneficial in establishing and growing their local programs. The engagement of key stakeholders in these governance structures helped promote the HARP-BCOP and build stakeholder engagement.
- A few smaller health services found their initial governance structures unnecessarily complex and subsequently incorporated oversight of HARP-BCOP into another relevant health service Clinical Governance framework.
- In a number of regions stakeholders were of the view that the Regional Alliance added little value to their governance and operations.

5.4 *Engagement of stakeholders*

5.4.1 IC4OP

- The majority of participating health services had good buy-in to the aims of the IC4OP initiative from their Boards, senior Executive staff and middle managers. During the course of the initiative a number of participating health services embedded patient centred care into their organisations Mission and Vision statements.

- A number of participating health services had significantly less buy-in to the aims of the IC4OP initiative from frontline staff in the target wards. Several project officers commented that changing practice of older nurses is sometimes very difficult.
- The roles played by the CPHI in the LSOP initiative have been very different across the state. Some have provided consistent and highly valued support to participating health services, while other health services indicated they received minimal support from their CPHI.
- The engagement of medical staff was problematic at many health services. Some health services reported good buy-in by some medical staff including geriatricians and medical directors. However, the majority of health services had difficulty in gaining support, especially from local GPs. Staff interviewed suggested the engagement they were seeking from medical colleagues included support to complete assessments, participation in planning of care and engagement in education sessions.

5.4.2 HARP BCOP

- Most HARP BCOP programs have had strong support from the executive, allied health and nursing professionals within participating health services.
- Most HARP BCOP programs have had strong support from other community-based healthcare providers.
- The engagement of medical staff within acute hospitals and in community-based General and Specialist practice has been quite variable across the initiative.
- Most HARP BCOP sites report a gradual increase in buy-in by medical staff within acute hospitals and in community-based General and Specialist practice over time.
- Typically HARP BCOP staff have initially focused on working with the 'early-adopter' medical practitioners who could see the value of accessing a care coordination service for their patients.
- Over time, the demonstrable improvement in the well-being of their chronically ill patients is converting some of the initially sceptical medical practitioners to engage with HARP activities.

5.5 *Health services Project Officer role*

5.5.1 IC4OP

- These project officers were universally identified as critical determinants of the success of implementation plans. Those who enabled others to change their way of caring for older patients were the most likely to succeed.
- It was felt by most organisations that these staff should have been provided with specific training for the project by the Department, including the provision of a formal induction program for all health service project officers.
- The preferred skill-set and background of the project officer to enhance the likelihood of achieving successful outcomes in their role included:
  - a background in acute care
  - the ability to be seen as part of the care team
  - strong knowledge of care of the older person

- the ability to provide practical on the spot advice and support.

5.5.2 HARP BCOP

- HARP-BCOP by and large recruited very capable, experienced staff who were highly motivated to deliver successful outcomes for the initiative.
- These Project Officers have typically been key contributors to the design and delivery of successful local initiatives.

5.6 *Department of Health staff roles*

5.6.1 IC4OP

- The majority of Regional Project Officers were highly valued by their participating organisations. While there was occasional reporting of a lack of 'value-adding' by some of these staff, the more typical response was that they played an essential role in supporting the delivery of the IC4OP and HARP BCOP initiatives.
- The bi-regional forums that occurred during the project were very highly valued by all participants as key opportunities for 'like to learn from like'. They have helped forge enduring networks of support and sharing across a number of the regions.
- Many organisations expressed concern regarding the number of changes in staffing for the LSOP project within DH centrally and associated perceived changes in project direction. They were perceived by many in the sector as conduits for information, rather than value-adding supports.
- Regional Project Officers themselves reported that they did not always get support for the LSOP project from within regional offices.

5.6.2 HARP BCOP

- The level of support provided by Regional Project Officers to HARP-BCOP varied greatly across the state. Some report 'fantastic' and 'excellent' support, other 'none at all'.

5.7 *State wide forums*

5.7.1 IC4OP

- Rural and regional health services reported that the majority of the Melbourne based forums were heavily slanted to the needs and interests of metropolitan teaching hospitals. They described this as a 'metro-centric' approach, which left them frequently disengaged and frustrated, especially given the time commitment required for their attendance at these forums.
- Metropolitan health service staff were more satisfied with these forums, especially when they were active participants and/or presenters at these forums.

5.7.2 HARP BCOP

- These forums were largely valued by HARP-BCOP staff, who reported them as valuable for both their educational and networking opportunities.

5.8 *The toolkit*

- *The toolkit* is universally acknowledged to be an extremely valuable resource for future endeavours to improve the care of older people in a variety of care settings.
- The majority of those interviewed did not believe that *The toolkit* was a resource suitable for use by ward-based staff. Most felt its greatest value would be realised by its use by Project staff, Clinical Governance staff, clinical educators and staff responsible for quality systems. The general information provided in each domain is useful for frontline or ward based staff, however the summary sheets and tools/forms are better suited to other staff.
- The majority of those interviewed reported that *The toolkit* development process was as a good idea in principle, which did not always work in practice.
- A number of health services that acted as Lead Agencies reported a lack of clarity regarding the expectations of their Lead Agency role. Many felt that the partnership approach was impractical, given time constraints, differences in knowledge and interests of the partners, and the lack of a dispute-resolution mechanism to resolve differences of opinion.
- Most partner organisations felt that they played little or no substantive role in the development of *The toolkit* and regional partners were often unaware what domains they were nominally involved in.

5.9 *Key performance indicators*

5.9.1 IC4OP

- There has been major criticism of the KPI's used in the IC4OP initiative expressed during the consultation process to date. These KPI's are felt to have little relationship to the quality of care delivered to patients and an excessive focus on the documentation of selected care processes in the medical record.
- The collection of KPI data was perceived as an onerous task. Given the perceived limited utility of the KPI's by health services this collection burden has been especially problematic for many participating organisations.
- Very few health services report an intention to continue to collect any of the project KPI's beyond the life of the project.
- The lack of a common approach to processes for the collection of data, training for data collection and the absence of a data-dictionary resulted in KPI data that cannot be compared across participating health services.
- Concerns were raised by several health services that some comparisons were made across regions with results, or that comparisons will be made in the future by staff unaware of the limitations of the data.

5.9.2 HARP BCOP

- The requirement to perform sequential Assessment of Quality of Life (AQoL) and six minute walk test (6MWT) has generated considerable discussion amongst HARP BCOP staff. There are clearly quite divergent views on the feasibility and utility of these important outcome measures. Some services were well aware of the importance of data collection and very happy to collect data but questioned the use of the AQoL and were actively looking for other measures that may more accurately reflect quality of life changes in their client group, such as disease specific tools.
- It is clear that while many health services were able to routinely report on these KPIs, others struggled to complete these measures for most clients. The explanation for these differences of opinion and compliance are most probably a complex amalgam of client and staff influences.
- Some health services reported the preference that future KPI's focus on how well they service their clients, rather than adding more activity indicators or descriptive epidemiological indicators.

6 KEY IMPACT AREAS AND DISCUSSION

The LSOP initiative set out to change several aspects of the care of older people within acute hospitals and in their management within their communities. These changes sought to improve the health and well-being of older persons by reducing their risk of functional decline while in hospital and their risk of avoidable hospital admissions. Across the COAG LSOP projects each individual health service has implemented the programs in their own unique way to best suit their own culture. The subtle differences are seen not only in the reports to DH but also in the site visits and discussions with project officers, executive sponsors and direct care staff. Throughout the consultations there were differences noted in the reports from project staff and direct care staff. However, all agreed that many positives have come from the COAG LSOP projects.

The following discusses and summaries the findings of the outputs and outcome measures under the key impact areas established in the evaluation framework (see methodology Appendix 2 for all outcomes:

- increase awareness of the needs of older people in hospital and the community
- improve the consistency and use of evidence based practice
- improve appropriateness of care
- decreased inappropriate hospital usage for older people

As part of the consultation process surveys were distributed for completion at each health service visited. The first survey was to be completed by the project officer and executive sponsor. The second survey was distributed to staff involved on the implementation ward/s. In total 45 surveys were received from project officers and executive sponsors and 365 from staff. Surveys were received from 28 health services. Where appropriate the results of the survey are included in the discussion. All results and a comparison of the Victorian results with results from an American survey are collated at Appendix 4.

6.1 *Increased awareness of the needs of older people in hospital and the community*

The initiative aimed to increase awareness of the needs of older people in hospital and the community. In this respect the LSOP initiative has been an outstanding success.

6.1.1 IC4OP

Level 1 implementation of IC4OP varied across health services. The basic requirement was the implementation of the Person Centred Care and Assessment domains in one acute ward.

All health services had governance structures in place including working groups or steering committees, most of which were multi disciplinary. Who these groups reported to differed across services from clinical practice, governance and risk, quality, continuum of care or executive committees. All governance structures had some reporting process through to senior executives and/or Board level. A number of health services combined both IC4OP and HARP BCOP committees.

The direct engagement of executive staff varied across health services, although it appears that the more engaged the senior executive the better the outcomes and acceptance across the health service.

6. Key Impact Areas and Discussion

Selection of implementation ward/s varied across the state. The majority of health services chose a medical ward, while some regional sites chose the only acute ward in the hospital, several health services chose an orthopaedic ward, and others chose several wards. In some cases the whole health service was involved.

All health services reported positive support for the communities of practice across the State. The sharing of ideas, positive outcomes and problems was seen as vital to project officers. Some health services in regional areas reported the need to further embrace video conferencing.

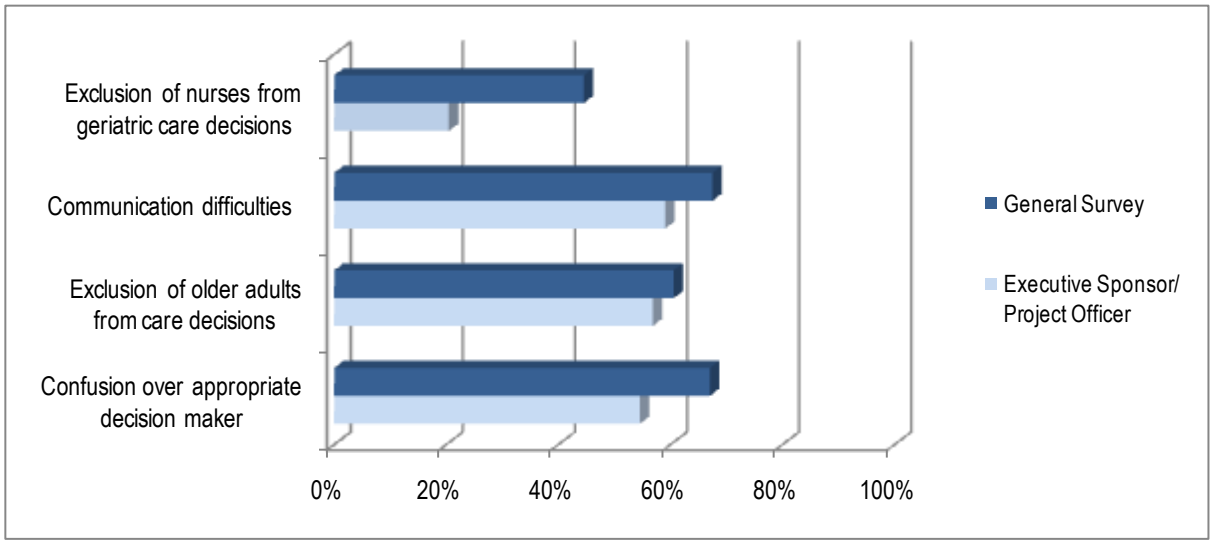
Stakeholder engagement was achieved through a variety of measures; regular newsletters, use of intranet sites, posters, pamphlets, media including local newspapers, project officers presenting at local, regional and statewide conferences.

> If I was to start LSOP again I would look at the whole patient journey rather than units in isolation. Development of a Global Admission Screen has led to review of processes before and after admission rather than the first point of call for patients, these being Outpatients and the Emergency Department.
>
> Creating a Person centred approach to the patient journey from these areas first could have resulted in the project creating a faster momentum to change. Some of the resistance to change was from staff stating "this should be started in ED" or "pre-admission".

The awareness and implementation of person centred care has occurred in a variety of ways. Most health services have embraced this concept globally and introduced the concept in their mission/vision statements, in strategic plans, through a general person centred policy approach or with person centred care being implemented through all policies including all Human Resource procedures such as position descriptions and performance reviews. A number of health services have used external consultants to support a culture change across their service. A few health services are yet to address person centred care globally. Many health services utilised the NARI "Benchmarking Person-Centred Health Care" survey as a starting point for implementation of not only person centred care but also the COAG LSOP IC4OP project.

The surveys provided a list of obstacles to making good decisions about the care of older people, and respondents were asked to identify the extent to which each interfered with care at their health service. *Figure 6-1* indicates the percentage of respondents that indicated the obstacles interfered with decision making.

Figure 6-1: Respondents who indicated obstacles that interfered with decisions about care provided to older people



All health services reported utilising the resources from HCOASC and also *The toolkit*.

Staff training and education in relation to functional decline and person centred care has been approached in different ways depending on the implementation ward and whether person centred care was introduced health service wide. A small number of health services now have both person centred care and all functional decline domains included in all orientation programs and scheduled as regular staff training. Others have only introduced the training/education on implementation wards. Competencies have been developed in some health services while others have developed e-learning programs. Regional communities of practice have developed and run a number of different training/education programs, including:

- Best Care for Older People Everywhere Expo
- Our Elders – Patients at Risk.

Several questions in the surveys asked about knowledge of caring for older people and also the training provided by the health service in relation to caring for older people. As highlighted in *Figure 6-2* 85% of respondents felt that the health service had done an excellent or adequate job on providing education/training.

Figure 6-2: Rating of how well health service has educated staff about the care of older person

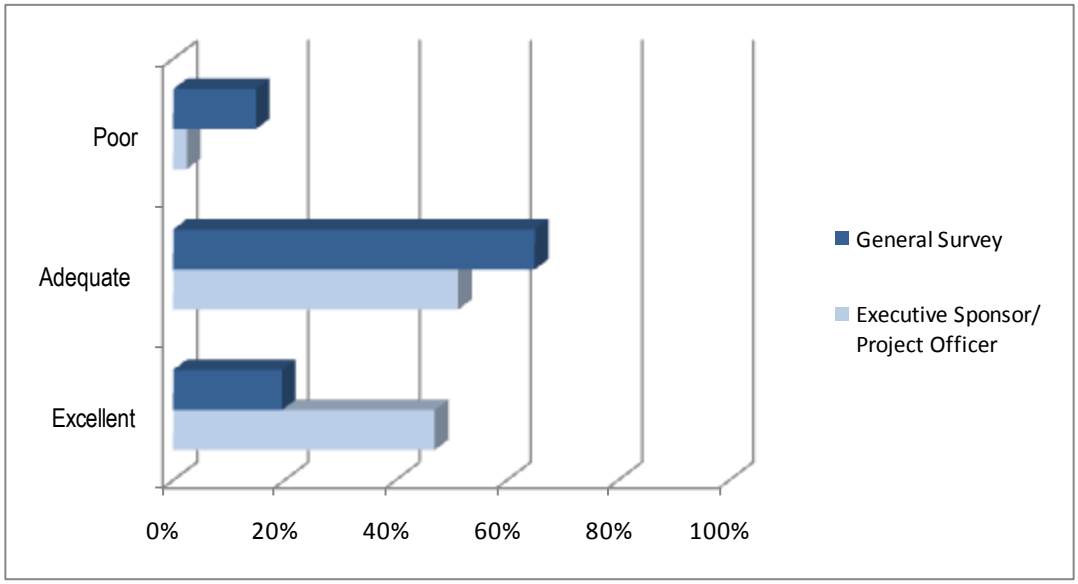


Figure 6-3 indicates 97% of respondents thought that they were very or somewhat knowledgeable about the basic principles of caring for an older person. While 55% of respondents indicated that their knowledge about caring for an older person had improved "a lot" in three years, suggesting that the training programs have been successful, *Figure 6-4*.

Figure 6-3: How knowledgeable do you consider yourself to be about basic principles for the care of older people

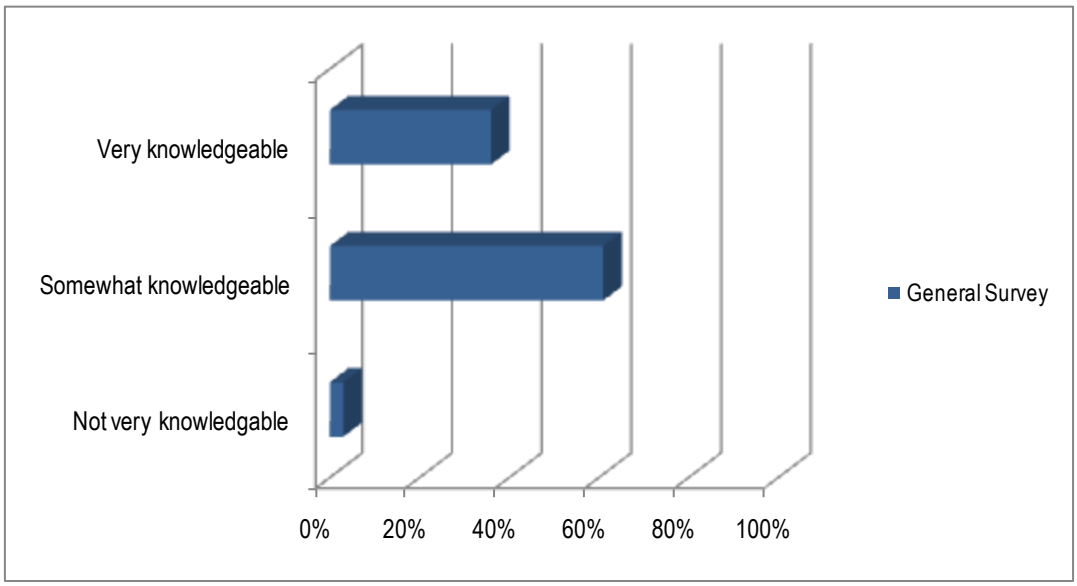
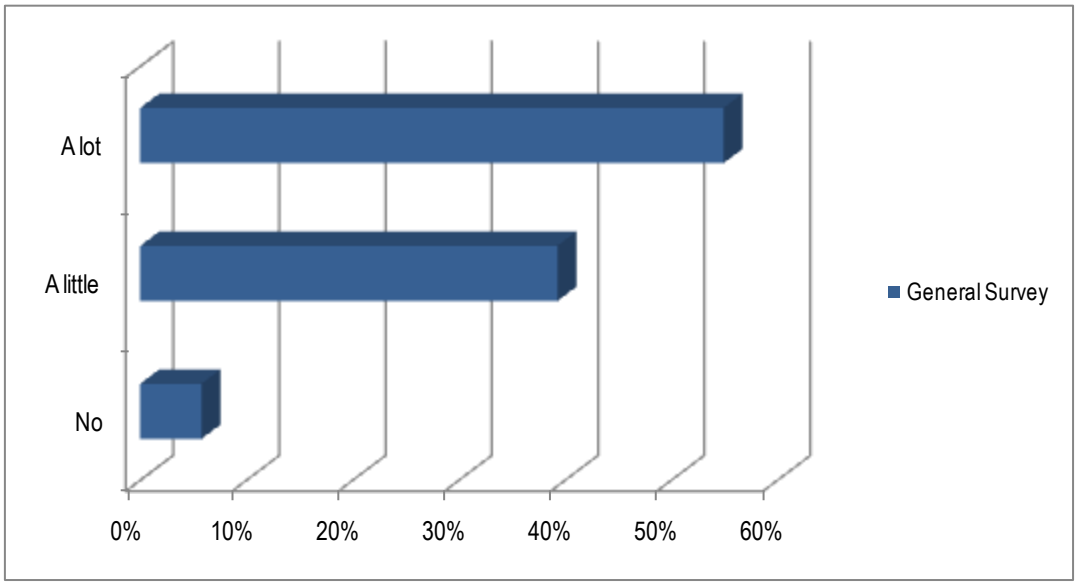


Figure 6-4: Has your knowledge regarding care of the older person improved in the last three years



6.1.2 HARP BCOP

As with the IC4OP component of the COAG LSOP, the implementation of the HARP BCOP project differed at each health service. While all health services focused on chronic disease management, some focused on specific diseases such as Cardiac Failure or Chronic Obstructive Pulmonary Disease. At other services those clients with complex needs were prioritised.

There was strong executive support and in many cases there were shared governance arrangements with the IC4OP project. The HIP guidelines had been used to develop the program and policies and procedures.

All sites reported being involved in a community of practice and appreciated the support received from other services with established HARP programs.

Key stakeholders had been engaged through direct contact, media, posters, pamphlets and attending local network meetings. A variety of techniques were used to engage local GPs including; regular visits by HARP team members, regular updates on clients through letters and phone calls, practice nurses being invited to meetings and health service medical staff providing information and support. However, a number of projects expressed frustration at the difficulty in fully engaging local GPs.

The developmental nature of models and interventions is quite apparent when reviewing each of the projects' core components. The HARP BCOP projects target a variety of aspects of health service system functioning and local health service provision. In line with the existing HARP services, most HARP BCOP projects have a particular emphasis on patients who are high current users of local hospital emergency services. The HARP BCOP projects developed at varying rates with some services established in 2006 and with one service reporting enrolment of their first client as late as mid-2009. This very divergent range of experience is reflected in reports of progress against plans by HARP BCOP services.

Project teams have clearly expended substantial effort in establishing their models and interventions within their local contexts. As was anticipated, projects have become 'live' at various stages over the reporting period. The extent of these delays relates in part to the complexity of the model/intervention being implemented and the characteristics of the underlying local service provision systems. Project teams have provided the following reasons as to why projects have taken longer than anticipated to become operational:

- difficulty in recruiting suitable staff
- delays in establishing collaborative working arrangements across the sector
- delays in developing the components and support mechanisms for the model/intervention
- the need to up-skill a range of participating clinicians prior to implementing the model.

6.1.3 Overall

Both the IC4OP and HARP BCOP have been instrumental in raising the profile of care of older patients within the participating acute hospitals. Throughout the sector consultation, stakeholders referenced the tangible changes in their organisations and their staff attitudes to caring for older patients and clients. The relentless focus of LSOP on improving the care of older patients and their experiences of care, together with the extensive education and training programs delivered over the course of the initiative have altered the 'care landscape' of most participating health services. There remains however, concern in some health services on how they will be able to embed these important principles across the whole health service.

The LSOP initiative has supported a growing acceptance within participating health services that older people are the predominant users of most hospital services and they deserve to be offered the best possible care. Given this fact, appropriate skills in the care of older patients should form a part of the core competencies of all staff. This includes sufficient knowledge about initial screening and assessment, functional maintenance, discharge planning, the needs of carers and how and when to refer for specialist assistance from the wide range of disciplines that older people may need to access for optimal care. Some health services have embedded the care principles underpinning the LSOP initiative into their hospitals' mission statements. Many have revised organisation-wide policies, procedures, protocols and guidelines to reflect a renewed focus on the provision of excellent care to older patients.

Very importantly, frontline care staff repeatedly reported a new enthusiasm for caring for older patients within target wards of IC4OP and the older clients within their communities in HARP BCOP programs.

The evaluation has found that one very important outcome of the LSOP initiative has been the creation of a knowledge sharing culture within participating health services. Traditionally many health services had worked in relative isolation, protective of their local initiatives and at risk of continually *reinventing the wheel*. *The toolkit* development process built on the existing knowledge and skills of participating health services, targeted leadership roles to those with known expertise, facilitated broader sharing of knowledge and information, and supported a collective ownership of domain contents within *The toolkit*. This shift in culture should support and enable future efforts at sector-wide improvements in care. *Table* 6-1 summaries the progress made throughout the COAG LSOP against Key Impact Area 1: *Increased awareness of the needs of older people in hospital and the community*. Delays in the release of *The toolkit* has impacted some areas however, all health services are on track to meet the target, relevant to their level of implementation.

Prior to level 2 Implementation the nurses on a busy orthopaedic ward knew that it was common for their patients to be confused. They cared for the patients and documented their confusion.

Their feedback to a questionnaire about delirium demonstrated that they recognised it as a common problem, but thought there was nothing they could do about it.

After consulting *the Toolkit* the following was implemented:

- ✓ the purchase of large analogue clocks, with calendars, for each room
- ✓ new screening tools introduced included use of AMTS to assess cognition and CAM to assess delirium on admission
- ✓ CAM scores were completed for 3 days post op for patients having major surgery
- ✓ the development of newsletters and posters using information from the toolkit
- ✓ regular education sessions about delirium.

Nurses reported seeing the benefits in having baseline information that identified patients at risk. Practice change occurred to reduce delirium and to manage those patients with delirium better. Changes included:

- ✓ paying more attention to small things, such as promoting the use of hearing aids and glasses
- ✓ improving their management of factors they could affect such as constipation
- ✓ talking to doctors and families about delirium
- ✓ changing the way they approached patients with delirium.

Progress ratings: A = Target met; B = On track

Table 6-1: Summary of progress against Key Impact Area 1

1. Increased awareness of the needs of older people in hospital and the community		
1.1. Increased key stakeholder engagement around functional decline and complex care needs of older people		
Outcome/Output Measure	***Status***	***COAG LSOP Victorian Initiatives outcome or deliverable***
Governance structures/ committees established with key stakeholders	**A**	Governance structures established and effective across LSOP initiative
Communities of practice implemented state-wide and regionally	**A**	LSOP Communities of Practice implemented
Engagement of Acute Executive staff	**A**	Acute executive support achieved in the majority of health services

6. Key Impact Areas and Discussion

1. Increased awareness of the needs of older people in hospital and the community		
Stakeholder engagement within LSOP funded health services	A	Very strong stakeholder support for LSOP within funded Health Services
Key stakeholders engagement in functional decline resource toolkit development	A	Effective stakeholder inputs in all domains of toolkit development
Key stakeholders engaged in development of performance indicators	A	There was stakeholder involvement in KPI development and review process
Key stakeholder engagement in the establishment of HARP BCOP projects	A	Extensive stakeholder involvement in HARP BCOP project design and implementation
Increased referral to HARP BCOP	A	Strong increase in HARP BCOIP referrals over course of LSOP initiative
1.2. Improved awareness and implementation of person-centred care		
Outcome/Output Measure	***Status***	***COAG LSOP Victorian Initiatives outcome or deliverable***
Increased client participation in decision making	A	Consistently increased involvement of clients in decision making seen in IC4OP and HARP BCOP
Increased patient and carer satisfaction	B	Consistently increased client satisfaction in HARP BCOP with examples of enhanced client and carer satisfaction in IC4OP
1.3. Availability and Uptake of resources developed that support the COAG LSOP initiative		
Outcome/Output Measure	***Status***	***COAG LSOP Victorian Initiatives outcome or deliverable***
Distribution of the COAG LSOP guidelines developed by HCOASC on behalf of AHMAC	A	Distributed to all participating Health services
Increased training and education opportunities for staff working with older people	A	All LSOP Health Services delivered extensive staff education and training throughout the initiative
Distribution of *The toolkit*	A	Distributed to all participating health services
The toolkit embedded in policy, procedure and clinical guidelines within health services	B	Health services' progress in embedding toolkit into policy, procedure and clinical guidelines is variable
HIP guidelines distributed to funded health services	A	Distributed to all participating health services
HIP guideline self assessment and implementation plan completed by health services	B	Completed by all participating health services

1. Increased awareness of the needs of older people in hospital and the community		
1.4. Increased confidence in responding to functional decline and chronic and complex care issues		
Outcome/Output Measure	***Status***	***COAG LSOP Victorian Initiatives outcome or deliverable***
Staff report increased confidence in managing older people and people with complex conditions	**A**	Measures of staff confidence in managing these patient groups have demonstrated improvement during LSOP initiative
Increased use of the COAG LSOP guidelines developed by HCOASC	**A**	Increased self-reports of use and monitored usage of these guidelines
Increased use of functional decline resources	**A**	Increased self-reports of use and monitored usage of these resources
For LSOP Level 3 health services, increased confidence in managing functional decline across the continuum of care	**A**	Increased self reports of confidence in managing functional decline across the continuum of care in all Level 3 Health services
HIP guidelines adopted by the health service in line with HS implementation plans	**A**	Achieved

6.2 *Improve the consistency and use of evidence based practice*

A second key aim of the initiative was to improve the consistency and use of evidence based practice in care of older persons.

6.2.1 IC4OP

Development and implementation of *Best care for older people everywhere - The toolkit* was a major focus for this component of the LSOP initiative. The resultant high quality toolkit is undoubtedly the most tangible product of the initiative and all comments indicate that it will be an invaluable and enduring resource for health services in Victoria and other Australian jurisdictions.

While *The toolkit* is yet to be fully embedded within health services awareness of *The toolkit* has been supported by availability on health service intranet sites, official launches, posters and local media events.

Health services have made progress in the development of policies and procedures that support minimisation of functional decline, including the identification of those at risk of functional decline and processes to minimise decline. All reports and sites visited indicated that they had commenced or completed a review of screening or assessment processes for older people entering the

> The toolkit and its development have provided the perfect evidence base to provide leverage to have a more comprehensive assessment introduced; this along with a consolidation of paperwork was strongly supported by senior ward staff.
>
> Our aim was to introduce a comprehensive document that covered all the domain areas and prompted an appropriate referral to the appropriate allied health discipline or other service. This is all done with a person centred care focus.

target ward and/or the health service. In most cases the new screening/assessment tools incorporated all domains. Reporting of Key Performance Indicators (KPIs) show the majority of health services have shown improvement on the assessment KPIs.

Some health services have also developed new care plans, discharge procedures and referral processes to complement new screening/assessment processes. In some health services these new processes are multi disciplinary. In many cases the new tools developed have resulted in the reduction in paperwork for staff.

As seen in *Figure 6-5*, 78% of respondents reported that there are processes in place to identify those older people at risk of functional decline.

Figure 6-5: Are there processes in place to identify older people at risk of functional decline?

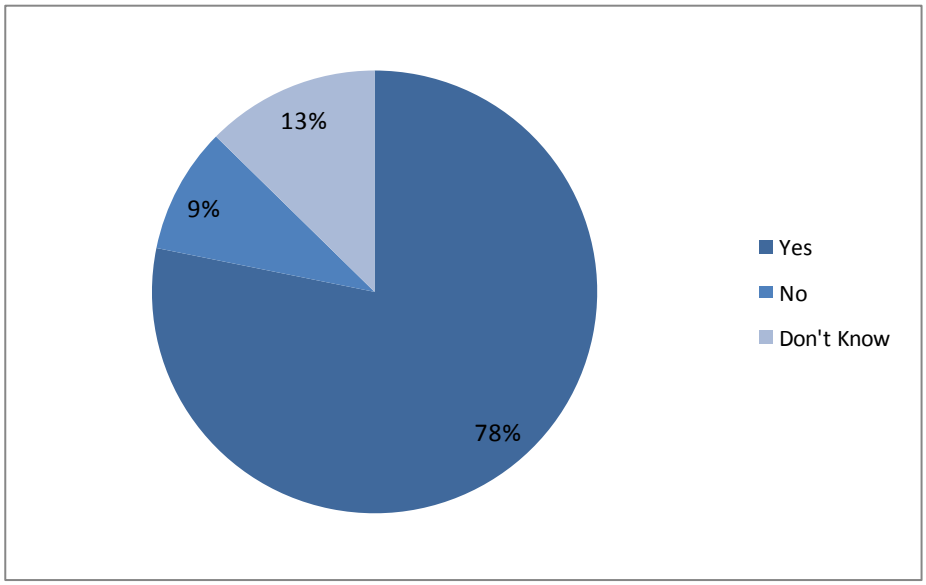
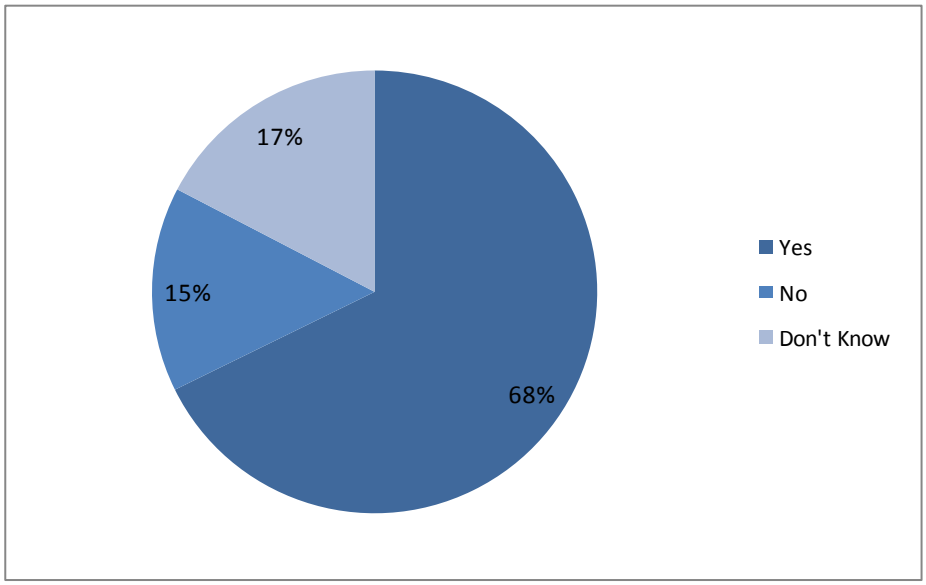


Figure 6-6 highlights that 68% of respondents indicated that the health service or target ward have guidelines or pathways for use in minimising risk of functional decline in at risk patients.

Figure 6-6: Are there guidelines or pathways in place to minimize the risk of functional decline in at risk patients?



Practice change has occurred at all sites, some of the examples include:

- introduction of functional maintenance programs, including use of allied health assistants or volunteers
- bedside handovers
- protected meal times
- communal meals
- introduction of key contacts
- music therapy
- "up and dressed' programs
- "falling star" – colour wrist bands for persons at risk of falling
- coloured napkins for persons needing assistance with meals.

6.2.2 HARP BCOP

All HARP BCOP sites have achieved improved integration of services and implementation of self management strategies for their client group.

6.2.3 Overall

While considerable progress has been made by many health services in terms of translating recommended best-practice into everyday care with the support of the information contained within this resource, there still remains much to be done across Victoria's acute public hospitals to reach the point where best practice care of older people is standard practice.

Table 6-2 summaries the progress made throughout the COAG LSOP against Key Impact Area 2: *Improved consistency and use of evidence based practice*. Delays in the release of *The toolkit* has impacted some areas however, all health services are on track to meet the target, relevant to their level of implementation.

Hurdles conquered along the way include, having to have the form passed by nursing documentation Committee, as even as a pilot we needed approval.

They also needed to be educated on the importance of inclusion of all the domain areas. We were required to get a bar code generated and format the form so it would become part of the Scanned Medical Record (as the organisation was moving towards scanned Medical Records during our pilot). We needed to design the form to align with the Clinical systems approach to documentation, as the organisation had just changed nursing documentation, including care plans, to this model and in the interest of minimising documentation confusion we needed to comply with this but also to have every domain are represented.

Progress ratings: A = Target met; B = On track

Table 6-2: Summary of progress against Key Impact Area 2

2. Improved consistency and use of evidence based practice		
2.1. Improved integration of services for people with functional decline and chronic and complex care issues		
Outcome/Output Measure	***Status***	***COAG LSOP Victorian Initiatives outcome or deliverable***
Evidence of minimising functional decline initiative in funded health service policies and procedures	**A**	All heath services have referenced components of the initiative within targeted policies and procedures
Implementation of orientation and education tools in health services	**B**	Many health services have implemented orientation and education tools, others are working towards achieving this
Functional decline resource toolkit embedded in policy, procedure and clinical guidelines within health services	**B**	Some health services have embedded *The toolkit* into everyday care, others are working towards achieving this
HIP guidelines adopted by the health service in line with DHS implementation plans	**A**	Achieved

2. Improved consistency and use of evidence based practice		
2.2. Implementation of self management strategies for people with chronic and complex health conditions		
Outcome/Output Measure	***Status***	***COAG LSOP Victorian Initiatives outcome or deliverable***
Implementation plan developed and documented for the HIP guidelines	**A**	Completed within all participating health services with HARP programs
Increase in number of staff trained in self management techniques	**A**	Achieved within all participating health services with HARP programs
2.3. Practice Change		
Outcome/Output Measure	***Status***	***COAG LSOP Victorian Initiatives outcome or deliverable***
Staff perception of practice change in the management of older people and people with complex care needs	**A**	Strong, universal staff perception of major changes in their management approach to these patients over course of LSOP initiative
Policy and procedure development in key domains in health services depending upon the level of implementation	**B**	Policy & procedure development has occurred to a variable extent within and across all levels of implementation
Increased care coordination for older people across the continuum of care for Level 3 LSOP health services	**B**	Increased care coordination for older people across the continuum of care has occurred to a variable extent for Level 3 LSOP health services
Increased care coordination for HARP BCOP	**A**	Achieved in all projects evaluated
2.4. Improved consistency and completeness of assessment		
Outcome/Output Measure	***Status***	***COAG LSOP Victorian Initiatives outcome or deliverable***
Assessment Performance indicators met	**A**	All health services have enhanced their screening and assessment processes during LSOP. There has been a significant improvement in all reported Assessment Performance indicators over the course of the initiative.

6.3 *Improve the appropriateness of care*

A third key aim of the LSOP initiative was to improve the appropriateness of care provided to older people in IC4OP and HARP BCOP.

6.3.1 IC4OP

The Level 2 and 3 implementation health services have changed a large number of care processes across all domains and have clearly improved the appropriateness of care for their older patients. Review of the implementation of IC4OP demonstrated the value of the approach of the LSOP initiative in empowering health services to design and implement tailor-made improvements to care. The

creativity, energy and enthusiasm of many participating health services are palpable when viewing reports, case studies and presentations and in conversations with them regarding their successes. The following case study example highlights how one steering committee embraced IC4OP concepts to include hospital wide changes, including person centred care and many domains.

The Steering Committee adopted the following:

- Improvements should be implemented hospital-wide as:
  - Older patients are admitted to all wards
  - the majority of patients are older *and/or* have complex issues and so would benefit from the new initiatives
- Need to maximize opportunities for promoting and facilitating greater patient responsibility in their care and improving the smooth transition for the patient through the organisation. This to be achieved through a change in current practices, including the processes for obtaining patient information and incorporating it into care needed to be reviewed. The locus of responsibility to be shifted from staff to a shared responsibility with patients and families at the centre. The admission and discharge process and documentation to begin on admission with direct patient/family input and responsibility in completing documentation, and the assessment information built on as the patient is moved through the hospital.

This was seen as a way to:

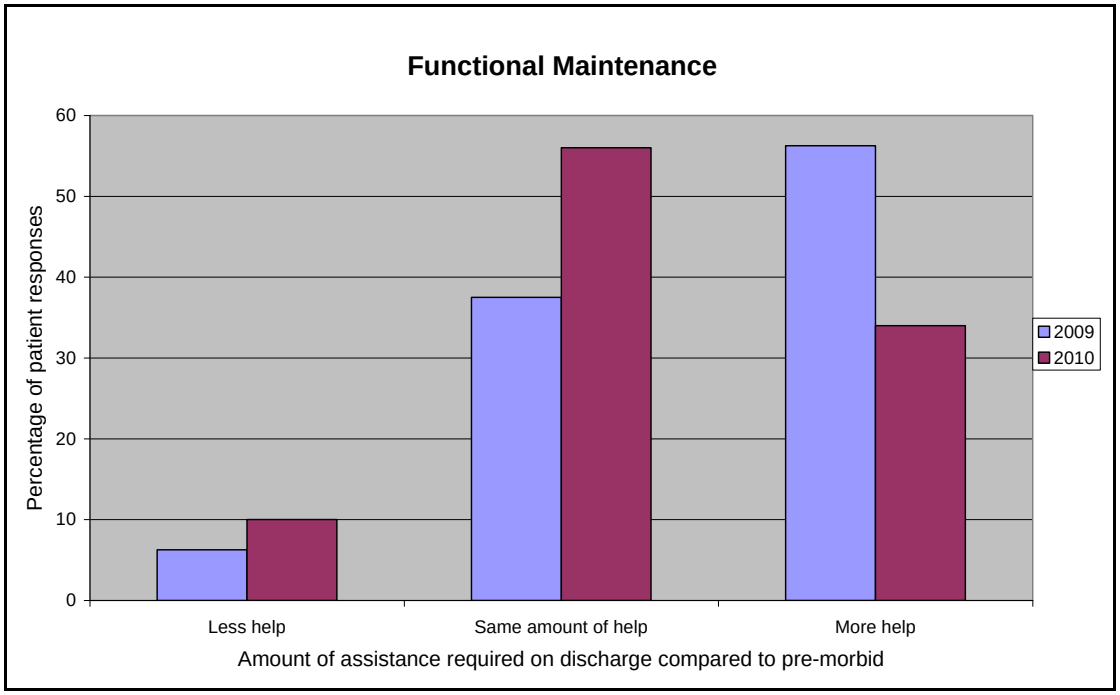
- Engage patient and family involvement in care from the point of admission
- Provide more person & family centred care through a sharing of responsibility and power in decision making about health care management and documentation
- Assist in getting to know the patient and providing care which is more specific to their care needs.
- Improve interdepartmental and interdisciplinary comprehensive assessment incorporating not just the patient's admission diagnosis but reflecting all the patient's needs which may impact on their recovery.
- Strengthen comprehensive screening and interdisciplinary assessment in the areas of Cognition through incorporating AMT4 and Nutritional status by incorporating a new screening tool and weight charting
- Improve care transitions and partnerships between wards and services fostering the sharing of information as the patient journeys through the organisation building on the information gathering process and planning for discharge
- Strengthen person-centred discharge planning by encouraging patient participation in planning and determining readiness for discharge.
- Promote health independence through the provision of patient educational material related to the 10 domains based on a wellness model, rather than a sickness model.
- Improve the environment for people with cognitive impairment and those at risk of functional decline by providing clocks in all patients' rooms to assist orientation, suitable music and patient educational information when appropriate. Brochure holders for education relating to the 10 domains are now being improved and standardized across all wards.

There was a progressive increase in the number of indicators reported by metropolitan health services from 2008 onwards. At the end of the project around half of the suite of indicators was being reported by more than half of participating health services.

There was also an improvement over time across participating health services in their reported performance across all indicators and domains. From discussions with stakeholders it is clear that these widespread improvements in KPI performance reflect a combination of improvement in their data recording and collection processes and a genuine enhancement in clinical care processes. The case studies embedded in progress reports and referenced in presentations complimented these routinely collected data and were important sources of information on key aspects of project performance.

Many health services have reported substantial improvements in the processes of care in the IC4OP (e.g. increases in global screening from initial levels close to zero to levels approaching 100% and significant reductions in average length of stay). There were also many examples of improved patient outcomes, including reductions in frequency of falls and reduction in the occurrence of functional decline. One example illustrated in *Figure 6-7,* saw the level of assistance required post discharge decline over 12 month period.

Figure 6-7: Functional Maintenance Southern Health Casey



All participating health services reported positive outcomes from the results of the funding rounds to address issues identified through the environmental audits. Examples of the work completed across the health services include:

- new entrances and ramps to health services, emergency department and ward areas
- removal of heavy doors, replacement with self opening doors
- installation of clocks and calendars in patient rooms
- installation of white boards at patient beds
- replacement or refurbishment of corridor hand rails
- purchase of new equipment; chairs, beds, pressure relieving devices, bladder scanners

- installation of en suites into patient bedrooms
- refurbishment of areas into activity rooms.

6.3.2 HARP BCOP

The state-wide HARP that preceded HARP-BCOP established a greater level of integrated service delivery and delivered a reduction in the demand for hospital services and an improvement in clients' health. In the HARP BCOP initiative, groups of acute and community-based health care providers formed consortia to implement a range of specific projects.

The HARP BCOP projects across rural and regional Victoria have also delivered impressive gains in client outcomes, in very large part by ensuring that clients had access to a set of services that were most appropriate to their needs. These HARP BCOP projects adopted a diverse approach to the task at hand. They have varying models of care, staff profiles and roles. Projects have universally succeeded in 'value-adding' to the profile of services available within their local communities by complementing and coordinating existing service providers. They have designed and implemented local solutions to recognised gaps in care. At an individual patient level, the employment of care coordinators, who assisted their clients in understanding their health condition, gaining access to appropriate services as well as promoting self-management, was of prime importance.

The performance reports for HARP BCOP focus heavily on project activity and client demographics. The case studies embedded in progress reports and referenced in presentations for HARP BCOP also complimented these routinely collected data and were important sources of information on key aspects of project performance, such as client satisfaction with their services.

The advances made in some services have been curtailed by lack of access to services required by clients. For example several services voiced concern at the difficulty for some clients to access funding for home oxygen. To receive subsidised home oxygen services clients have to meet set criteria which requires blood gas analysis. In some rural communities access to blood gas analysis is difficult and time consuming for both clients and staff resulting in increased travel and cost. Also, there have been issues for these clients in accessing specialist medical services in some communities. Long waiting lists and extensive travel for clients with chronic disease is difficult.

These successes have seen HARP BCOP services mainstreamed as of July 2010, becoming part of the state-wide HARP services.

6.3.3 Overall

Table 6-3 summarises the progress made throughout the COAG LSOP against Key Impact Area 3: *Improved appropriateness of care*.

The delay in the release of *the toolkit* has meant that insufficient time has elapsed, since practice implementation, to see changes in data for some outcome/output measures in this Key Impact Area. However, early indications are that all health services are on track to meet the target, relevant to their level of implementation.

Progress ratings: A = Target met; B = On track

Table 6-3: Summary of progress against Key Impact Area 3

3. Improved appropriateness of care		
3.1. Improved care outcomes for older people		
Outcome/Output Measure	***Status***	***COAG LSOP Victorian Initiatives outcome or deliverable***
Decreased LOS	**A**	There has been a strong trend towards reduced LOS in target patient populations in many participating health services
Decreased unplanned presentations and readmissions	**A**	There has been reduction in unplanned presentations and readmissions in HARP BCOP clients
Increased rate of target population returning to residence of origin	**B**	These rates are yet to consistently increase across health services
Increased functional independence as evidenced by improved performance all functional decline domains dependent upon level of implementation	**B**	There is evidence of increased functional independence, but as yet this is not consistently monitored by most health services
Level 3 LSOP funded health services develop and implement improved pathways of care for older people and people with complex care needs	**A**	Achieved
Improved access to HARP BCOP in rural areas	**A**	Achieved
Increased referral to HARP BCOP	**A**	Has been seen across the HARP BCOP projects
Improved quality of life for older people with chronic or complex conditions	**A**	Has been a feature of almost all HARP BCOP projects
Increased services delivered in residential facilities	**B**	Has not been a focus of many projects and targets have been met with community based clients
3.2. Improved performance against 10 key domains for functional decline in line with the level of implementation funded within health services		
Outcome/Output Measure	***Status***	***COAG LSOP Victorian Initiatives outcome or deliverable***
Increased number of Performance Indicators met by Health Services	**A**	The proportion of KPI's reported & the reported performance have improved significantly over the course of the initiative

3. Improved appropriateness of care		
3.3. Improved environments to support older person's needs		
Outcome/Output Measure	***Status***	***COAG LSOP Victorian Initiatives outcome or deliverable***
100% of funded Environmental Improvements completed	**A**	Achieved
3.4. Improve appropriate discharge options for older people		
Outcome/Output Measure	***Status***	***COAG LSOP Victorian Initiatives outcome or deliverable***
Increase in the percentage of older people returning to usual place of residence after hospital admission	**B**	These rates are yet to consistently increase across health services

6.4 *Decreased inappropriate hospital usage for older people*

The final key aim of the LSOP initiative in Victoria was to decrease inappropriate hospital usage for older people.

> While there was enthusiastic uptake and broad participation in the development of the revised documentation and processes, with all disciplines represented, many of the nursing staff were initially apprehensive about asking the patient (and family) to complete the admission screening form, prior to or on admission, believing it to be too difficult or burdensome for them. However, this has proven to not be the case and consumer feedback has been positive. Family have commented that they feel more listened to and involved in the care. Ongoing feedback from patients indicates that the new admission form is easy to understand and although time consuming to complete, they do value the new process as it identifies relevant issues which leads to timely and appropriate follow up care. The patient is involved in completing the discharge documentation which contains information about the discharge plan and follow-up requirements, signing if they are feeling ready for discharge.
>
> The form has numerous risk screens built into it to assist early discharge planning and referral to appropriate support services which may be required for safe discharge (e.g. HARP, RDNS) and assists in working towards a more seamless transition of care across the continuum.

In HARP BCOP the focus was on reducing unplanned presentations and admissions and avoidable readmissions.

The evaluation found strong evidence of success in respect of this key aim in both IC4OP and HARP BCOP. The myriad of factors that potentially impact on acute hospital length of stay (LOS) and

readmission make attribution of the observed favourable changes in these measures in the IC4OP projects somewhat difficult. However, the consistent and substantial changes in these measures of avoidable hospital usage in HARP BCOP clients across the state provide compelling evidence for the success of these projects in this respect.

The interim evaluation completed by the Department indicated that HARP BCOP has had a positive impact on hospital utilisation in rural Victoria by significantly reducing the hospital and ED utilisation of the HARP BCOP cohort[3]:

- 64% reduction in hospital separations post intervention
- 55% reduction in the number of emergency department (ED) presentations, compared to pre-HARP BCOP utilisation
- 39% reduction in the number of clients presenting to the ED post discharge from HARP BCOP.

> Mr.W is a 78 year old man living at home with his wife. He has a complex medical history including; Legally blind, COPD with related Panic Attacks, Retrosternal Thyroid with tracheal compression, Rheumatoid Arthritis, Aortic Valve Replacement, Coronary Artery Stent, Ulcerative Colitis and hearing impairment.
>
> Prior to HARP Mr. W. had 6 ward admissions for COPD exacerbation/ respiratory support in 4 months and 9 presentations to Emergency Care Department Via Ambulance
>
> During HARP admission Mr W had 18 contacts over a 7 month period, which included not only education and support by HARP staff but referral to multiple other services. This resulted in greatly improved AQoL scores and reduced carer strain.
>
> During his seven month HARP admission Mr W had one hospital admission. Since discharge (five months ago) he has had no ED or hospital admissions. He does however now see his GP monthly.

Table 6-4 summarises the progress made throughout the COAG LSOP against Key Impact Area 4: *Decreased inappropriate hospital usage for older people*.

As with the previous Key Impact Area, the delay in the release of *the toolkit* has meant that insufficient time has elapsed, since practice implementation, to see changes in data for some outcome/output measures in this Key Impact Area. However, early indications are that all health services are on track to meet the target, relevant to their level of implementation.

[3] HARP BCOP Fact Sheet, Victorian Department of Health

Progress ratings: A = Target met; B = On track

Table 6-4: Summary of progress against Key Impact Area 4

4. Decreased inappropriate hospital usage for older people		
4.1. Reduced number of older people with unplanned presentations and readmissions		
Outcome/Output Measure	***Status***	***COAG LSOP Victorian Initiatives outcome or deliverable***
Reduced unplanned presentations and readmissions	**A**	These rates have reduced significantly in HARP BCOP clients. Several IC4OP sites have also reductions in unplanned readmissions.
4.2. Improved integration of services for older people in rural areas		
Outcome/Output Measure	***Status***	***COAG LSOP Victorian Initiatives outcome or deliverable***
Reduced length of stay resulting from of improved integration of services within rural areas	**A**	Many rural and regional sites have recorded a reduction in length of stay in target wards of IC4OP because of the HARP BCOP services. Also seen has been a reduction in the length of stay of HARP BCOP patients when they require in patient services.
4.3. Increased access to acute services		
Outcome/Output Measure	***Status***	***COAG LSOP Victorian Initiatives outcome or deliverable***
Reduced length of stay resulting from increased access to acute services	**B**	While there has been reduced length of stay recorded (see above) this cannot be attributed to increased access to acute services.
Reduced number of people discharged to nursing home for long term care	**B**	To date relatively few LSOP sites have recorded a reduction in the number of people discharged to nursing home for long term care
4.4. Improved care pathways		
Outcome/Output Measure	***Status***	***COAG LSOP Victorian Initiatives outcome or deliverable***
Increased direct admission to subacute settings from Emergency Departments for LSOP, Level 3 funded health services	**B**	Too early in full implementation to assess fully
Level 3 LSOP funded health services develop and implement improved pathways of care for older people and people with complex care needs	**B**	All Level 3 LSOP funded health services have successfully developed and implemented improved pathways of care for older people and people with complex care needs

7 SUMMARY

7.1 *Introduction*

As highlighted in the literature and horizon scan (Appendix 1) and from feedback in consultations and reports from health services, there are a number of barriers to the widespread implementation of the standards of care articulated in the IC4OP policy and embodied by the implementation guidance contained within *The toolkit*. These include:

- ageism
- poor screening, assessment and evaluation
- a failure to design and deliver individualised care
- too little involvement of patients and carers in decision-making
- fragmented care delivery systems
- limited research involving older persons
- inadequate education and training of staff
- poor quality of work life
- inadequacies in workforce (in terms of numbers and skill-mix)
- unsuitable care environments
- lack of awareness of cultural difference
- lack of clinical leadership for change
- lack of organisational vision about improving services for older patients
- lack of system drivers to improve care of older patients.

The literature and horizon scan (Appendix1) identified some key lessons learned for translating best practice into everyday practice. A summary of these lessons are:

1. strong executive support aids translation
2. clinical leadership aids translation and speed of change
3. data collection that influences both clinicians and those in charge of budgets support translation
4. if culture change is required, plan for translation to take longer
5. if multiple departments or disciplines are involved, plan for translation to take longer
6. plan for long term change early in the process, use resources to develop infrastructure that will support and maintain translation
7. ensure the infrastructure developed meets the needs of all stakeholders involved in translation
8. speed translation by ensuring all stakeholders are aware that translation will protect them from other threats

The diversity of approaches to improving care that characterise both platforms of the LSOP initiative is a two-edged sword. The lack of standardisation of approach contributed to implementation delays (as local invention and reinvention takes time) and has limited the ability to compare between models/programs (as, by and large, we are not able to compare like with like). However, the local

tailoring of interventions increased the likelihood of local success, although it limits the transferability of these innovations into other care environments.

It is noted that stakeholders have expressed divergent opinions on the relative merits of *standardisation* versus *local invention*. Often smaller health services or those with less experience of changing care processes had a preference for at least some standardised state-wide approaches to improving care whilst larger health services and those with greater prior experience of system-wide healthcare improvement preferred to design and implement their own innovative programs.

> *Increasingly, older adults are the central business of hospitals and health systems. Patients 65 and older already constitute the largest volume of care these facilities provide. Nevertheless those providing care too often opt out, by custom or inclination, from seeking higher-quality and more cost-effective care for older patients.*

7.2 *HARP BCOP*

This evaluation has shown that in the HARP BCOP projects there were many project characteristics that were key drivers of success, including:

- access to high quality education and training for staff
- effective collaboration and/or partnerships with other care providers
- information processes/systems that facilitated communication within the interdisciplinary team and helped to:
  - promote health and prevent illness.
  - provide better health outcomes.
  - prevent or reduce hospital admissions.
  - foster patient education and self-care.

The HARP BCOP projects all shared a team-based approach to the management of patients with chronic and complex disease at high risk of hospitalisation. These projects were all however very different in scope and structure, yet all pursued three common purposes. They all provided the best possible care environment and improved access for patients with a chronic disease to services in their local community. They all ensured that their project team members had access to the tools and resources necessary to provide high-quality care for patients with chronic and complex diseases. They all provided patients with the tools and support required to manage chronic illness effectively.

7. Summary

The evaluation of HARP BCOP demonstrated that it is possible to design and implement effective, team based approaches to care coordination that are tailored to the particular circumstance of a rural or regional healthcare setting. The *recipe* for success includes, but is not limited to:

- effective communication
- patient centred programs
- clinician engagement
- community involvement and empowerment
- community outreach
- strong support from senior leadership.

Leadership, an interdisciplinary team approach, effective information management systems, patient self management tools and support, and the monitoring of health outcomes will be basic components for the successful application of team-based approaches to care coordination within other comparable communities.

To be successful, not all systems need to be the same, but these key concepts were essential for successful program implementation and sustainability.

HARP has driven a stronger focus on hospital and community collaboration. Local governance groups have brought a broad range of key stakeholders together around the table to deliver health care in partnership – including hospital services, community health, district nursing and general practitioners.

7.3 *IC4OP*

The sector consultation confirmed that stakeholders had divergent views on the desirability of the proposed staged implementation approach designed into the IC4OP component of the LSOP initiative. Most agreed that a narrow focus in one (or a few) target wards had advantages in terms of effective use of the available human and fiscal project resources.

However, others believed that a whole of organisation approach may have helped deliver more effective and sustainable changes in care. It is noted that staff and patients frequently move between wards.

Health services which sought to embed changes in care by changing organisational-wide policies and procedures believed that this approach reduced the risk that these changes would be viewed as time-limited projects or trials by staff, thus increasing the buy-in by front-line staff and their adoption of the revised care processes.

Most stakeholders reflected on their need to develop and implement plans to sustain the gains achieved during LSOP and to spread their successful innovations in care of older patients beyond their target acute ward to *whole of hospital* and eventually *whole of health service* before they would begin to see genuine system benefits from the LSOP initiative.

In the more successful health services such planning for spread and sustainability began when their proposed innovations were being designed for piloting.

The LSOP initiative had always stressed the need for implementing sustainable approaches to change. Despite this direction it was noted that some IC4OP projects were extremely dependent on the efforts

and activities of LSOP funded staff. Rather than relying on changing the care delivered by those staff providing usual care for older patients, these projects relied upon direct inputs from the staff supported by LSOP funds (e.g. project officers and additional allied health assistants).

Such projects resulted in changes to care that were practically achievable in their target ward/s, but would not be able to be scaled up to span whole of hospital or whole of organisation without continued access to significant additional resources. These innovations will only spread and be sustained if commensurate investments are to be made to provide sufficient numbers of additional appropriately trained staff.

The effectiveness and efficiency of *The toolkit* development processes was canvassed with stakeholders during the sector consultation process. Health services who provided domain leadership all reported increased buy-in by their own staff for initiatives involving that domain. It was felt that their health service's commitment to delivering materials suitable for use in the toolkit helped overcome resistance to change when implementing or trialling better care processes locally.

7.4 *Issues identified*

There were a number of issues with implementation of the LSOP initiative that the sector consultation process highlighted. These were thematically categorised and conveyed to the Department of Health in interim evaluation reports. Some were system wide issues and others were specific to particular services, because of rurality, size and complexity of service and/or links to their services and support by DH personnel. They included:

- Health services universally had concerns regarding their perception that funding for the LSOP initiative was not secure. The challenges in recruiting, retaining and replacing project staff have hindered progress of the initiative in some health services, particularly in rural and regional health services. Most health services reported that these challenges were exacerbated by the DH practice of only providing written confirmation of annual funding to health services.
- Some health services expressed concerns that the IC4OP initiative lacked structure and focus during the first year or two of the initiative. Staffing changes within the Department were perceived to have contributed to miscommunication and there were concerns about a lack of clarity in project goals. These concerns were most strongly expressed by rural and regional health services.
- Staff at many health services have very limited time for any educational activities. This paucity of training opportunities acted as a major impediment to progress of the initiative in some health services.
- At some health services the identification of risks/issues at assessment/screening, while appropriate, was also problematic when there was little opportunity to mitigate risks because of limited or no access to specialist staff such as continence nurses, wound specialists, psychologists, other allied health professionals and specialist medical support including geriatricians, general physicians, and respiratory physicians.
- Some rural and regional health services believed they were under-resourced for the required tasks. The funding provided did not allow for a full time project officer, time required to travel to meetings and reporting requirements of the project impinged on time to support health service staff. Also, the culture change required across the health service required more resources.

- Many health services noted that there was considerable reluctance to change established patterns of care of older patients amongst some front-line staff and this resistance to change in care in acute hospitals was reinforced by:
  - the status of the initiative as a time-limited project
  - the perception that some innovations were merely pilots or trials that would not be sustained
  - the origin of the initiative in the subacute (rather than the acute) sector and the perceived lower status of the subacute sector
  - the championing of the initiative by subacute clinicians.
- Almost all stakeholders expressed concern that there were significant delays in finalising *The toolkit*. These delays saw the final version of *The toolkit* only being widely available during the last year of the initiative. A number of stakeholders noted that the delayed arrival of this vital resource had considerably hampered the effectiveness of the initiative within their health service. This concern was especially prominent in reports from the relatively less-well resourced rural and regional health services.

7.5 *Successes of the LSOP Initiative*

While there were some issues identified, as noted above, this is to be expected and should be used to improve future projects. However, the successes of the COAG LSOP have been broad and many long lasting. Some of the successes are listed below.

- LSOP raised organisational visibility for older patient care, through; local, regional and national presentations and posters related to the program; publicity in local media; recognition in the community as a healthcare system dedicated to excellence in care of older persons; program staff playing a role in advising hospital about issues regarding the care of older patients.
- LSOP played a role in improving quality of care at the participating hospitals. This has been manifest in strengthened interdisciplinary ties at the institution; assisting with meeting hospital accreditation or quality assurance standards; and the receipt of accreditation agency commendations.
- LSOP played a role in providing cost-effective care, with costs decreased through reduction in delirium and length of stay and volunteer components facilitated provision of cost-effective care.
- LSOP played a role in improving hospital outcomes for older persons. This has been manifest in substantial improvement in clinical outcomes for patients, including reduced rates of delirium and functional decline, fewer falls and reduced Foley catheter use
- LSOP played a role in providing nursing education and possibly improving nursing job satisfaction. This was achieved through changes and improvement in nursing orientation and ongoing educational sessions; improved nurses' knowledge and skill in working with elderly patients and increased nursing satisfaction.
- LSOP played a role in enhancing patient and family satisfaction with hospital care, this was seen in improved rates of patient and family satisfaction on surveys and feedback forms.
- LSOP played a role in improving public relations and community outreach for the hospital including; improved community relations through volunteer program, outreach, and providing lectures on aging; strengthened ties with long-term care facilities, community health agencies, ambulatory care providers and funding significant improvements in health service environments.

7. Summary

- LSOP played a role in creating regional integration and collaboration with the development of regional alliances for relevant services and beyond. In many cases nothing like this had ever existed before, linking the care of older hospitalised patients to sub-acute, HIP and so on. It also supported the development of an executive regional committee to keep driving the work strategically and hopefully operationally.

7.6 *Conclusion*

The LSOP initiative has been successfully implemented at 36 sites across Victoria, impacting the care of a large number of patients and changing the way organisations and staff approach the care of older patients over the past four years. Local tailoring of health services approach to implementation were present across multiple areas, including LSOP team composition, patient populations, intervention protocols, quality assurance procedures, and outcome tracking. Local circumstances drove these adaptations, and the reasons and types of adaptations were distinctive across sites.

Although adaptation may well be essential for successful implementation, the effects of these adaptations make comparisons between participating health services very difficult. Ideally health services will continue to fully evaluate their improvement activities locally and use their site-specific data and local successes to compelling hospital management to support continued growth and expansion of improvements in care of older patients within their organisations.

Integration with existing programs is integral to the successful implementation of any new program, and the LSOP initiatives at many health services successfully integrated with a number of existing programs at the institution, including Acute Care for the Elderly (ACE) units, Medical Assessment and Planning Units (MAPU), Geriatric Evaluation and Management (GEM) units, falls prevention programs, stroke care programs, skin integrity programs, Redesigning Hospital Care Program, Transitional Care Programs, other geriatric programs and other volunteer programs. The LSOP initiative became a flagship program for geriatrics at many health services.

Demonstrating positive outcomes, particularly those that are compelling at the local institutional level, was a major enabler of success in established the program of improved care. All of the sites have demonstrated their local advantages and successes well, within the submitted final project reports.

Strong clinical leadership was an important element in the initiative's sustainability. The evaluation has seen hospitals that lost momentum or abandoned initiatives when executive and/or clinician leaders who had been strong advocates for the program left the hospitals and were not replaced.

7. Summary

At hospitals with sustained success leaders not only played important clinical roles but acted as strong supporters with senior administration.

In addition to leadership, the hospitals that were successful in maintaining change were those who were able to adapt the initiative and the program goals to suit their specific needs and circumstances. One common adaptation involved changing forms and documentation to avoid redundancies. Some data requirements were deemed too time-consuming and were dropped, but more commonly, data collection methods were modified to fit better with their existing processes.

Successful innovations in health care must not only be effectively adopted; they must also be sustainable over time. In studying the LSOP initiative we have found that securing clinical leadership and adequate resources remained critical issues that will require ongoing commitment and attention by health services and the Department.

8 RECOMMENDATIONS

8.1 *Introduction*

The literature and horizon scan presented the results of a number of studies to improve care for older people in hospital and lessons learned on spreading and sustaining changes in healthcare:

- The roles of senior management, clinical leadership, and credible data are important to success.
- Diffusion does not occur spontaneously, it requires the creation of an infrastructure dedicated to translating the innovation from a research setting into a practice setting.
- Specific features of the innovation and the diffusion effort are central to the speed and success of diffusion.
- The translation process depends on the characteristics and resources of the adopting organisation, and on the degree to which people believe that the innovation responds to immediate and significant pressures in their environment.

As discussed in the previous chapter, the implementation of the Victorian COAG LSOP initiative has taken into account each of the requirements needed to successfully translate best practice into every day practice and improve the care for older people in Victorian hospitals and community. Although in most health services the scope of the implementation was individual target wards, the benefits to the whole health service have been apparent in many cases.

Recognising that key areas were included in the implementation, this chapter provides recommendations specifically for the COAG LSOP initiative and makes some general recommendations for DH based on the observations and learnings from the evaluation.

As HARP BCOP has already been mainstreamed into the HARP program the following recommendations are focused on IC4OP program.

The recommendations have been formulated utilising the key lessons, noted above, and the evaluation feedback. The recommendations are provided under the following topic areas:

- executive support
- funding
- project officers
- supporting minimising functional decline as an appropriate model of care across health services
- reform through existing governance structures
- *The toolkit*
- clinical champions
- minimising functional decline training.

8.2 *Executive support*

Strong executive support is essential to success of any project within a health service. This is seen not only in the literature but was also seen throughout the COAG LSOP initiative. Effective executive

support straddles not only professional disciplines but also units and programs within the health services, for example acute, subacute and aged care.

For long term projects executive sponsors need to be kept up to date with project objectives and results as well as any changes that may affect the project. This should occur from within the health service through project staff and reporting processes and also from funding sources such as DH.

Feedback from health services suggests that regular meetings with executive sponsors are important for big projects such as the COAG LSOP initiative. However, these meetings need to be focused and direct (short and sharp), and while they should be regular there should be flexibility in both the time and days on which the meetings are held. Alternative venues and methods of attendance need to be available including video conferencing and teleconferencing.

Recommendation 1 Executive sponsors

1.1 To be effective executive sponsors in health services need influence that cross not only disciplines but also program boundaries

1.2 For multi site projects regular meetings with executive sponsors should occur; these meetings should be regular and planned to be short and focused with alternative, times, venues and methods of attendance.

8.3 *Funding*

The Department should provide surety of funding up front for the duration of the project where possible. Funding projects year to year affects not only the health service ability to attract and recruit good staff it may also affect executive support.

Throughout this evaluation the importance of infrastructure and appropriate environment was highlighted in the research, best practice recommendations and the consultations. While funding was provided during the initiative for capital works to be completed following environmental audits. The Department should investigate ways to quarantine capital funding to enable health services to respond to findings of environmental audits in the future.

Recommendation 2 Funding

2.1 Funding surety needs to be established for life of projects

2.2 The DH should investigate ways to quarantine capital funding to respond to environmental audits.

8.4 *Project officers*

8.4.1 Training

The role of project officers is vital to projects like the COAG LSOP project and many other projects across the health and community sectors. The importance and difficulty faced by health services,

especially regional and rural based health services, in recruiting and training project officers have been highlighted in this report. To help build capacity within the system, the Department should consider the development and provision of generic project officer training that could be held on a regular basis. Training should include data collection, project management and report writing.

Having a pool of people who had completed generic project officer training may enable faster recruitment when projects arise. Project officers can then have an orientation that is specific to the project, including key deliverables.

8.4.2 Project officer forums

For projects across multiple sites regular project officer forums should be established. For statewide projects, such as COAG LSOP, a proportion of these forums should be statewide. However, as there is a vast difference between the issues encountered and the operation of a large metropolitan health service compared to smaller rural service, the majority of forums should be regionally based.

The availability of regional forums and technologies such as video conferencing are important where project officers are part time as travel and time spent away at forums reduces time within the health service.

8.4.3 Project officer qualities

The literature and this project support project officer ideal qualities as:

- project experience – or having completed training
- familiarity with organisation (particularly if part time)
- respect within the organisation
- good writing, information management and time management skills.

On review of the findings from this project, for COAG LSOP the preferred skill-set and background of the project officer to enhance the likelihood of achieving successful outcomes in their role included:

- a background in acute care
- the ability to be seen as part of the care team
- strong knowledge of care of the older person
- the ability to provide practical on the spot advice and support.

Recommendation 3 Project officers

3.1 To build health sector capacity DH should consider funding/supporting health services to offer scholarships (or similar) to complete appropriate project officer training. For example *BSBCMN 419A: Manage Projects* is a current unit of competency from the Australian Vocational Education and Training (VET) system *Business Services Training Package*.

3.2 For multi site projects regular project officer meetings/forums should occur; a number of the meetings should be statewide however, the majority should be regionally based meetings

8.5 *Supporting minimising functional decline as an appropriate model of care for all health services users*

The literature, common sense and feedback from the evaluation support that minimising function decline in acute care is important not only for older patients but, for all patients. Therefore, minimising function decline could be seen as an appropriate model for all patients. It is recommended that the Department investigate ways to support health services to expand minimising functional decline as a model of care across the health services. The starting point for this has been the Level 3 health services who have been integrating the philosophy of minimising functional decline across the continuum of care.

As identified later, working within existing structures, or combining with other projects may be a way of supporting this change.

Recommendation 4 Supporting minimising functional decline as a appropriate model of care for all health service users

4.1 It is recommended that DH support all health services to adopt minimising functional decline as an appropriate model of care for all health service users, across the continuum of care

8.6 *Reform through existing structures*

There are a variety of approaches that could be taken to further embed the aims of the COAG LSOP within health services, incorporating all wards and areas of the health service.

8.6.1 Existing governance structure

Most health services have existing governance structures, for example Quality and Risk Committees or Clinical Governance Committees. These committees have reporting structures that extend by up through executives to Boards and down through ward and program areas.

In this approach, the existing staff and systems used by hospitals to improve care would be harnessed to focus on improving the care of for all persons through performance monitoring and improvement actions. There is a strong synergy between the focus of the COAG LSOP initiative on person centred care and the domains and the new *Core Standards for Safety and Quality in Health Care*, Core Standard 2 Clinical practices; which requires not only person centred services across the continuum of care; but also the use of clinical pathways or guidelines; and early identification, early intervention and appropriate management of patients who exhibit risk factors.

Some health services have already commenced health service wide changes introduced through multi disciplinary working groups and continued with support from quality and risk or clinical governance staff, including:

- person centred care embedded in:
  - strategic plans
  - all policies and procedures
  - position descriptions and performance reviews

- screening and assessment tools, related to functional decline domains, implemented across all patients in health service
- care planning, observations charts and discharge planning tools linked to screening and assessment tools
- resources developed for COAG LSOP available to all staff (also see *The Toolkit* below)
- education and regular training on each of the domains embedded in annual training plans and in orientation programs for all staff
- development of KPIs, regular auditing against KPIs and reporting through governance committee.

8.6.2 Combined projects

During the consultations all health services commented on the number of funded projects they were participating in. Health services mentioned projects both in hospitals and in the community sector, which included, but were not limited to:

- Best Practice Person-Centred Health Care
- Enhancing Practice Program
- Dementia Care in Hospital
- Redesigning Hospital Care Program
- Active Service Model
- HACC Assessment Model

Both the DH and health services need to ensure each project does not compete for time and commitment of health service staff. Both DH and health services need to ensure economies of scale are achieved through combining projects wherever practicable.

A key example would be combining the resources of the Redesigning Hospital Care Program and the Level 3 implementation of COAG LSOP.

Recommendation 5 Reform through existing structures

5.1 To support the transition of the IC4OP initiative from a project to long term model of care health services need to be supported to transition projects into existing processes, such as quality/clinical governance systems.

5.2 It is recommended that DH support health services to combine projects wherever possible.

8.7 *The toolkit*

A key outcome of the COAG LSOP has been the development of *The toolkit*. *The toolkit* is a valuable document with key information important for health services in addressing functional decline across the key domains. However, feedback from the evaluation identified that *The toolkit*, although targeted at frontline staff, was better suited for staff involved with education, quality or clinical governance.

There were several reasons for this including; organisations wanting consistency in policy and process across the organisation. Staff being able to access and utilise multiple different tools jeopardises consistency.

Both the hardcopy and the electronic versions of *The toolkit* includes useful background information for each domain and then identifies a number of tools and forms that can be used in assessment, monitoring and planning support. Before these tools and forms are accessed *The toolkit* provides a electronic summary sheet about the tool/form – this summary sheet is noted to be long and in some cases confusing. Staff commented that having to work through this form discourages frontline staff from accessing more information.

Recommendation 6 *The toolkit*

6.1 It is recommended that *The toolkit* be marketed at educators', quality and clinical governance staff who can ensure appropriate health service protocols are met to introduce new tools/forms.

8.8 *Clinical champions*

Both the literature and the majority of health services expressed a preference to see the future approach being to resource and establish a new function within acute hospitals to continue to progress the improved care of older patients through the introduction of clinical champions. A number of different models for the introduction of clinical champions were highlighted throughout the evaluation. A discussion of three separate models follow, they include the model supported throughout the implementation of IC4OP, a specific champion for care of the older person. The models include:

Model 1. a general champion for minimising functional decline and/or caring for older people on each ward/unit

Model 2. specific champion for care of older people per health service

Model 3. champions for each functional domain within a health service, available for all staff to consult if they identify an issue.

A model for a general champion on each ward/unit already exists (Model 1), that of a Geriatric Resource Nurse (GRN), a summary is at Figure 8.1

Figure 8-1: Model 1, Geriatric Resource Nurse

Geriatric Resource Nurse (GRN)

The GRN model was developed in Boston in the early 1980's at Beth Israel Hospital and later expanded at Yale New Haven Hospital. The model is based on the idea that nurses know the most about the older patients in their units. The model recruits ward-based nurses and provides specialized education and enhanced skills in the care of older adults. After training, the GRN serves as a resource for geriatric best practices to other nurses. Using this model, studies show that about 80% of problems encountered in care of older patients can be handled by staff nurses of that unit.

The GRN model of improving the care of older patients health services involves Ward/Unit based experts from existing staff resources. In this model, unit-based nurses acquire competency in elder care and improve care by modelling best practices and providing unit/ward consultation for elder care. This strategy allows staff to choose to participate in the hospitals efforts to provide better care to older adults.

There are a number of models already available to introduce specific care of older people per health service (Model 2), these include a Gerontology Clinical Consultant, see Figure 8.2 and the Gerontology Nurse Practitioner, see Figure 8.3

Figure 8-2: Model 2a Gerontology Clinical Consultant

Gerontology Clinical Consultant

A key member of that team would be the expert resource person in older patient care. Most stakeholders expressed the view that this person would be likely to have a background in either acute hospital nursing or allied health. For the purposes of this discussion we will refer to these expert resource persons as 'Gerontology Clinical Consultants' (GCC). This person would play a role very similar within health services to that of other content experts within our current health system (e.g. Clinical Nurse Consultants such as Infection Control Nurses).

These GCC positions would need to be established at least in each health service to consult and work on staff education, practice and service improvement and research. These positions would offer another career pathway for Nurses and Allied Health clinicians with an interest in acute care of older patients, and help to retain nurses and allied health clinicians interested in more senior clinical roles.

Figure 8-3: Model 2b Gerontology Nurse Practitioner

Gerontology Nurse Practitioner

The Gerontology Nurse Practitioner (GNP) position would have a direct clinical role facilitating case review/management as well as facilitating work practice review and addressing a wide range of skills within the entire multidisciplinary team. The GNP's would advocate for research and strategic development of acute care nursing across their region in conjunction with a supervising Geriatrician and the health service GCC's.

The role of the GNP is very new in Australia. To date it has largely been explored in residential aged care settings. Aged care nurse practitioners roles have been trialled and implemented in aged care and have been proven to be an innovative, cost effective path towards improving the quality and timeliness of health care delivery to the aged care sector. One LSOP regional site has successfully expanded the GNP role to embrace the acute care setting as a core component of their LSOP implementation.

A model for functional domain champions (Model 3) also exists with current nursing or allied health specialists. There are recognised specialised nursing positions including Continence Nurses and Wound Nurses across the health system. There are also positions in health services that address falls prevention, these positions support Allied Health professionals address the mobility/vigour/self care domain. Dieticians and pharmacists are available in each health services and are key for the nutrition and medication domains. In spite of the value of these roles, a number of acute health services commented throughout the evaluation that they do not have access to continence nurses or wound nurses within their acute wards.

In this model support would be required to ensure all health services have access to specialist nursing/allied health services. In regional areas support may need to be provided on a regional basis rather than per health service. Models for developing regional based specialist services can be seen in the areas of infection control and transfusion nurses.

Recommendation 7 Clinical champions

7.1 DH continue to support health services to adopt clinical champions, utilising a model that bests suits the health service or the region.

8.9 *Minimising functional decline training*

The literature and findings from this evaluation support the need for minimising functional decline as an important model of care for all people entering hospital, in any residential facility or being cared for in the community. At a broad level, it is recommended that the Department use their influence on key professional groups to support inclusion of minimising functional decline in key professional curricula.

8. Recommendations

It is recommended that health services are supported to implement training for all staff including medical, allied health, nursing and ancillary staff in all domains, recognised to minimise functional decline. This training should be included in orientation programs and regular required training.

Recommendation 8 Minimising functional decline training

8.1 DH should use its influence on key professional groups to encourage the concepts of minimising functional decline in the curricula of health professionals

8.2 Health services should be supported to implement training in all domains that support minimising functional decline to all health professionals. Information should be included in all orientation programs and regular required training.

Australian
Healthcare
Associates

Appendix 1
Literature Review and Horizon Scan

Table of Contents

1. Executive Summary

1 EXECUTIVE SUMMARY

There is a substantial body of knowledge, accumulated over the past 2 decades or so, on how to deliver health services that improve the outcomes of older patients. It is known how to reduce their risk of functional decline when they are acutely ill in hospital and how to reduce the need for acute hospital care in chronically ill older persons by changing their care in the community. Indeed the hundred or so citations in this report[1-142] could readily have grown to over a thousand citations if we had sought to be exhaustive, rather than selective in our review processes.

Q. Why is there so much attention to these matters?

A *traditional* approach to the delivery of health services sees older patients, the largest users of in-patient beds in acute hospitals, with relatively poor outcomes of acute hospitalisation. A *traditional* approach to community-based care of older patients with chronic diseases leaves them at increased risk of preventable hospital attendance, admission and unplanned readmission.

Given demographic trends, if we do not move away from these *traditional* approaches to care of older Australians, in the near future demands for acute hospital beds will escalate dramatically and the cost to the community of caring for older patients will skyrocket.

Q. Are hospitals especially dangerous places for older patients?

Yes. Hospitals are acknowledged to be dangerous places, with a distressingly large number of patients suffering adverse events during acute hospital care. Older patients are at increased risk of iatrogenic harm in relationship to the care of their admission illness (such as complications from assorted diagnostic procedures and of many therapies, especially new medications).

Older patients are also at risk of experiencing functional decline that is independent of the specific nature of their admission illness. Here the hospital environment per se and *traditional* approaches to the delivery of care in hospital put them at risk of experiencing:

- acute confusion (delirium)
- falls
- continence issues
- loss of muscle condition, coordination & mobility
- malnutrition
- breaks in skin integrity(tears and ulceration)
- a reduction in their ability to self-care
- depression.

Q. Can functional decline in hospitalise older patients be minimised?

Yes. It is known how to change the environment in which care is delivered and the processes of care to achieve significant reductions in the frequency and severity of functional decline in hospitalised older patients.

Q. Can the need for acute hospital care in older patients with chronic illness be reduced?

Yes. Coordinated approaches to care of chronic diseases (such as Chronic Disease Management) can reduce hospital attendances and admissions.

1. Executive Summary

Q. Given the above, why are initiatives like the Victorian LSOP initiative needed?

Knowing what constitutes best practice care does not in itself ensure that best practice care will be routinely applied in the real world.

Our health systems are very good at recognising problems in care delivery and in designing potential improvements in care delivery. They are also quite good at performing *pilot studies* or *clinical trials* to provide proof that these new ways of delivering care are indeed better (i.e. providing the evidence base for change).

Health systems are not as good at designing and implementing strategies that support the spread (or dissemination) of best practice across all relevant care environments. Health systems are also not very good at ensuring that improvements in care delivery are sustained over time.

There is an increasing, albeit incomplete, understanding of how to successfully disseminate clinical practice improvements and sustain change over time. Spread and sustainability requires enduring changes to the ways individual health professionals, health service provider organisations, funding bodies, regulatory and accreditation agencies, patients and carers and even the broader community think and behave.

Q. How does this literature and horizon scan shape the focus of the evaluation of the Victorian LSOP initiative?

This initiative is a classic exercise in *translating evidence into practice*. Given the above discussion, a key focus of the evaluation will not necessarily be simply *what worked* (because much is already known about what will work when operating in *project-mode*). Rather there needs to be a strong focus on learning the characteristics of successful changes that have supported, or will be likely to support, their spread and adoption by others and sustainability of change over time.

2 BACKGROUND

2.1 The initiative's aims and strategies

The COAG LSOP Initiative seeks *to improve the capacity of health services to provide more appropriate care for long stay older patients in public hospitals and reducing avoidable or premature admission of older people to hospitals, particularly in rural areas.*

Key strategies in the Victorian LSOP initiative are:

- Improving Care for Older People (IC4OP)
- Hospital Admission Risk Program - Better Care for Older People (HARP BCOP).

2.2 The context

2.2.1 Demography

Shifting demographics and increasing life expectancy are having a growing and incontrovertible impact on hospitals[1,2]. Currently, more than one-third of all people admitted to our hospitals are over 65 years of age and people in this age group account for over 50% of inpatient hospital days. The ageing of the population will particularly quicken from 2010 when the bulk of the post-war *baby boom generation* begins passing 65 years of age.

In 2005–06, people aged 65 years and over represented 13.2% of Australia's population[1,2]. This proportion is expected to increase to 25% by 2047. These changes will see an increasing proportion of hospital activity and expenditure focused on acute care of older Australians. The second intergenerational report (IGR2) states that Australian Government health expenditure will almost double over the next 40 years.

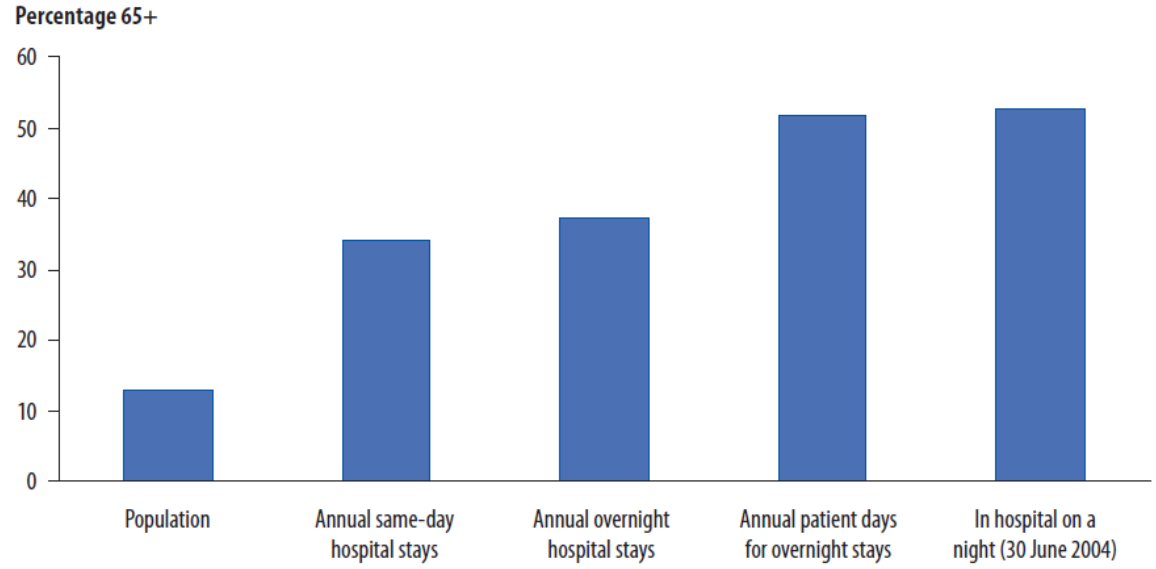
The cost of hospitals and health services (being principally the costs of public hospitals, private health insurance rebates and hospital care for veterans) will increase by 80% in real terms to 2.2% of Gross Domestic Product (GDP) in 2047. This projected increase is not just a result of demographic change but also reflects a continued investment in new technology[1,2].

An intergenerational report (IGR) is produced by the Australian Government every five years to assess the sustainability of government policies over the next 40 years. The second report (IGR2), released in 2007, forecasts that Australia's population will grow to 28.5 million by 2047 and 25% of the population will be over 65 years of age. This will partly be a result of the average life expectancy increasing by seven years for men, to 86 years, and women, to 90 years.

Patients 65 years and older already constitute the largest volume of care that hospitals and health systems provide[1-3]. Increasingly, care of older adults needs to be seen to be the central business of these facilities. Acute health services need the tools to manage this changing patient population mix effectively and the vision to see the opportunities to improve both the quality of their care and the value delivered to the community.

2. Background

Figure 2-1: Population and hospital use: people aged 65 and over as percent of total, 2004-05



Source: AIHW. Older Australians in Hospital. Bulletin 53. August 2007.

Older Australians have a higher rate of admission to hospitals than the general population[3]. They are admitted for a different mix of reasons and their stay in hospital is generally longer. A significant percent (5-10%) of all public hospital admissions for people aged 65 years and over are for subacute care, including rehabilitation and geriatric evaluation management.

Overnight patients aged 65 years and over have longer hospital stays than patients less than 65 years[3]. Those aged over 85 years have even longer average hospital stays. People 65 years and over staying overnight in hospital had an average stay of 8.6 days, compared with an average of 6.2 days for all Australians. The average length of stay was even higher in oldest age groups, being more than 10.6 days for people aged 85 years or more.

Figure 2-2: ALL Hospitals - average length of stay (overnight patients) public and private hospitals by age group, Australia, 2005-06

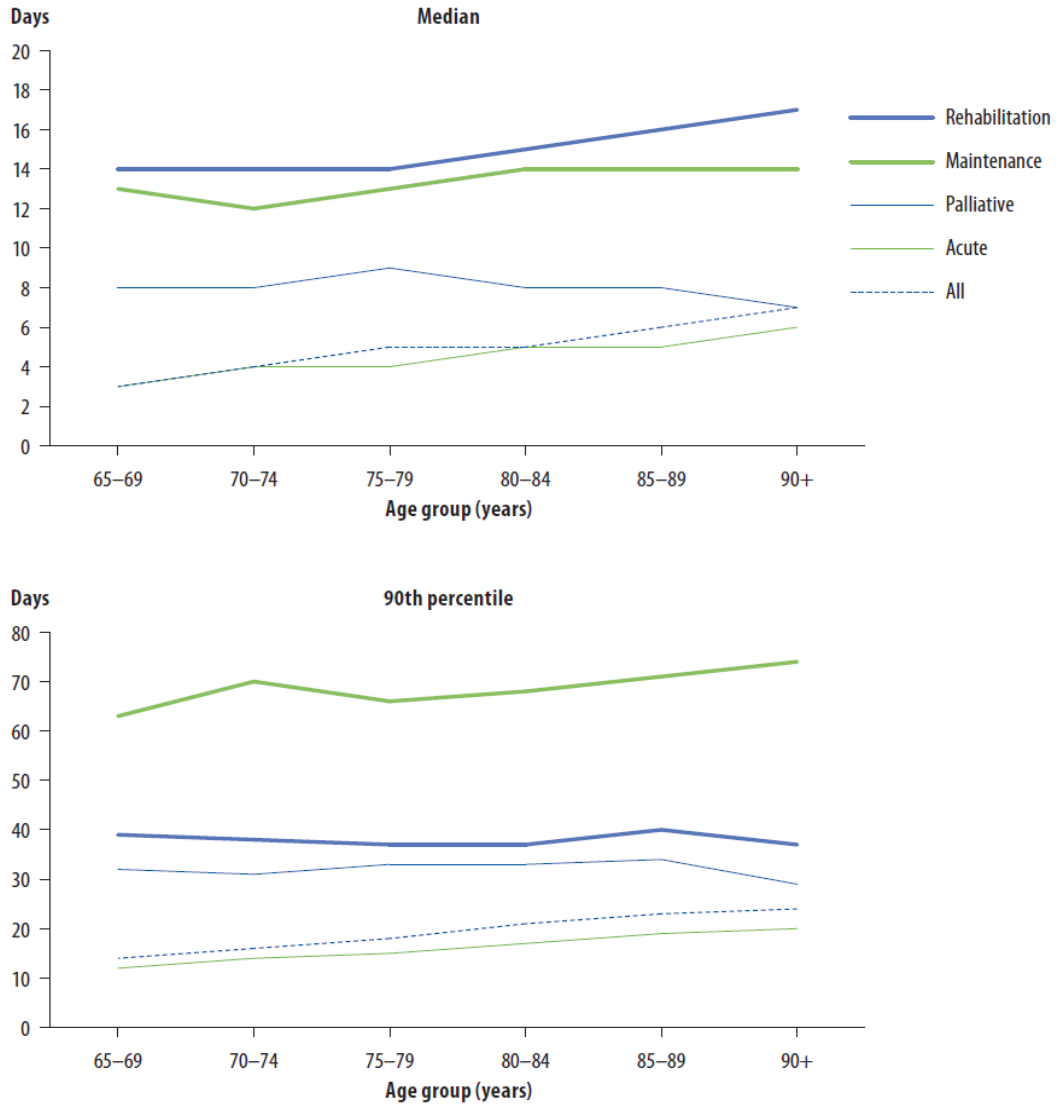
	0-64 yrs	65-74 yrs	75-84 yrs	85 yrs and over	65 yrs and over	All ages
Private hospitals (days)	4.1	5.6	7.7	9.9	7.4	5.4
Public hospitals (days)	5.2	7.7	9.5	11.0	9.2	6.6
Total	**4.8**	**7.0**	**8.8**	**10.6**	**8.6**	**6.2**

Source: Australian Government Department of Health and Ageing Annual Report 2008

The reasons for increasing length of stay for older people include a greater likelihood of carrying co-morbidities or health problems other than the one for which they were admitted and a slower recovery from treatment because of a decline in a number of body functions.

2. Background

Figure 2-3: Length of overnight stays for common care types for older clients, 2004-05 (days)



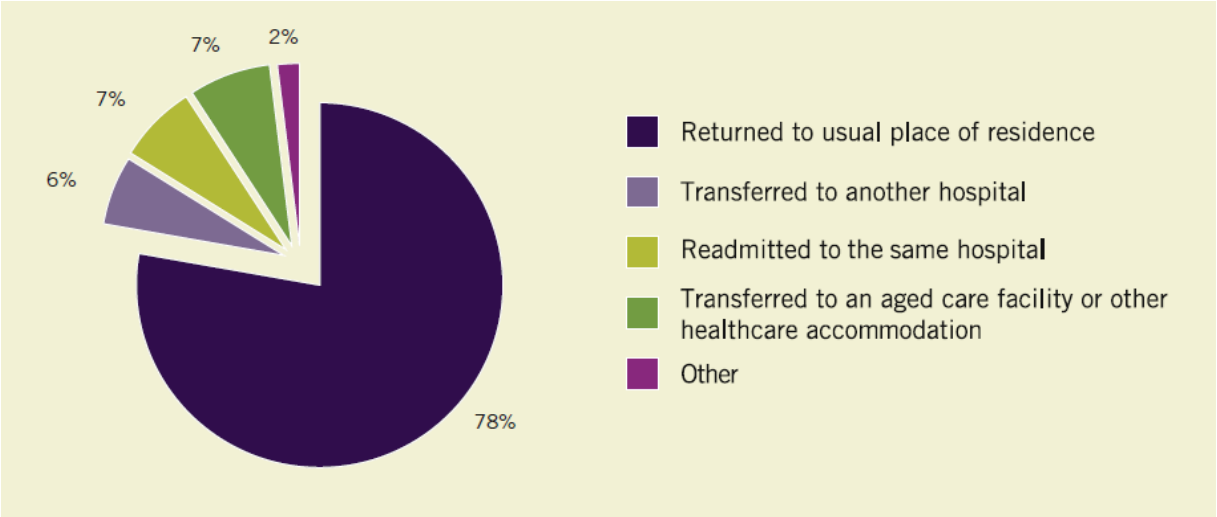
Source: AIHW. Older Australians in Hospital. Bulletin 53. August 2007.

Why are older Australians admitted to public hospitals?

Renal dialysis, cardiology and respiratory medicine and orthopaedics are the most common reasons that older people are admitted to public hospitals. People aged over 65 years represent a particularly high proportion of patients admitted for ophthalmology, which commonly involves surgical lens procedures for cataract treatment[3].

2. Background

Figure 2-4: Rehabilitation and Geriatric Evaluation Management - admissions of patients aged 65 years and over, by mode of separation, public hospitals, Australia 2005-06



Source: Australian Government Department of Health and Ageing Annual Report 2008

Older Australians and elective surgery

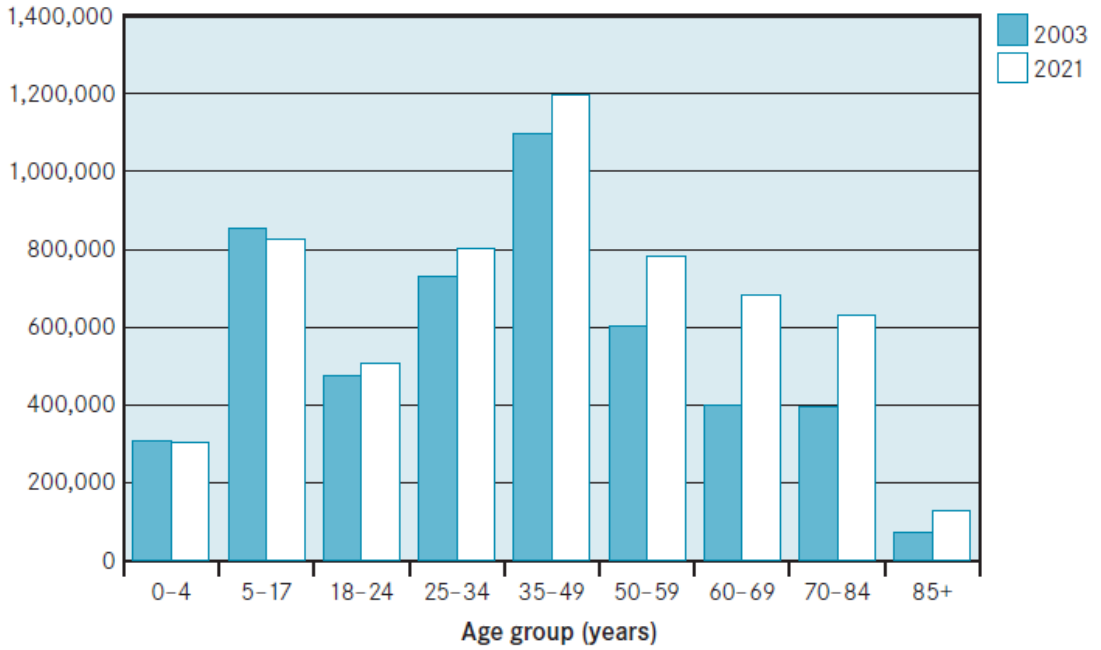
People over the age of 65 comprised 28% of public hospital admissions for emergency surgery and 28% for elective surgery in 2005–06[3]. The median waiting time for all elective surgery in public hospitals was higher in the 65–84 years age groups than for the general population. This is influenced by the relatively long waits for joint replacement and cataract treatment that are commonly required by older people.

Older Australians and emergency departments

Older Australians have a higher overall rate of presentation to emergency departments than other age groups[1-3]. They also require more urgent attention than other age groups, being over 30% of people in the two highest triage categories (Resuscitation and Emergency). More than 50% of the older people presenting to an emergency department are admitted to the same hospital, or referred to another, compared with 22% of people less than 65 years of age.

Victoria's public hospitals continue to treat a growing number of patients. They are currently on target to admit over 1.4 million patients this year, compared to one million in 1999-2000. Older people are significant users of acute health services in Victoria, with people over the age of 65 using around half of all multiday patient stays. As the population ages Victoria's health services, like others in the developed world, will experience a steep rise in the percentage of older people requiring acute hospital treatment and care.

Figure 2-5: Victorian population structure projections 2003-2021



Source: Improving care for older people: a policy for health services (2003) www.health.vic.gov.au/older/improvingcare.pdf

2.2.2 Policy

Over the past decade the Australian and state and territory governments have had a strong focus on collaborating on initiatives to improve the care of long-stay older patients in public hospitals and their access to appropriate long-term care options.

In 2001 AHMAC established the Care of Older Australians Working Group (COAWG), now known as the Health Care of Older Australians Standing Committee (HCOASC). They commissioned a number of studies[1] including:

Service Provision for Older People In The Acute – Aged Care System (The National Ageing Research Institute and the Centre for Applied Gerontology) 2002

Stocktake of Models of Care At The Acute – Aged Care Interface

(Howe, Rosewarne and Opie) 2002

Examination of Length of Stay For Older Persons In Acute And Sub-Acute Sectors (Aged Care Evaluation and Management Advisors) 2003

Review of Assessment And Transition Practices For Older People In Acute Public Hospitals (University of South Australia) 2003

Feasibility Study on Linking Hospital Morbidity and Residential Aged Care Data to Examine The Interface Between The Two Sectors (AIHW) 2002

Unnecessary and Avoidable Hospital Admissions For Older People (Siggins Miller) 2003

In 2004 they released a key framework document; *Age-friendly principles and practices: Managing older people in the health service environment.* This established an overarching national framework for

health services in managing older people's health care needs. This document outlined seven principles and associated practices to inform service development for older people.

The HCOASC followed the release of *the age-friendly principles* with a number of resources to assist health services in implementation of better care for older patients. These included:

- A National Action Plan for improving the care of older people across the acute-aged care continuum, 2004–2008 ('Hospital to home')
- Best Practice Approaches to Minimise Functional Decline in the Older Person Across Acute, Subacute and Residential Aged Care Settings
- The 'how to' guide – turning knowledge into practice in the care of older people. September 2008.
- A Guide for Assessing Older People in Hospitals
- Clinical Practice Guidelines for the Management of Delirium in Older People
- Stroke Care Pathway.

Over the past 10 or more years there have been a number of national policy initiatives that have sought to deliver improved care of older Australians in acute hospitals including:

- ***Phase 4 of the National Demonstration Hospitals Project (NDHP4)*** focused on improving acute care of the older patient in hospitals
- ***The Pathways Home Program***, that provided funding to the states and territories to improve their rehabilitation and step-down services; and more recently
- ***The Transition Care Program***. This was an initiative of the Australian and state and territory governments seeking to help older Australians return home after their hospital stay. The program was announced in the 2004/05 Australian Government Budget and jointly funded by the Australian Government and the state and territory governments.

  This program is designed to help older people leaving hospital to return home rather than inappropriately enter residential care.

  Transition care provides older people with a package of services that includes low-intensity therapy (such as physiotherapy, occupational therapy and social work), case management, as well as nursing support and personal care. It helps older people complete their recovery and optimise their functional capacity, and may also provide additional time for the older person or their family or carer to consider long-term care arrangements.

  An evaluation of the Transition Care Program[2] concluded that the Program provided additional treatment and care options following hospitalization that were highly valued by patients and their families. Functional improvements occurred. When compared with similar groups of frail older people discharged from hospital during the same time period, those who received Transition Care had fewer readmissions to hospital and were less likely to move into permanent residential aged care.

  The evaluation reported that when compared to the control groups the outcomes were achieved at a comparatively high cost. For every day a recipient of Transition Care survives without institutional care i.e. without hospital or residential aged care over a six month period it costs

$344 per day. It was noted however, that the evaluation was completed at an early stage of implementation when development and set up costs are high.

Under the current national policy initiative in this arena *'Improving Care for Older Patients in Public Hospitals'*, the Australian Government has provided a total of $150 million to the states and territories to implement a range of initiatives that will complement existing older patient care improvement programs in each jurisdiction. The initiative focuses on reducing unnecessary admissions, improving admitted patient services, and improving the transition to appropriate long-term care in metropolitan and rural areas. There is a focus on improving the flexibility and capacity of rural hospitals to provide more age-friendly services.

Within the Victorian policy context *Improving care for older people: a policy for health services was* released in 2003. This highlighted the need for health services to change the way they care for older patients in response to these shifting demographics in the Victorian population.

The IC4OP policy focused on improving the care provided for older people by health services and better integrating care across settings to ensure that people receive the right care in the right place at the right time.

Three fundamental drivers were identified to stimulate improvements in the care for older people. These were the need to:

1. Adopt a strong person-centred approach to the provision of care and services
2. Better understand the complexity of older people's health care needs
3. Improve integration within health services' community-based programs and between health services and ongoing support services available in the broader community.

The IC4OP policy is underpinned by 12 principles that inform the practice and process changes required. These principles were:

1. Health services apply practice based on best evidence to the care of older people, including specific attention to the risk of malnutrition, decreased functional mobility, loss of skin integrity, incontinence, falls, the development of delirium, problems with medication, poor self-care and depression.
2. Health services take clinical governance responsibility for the care of older people.
3. Treatment and care provided by health services places the person at the centre of their own care and considers the needs of the older person's carers.
4. Health services identify older people at risk of adverse health outcomes and/or having existing or potential supportive care requirements.
5. Treatment and care provided for older people with a positive risk screen includes a comprehensive assessment.
6. Treatment and care provided for older people includes interdisciplinary care planning that is founded on evidence-based care pathways.
7. Treatment and care provided for older people is coordinated to achieve integrated care across settings.
8. Older people receive treatment and care in the setting that best meets their needs and preferences where it is safe and cost effective to do so.

9. Health services integrate their community-based programs to provide the appropriate treatment, therapy and supportive care to meet the needs of older people.
10. Robust protocols and agreements developed between health services and ongoing community support providers ensure that older people continue to receive the care they require in a coordinated and integrated manner.
11. An adequate level of support for people awaiting long-term care options is provided in the setting that best meets their needs.
12. All people across Victoria have access to Centres Promoting Health Independence.

The implementation of this policy required a multifaceted, incremental approach. A key aspect of this has been the state-wide collaborative partnerships with key stakeholders. In addition to working with health services, the department developed partnerships with the Commonwealth Department of Health and Ageing, consumers, peak organisations, professional bodies and tertiary institutions.

This involved partnerships such as:

- incorporating consumers onto advisory committees
- engaging the National Ageing Research Institute (NARI) to undertake resource development projects
- engaging the Council on the Ageing (COTA) and Northern Health in rolling out a training program to support culture change in health services
- working with Latrobe University in evaluation.

Such partnerships helped to support and resource health services to deliver service development against their agreed plans.

To support health services to improve the way care is delivered to older people with complex care needs, the department funded four state-wide projects. These projects aimed to ensure a foundation of evidence based practice and education for person-centred care, support the development of cognition management and assist in identifying and planning for environmental improvements.
These projects are:

- Best Practice in Person-centred Health Care
- Enhancing Practice Program
- Improving the environment for older people in Health Services: An audit tool
- Dementia Management in Hospitals Program.

A summary of key results of IC4OP was published in 2008[1]. This report demonstrated that participating health services had demonstrated significant practice changes, including:

- A refocusing of culture towards person-centred care and recognising that older people are key stakeholders in health services
- All health services strove to better understand older people's complex healthcare needs and to minimise functional decline in the areas of nutrition, functional mobility, skin integrity, continence, falls, medication management, dementia, delirium, depression and self-care. This work highlighted the need to have evidence-based resources available to support the systems change required.

- Application of the environmental audit tool and subsequent physical improvements had a profound impact on accessibility for older people in hospital settings, on the morale and awareness of staff to the needs of older people and on the morale of patients and carers.

The IC4OP initiative was completely congruent with national policy directions.

The LSOP initiative sits alongside Victoria's health independence programs model of care. These Health independence programs include:

- Post-Acute Care (PAC) services
- Sub-acute Ambulatory Care Services (SACS), including centre-based, home-based and specialist clinics
- Hospital Admission Risk Program (HARP) services.

Figure 2-6: Health independence programs model of care

Source: Health independence program guidelines www.dhs.vic.gov.au/ahs/continuingcare/hipguidelines.pdf

The alignment of PAC, SACS and HARP seeks to:

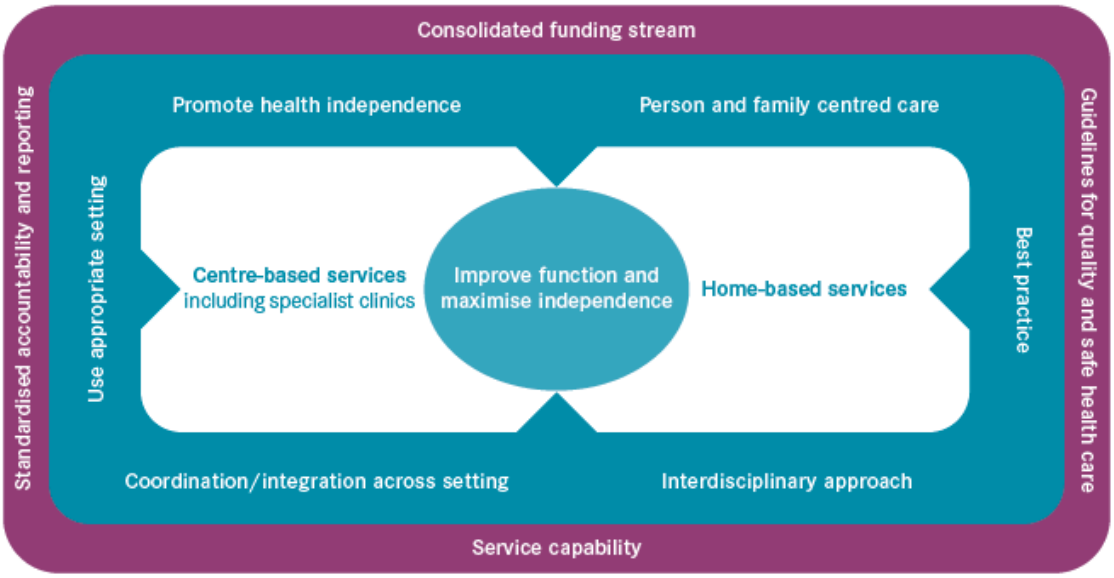
1. Simplify the service system
2. Produce efficiencies in service delivery
3. Minimise duplication
4. Improve equity
5. Enhance coordination
6. Reduce fragmentation of service delivery across funding streams
7. Enhance flexibility in service delivery.

Collaboration and coordination across the care continuum are key success factors for providing the best experience for clients enrolled in health independence programs. To provide integrated and Health independence programs must work collaboratively with each other and other services, including Home and Community Care (HACC) and other community health services, to ensure that people have access to an appropriate range of services to meet their post-hospital and ongoing care needs.

2. Background

Figure 2-7 illustrates the integrated service platform that the department and health services are working towards for health independence programs. Common processes and core principles underpin the platform and will assist health independence programs in integration.

Figure 2-7: Health independence programs framework



Source: Health independence program guidelines www.**dhs.vic.gov.au**/ahs/continuingcare/hipguidelines.pdf

The Victorian Department of Health policy direction is focused on aligning and integrating community-based programs to support the discharge from inpatient services and preventing or substituting for hospitalisation. The relevant state policies and planning frameworks include:

- *Improving care for older people: a policy for health services (2003)* www.health.vic.gov.au/older/improvingcare.pdf A policy framework for the effective care of older people by health services, which focuses on integrating care across settings to ensure people have the appropriate care in the appropriate place.
- *Directions for your health system: Metropolitan Health Strategy (2003)*www.health.vic.gov.au/metrohealthstrategy/index.htm A policy and planning framework for providing health care services across metropolitan Melbourne, including an expanded role for ambulatory care services as a cornerstone in the configuration of health care services.
- *Rural directions for a stronger healthier Victoria (2009):* A policy and planning framework that is an update of; *Rural directions for a better state of health*. It provides an opportunity to build on what has already been achieved, outlines the next phase of continuing service development, and acknowledges the major support all health services provide for their rural communities. The framework contains three broad directions, with a revised focus to update development priorities. The three directions are; improving the health of rural Victorians, supporting a contemporary health system and strengthening and sustaining rural health services. www.health.vic.gov.au/ruralhealth
- *Care in your community: A planning framework for integrated ambulatory health care (2006)* www.health.vic.gov.au/ambulatorycare/downloads/care_in_your_community.pdf The framework encompasses all community-based ambulatory care services. The vision is for a modern, integrated and person-centred health system aimed to meet the future needs and

expectations of communities and individual users of health care services, and to provide integrated and accessible services in local communities.

- *Improving care: Hospital Admission Risk Program public report (2006)* www.health.vic.gov.au/harp-cdm/improvingcare.pdf This report is an independent evaluation of HARP that outlines the characteristics of HARP projects and the integration into ongoing services. It identifies key outcomes of HARP and provides direction for further development of HARP services.
- *Victorian services coordination practice manual (2007)* www.health.vic.gov.au/pcps/downloads/sc_pracmanual.pdf This manual defines the practices, processes, protocols and systems that support service coordination across Victoria.

2.2.3 Exclusions

It should be noted that there are numerous initiatives that potentially impact on health care delivery to older persons (such as improving care in Residential Aged Care facilities, health promotion and preventative health in older persons) have not been canvassed in this literature and environmental scan. Given the focus of the evaluation of the Victorian LSOP initiative we have restricted this review to issues impacting acute inpatient care of older patients and strategies to reduce emergency department attendances and inpatient care of older patients.

3 THE VICTORIAN LSOP INITIATIVE

The Victorian implementation plan for the COAG LSOP initiative funding built on two existing policy platforms - Improving Care for Older People (IC4OP) and the Hospital Admission Risk Program (HARP). This provided Victoria with an excellent opportunity to further expand and embed these initiatives across the state.

Victoria's COAG LSOP implementation plan focuses on improving the capacity of health services to provide more appropriate care for long-stay older patients in public hospitals and reducing avoidable or premature admission of older people to hospitals, particularly in rural areas.

Victoria's LSOP aims to prevent avoidable hospital admissions for older people. In the event that people do require a hospital stay the focus will be on improving the care older people receive and minimising their risk of functional decline.

Together these initiatives ultimately aim to prevent people reaching a 35-day stay in hospital and divert the potential requirement for residential aged care placement.

The COAG LSOP has allowed the extension of the work started in the IC4OP initiative into other areas including:

- Development in metropolitan settings including new health services being incorporated into the work to provide more appropriate care for long-stay older patients in public hospitals
- Extension of the initiative into rural settings while supporting rural and regional health settings to provide more appropriate care for long-stay older patients
- Reducing avoidable or premature admission of older people to public hospitals.

The initiative was implemented at 36 health services across the state, including 17 agencies already involved with the implementation of IC4OP, and an additional 19 health services.

The LSOP program is also informed by work undertaken with the support of the Department of Health in Victorian public hospitals over the past decade to improve care of older patients within initiatives such as:

- HARP CDM
- Acute to Subacute Breakthrough Collaborative
- Process Redesign

Several other program areas relate to the initiative

- Transition Care Program
- Aged Care Assessment Program
- Common assessment tool & wait list registers
- Residential Aged Care Service sector initiatives

The guidelines Best practice approaches to minimise functional decline in the older person across the acute, sub-acute and residential aged care settings commissioned by the Australian Health Ministers Advisory Council (HCOASC) were used as a platform for the development and implementation of a functional decline prevention program.

4 EVIDENCE BASE

Traditionally, acute care for older patients in most hospitals in the developed world has not been differentiated from that provided to younger adults[4-7]. Even when older patients with acute illnesses are placed geographically together in the same hospital ward, their care-plans are often extrapolated from the biomedical model used in younger adults, which focuses on the treatment of single system diseases that immediately precede hospitalization.

When acutely ill elderly patients have an illness that requires hospitalization, they frequently experience functional decline. Elements of hospitalization, including iatrogenic illnesses, bed-rest and immobility can contribute to a poor result, leading to prolonged hospital stays, nursing home placement, and death. Too often, this decline is accepted as an inevitable outcome of hospitalization.

Frail older persons presenting with multiple illnesses at hospital admission are at greatest risk of experiencing a downward trajectory in their well-being during hospitalisation. Frailty refers to the vulnerability of older persons to adverse outcomes, such as cognitive impairment, side effects from polypharmacy and immobilization, and iatrogenesis, all of which are common complications that arise during hospitalization[4-16]. These contribute to a vicious cycle of further physical, mental and functional decline, which in turn results in social dependency and higher institutionalization rates[4-22].

4.1 Approaches to improving acute hospital care of the older patients

Increasingly, older adults are recognised to be the core business of hospitals and health systems in the developed world[3]. Patients 65 and older already constitute the largest volume of care these facilities provide[3]. Nevertheless, service divisions and service providers too often opt out, by custom or inclination, from seeking to deliver higher-quality and more cost-effective care for older patients. Several interventions have been proposed to improve the effectiveness and efficiency of hospital care for older people with acute medical disorders.

In-hospital geriatric units are not new[10, 15, 22]. Geriatric evaluation and management units (GEMU) were initially set-up in the 1980's and have been successful in improving functional outcomes of older patients with multiple medical and functional problems[22]. However, GEMUs traditionally target patients with subacute medical illnesses, or at least when patients' acute illnesses have stabilized. Such assessment of geriatric patients by a multidisciplinary consultation team has not shown benefits for case fatality, functional decline, or place of residence at discharge.

Adequate hospital care for older people (≥65 years) with acute medical disorders requires a comprehensive assessment by multidisciplinary teams to detect early those patients at highest risk of functional decline and institutionalisation. Such care also requires early planning for discharge, and follow-up. The primary aim of this model of care is to reduce functional decline, which is the main determinant of quality of life, cost of care, and vital prognosis. Delaying functional decline and increasing the chances of living at home are at least as important as effective treatment of the disease prompting their acute hospital admission in reducing case fatality in frail older people.

Fortunately not all health services have been satisfied with *historical* approaches to care of the acutely ill older patient. In 1989, doctors and nurses at the University Hospitals of Cleveland (UHC) developed an intervention that redesigned hospital care for elders. They created a new hospital unit specifically designed to incorporate home-like features and help patients be as active as possible and involved in

their care and the workings of the facility. The result was the Acute Care for Elders (ACE) unit, which integrated geriatric assessment into the medical and nursing care of older patients using an interdisciplinary team[5].

The ACE unit team, jointly led by the medical director and nurse manager, developed guidelines for optimal medical care for older patients, and collected them into a care manual. The hospital modified the physical environment of the unit to encourage patient mobility and self-care and to create a more home-like feel. When the unit began operations, it commenced daily rounds by the entire interdisciplinary team.

During rounds, the team reviewed the status of each patient and the therapeutic goals for the hospitalization and length of stay. Rounds included a focus on preventing functional decline and developing a plan of care for going home from the hospital and home care needs.

Intensive medical care review was employed to prevent complications due to medicines and procedures. Nearly five months after UHC created the ACE unit, a clinical trial evaluated the unit's effectiveness. It found that patients in the ACE unit had better functional outcomes than patients receiving usual care, and fewer ACE patients were discharged to long-term care institutions. Costs of care for both units were comparable[5,7].

In subsequent studies, costs of care for ACE unit patients were less than those for patients receiving usual care[7, 10, 11 and 18]. Since the original reports of its success the ACE model has been replicated at many academic medical centres and community hospitals throughout the United States, Canada and Europe. The model has also been applied to special populations, such as patients in stroke and cardiology units. ACE units have also been found, anecdotally, to influence providers' care and treatments for non-ACE patients, as well, resulting in better care across the hospital[8].

Studies have shown that patient and nursing satisfaction is generally higher in ACE units than on traditional hospital floors[4-6, 12-40]. ACE units produce cost savings or remain budget neutral; with initial development costs offset by shorter lengths of stay and reduced patient costs[7, 10,11,18,32]. The units have also been shown to make more efficient use of scarce hospital staff, concentrating staff efforts on patients who need more care[7, 10,11,18,32].

The ACE model has been widely acknowledged as a tool to improve care quality and prevent functional decline among elders in the hospital[5-40]. But, because it requires a change in hospital design and culture, it takes commitment from all levels of leadership and perseverance to make the model succeed.

The ACE model addresses functional decline by redesigning hospital care. It employs an interdisciplinary team that provides care based on proven, effective practices. Skilled interdisciplinary staff and trained volunteers implement intervention protocols targeted toward six delirium risk factors: orientation, therapeutic activities, early mobilization, vision and hearing optimization, oral volume repletion, and sleep enhancement. The program is designed to be superimposed on existing hospital units and does not require a separate, dedicated geriatric unit. It prepares the hospital environment to "fit the patient," encouraging patient mobility and creating a home-like feel. Medical and nursing review is employed to prevent complications from medicines and procedures[5-40].

A similar intensive intervention program, *'The Hospital Elder Life Program (HELP)'* has been shown to be both successful and cost-effective in reducing episodes of delirium and functional decline in hospitalised older adults[4,6,30,31,118].

4. Evidence Base

A systematic review of the evidence supporting specific care teams, focusing on acute care in the elderly[9] concluded, that there is some moderate quality evidence to suggest that an ACE model of care may reduce mortality, improve functional ability and increase the number of patients discharged to home rather than long-term care in selected populations of older patients. ACE units result in significant differences in process of care and drug profiles of the patients and there are no significant increases in the costs of treating patients in an ACE unit as compared to a usual care unit[5-118].

A recent meta-analysis of care of acutely ill older patients by multidisciplinary geriatric teams in ACE or acute geriatric units[117,] confirmed that care of people aged 65 or more with acute medical disorders in such units produces a functional benefit compared with conventional hospital care (i.e. an18% reduction in functional decline) and increases the likelihood of living at home after discharge[117].

Given these successes in improving the quality and value of acute care of the older patient in hospital, a systematic, tailored approach to the provision of medical services to older patients should now be an integral part of any acute health centre's strategic plan. Indeed it will hopefully become the 'next big thing' in acute healthcare.

Increasing nurses' competence in caring for older patients while creating systematic change [see NICHE (Nurses Improving Care to Health system Elders) at www.nicheprogram.org] can bring evidence-based practices to hospital care and lead to better patient outcomes and staff retention.

After training, Geriatric Resource Nurses are a relatively low-cost option for putting knowledge about best practice in care of the older patient across into inpatient units and clinics. Hospitals have also reported impressive results using a geriatrician co-management models to ensure that patients receive appropriate care[115-117].

Better care for older patients requires efficient management of transitions between health care settings represents another opportunity where health systems can improve their performance[119-131]. Transfers between the hospital, rehabilitation centre, nursing home, and other settings can be highly stressful for patients and carers. Because geriatricians, geriatric nurses and social workers are more aware of particular vulnerabilities older patients face in transfers, and because they are comfortable working across settings, these clinicians can make major contributions to ensuring patient safety and satisfaction during care transitions. Appropriately trained and experienced clinicians also are aware of the importance of the efficient transfer of comprehensive information during patient care transitions—especially for older adults who may have complicated health problems and treatment regimens involving multiple providers.

Unplanned readmission to hospital, typically defined as hospital readmission within 30 days of a hospital discharge, is a common, expensive, and life threatening event too often associated with gaps in follow-up care[119-126]. New evidence shows that when hospitals focus on the discharge process, patient care and safety improve and costs decline[125, 126]. Given these advantages, it is difficult to understand why more hospitals have not already overhauled their patient discharge protocols. The answer is counterintuitive: until recently, properly planned, communicated, and executed hospital discharges have not been a primary focus for hospitals or clinicians.

Studies have shown that many patients do not understand their discharge medications and cannot recall their primary diagnoses[119-126]. Discharge summaries, for example, often lack critical data and are often not sent to the primary care physician promptly; clinicians are unaware of test results prior to discharging patients; and evaluations scheduled to be performed post discharge are often not completed. Patient discharge is variable, fragmented, and characterized by poor communication,

leaving many patients unprepared to care for themselves or to know how or when to seek follow-up care. This, in turn, is a reason why readmission occurs so frequently, research has found[125, 126]. New research findings provide a detailed road map that shows how to reduce a sizable percentage of readmission. A study funded by the Agency for Healthcare Research and Quality (AHRQ) found that patients who have a clear understanding of their after-hospital care instructions are 30% less likely to be readmitted or visit the ED than patients who lack this information[126].

4.2 Approaches to reducing use of acute hospital care in older patients

A large body of literature supports the effectiveness of *'Chronic Disease Management (CDM) '*in improving the outcomes of older patients with chronic disease and reducing their dependency on use of acute hospital services[127-143]. A recent systematic review of CDM in the Australian context[143] confirmed that such programs work. The interventions most likely to be effective in the context of Australian primary care were engaging primary care in self-management support through education and training for general practitioners and practice nurses, and including self-management support in care plans linked to multidisciplinary team support[143].

Indeed it could be said that preventing chronic disease and promoting healthy lifestyles should be the cornerstones of contemporary health care systems. To maximize efficiencies and improve health outcomes for people with a chronic disease, more attention needs to be focused on implementing effective and sustainable primary health care programs. It is possible to design and implement effective, PHC team-based approaches to CDM. The *recipe* for success includes, but is not limited to:

- effective communication
- patient centred programs
- clinician engagement
- community involvement and empowerment
- community outreach
- strong support from senior leadership.

Leadership, an interdisciplinary team approach, an electronic database, patient self management tools and support, and the monitoring of health outcomes are known to be basic components for the application of primary care team-based approaches to CDM within communities[134].

To be successful, not all systems need to be the same, but these key concepts are essential for program implementation and sustainability.

4.3 Towards making 'usual care' 'best practice' care

It is all very well having knowing what evidence based best practice for hospital care of the acutely ill older patient or CDM looks like. It is necessary to ensure that two additional steps follow awareness regarding best practice care in any particular context[134]:

1. That consultation between stakeholders and policymakers shape policy options that support the implementation of best practice care.
2. That best practice dissemination strategies are designed and implemented so that everyday care becomes best practice care in the targeted service delivery environments.

4. Evidence Base

The effective translation of scientific evidence into clinical practice is of paramount importance to ensure that patients and the broader community benefit from scientific research[118]. Substantial resources are devoted to developing and testing the efficacy of clinical innovations that improve the health of patients and their families.

Yet translating such innovations into practice remains a major challenge. There are numerous examples of evidence-based programs and interventions that are only partially adopted into clinical practice, if adopted at all[118].

The failed translation of research into clinical practice has caught the attention of funding bodies that want to support efforts to improve the quality of care. There is growing concern over the limited resources available to ensure the adoption of effective and beneficial health care innovations. It becomes all the more important to understand which methods work best. There are several key lessons for those wishing to translate best practice into everyday practice[118].

Table 4-1: Key Lessons Learned About Diffusing Innovation into Practice

***Lesson* 1**	The strong support of senior management at the adopting organizations increases the success of adoption.
***Lesson* 2**	Effective clinical leadership in the adopter organizations speeds adoption.
***Lesson* 3**	Data to support start-up, implementation, and ongoing evaluation must be credible and persuasive to those who influence budget decisions.
***Lesson* 4**	The speed of adoption is influenced by the degree to which the innovation requires changes in organizational culture.
***Lesson* 5**	The diffusion process is slowed when the effort requires coordination across departments or disciplines.
***Lesson* 6**	Plan for program sustainability from the start. To speed adoption, create a specific infrastructure with resources and expertise devoted to diffusion.
***Lesson* 7**	The relationship between the dissemination infrastructure and the adopting organizations affects the speed of adoption.
***Lesson* 8**	The perceived ability of an innovation to reduce external threats can influence the speed of its diffusion.

A recent study examining key factors that influence sustainability following the diffusion of an evidence-based, multifaceted, innovative program to improve care for hospitalized older adults[141] found three critical factors that influenced whether the program was sustained:

1. The presence of clinical leadership
2. The ability and willingness to adapt the original protocols to local hospital circumstances and constraints, and
3. The ability to obtain longer-term resources and funding for the program.

This and related studies have revealed important lessons on how to speed along the translation process[1140, 141]. First, the roles of senior management, clinical leadership, and credible data are

important to success. Second, diffusion does not occur spontaneously. It requires the creation of an infrastructure dedicated to translating the innovation from a research setting into a practice setting.

Finally, specific features of the innovation and the diffusion effort are central to the speed and success of diffusion. The translation process also depends on the characteristics and resources of the adopting organization, and on the degree to which people believe that the innovation responds to immediate and significant pressures in their environment.

From these lessons in spreading and sustaining change in healthcare a set of "best practices" have been developed for diffusing new, evidence-based programs into clinical practice:

Table 4-2: Best Practices to Speed the Translation of Evidence-Based Innovations in Clinical Practice, Based on Four Case Studies

#1	Target diffusion efforts toward organizations that have or can develop strong senior management support for adoption of the innovation.
#2	Identify and support clinical champions in the adopter organization who can enhance buy-in from clinicians.
#3	Develop simple methods of collecting and reporting data that will be credible to the organization, and that demonstrate the program is fulfilling the organization's strategic goals.
#4	Expect the diffusion to take longer if it involves changes in the adopting organization's culture or extensive interdepartmental collaboration.
#5	Plan for sustainability from inception, and invest adequately in the infrastructure needed to manage the dissemination and diffusion process.
#6	Anticipate changes in the external environment and demonstrate how the innovation can help the organization adapt to market and regulatory pressures.

5 OTHER RELATED INITIATIVES

Over the past decade there have been a range of clinical practice improvement projects undertaken in Australia and internationally where the application of knowledge regarding the preferred methods for dissemination of best practice in healthcare is being used to improve care of older patients.

A synopsis of key initiatives is provided in the following tables.

NATIONAL PROGRAMS

LOCATION	TARGET POPULATION	ACTIONS
ACT	Older Patients	Age-friendly principles incorporated into ACRS guidelines.
	Older Patients	The ACT has distributed copies of national best practice documents (such as Best practice approaches to minimise functional decline in the older person across acute, sub-acute and residential aged care setting and A guide for assessing older people in hospitals) to all acute healthcare facilities in ACT who have developed strategies developed to implement
	Older Patients	ACRS have developed admission assessment form with tools incorporated
	Older Patients	Established Medical assessment and planning unit (MAPU) at the Canberra Hospital in 2007. MAPU is a new 14-bed unit, designed as a short-stay ward, intended for patients over the age of 75 that has been specifically staffed and equipped to receive patients from the emergency department for comprehensive assessment, care and treatment.
	Older Patients	The Access Improvement Program education initiative for emergency department staff supports to effective triage and management of the older person at presentation and reduces waiting time in the emergency department. A discharge planning redesign process commencing supported improved assessment and management of older patients in hospital
NSW	The Redesign Program delivered over 75 redesign projects across the NSW health system focused on improving patient journeys to deliver better patient experiences and improve overall performance, quality and safety. The development of care pathways through the NSW Clinical Service Redesign Program included the mapping of the journeys of older people through the continuum of care to identify opportunities for improved care. These projects included:	OPERA (Older Persons Evaluation Review and Assessment) http://www.archi.net.au/e-library/moc/older-moc/opera ACE (Acute care of the Elderly) http://www.archi.net.au/e-library/moc/older-moc/ace Transitional Aged Care http://www.archi.net.au/e-library/moc/older-moc/transitional Delirium prevention http://www.archi.net.au/e-library/moc/older-moc/delirium Falls prevention http://www.archi.net.au/e-library/moc/older-moc/falls HOPE (Healthcare for Older People) http://www.archi.net.au/e-library/performance/avoidable/healthcare-older ASET (Aged Care Services in Emergency) http://www.nscchealth.nsw.gov.au/services/hornsby/hkhs/asetmain.htm GRACE (Geriatric Rapid Acute Care Evaluation) http://www.nscchealth.nsw.gov.au/services/hornsby/hkhs/gracemain.htm AARCS (Acute to Aged-related Services) with responsibility for establishing and maintaining formal processes for the early identification of older patients who are likely to require specific aged care intervention, rehabilitation or entry to an aged care place on discharge. This is done by providing specialist input into comprehensive assessment and care planning for those patients via a case management model. AARCS coordinators take a lead role and work in close conjunction with inpatient health care teams to facilitate appropriate care, timely referral, assessment and ACAT approval and

5. Other Related Initiatives

LOCATION	TARGET POPULATION	ACTIONS
		the provision of information to assist older patients and their carers/families to negotiate the entry process to appropriate residential or community-based care. *ComPacks, a joint discharge program between multidisciplinary health teams and non health community case managers. It is designed to assist patients to leave hospital and return to functionality in a timely manner. The focus is on maximising patient independence and capacity in line with their preferences and goals while helping to manage demand across the health system. ComPacks clients are patients whose hospital length of stay may have been extended, or is at risk of being extended, because of difficulties or concerns about the availability of community support services needed to allow the person to leave hospital. ComPacks aims to optimise patient access to the community services they need for a safe and supported return home.* http://www.archi.net.au/e-library/moc/community-moc/compacks
NT	*Older patients*	*Developed a screening tool and screening process for older patients at Royal Darwin Hospital emergency department. Developed a model of care that provided Older Patients access to immediate multidisciplinary assessment and expertise for older patients within the emergency department of Royal Darwin Hospital.*
	Older Patients	*Distributed key national documents to all NT hospitals and health centres.*
Queensland	*Older patients*	*Mandatory screening, assessment and referral pathway of all HACC clients using the Ongoing Needs Identification (ONI) implemented.*
	Older Patients	*Early Intervention for the Elderly Program developed a care pathway for the admission of aged persons entering the emergency department after hours (early risk screening and care planning) at PAH.*
	Older Patients	*Client-centred care training has been provided for all personal care workers and therapy assistants in Queensland Health. Statewide training has been provided for the community rehabilitation workforce.*
	Older Patients	*The Clinical practice guidelines for the management of delirium in older people was distributed throughout Queensland and used as a supplementary teaching aid in the Central Area Health Service.*
	Older Patients	*Stroke care Pathway has been administered to all relevant CAHS Services including the Rural Stroke Outreach Service. The Stroke care pathways complemented other initiatives for stroke management.*
SA	*Older Patients*	*The SA Department of Health distributed copies of the age-friendly principles and practices to hospitals, health centres and aged care services providers throughout the state and provided funding for a12-month project to disseminate the guidelines.*
	Older Patients	*There were training forums across all of the released best practice guidelines including: A guide for assessing older people in hospital, Stroke care pathways, Best practice approaches to minimise functional decline and the Delirium guidelines.*
Tasmania	*Older Patients*	*Have implemented HALT (Hospital Aged Care Liaison Team) into LGH which provide single referral point for GP's & RACF's, early ED assessment and tracking of the whole patient/resident journey in hospital and an Outreach service to RACF's*

5. Other Related Initiatives

LOCATION	TARGET POPULATION	ACTIONS
WA	*In WA the three core elements of the Long Stay Older Patients Initiative are:*	*1. Implementing the Australian Health Minister's Advisory Council National Action Plan to provide age friendly services across all health service regions and health sites;* *2. Enhancing system-wide coordination for older patients accessing aged care services and improve their management on entry to and as an inpatient of acute care through the establishment of an eldercare pathway;* *3. Strengthen existing hospital strategies, especially emergency department initiatives, to reduce avoidable admissions of older patients to hospital.*
	Older Patients	*WA's model of care for aged care drew on the policy and principles laid down through the National Action Plan and associated age friendly principles. The model also builds on the objectives and progress of the WA State aged care plan 2003–2008 http://www.health.wa.gov.au/waacac/publications /docs/AgedCare.pdf*
	Older Patients	*WA have developed models of care for older patients http://www.healthnetworks.health.wa.gov.au/modelsofcare/docs/Older_Person_Model_of_Care.pdf and for geriatric assessment and management http://www.healthnetworks.health.wa.gov.au/modelsofcare/docs/GEM_Model_of_Care.pdf and implemented CCT (Care Coordination Teams) into several public hospitals in WA.*

INTERNATIONAL PROGRAMS

PROGRAM & LOCATION	TARGET POPULATION	ACTIONS
Boston Medical Centre *Re-Engineered Discharge/RED* *http://www.bu.edu/fammed/projectred/*	*All adult BMC patients*	*Patient education; comprehensive discharge planning; AHCP; post-discharge phone call for medication reconciliation*
Transitional Care Model (TCM) *http://www.transitionalcare.info/*	*High-risk, elderly patients with chronic illness*	*Care coordination; risk assessment; development of evidence-based plan of care; home visits and phone support; patient and family education*
Kaiser Permanente Chronic Care Coordination *http://www.innovativecaremodels.com/care_models/13/overview*	*Patients with four or more chronic illnesses; recently discharged; high ED utilization or recently discharged from a SNF*	*Multidisciplinary chronic care team; needs-based care plans; patient communications via phone*
IHI Transition Home for Patients with Heart Failure: St. Luke's Hospital *http://www.ihi.org/IHI/Programs/StrategicInitiatives/TransformingCareAtTheBedside.htm*	*Patients with congestive heart failure*	*Admission assessment for post-discharge needs; teaching and learning; early post-acute care follow-up; patient and family centered handover*
INTERACT *http://www.cfmc.org/caretransitions/files/Ouslander%20Care%20Transitions%20Call%20Presentation%20030308.pdf*	*Nursing home patients*	*Care paths, communication tools, advance care planning tools, risk appraisal*
Project BOOST *http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/CT_Home.cfm*	*Older adults*	*Medication reconciliation; general assessment of preparedness (GAP); teach-back; patient/caregiver education; communication; phone follow-up*

5. Other Related Initiatives

PROGRAM & LOCATION	TARGET POPULATION	ACTIONS
HealthCare Partners Medical Group *http://www.healthcarepartners.com/*	*Uses risk assessment to stratify patients and match to four levels of programs; special programs for frail patients*	*Self-management and health education; complex case management; high-risk clinics; home care management; disease management*
John Muir Physician Network *Transforming Chronic Care (TCC) Program* *http://www.johnmuirhealth.com/index.php/chronic_care_referral_program.html*	*Eligible frail patients—most have heart failure, COPD, or diabetes*	*CTI; complex case management; disease management*
Sharp Rees-Stealy Medical Group *http://www.sharp.com/rees-stealy/*	*High-risk patients, including all discharged from hospital or ED*	*Continuity of Care Unit (CCU); Telescale for HF patients; Transitions program for those near end-of-life*
St. Luke's Hospital, Cedar Rapids, IA *Transitions Home for Patients with Heart Failure* *http://www.innovations.ahrq.gov/content.aspx?id=2206*	*Heart failure patients in pilot*	*Patient education using —teach-back‖; home visit; post-discharge phone call; outpatient classes*
State Action on Avoidable Rehospitalisation (STAAR) *http://www.ihi.org/IHI/Programs/StrategicInitiatives/STateActiononAvoidableRehospitalizationsSTAAR.htm*	*All patients*	*Enhanced assessment of post-discharge needs; enhanced teaching and learning; enhanced communication at discharge; and timely post-acute follow-up*
Summa Health System, Akron, OH *http://www.summahealth.org/*	*Low-income frail elders with chronic illnesses in community-based long-term care*	*Risk appraisal; integrated medical and psychosocial care based on Naylor and Coleman models*
Colorado foundation for Medical Care (CFMC) *Care Transitions Intervention (CTI), pilot project* *http://www.cfmc.org/*	*Elderly clinic patients, medical beneficiaries who have been hospitalized*	*Hospital visit, home visit, and follow-up calls by coach, focusing on the four CTI pillars*
Visiting Nurse Service of New York (VNSNY) *http://www.vnsny.org/*	*Nursing Home patients post-hospitalization*	*Risk assessment with stratified interventions; self-management support*
Project RED (Re-Engineered Discharge) *http://www.bu.edu/fammed/projectred/index.html*	*Older adults*	*Medication reconciliation; general assessment of preparedness (GAP); teach-back; patient/caregiver education; communication; phone follow-up*
Care Transitions Program *http://www.caretransitions.org/*	*Older adults*	*Medication reconciliation; general assessment of preparedness (GAP); teach-back; patient/caregiver education; communication; phone follow-up*

6. References

6 REFERENCES

1. Improving care for older people initiative Achievements report: January 2005–December 2007. Published on www.health.vic.gov.au/subacute November 2008 (081017)
2. National Evaluation of the Transition Care Program. Australian Government Department of Health and Ageing. 2008.
3. AIHW. Older Australians in Hospital. Bulletin 53. August 2007.
4. Inouye SK, Bogardus ST Jr, Baker DI, et al. The Hospital Elder Life Program: a model of care to prevent cognitive and functional decline in older hospitalized patients. J Am Geriatr Soc 2000;48:1697–706.
5. Landefeld, C.S., Palmer, R.M., Kresevic, D.M., Fortinsky, R., and Kowal, J. A randomized trial of care in a hospital medical unit especially designed to improve the functional outcomes of acutely ill older patients. *New England Journal of Medicine,* 1995, 332(20): 1338-1344.
6. Inouye SK, Bogardus ST Jr, Charpentier PA, et al. A multicomponent intervention to prevent delirium in hospitalized older patients. N Engl J Med 1999;340:669–76.
7. Rizzo JA, Bogardus ST Jr, Leo-Summers L, et al. Multicomponent targeted intervention to prevent delirium in hospitalized older patients: what is the economic value? Med Care 2001;39:740–52.
4. Leslie DL, Zhang Y, Bogardus ST, et al. Consequences of preventing delirium in hospitalized older adults on nursing home costs. J Am Geriatr Soc 2005;53:405–9.
5. Allen, K and Turner, T. Effectiveness of Acute Care of the Elderly (ACE) Units, Melbourne, Victoria: Centre for Clinical Effectiveness, Southern Health. 2008.
6. Collard AF, Bachman SS, Beatrice DF. Acute care delivery for the geriatric patient: an innovative approach. Qual Rev Bull 1985 11: 180-5.
7. Harris RD, Chalmers JP, Henschke PJ, Tonkin A, Popplewell PY, Stewart AM et al. A randomized study of outcomes in a defined group of acutely ill elderly patients managed in a geriatric assessment unit or a general medical unit. Aust NZ J Med 1991; 21: 230-4.
8. Covinsky KE, King JT, Quinn L, Siddique R, Palmer R, Kresevic DM et al. Do acute care for elders units increase hospital costs? A cost analysis using the hospital perspective. J Am Geriatr Soc 1997; 45: 729-34.
9. Asplund K, Gustafson Y, Jacobsson C, Bucht G, Wahlin A, Peterson J. Geriatric-based versus general wards for older acute medical patients: a randomized comparison of outcomes and use of resources. J Am Geriatr Soc 2000; 48: 1381-1388.
10. Counsell SR, Holder CM, Liebenauer LL, Palmer R, Fortinsky RH, Kresevic DM. Effects of a multicomponent intervention on functional outcomes and process of care in hospitalized older patients: a randomized controlled trial of acute care for elders (ACE) in a community hospital. J Am Geriatr Soc 2000; 48: 1572-1581.
11. Meissner P, Andolsek K, Mears PA, Fletcher B. Maximizing the functional status of geriatric patients in an acute community hospital setting. Gerontologist 1989; 29: 524-8.
12. Stewart M, Suchak N, Scheve A, Popat-Thakkar V, David E, Laquinte J et al. The impact of a geriatrics evaluation and management unit compared to standard care in a community teaching hospital. Md Med J (Maryland) 1999; 48 (2): 62-7.

6. References

13. Wong RY, Chittock DR, Malean N, Wilbur K. Discharge outcomes of older medical in-patients in a specialized acute care for elders unit compared with non-specialized units. Can J Geriatr 2006; 9: 96-101.
14. Zelada MA, Salinas R, Baztán JJ. Reduction of functional deterioration during hospitalization in an acute geriatric unit. Arch Gerontol Geriatr (2007), doi: 10.1016/j.archger.2007.09.008
15. Barrick C, Karuza J, Levitt J. Impacting quality: assessment of a hospital-based geriatric acute care unit. Am J Med Quality 1999; 14: 133-7.
16. Jayadevappa R, Chatre S, Weiner M, Raziano DB. Health resource utilization and medical care cost of acute care elderly unit patients. Value in Health 2006; 9: 186-92. 2
17. Barker WH, Williams TF, Zimmer JG. Geriatric consultation teams in acute hospitals: Impact on back-up of elderly patients. J Am Geriatr Soc 1985; 33:422-8.
18. Campion EW, Jette A, Berkman B. An interdisciplinary geriatric consultation service: A controlled trial. J Am Geriatr Soc 1983; 31 :792-6.
19. Cole MG, Fenton FR, Engelsmann F, Mansouri I. Effectiveness of geriatric psychiatry consultation in an acute care hospital: A randomized clinical trial. J Am Geriatr Soc 1991; 39:1183-8.
20. Fretwell MD, Raymond PM, McGarvey ST, Owens N, Traines M, Silliman RA et al. The senior care study: A controlled trial of a consultative/unit-based geriatric assessment program in acute care. J Am Geriatr Soc 1990; 38:1073-81.
21. Friedman G, Brodsky J, Bentur N, Ben-Yehuda A, Stern Z, Isaacs B. Evaluation of a geriatric consultation unit in an acute university hospital. Aging Clin Exp Res 1995; 7: 234-6.
22. Gayton D, Wood-Dauphinee S, Lorimer M, Tousignant P, Hanley J. Trial of a geriatric consultation team in an acute care hospital. J Am Geriatr Soc 1987; 35: 726-36.
23. Hogan DB, Fox RA, Badley BWD, Mann OE. Effect of a geriatric consultation service on management of patients in an acute care hospital. Can Med Assoc J 1987; 136:713-7.
24. Hogan DB. Impact of geriatric consultation services for elderly patients admitted to acute care hospitals. Can J Aging 1990; 9:35-44.
25. Hogan DB, Fox RA. A prospective controlled trial of a geriatric consultation team in an acute-care hospital. Age Ageing 1990; 19:107-13.
26. Inouye SK, Wagner DR, Acampora D, Horwitz RI, Cooney LM, Tinetii ME. A controlled trial of a nursing-centered intervention in hospitalized elderly medical patients: the Yale Geriatric Care Program. J Am Geriatr Soc 1993; 41):1353.-60.
27. Inouye SK, Acampora D, Miller RL, Fulmer T, Hurst LD, Cooney LM. The Yale Geriatric Care Program: A model of care to prevent functional decline in hospitalized elderly patients. J Am Geriatr Soc 1993; 41: 1345-52.
28. Kircher TTJ, Wormstall H, Muller PH, Schwarzler F, Buchkremer G, Wild K, et al. A randomised trial of a geriatric evaluation and management consultation services in frail hospitalised patients. Age Ageing 2007; 36:36-42. 3
29. McVey LJ, Becker PM, Saltz CC, Feussner JR, Cohen HJ. Effect of a geriatric consultation team on functional status of elderly hospitalized patients. A randomized, controlled clinical trial. Ann Intern Med 1989; 110:79.-84.

6. References

30. Naughton BJ, Moran MB, Feinglass J, Falconer J, Williams ME. Reducing hospital costs for the geriatric patient admitted from the emergency department: A randomized trial. J Am Geriatr Soc 1994; 42:1045-9.

31. Owens NJ, Sherburne NJ, Silliman RA, Fretwell MD. The senior care study: The optimal use of medications in acutely ill older patients. J Am Geriatr Soc 1990; 38:1082-7.

32. Reuben DB, Borok GM, Wolde-Tsadik G, Ershoff DH, Fishman JK, Ambrosini VL, et al. A randomized trial of comprehensive geriatric assessment in the care of hospitalized patients. New Engl.J.Med 1995; 332:1345-50.

33. San Jose A, Vilardell M. Functional interdisciplinary geriatrics units in general hospitals. Functioning and analysis of effectiveness. Med Clin (Barc) 1996; 106:336-43.

34. Silliman RA, McGarvey ST, Raymond PM, Fretwell MD. The Senior Care Study. Does inpatient interdisciplinary geriatric assessment help the family caregivers of acutely ill older patients?. J Am Geriatr Soc 1990; 38:461.-6.

35. Slaets JP, Kauffmann RH, Duivenvoorden HJ, Pelemans W, Schudel WJ. A randomized trial of geriatric liaison intervention in elderly medical inpatients. Psychosomatic Medicine 1997; 59:585-91.

36. Styrborn K. Early discharge planning for elderly patients in acute hospitals - An intervention study. Scand J Soc Med 1995; 23:273-85.

37. Thomas DR, Brahan R, Haywood BP. Inpatient community-based geriatric assessment reduces subsequent mortality. J Am Geriatr Soc 1993; 41:101-4.

38. Winograd CH, Gerety MB, Lai NA. A negative trial of inpatient geriatric consultation. Lessons learned and recommendations for future research. Arch Intern Med 1993; 153:2017-23.

39. Applegate WB, Miller ST, Graney MJ, Elam JT, Burns R, Akins DE. A randomized, controlled trial of a geriatric assessment unit in a community rehabilitation hospital. New Engl J Med 1990; 322:1572-8.

40. Applegate WB, Graney MJ, Miller ST, Elam JT. Impact of a geriatric assessment unit on subsequent health care charges. Am J Public Health 1991; 81:1302-6.

41. Cohen HJ, Feussner JR, Weinberger M, Carnes M, Hamdy RC, Hsieh F, et al. Controlled trial of inpatient and outpatient geriatric evaluation and management. New Engl J Med 2002; 346: 905-12.

42. Garäsen H, Windspoll R, Johnsen R. Intermediate care at a community hospital as an alternative to prolonged general hospital care for elderly patients: a randomised controlled trial. BMC Public Health 2007; 7: 68

43. Karppi P. Effects of a geriatric inpatient unit on elderly homecare patients: A controlled trial. Aging Clin Exp Res 1995; 7:207-11. 4

44. Karppi P, Tilvis R. Effectiveness of a Finnish geriatric inpatient assessment. Two-year follow up of a randomized clinical trial on community-dwelling patients. Scand J Prim Health Care 1995; 13:93-8.

45. Lefton E, Bonstelle S, Frengley JD. Success with an inpatient geriatric unit: a controlled study of outcome and follow-up. J Am Geriatr Soc 1983; 31:149-55.

46. Nikolaus T, Specht-Leible N, Bach M, Oster P, Schlierf G. A randomized trial of comprehensive geriatric assessment and home intervention in the care of hospitalized patients. Age Ageing 1999; 28:543-50.

6. References

47. Rubenstein LZ, Josephson KR, Wieland GD, English PA, Sayre JA, Kane RL. Effectiveness of geriatric evaluation unit. A randomized clinical trial. New Engl J Med 1984; 311: 1664-70.

48. Rubenstein LZ, Wieland GD, Josephson KR, Rosbrook B, Sayre J, Kane RL. Improved survival for frail elderly inpatients on a geriatric evaluation unit (GEU): who benefits? J Clin Epidemiol 1988; 41: 441-9.

49. Rubenstein LZ, Stuck AE, Siu AL, Wieland D. Impacts of geriatric evaluation and management programs on defined outcomes: Overview of the evidence. J Am Geriatr Soc 1991; 39 (supple):8S-16S.

50. Rubenstein LZ, Josephson KR, Harker JO, Miller DK, Wieland D. The Sepulveda GEU study revisited: Long-term outcomes, use of services, and costs. Aging Clin Exp Res 1995; 7: 212-7.

51. Salva A, Vellas B, Roig T, Albarede JL. Evaluación geriátrica. Primeros resultados de una unidad de evaluación geriátrica. Rev Gerontol 1994; 4: 174-9

52. Trentini M, Semeraro S, Rossi E, Giannandrea E, Vanelli M, Pandiani G, et al. A multicenter randomized trial of comprehensive geriatric assessment and management: Experimental design, baseline data and six-month preliminary results. Aging Clin Exp Res 1995; 7:224-33.

53. White SJ, Powers JS, Knight JR, Harrell D, Varnell L, Vaughn C, et al. Effectiveness of an inpatient geriatric service in a university hospital. Journal of the Tennessee Medical Association 1994; 87:425.-8.

54. Wooldridge DB, Parker G, MacKenzie PA. An acute inpatient geriatric assessment and treatment unit. Clin Geriatr Med 1987; 3:119-129.

55. Young J, Green J, Forster A, Small N, Lowson K, Bogle S et al. Postacute care for older people in community hospitals: A multicenter randomized, controlled trial. J Am Geriatr Soc 2007; 55;1995-2002.

56. Powell C, Montgomery P. The age study: the admission of geriatric patients through emergency. Age Ageing 1990; 19 (suppl 1): 21

57. Saltvedt I, Opdahl-Mo ES, Fayers P, Kaasa S, Sletvold O. Reduced mortality in treating acutely sick, frail older patients in a geriatric evaluation and management unit. A prospective randomized trial. J Am Geriatr Soc 2002; 50:792-8. 5

58. Saltvedt I, Saltnes T, Opdahl-Mo ES, Fayers P, Kaasa S, Sletvold O. Acute geriatric intervention increases the number of patients able to live at home. A prospective randomized study. Aging Clin Exp Res 2004; 16: 300-6.

59. Saltvedt I, Jordhoy M, Opdahl-Mo ES, Fayers P, Kaasa S, Sletvold O. Randomised trial of in-hospital geriatric intervention: Impact on function and morale. Gerontology 2006; 52: 223-30.

60. Stewart DA, Burns JM, Beard K, Dall JL, Lennox IM, Roberts MA, et al. The roles of general and geriatric medicine in the provision of acute medical care for elderly patients. Health Bulletin 1992; 50:259.-66.

61. Teasdale TA, Shuman L, Snow E, Luchi RJ. A comparison of placement outcomes of geriatric cohorts receiving care in a geriatric assessment unit and on general medicine floors. J Am Geriatr So 1983; 31: 529-34.

62. Flamer HE, Christophidis N, Margetts C, Ugoni A, McLean AJ. Extended hospital stays with increasing age: The impact of an acute geriatric unit. Med.J.Aust 1996; 164:10-3.

63. Huber M, Kennard A. Functional and mental status outcomes of clients discharged from acute gerontological versus medical/surgical units. Journal of Gerontological Nursing 1991; 17: 20-4.

6. References

64. Jitapunkul S, Aksaranugraha S, Leenawat B, Sornthonchartwat B, Nuchprayoon C, Chaiwanichsiri D et al. A controlled clinical trial of multidisciplinary team approach in the general radical wards of Chulalongkorn hospital. J Med Assoc Thai 1995; 78: 618-23.

65. Mudge A, Laracy S, Richter K, Denaro C. Controlled trial of multidisciplinary care teams for acutely ill medical inpatients: enhanced multidisciplinary care. Intern Med J 2006; 36: 558-63

66. Abizanda Soler P, Romero Rizos L, Luengo Márquez C. Eficiencia de una unidad de geriatría en la gestión de camas hospitalarias. Rev Esp Geriatr Gerontol 2006; 41 (2): 143

67. González-Guerrero J, García-Mayolín N, Valverde M. Eficiencia de una unidad de Geriatría en la gestión de camas hospitalarias. Rev Esp Geriatr Gerontol 2005; 40 (6): 330-4.

68. Rai GS . Who should provide hospital care of elderly people?. Lancet 1985 (1): 683-5.

69. Rodríguez C, Olcoz MT, Portela D, Lariño S, Rey G. Análisis de funcionamiento de una unidad de agudos de Geriatría: Gestión clínica. Rev Esp Geriatr Gerontol 1998; 33 (supl 1):21-2.

70. Salcedo MJ, Areosa A, Gili P, Martínez N, Guillén F. Índices de ocupación de camas por mayores de 65 y 80 años en distintos servicios médicos hospitalrios. Análisis coste-eficacia de los principales GRD. . Rev Esp Geriatr Gerontol 2002; 37 (supl 1): 65-6.

71. Saunders RH, Hickler RB, Hall SA, Hitzhusen JC, Ingraham MR, Li L. A geriatric special-care unit: experience in a university hospital. J Am Geriatr Soc 1983; 31: 685-93. 6

72. Flaherty J, McClanahan S, Messner C. Morley J. ACE (acute care of elderly) unit interventions decrease hospital length of stay. J Am Geriatr Soc 1998; 46: S89.

73. Blanc-Bisson C, Dechamps A, Gouspillou G, Dehail P, Bourdel-Marchasson I. A randomized controlled trial on early physiotherapy intervention versus usual care in acute care unit for elderly: Potential benefits in light of dietary intakes. J Nutr Health Aging 2008; 12:395-9.

74. Boyer N, Chuang JL, Gipner D. An acute care geriatric unit. Nurs Manage. 1986 17(5): 22-5.

75. Canga Armayor AD, Narvaiza MJ. Nursing interventions aimed at reducing complications set in the hospitalisation of the elderly. Gerokomos 2006;17(1):24-31

76. Fishman WLM, Emro MA. Active use of serial functional assessment improves outcome and shortens acute geriatric hospitalization. Top Geriatr Rehabil 1994; 9:16-29.

77. Ledesert B, Lombrail P, Yeni P, Carbon C, Brodin M. The impact of a comprehensive multi-dimensional geriatric assessment programme on duration of stay in a French acute medical ward. Age Ageing 1994; 23: 223-7.

78. Pawlson LG. Hospital length of stay of frail elderly patients. Primare care by general internists versus geriatricians. J Am Geriatr Soc 1988; 36; 202-208.

79. Siebens H, Aronow H, Edwards D, Ghasemi Z. A randomized controlled trial of exercise to improve outcomes of acute hospitalization in older adults. J Am Geriatr Soc 2000; 48 :1545-52.

80. Popplewell PY, Henschke PJ. What is the value of a Geriatric Assessment Unit in a teaching hospital? A comparative study of the management of elderly inpatients. Australian Health Review 1983; 6:23-5.

81. Rozzini R, Sabatini T, Trabicchi M. Hospital organization: general internal medical and geriatrics wards. J Gerontol A Biol Med Sci 2005; 60: 535.

82. Clarfield AM. A long-term geriatric teaching ward in an acute-care hospital: a three-year experience. J Am Geriatr Soc 1982; 30:457-65.

6. References

83. Covinsky KE, Palmer RM, Kresevic DM, Kahana E, Counsell SR, Fortinsky RH, et al. Improving functional outcomes in older patients: lessons from an acute care for elders unit. Jt Comm J Qual Improv 1998; 24.(2):63.-76.

84. Crooks V, Lee P, Yoshikawa TT. Geriatric medicine: A multidisciplinary training and education model in an acute care medical center. J Am Geriatr Soc 1982; 30: 774-80.

85. Epstein AM, Hall JA, Besdine R. The emergence of geriatric assessment units. The 'new technology of geriatrics'. Ann Intern Med 1987; 106: 299-303. 7

86. Farag RR, Tinker GM. Delay in discharge of patients from an acute geriatric unit. Health Trends 1985; 17: 41.

87. Fillit H. Challenges for acute care geriatric inpatient units under the present Medicare prospective payment system. J Am Geriatr Soc 1994; 42: 553-8.

88. Lamont CT, Sampson S, Matthias R, Kane R. The outcome of hospitalization for acute illness in the elderly. J Am Geriatr Soc 1983; 31: 282-8.

89. Maguire PA, Taylor IC, Stout RW. Elderly patients in acute medical wards: Factors predicting length of stay in hospital. Br Med J 1986; 292: 1251-3.

90. Marengoni A, Cossi S, De Martines M, Ghisla MK, Calíbrese PA, Zanolini G, et al. Adverse outcomes in older hospitalized patients: The role of multidimensional geriatric assessment. Aging Clin Exp Res 2003; 15:32-37.

91. Martin AL, Oliver M, González P, Rollón MU, García-Alhambra MA, García Navarro JA, Ribera Casado JM. Assessment of quality of care in a geriatric acute care unit. Aging Clin Exp Res 1995; 7: 245-6.

92. Mitchell J, Kafetz K, Rossiter B. Benefits of effective hospital services for elderly people. Br Med J 1987; 295: 980-3.

93. Miller DK, Coe RM, Romeis JC, Morley JE. Improving quality of geriatric health care in four delivery sites: suggestions from practitioners and experts. J Am Geriatr Soc 1995; 43: 60-5.

94. Pound P, Sabin C, Ebrahim S. Observing the process of care: A stroke unit, elderly care unit and general medical ward compared. Age Ageing 1999; 28: 433-40.

95. Trella RS. A multidisciplinary approach to case management of frail, hospitalized older adults. J Nurs Adm 1993; 23: 20-6.

96. Wong RY, Miller WC. Adverse outcomes following hospitalization in acutely ill older patients. BMC Geriatrics 2008; 8: 10.

97. Burton LC, Weiner JP, Stevens GD, Kasper J. Health outcomes and medicaid costs for frail older individuals: a case study of a MCO versus fee-for-service care. J Am Geriatr Soc 50 (2):382 -8.

98. Hebert R, Robichaud L, Roy PM, Bravo G, Voyer L. Efficacy of a nurse-led multidimensional preventive programme for older people at risk of functional decline. A randomized controlled trial.[see comment]. Age Ageing 2001; .30: 147-53.

99. Rockwood K, Howlett S, Stadnyk K, Carver D, Powell C, Stolee P. Responsiveness of goal attainment scaling in a randomized controlled trial of comprehensive geriatric assessment. J Clin Epidemiol 2003; 56:736-43. 8

100. Trentini M, Semeraro S, Motta A, Giannandrea M, Vanelli G, Pandiani E et al. Effectiveness of geriatric evaluation and care. One-year results of a multicenter randomized clinical trial. Aging Clin Exp Res 2001; 13 (5):395-405.

6. References

101. Amador LF, Reyes-Ortiz CA, Reed D, Lehman C. Discharge destination from an acute care for the elderly (ACE) unit. Clin Interv Aging. 2007;2(3):395-9.

102. Cameron S, McKenzie F, Warnock L, Farquhar D. Impact of a nurse led multidisciplinary team on a acute medical admissions unit. Health Bull 2000; 60: 512-4.

103. Chang E, Hancock K, Hickman L, Glasson J, Davidson P. Outcomes of acutely ill older hospitalized patients following implementation of tailored models of care: a repeated measures (pre- and post-intervention) design. Int J Nurs Stud. 2007; 44: 1079-92.

104. Glasson J, Chang E, Chenoweth L, Hancock K, Hall T, Hill-Murray F, Collier L. Evaluation of a model of nursing care for older patients using participatory action research in an acute medical ward. J Clin Nurs. 2006 May;15(5):588-98.

105. Egger SS, Bachmann A, Hubmann N, Schlienger R, Krähenbühl S. Prevalence of potentially inappropriate medication use in elderly patients: Comparison between general medical and geriatric wards. Drugs Aging 2006; 23: 823-7.

106. Harari D, Martin FC, Buttery A, O'Neill S, Hopper A. The older persons' assessment and liaison team 'OPAL': Evaluation of comprehensive geriatric assessment in acute medical inpatients. Age Ageing 2007; 36: 670-5.

107. Kleimpell RM. Randomized trial of an intensive care unit-based early discharge planning intervention for critically ill elderly patients. Am J Crit Care 2004; 13: 335-45.

108. Laroche ML, Charmes JP, Nouaille Y, Fourrier A, Merle L. Impact of hospitalisation in an acute medical geriatric unit on potentially inappropriate medication use. Drugs Aging 2006; 23: 49-59.

109. Palomera García M, Domingo García V, Vega Pérez MP, García Hervias E, González Lahera B, Ruipérez Cantera I. Valoración de eficiencia y eficacia de una unidad geriátrica de agudos. Estudio prospectivo, aleatorio y controlado. Rev Esp Geriatr Gerontol 1997; 32 (supl 1): 42.

110. Spinewine A, Swine C, Dhillon S, Lambert P, Nachega JB, Wilmotte L, et al. Effect of a collaborative approach on the quality of prescribing for geriatric inpatients: a randomized, controlled trial. J Am Geriatr Soc 2007; 55:658-65.

111. Steeman E, Moons P, Milisen K, De Bal N, De Geest S, De Froidmont C, et al. Implementation of discharge management for geriatric patients at risk of readmission or institutionalization. Int.J.Qual.Health Care 2006; 18:352-8.

112. Tucker D, Bechtel G, Quartana C, Badger N, Werner D, Ford I et al. The OASIS Program: redesigning hospital care for older adults. Geriatric Nursing 2007; 27: 112-7.

113. Bazta, Suarez-Garcıa, Lopez-Arrieta,Rodr´ıguez-Manas, Rodrıguez-Artalejo, Effectiveness of acute geriatric units on functional decline,living at home, and case fatality among older patients admitted to hospital for acute medical disorders: meta-analysis.BMJ 2009;338:b50

114. Elizabeth Bradley, Tashonna Webster, Dorothy Baker, Mark Schlesinger, Sharon Inouye, Michael Barth, Kate Lapane, Debra Lipson, Robyn Stone, and Mary Jane Koren. Translating Research into Practice: Speeding the Adoption of Innovative Health Care Programs. The Commonwealth Fund Issues Brief. July 2004.

115. Makaryus AN, Friedman EA. Patients' understanding of their treatment plans and diagnosis at discharge. Mayo Clin Proc. 2005;80:991-994

116. Kripalani S, LeFevre F, Phillips CO, Williams MV, Basaviah P, Baker DW. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. JAMA. 2007;297:831-841.

6. References

117. van Walraven C, Seth R, Austin PC, Laupacis A. Effect of discharge summary availability during post-discharge visits on hospital readmission. J Gen Intern Med. 2002;17:186-192.

118. Roy CL, Poon EG, Karson AS, et al. Patient safety concerns arising from test results that return after hospital discharge. Ann Intern Med. 2005;143:121-128.

119. Forster AJ, Murff HJ, Peterson JF, Gandhi TK, Bates DW. The incidence and severity of adverse events affecting patients after discharge from the hospital. Ann Intern Med. 2003;138: 161-167.

120. Forster AJ, Clark HD, Menard A, et al. Adverse events among medical patients after discharge from hospital. CMAJ. 2004;170:345-349.

121. Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. N Engl J Med. 2009;360:1418-1428.

122. Jack BW, Chetty VK, Anthony D, et al. A reengineered hospital discharge program to decrease rehospitalisation: a randomized trial. Ann Intern Med. 2009;150:178-187

123. Department of Health. National Service Framework for Older People. London: UK Department of Health.2001

124. Department of Health. Caring For Older People a Nursing Priority Integrating Knowledge Practice and Values. Report by the Standing Nursing and Midwifery Advisory Committee. London: UK Department of Health.2001.

125. Health Advisory Service. Not Because They Are Old. An Independent Inquiry into the Care of Older People in Acute Wards In General Hospital. HAS: London.2000.

126. Brown, K., Ryan, J., Solomon, J., Lloyd, A., Bene, J. And Grant, M. Promoting Autonomy and Independence for Older People in Acute Hospital Care. In Shaw &Sanders (Eds) Foundation of Nursing Studies Dissemination Series. Vol.2. No.7. 2004.

127. Older People in Acute Care. NHS Quality Improvement Scotland.2004. www.nhshealthquality.org

128. Sarah M Dennis, Nicholas Zwar, Rhonda Griffiths, Martin Roland, Iqbal Hasan, Gawaine Powell Davies and Mark Harris. Chronic disease management in primary care: from evidence to policy. MJA 2008; 188 (8 Suppl): S53-S56

129. Tsai A, Morton S, Mangione C, Keeler E. A meta analysis of interventions to improve care for chronic illnesses. American Journal of Managed Care; 11: 478–488. 2005.

130. Nolte E, McKee M. (2008). Caring for people with chronic conditions: An introduction. In E Nolte and M McKee (Eds), Caring for People with Chronic Conditions: A Health System Perspective. European Observatory on Health Systems and Policies Series. Maidenhead, UK: Open University Press.

131. Khan S, McIntosh C, Sanmartin C, Watson D, Leeb K. (2008). Primary Health Care Teams and Their Impact on Processes and Outcomes. Ottawa: Statistics Canada.

132. Weingarten SR, Henning JM, Badamgarav E, Knight K, Hassalblad V, Gano A, Ofman J. (2002, October 26). Interventions used in disease management programmes for patients with chronic illness – which ones work? Meta-analysis of published reports. British Medical Journal; 325: 1–8.

133. McAlister F, Lawson F, Teo K, Armstrong P. (2001). A systematic review of randomized trials of disease management programs in heart failure. American Journal of Medicine;110: 378– 384.

134. Wagner EH. (1998). Chronic disease management: What will it take to improve care for chronic illness? Effective Clinical Practice; 1(1): 2–4.

6. References

135. Wagner EH. (2000). The role of patient care teams in chronic disease management. British Medical Journal; 320: 569–572.

136. Coleman K, Austin BT, Brach C, Wagner EH. (2009). Evidence on the chronic care model in the new millennium. Health Affairs; 28(1): 75–85.

137. Gress S, Baan C, Calnan M, Dedeu T, Groenewegen P, Howson H, Maroy L, Nolte E, Redaelli M, Saarelma O, Schmacke N, Schumacher K, Jan van Lente E, Vrijhoef B. (2010). Coordination and Management of Chronic Conditions in Europe: The Role of Primary Care. Position paper of the European Forum for Primary Care. Quality in Primary Care; 17: 1–12 (Pre-publication copy: cited with permission).

138. Greenhalgh T. (2009). Patient and public involvement in chronic illness: Beyond the expert patient. British Medical Journal; 338: b49.

139. Powell Davies G, Harris M, Perkins D, Roland M, Williams A, Larsen K, McDonald J. Coordination of care within primary health care and with other sectors: A systematic review. Research Centre for Primary Health Care and Equity, School of Public Health and Community Medicine, UNSW 2006.

140. Bradley EH, Webster TR, Schlesinger M, Baker D, Inouye SK. Patterns of diffusion of evidence-based clinical programmes: a case study of the Hospital Elder Life Program. Qual Saf Health Care 2006;15:334–338.

141. The 'how to' guide – turning knowledge into practice in the care of older people. September 2008

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Appendix 2
Project Methodology

1 INTRODUCTION

This project plan outlines the methodology that was used for the Evaluation of the COAG LSOP Victorian Initiatives.

1.1 Evaluation Requirements

The objective of this project was to examine the performance of the Victorian implementation of the COAG LSOP Initiative against the set aims of the initiative, with a focus on measuring the effectiveness and efficacy against four key impact areas:

- Strengthening attention to the needs of older people in the hospital and community
- Improving consistency and integration of service delivery
- Improving access to a range of 'age friendly', appropriate services and settings
- Reducing the incidence of inappropriate hospital usage by older people.

The two components under the LSOP umbrella that are the target for this evaluation are:

1. Improving Care for Older People (IC4OP)
2. Hospital Admission Risk Program – Better Care for Older People (HARP –BCOP).

1.2 Evaluation framework

The Department of Health developed an overarching Victorian evaluation framework using a Logic Model approach. The use of program logic in the development of the COAG LSOP key impact areas for the evaluation is consistent with AHA's preferred approach to conducting evaluations.

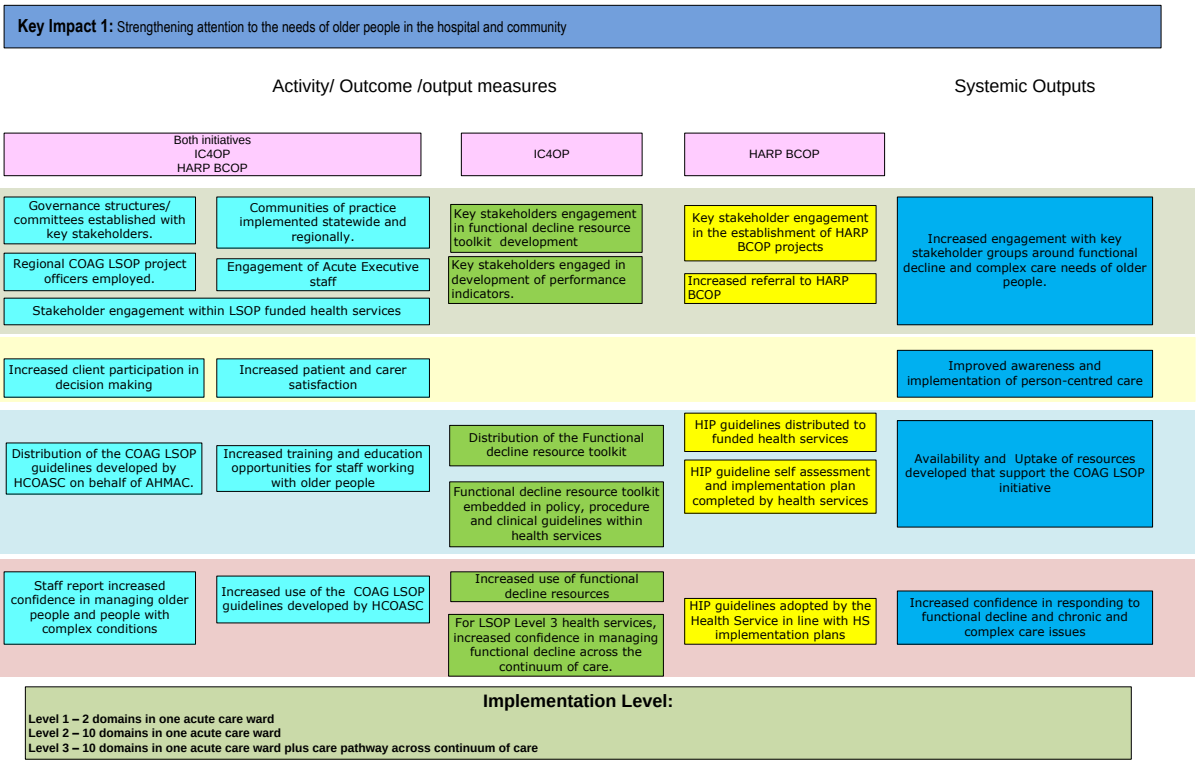
The Evaluation Framework for COAG LSOP February, 03 2009 outlines:

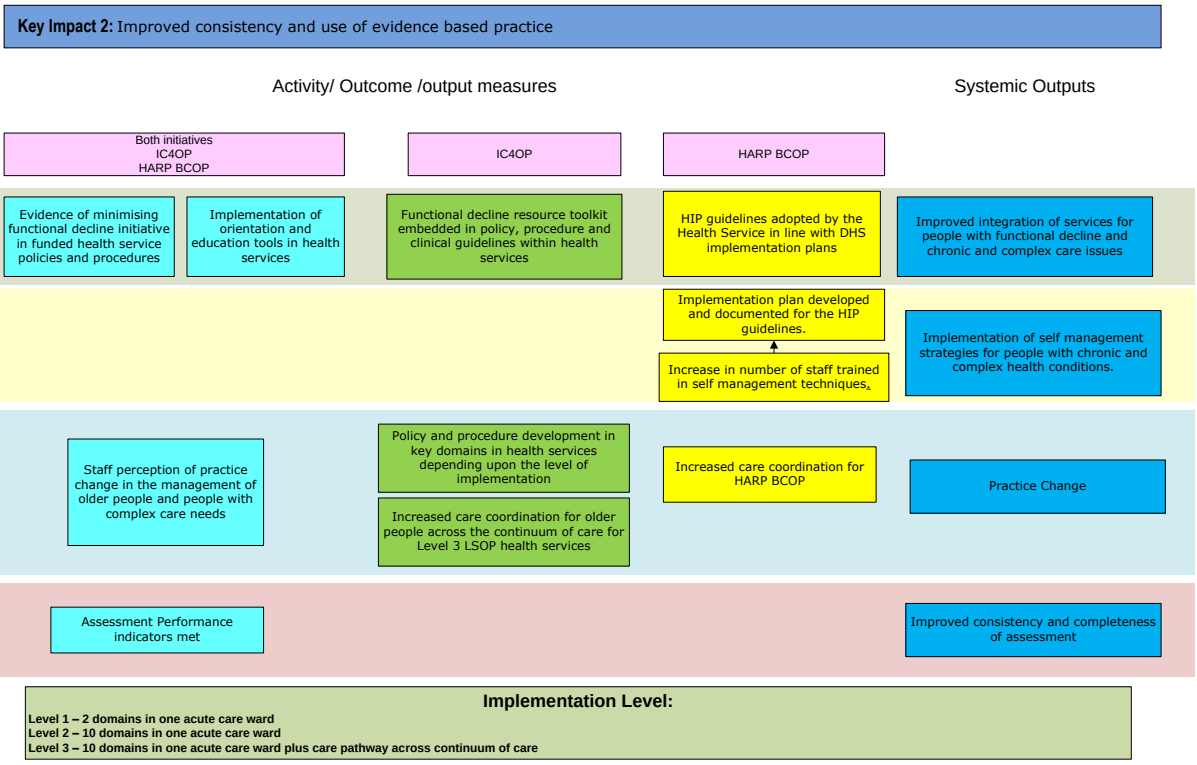
- the four key impacts to be evaluated
- contributing project impacts
- outcome/output measures
- data sources and
- data collection responsibilities.

The following are pictorial representations of the four key impact areas to be evaluated including the key activities, outcomes or outputs identified for each impact. The activities, outputs and outcomes have been divided into either IC4OP alone, HARP BCOP alone or both programs.

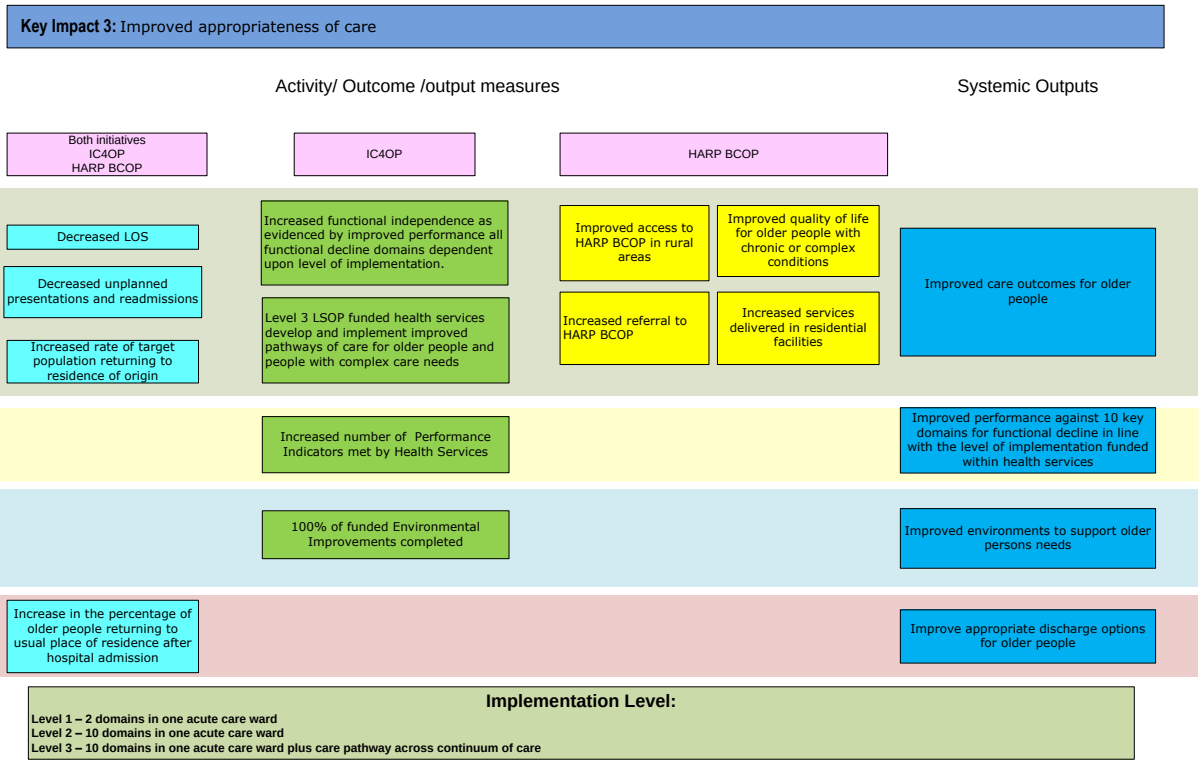
Also identified are influencing factors such as implementation levels.

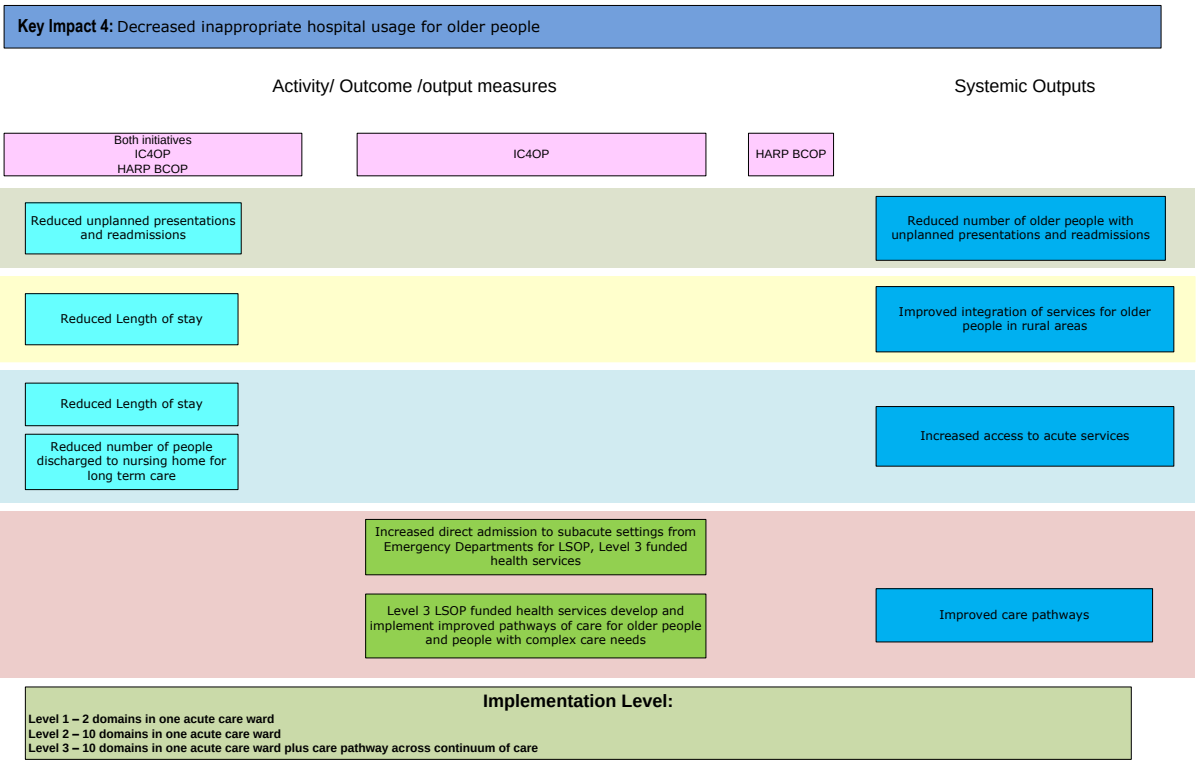
COAG LSOP – Project Methodology





COAG LSOP – Project Methodology





2 METHODOLOGY

The methodology was implemented in four phases as follows:

- ***Phase 1: Project Initiation***
- ***Phase 2: Conducting Evaluation Activities***
- ***Phase 3: Data Analysis***
- ***Phase 4: Reporting***

2.1 Phase 1: Project Initiation

The first phase entailed:

A. initial project briefing
B. finalise project plan, stakeholder list
C. establish a 1300 number, webpage and email account
D. develop evaluation framework and methodology
E. establish consultation strategy
F. literature scan and document review.

2.1.1 Phase 1A: Initial project briefing

On signing the contract, an initial briefing with the Department and the COAG LSOP Evaluation Advisory Group was held, to discuss a range of matters including:

- terms of reference
- project plan
- stakeholder consultation, tools and methods
- access to data and information that will assist in the evaluation
- reporting requirements and structure of reports
- meeting schedule
- determine key stakeholders for preliminary consultation

Preliminary consultations were conducted with three localities that had implemented the IC4OP and/or HARP BCOP components of COAG LSOP to gain greater clarity about the different ways that the program has been rolled out in different contexts. The three preliminary localities were Benalla and District Memorial Hospital, Barwon Health and Alfred Health, representing the metro and regional areas and small and large services.

These consultations informed the development of the consultation tools.

2.1.2 Phase 1B: Finalise Project Plan, Stakeholder List

A finalised Project Plan and Stakeholder List were submitted for approval in July 2010.

2.1.3 Phase 1C: Establish a 1300 number, webpage and email account

To enhance stakeholder engagement and to ensure that they are abreast of the evaluation program of activities, a 1300 telephone number, webpage and email account were established. This also provided the capacity for stakeholders to seek clarification in relation to aspects of the evaluation.

2.1.4 Phase 1D: Develop Evaluation Framework and Methodology

An evaluation framework was developed in line with the program logic framework provided by the Department of Health. The framework identified the key questions within the four key impact areas to be addressed through the evaluation process and a detailed methodology for achieving the evaluation objectives.

There were two levels of evaluation; the first level was a program specific evaluation of each of the two program areas whilst the second is a higher level evaluation that reflects on the impact of the LSOP initiative overall and in line with the COAG aspirations for the funding.

2.1.5 Phase 1E: Establish consultation strategy

During this phase a consultation strategy was established which detailed all stakeholders, method of communication and the method of consultation.

2.1.6 Phase 1F: Literature and horizon scan, document review and initial consultation

A literature and horizon scan was conducted, which is detailed in Appendix 1. Broadly, the literature and horizon scan explored the evidence base in relation to:

- improving the acute hospital care of older patients
- approaches to reducing use of acute hospital care in older patients
- making 'usual care' 'best practice' care.

A scan was conducted of the different types of programs that have been implemented in other jurisdictions across Australia and their effectiveness in achieving the goals of the LSOP initiative.

Other documents reviewed during this phase include:

- National reports relevant to LSOP
- Victorian reports on LSOP and other relevant programs
- implementation of LSOP by other states/territories
- LSOP provider reports to DH.

In addition, documents relevant to the Victorian implementation of LSOP were reviewed including Service Description Schedule, Tender specification, policies, and related initiatives.

2.2 Phase 2: Conducting the Evaluation Activities

In summary this phase consisted of:

A. analysis of available data

B. development of consultation instruments

C. consultation with stakeholders

D. collection of case studies.

2.2.1 Phase 2A: Analysis of available data

The data to be analysed was drawn from:

- data collected specifically for the LSOP initiative
- reports provided by the HARP BCOP funded projects to the Department
- reports on environmental audits, staff perceptions, work practices and expenditure of program funds provided by the funded IC4OP projects to the Department.

The HARP BCOP data and reports where available provided an indication of the following:

- number and demographics of people assisted
- length of involvement
- outcomes of assistance; types of care/support that participants are linked to.

Reports provided by IC4OP settings gave an indication of:

- progress against structural indicators
- progress against process indicators
- activities undertaken to address staff knowledge and practices
- audits against implementation of domains
- resultant changes to practice including person-centred approach, monitoring of functional decline and the implementation of tool kits to reduce risk of decline
- other activities completed.

The analysis also identified the gaps in information that needed to be addressed through the stakeholder consultations.

2.2.2 Phase 2B: Development of consultation instruments

Based on the analysis of available data and input from preliminary consultations with the evaluation advisory group and other stakeholders, structured interview instruments were developed for the purpose of collecting additional qualitative data.

Interview and focus group questions were developed to suit each type of funded service, taking into account:

- Initiative (IC4OP or HARP BCOP)
- Locality – metropolitan/regional
- Implementation level.

The interview instruments focused on collecting data in relation to understanding the progress made at each site as well as the different approaches to implementation of the Victorian model of LSOP by each of the localities

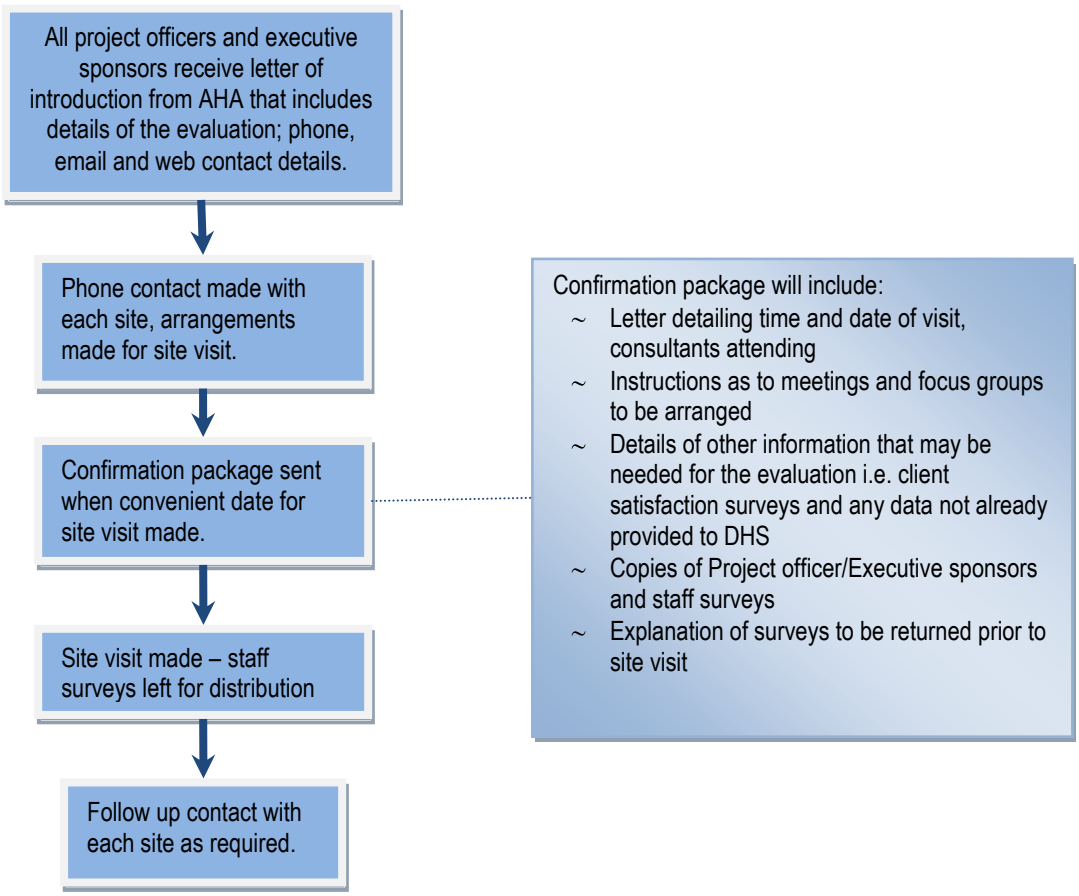
Surveys
The surveys for general staff and for project officers and executive sponsors were developed based on validated tools used for similar projects. The surveys were designed to elicit information related to staff knowledge of caring for older people and functional decline and if changes have occurred over the lifetime of the COAG LSOP initiatives.

For the staff surveys reference to the COAG LSOP initiative was not made, as some funded sites have not "branded" activities as COAG LSOP. Reference is made to the COAG LSOP initiative in the project officer and executive sponsor survey.

The general survey was available online, and was also distributed in hardcopy at each site visit. The project officer and executive sponsor survey was distributed electronically at the time of arranging the site visit.

2.2.3 Phase 2C: Consultation with stakeholders

To establish contact with and engage the relevant stakeholders at each health service, the following process was followed:



The stakeholder consultation provided insight into the effectiveness and challenges associated with the implementation of the two programs and the initiative more broadly. The qualitative data was collected by:

- conducting detailed interviews/focus groups with staff and management involved with each of the 13 HARP BCOP programs and other relevant stakeholders from within the auspice organisation
- detailed interviews/focus groups with hospital staff and management responsible for implementing IC4OP and other relevant stakeholders from within the auspice organisation.

The primary focus was consulting core management and staff involved in implementing the COAG LSOP initiative in each locality as well as other stakeholders within those organisations that have relevant information for the evaluation.

The consultations at each health service with the management and staff involved in the implementation of IC4OP and HARP BCOP provided insight into the program elements that have contributed to the effectiveness or otherwise of these models.

These consultations also assisted with the identification of systemic issues that are impacting on the achievement of desired outcomes, for example the availability of places in Residential Aged Care Services or with Packaged Care Providers.

Linkages and coordination between acute, subacute, primary care and community care providers were also explored through these consultations.

In addition to the general consultations at each funded site, consultations also occurred at regional meetings and forums.

2.2.4 Phase 2D: Case studies

The case studies that have been collected will be reviewed with respect to the way that they exemplify the work undertaken as part of the initiative and the associated achievements.

2.3 Phase 3: Data Analysis and Interpretation

In summary this phase consisted of:

A. individual program level assessments
B. higher level LSOP initiative assessment.

2.3.1 Phase 3A: Individual program level assessments

Statistical and thematic analysis of the data was undertaken. The thematic analysis was conducted using Grounded Theory. This uses a constant comparative method of coding and recoding.[1,2]

Data will be extracted from reports and relevant datasets with regard to progress on implementing the structural and process indicators as well as the domains. An analysis of the extent and effectiveness of implementation will also be conducted.

2.3.2 Phase 3B: Higher level LSOP initiative assessment

A summative analysis was completed on all the data collected during the period. This analysis was also used to inform the questions that have been raised through the finalisation of the Evaluation Framework (see ***Section 1.2***) for the purpose of determining the impact of the LSOP initiative overall.

2.4 Phase 4: Reporting

This phase entailed the drafting and submission of:

A. interim reports
B. submission of draft evaluation report
C. submission and acceptance of final evaluation report.

[1] Glaser, B., & Straus, A.L. (1967). *The discovery of grounded theory.* New York. Nadine.
[2] DePoy, E., Gitlin, L. (1998). *Introduction to research: understanding and applying multiple strategies.* (2nd Ed.)St Louis: Mosby.

2.4.1 Phase 4A: Interim Reports

Two interim reports were provided in accordance with the tender requirements, in September 2010 and November 2010.

2.4.2 Phase 4A: Submission of Draft Evaluation Report

Following the consultations and data analysis, a draft Final Report was provided to the Evaluation Advisory Group, using the structure previously agreed. The report addressed the key evaluation questions and presented the evaluation findings. The report included recommendations and provided advice about the future of the initiatives.

2.4.3 Phase 4B: Submission and Acceptance of Final Evaluation Report

Following provision of feedback from the Department on the draft report, refinements will be made to the draft report. The final report will then be submitted for acceptance by the Department.

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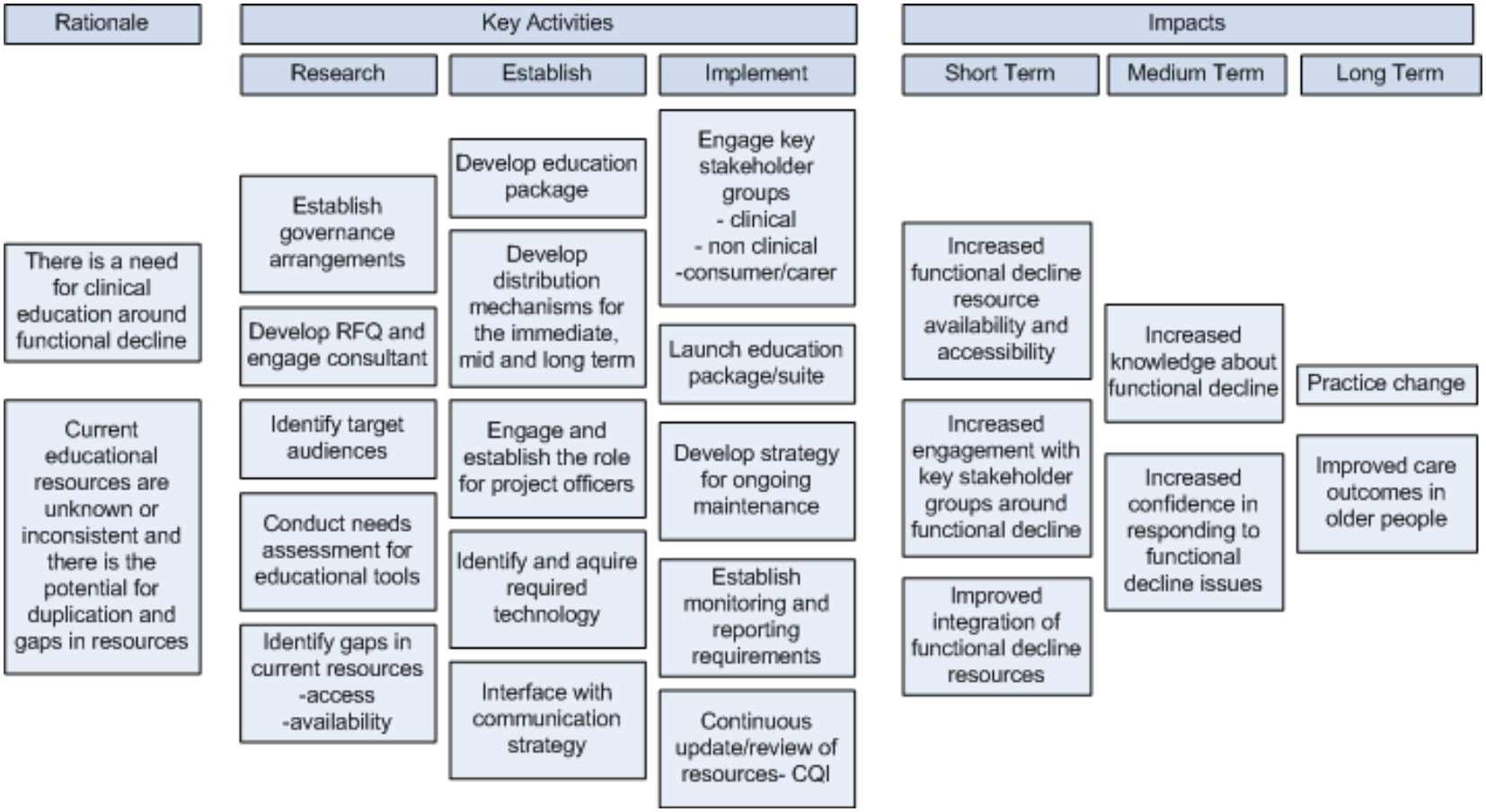
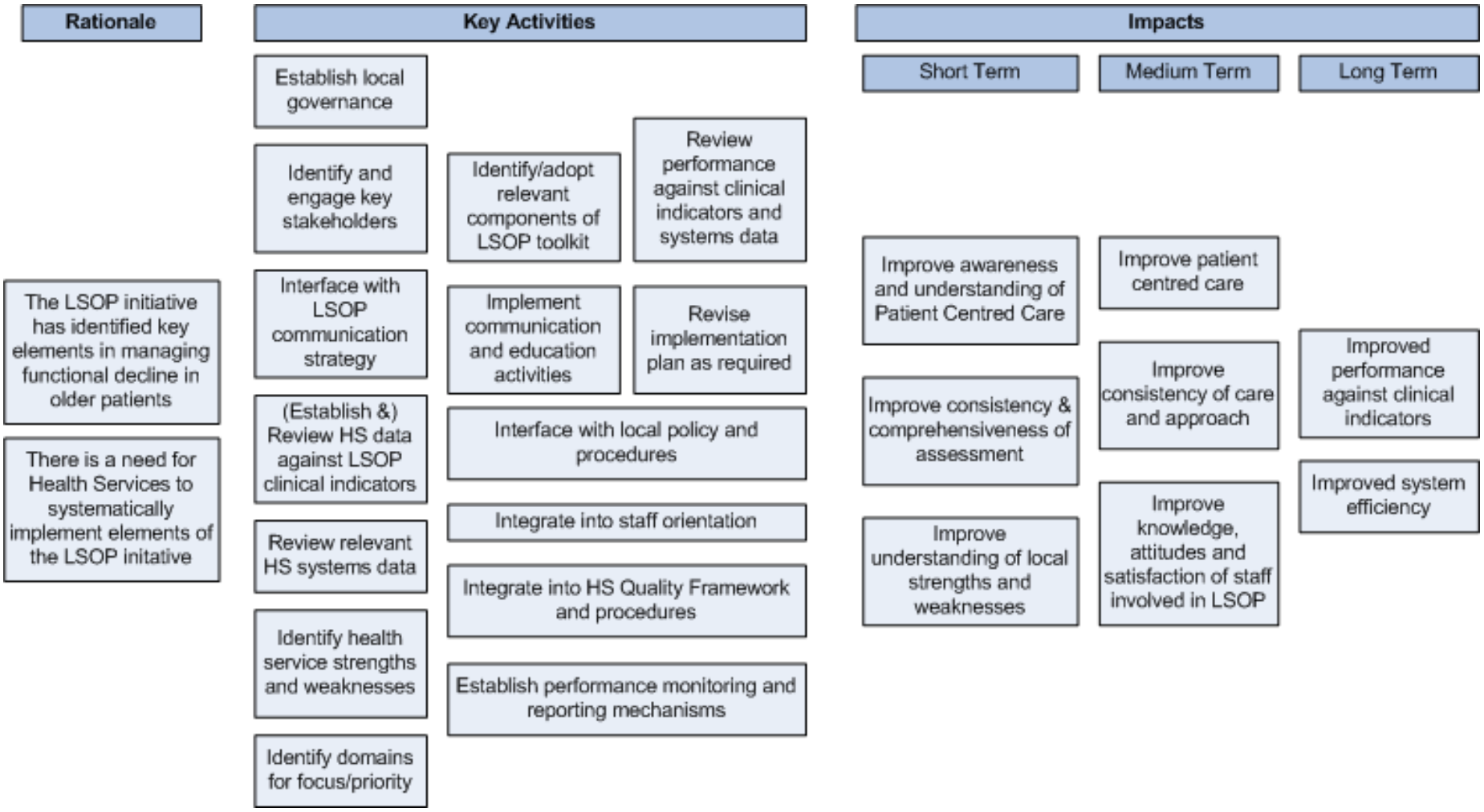
Appendix 3
Statewide Implementation Strategies

Program Logics for LSOP Project Groups

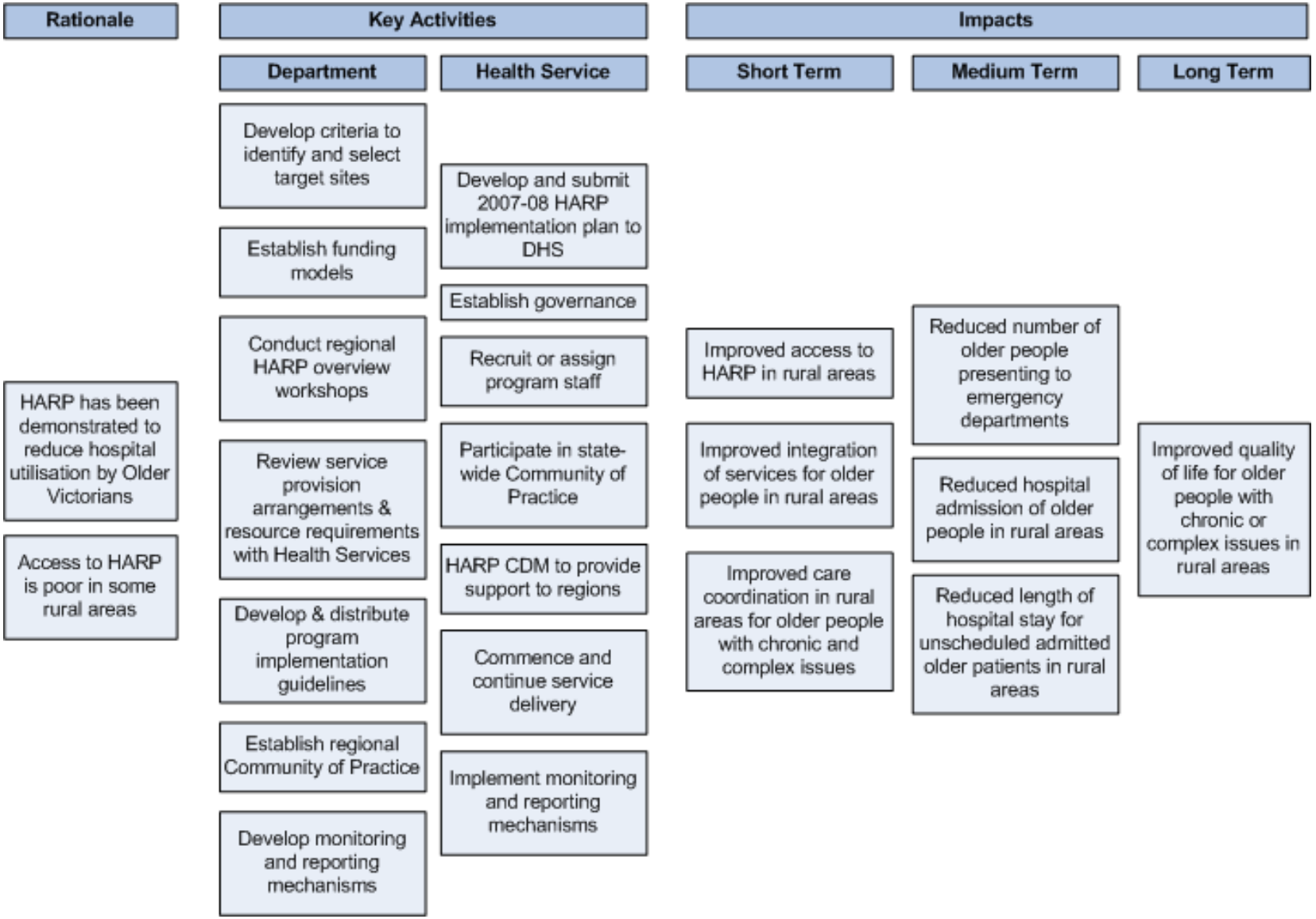
a. Program Logic for LSOP Project Group Communication Strategy Project Group



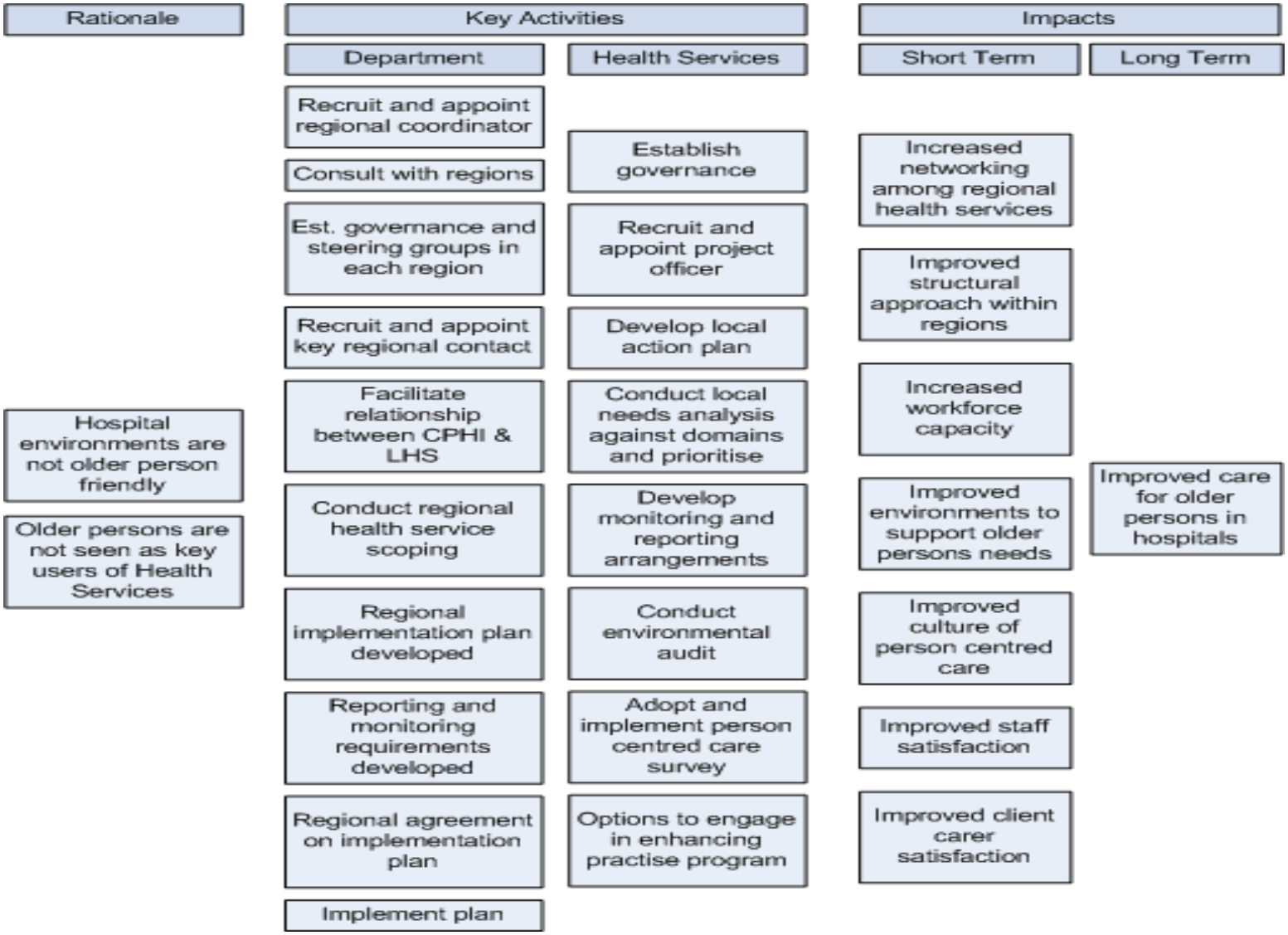
b. Metropolitan Implementation Approach



c. HARP BCOP Implementation Approach



d. Rural and Regional Implementation Approach



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Appendix 4
Survey Report

Appendix 4. Survey Report

The surveys used in the evaluation of the LSOP initiative were based on two validated survey instruments, the Geriatric Institutional Assessment Profile (GIAP) and The Hospital Elder Life Program (HELP) Dissemination Survey.

These tools study staff knowledge and attitudes towards older adults and help identify institutional barriers and supports for quality care of older patients. They also sensitize staff to elder care issues.

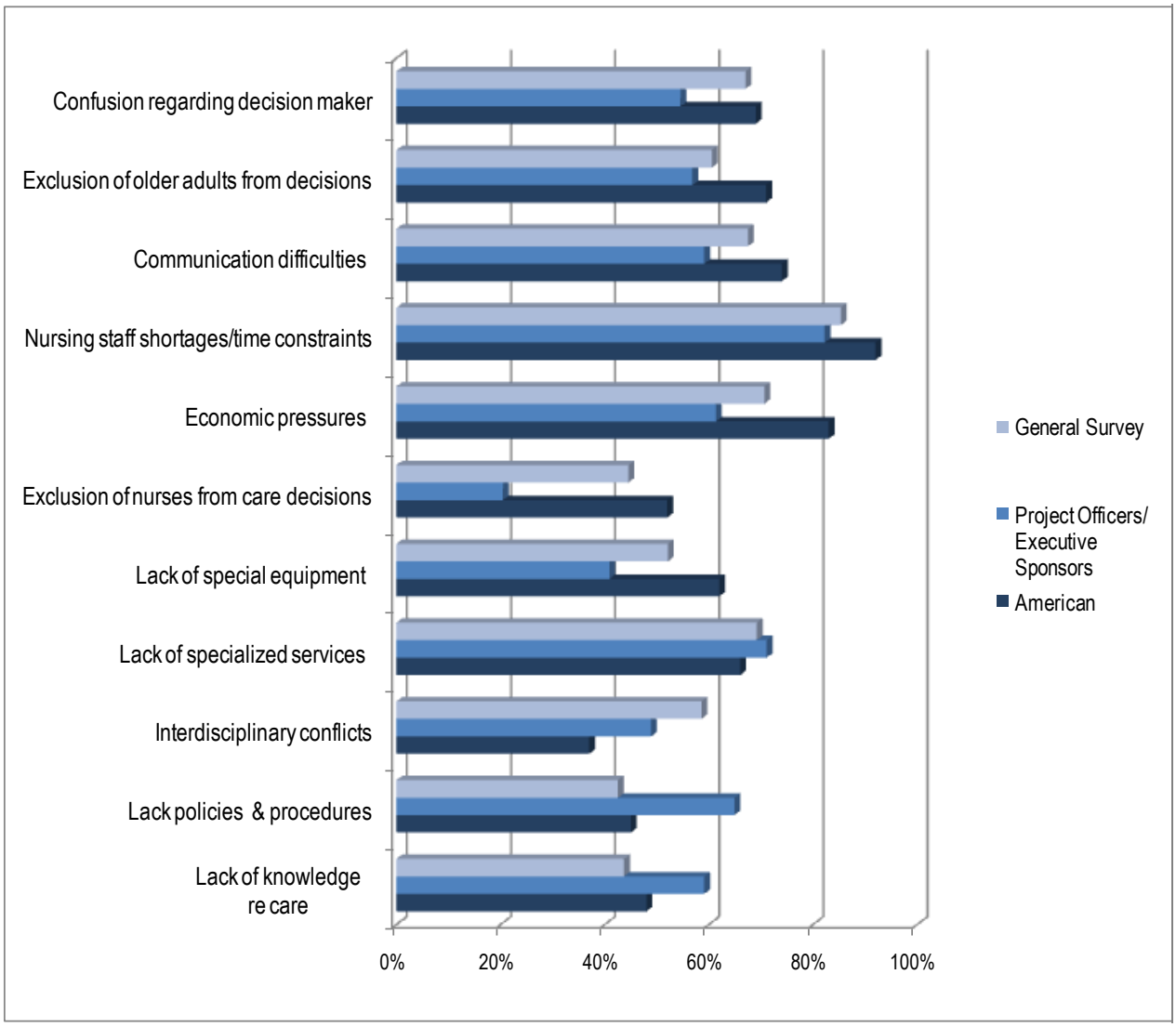
Use of surveys derived from these instruments allowed the opportunity of benchmarking data from our evaluation with comparable acute hospitals that have completed these surveys in North America and Canada (collectively referred to as 'America' in this report). In the case of the GIAP comparators this comprises data from 14,215 survey participants in 75 acute hospitals. In the case of the HELP comparator this comprises data from staff at 62 acute hospitals.

Respondent Characteristics

Characteristic	America	LSOP General Survey respondents (n= 365)	LSOP Executive Sponsor and Project Officer Survey respondents (n= 45)
Age (mean +/- SD)	39.9 yrs +/- 10.1 yrs	39.93 yrs +/- 12.62 yrs	43.5 yrs +/- 10.47
Sex (% Female)	91.5%	89.6%	91.1%
Experience (Range in yrs)	1 to 55 yrs	1 to 48 yrs	3 to 42 yrs
Experience (mean +/- SD)	13.4 yrs +/- 10.1 yrs	16.73 +/- 12.49 yrs	22.09 +/- 9.43 yrs

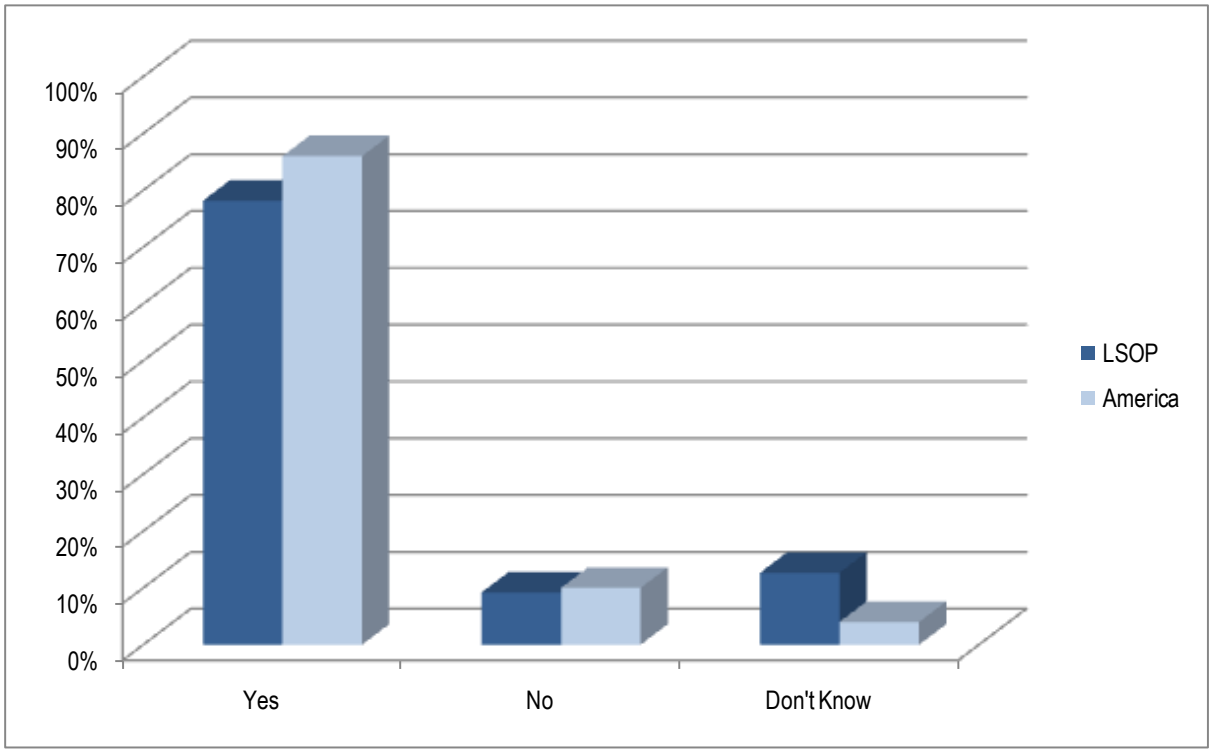
Appendix 4. Survey Report

Obstacles to care of older patients

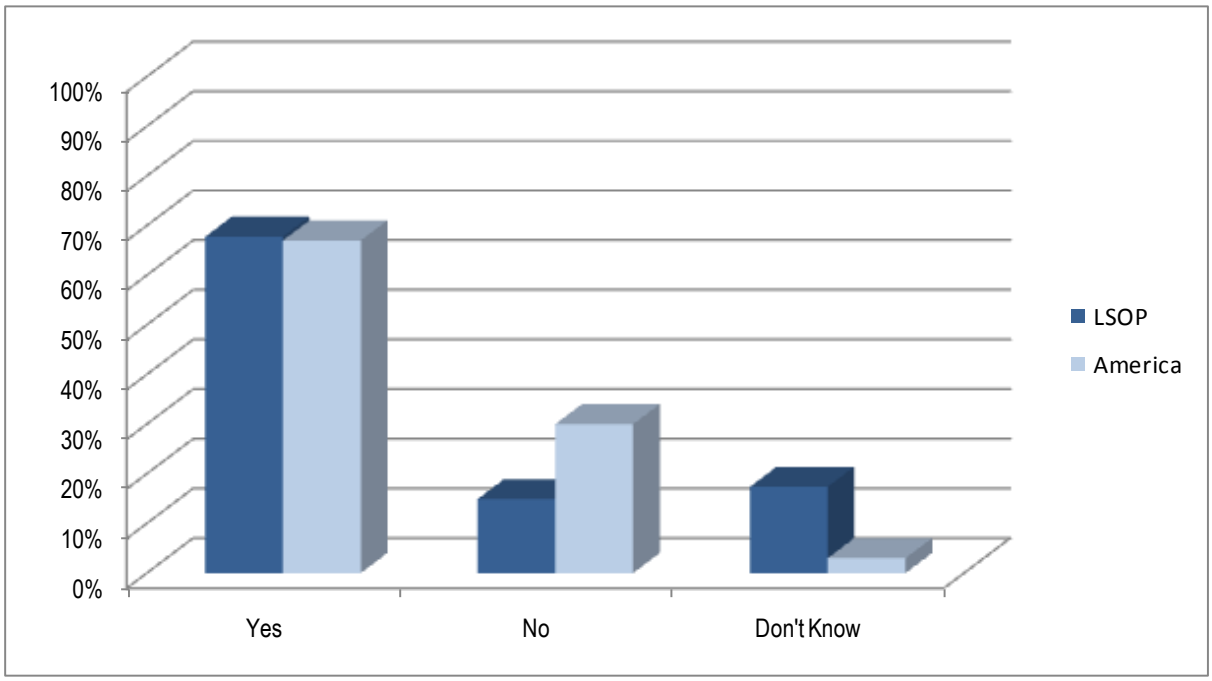


Appendix 4. Survey Report

Use of protocols or standardised processes to improve the identification of older patients at high risk of experiencing functional decline

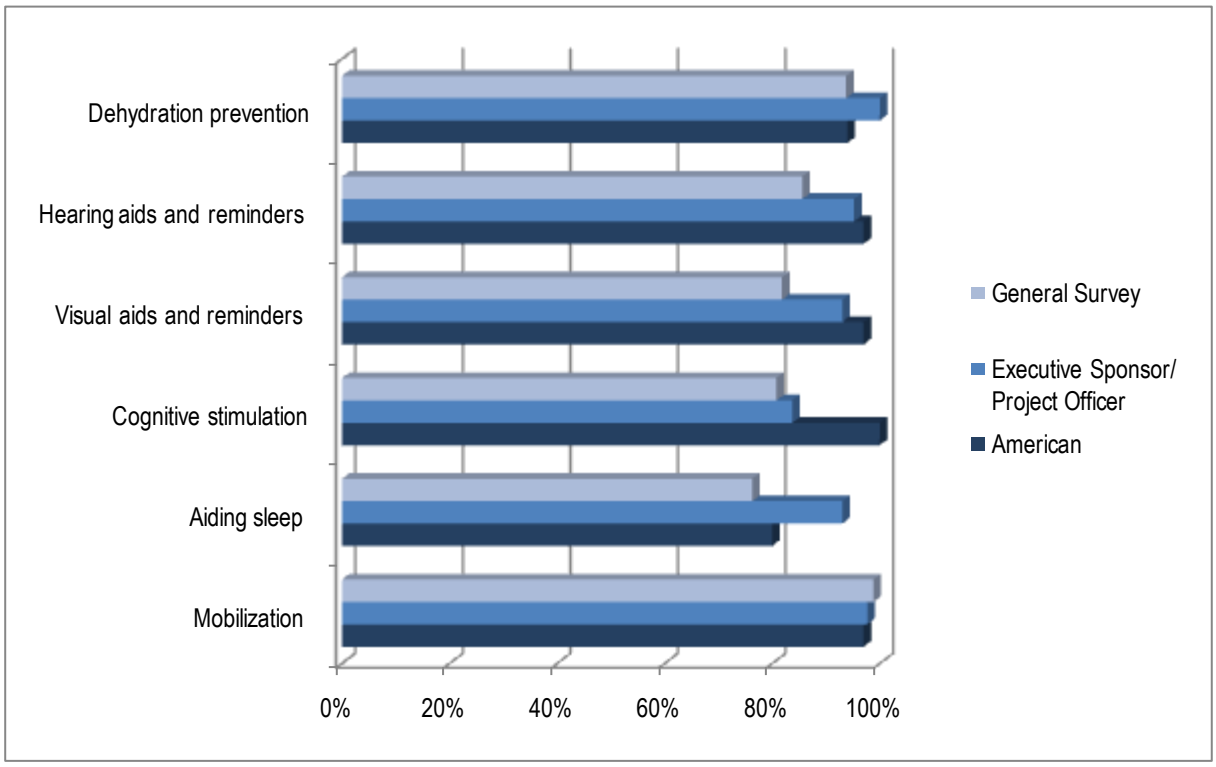


Use of clinical guidelines or pathways in minimizing the risk of functional decline

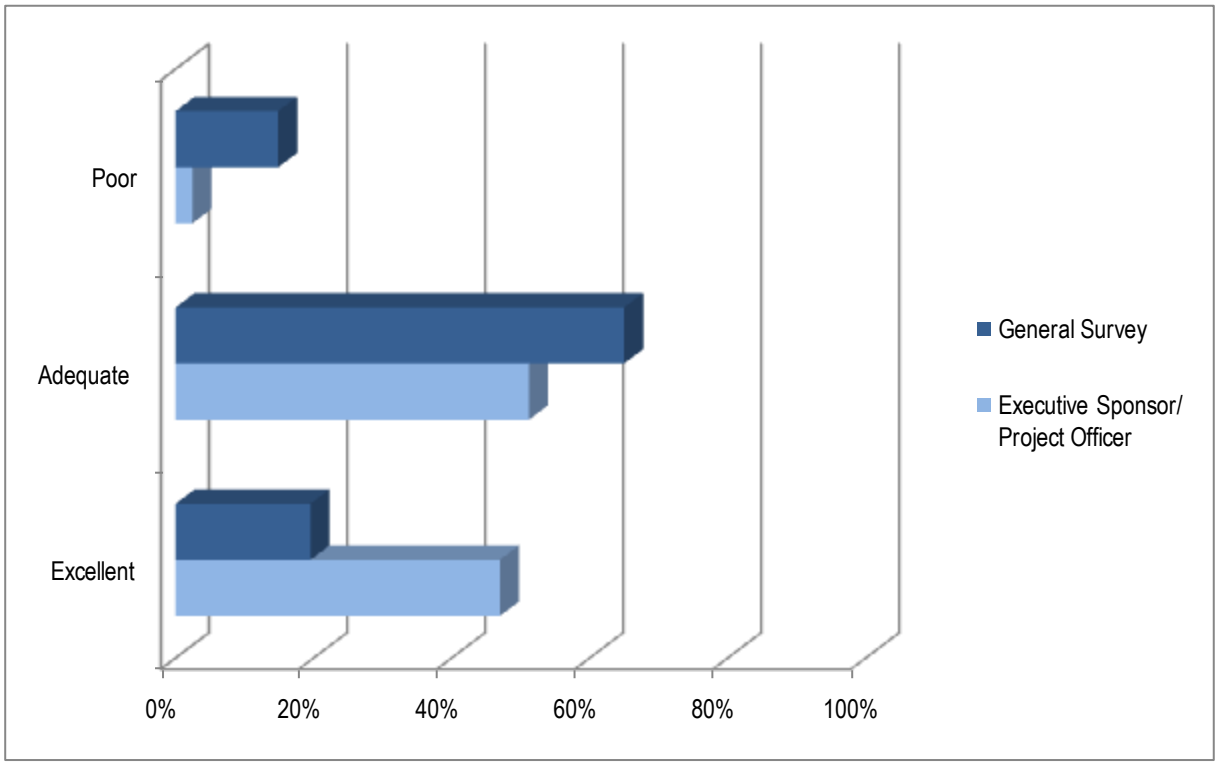


Appendix 4. Survey Report

Routine interventions in health services to limit functional decline

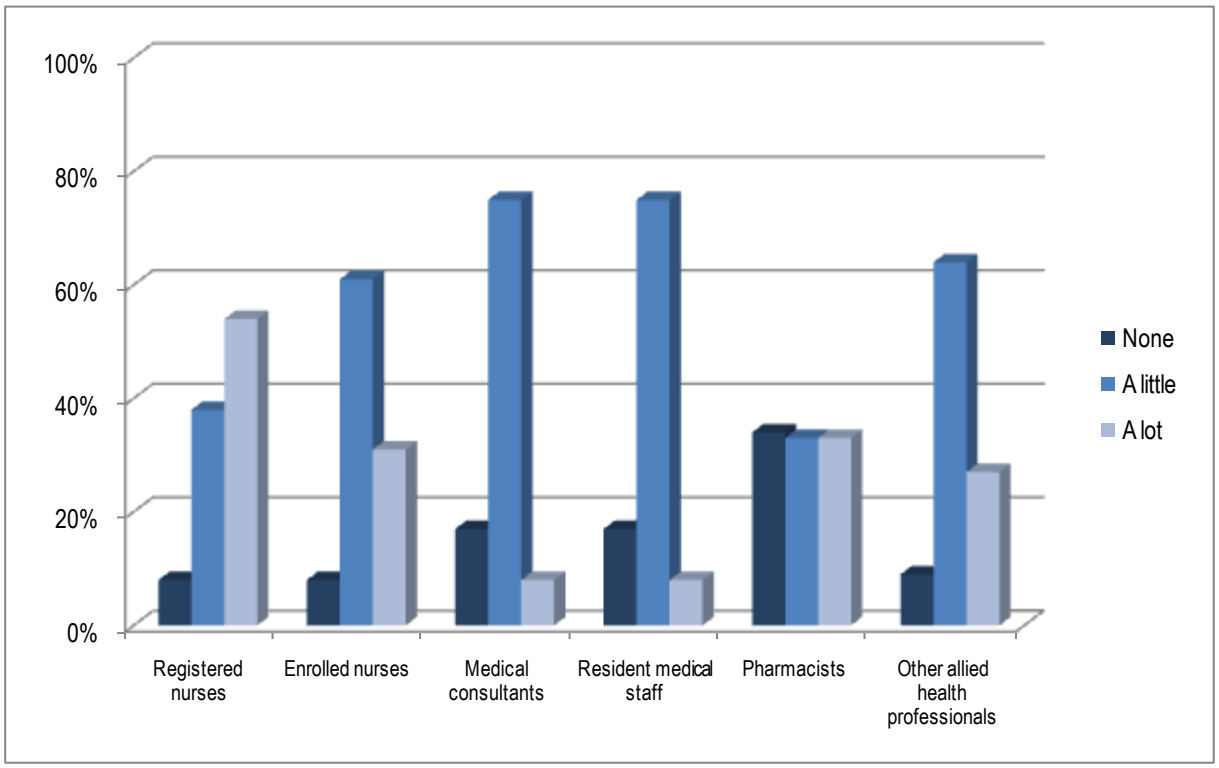


Rating of staff education programs regarding the care of older adults

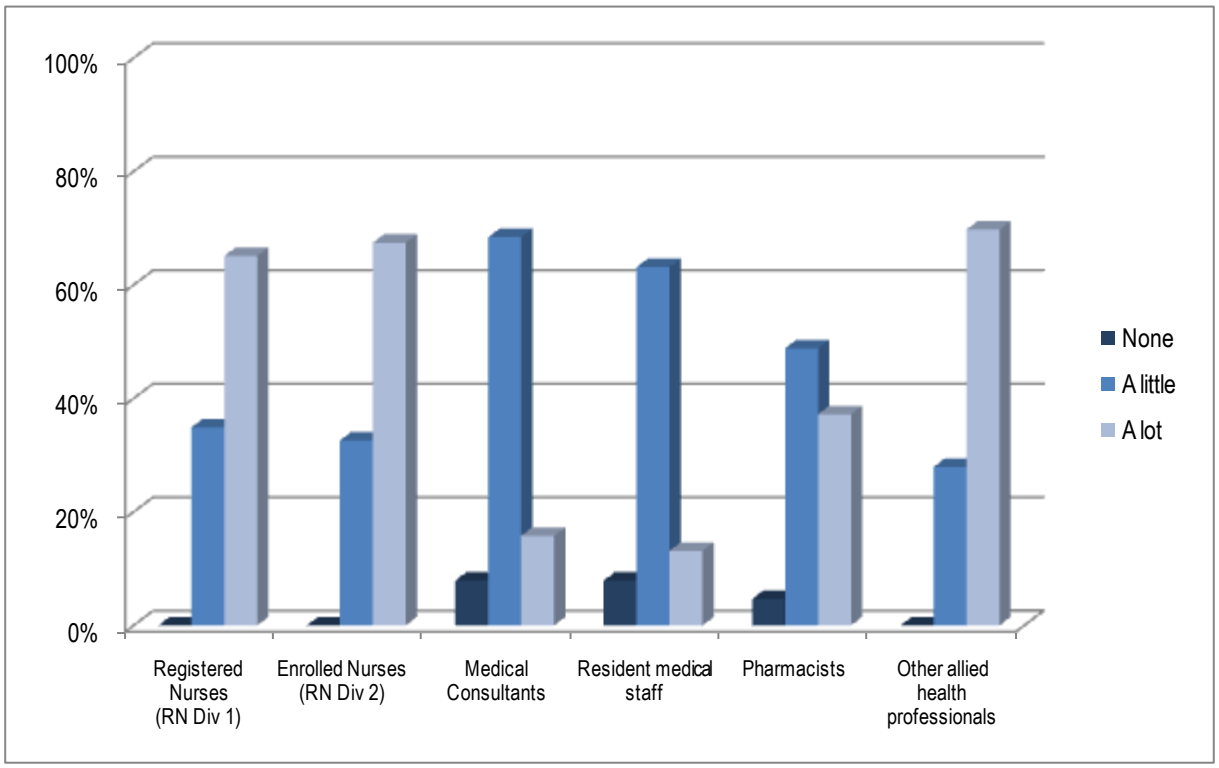


Appendix 4. Survey Report

Impact of HELP program on knowledge of care for older patients – American survey results

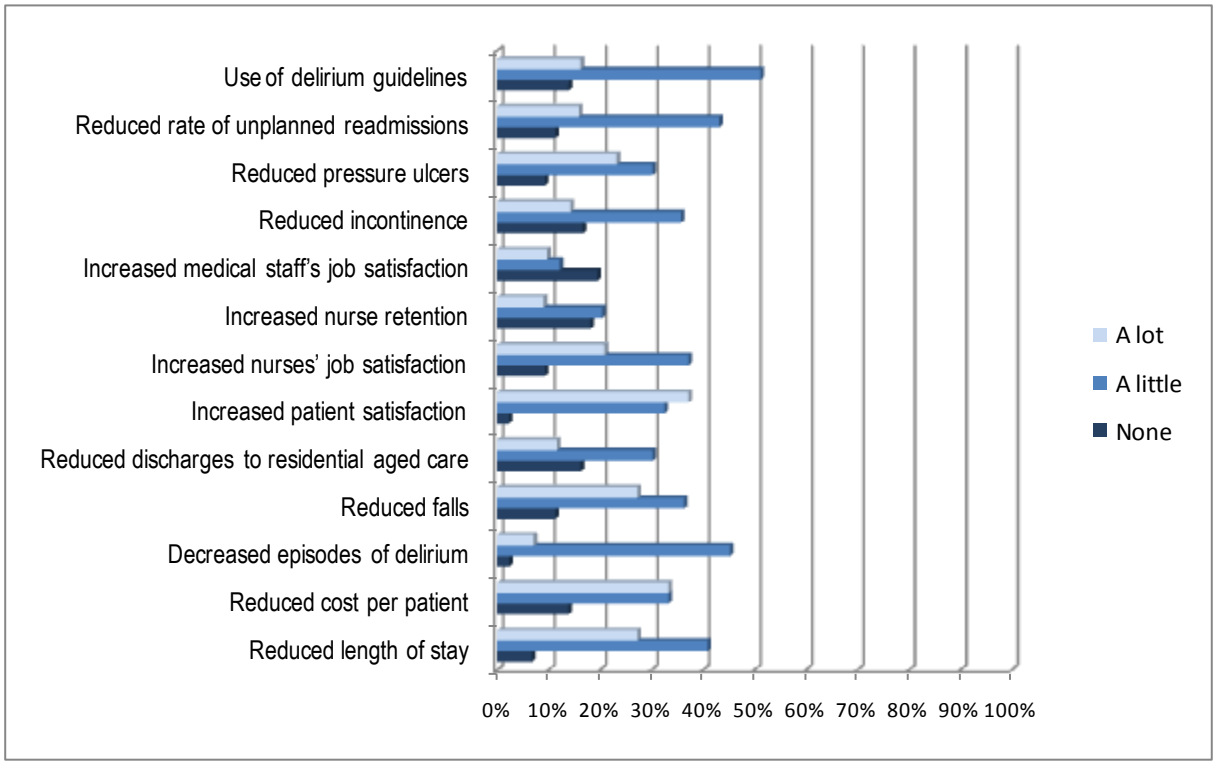


Impact of LSOP program on knowledge of care for older patients – LSOP Project Officer/Executive Sponsor Survey Results



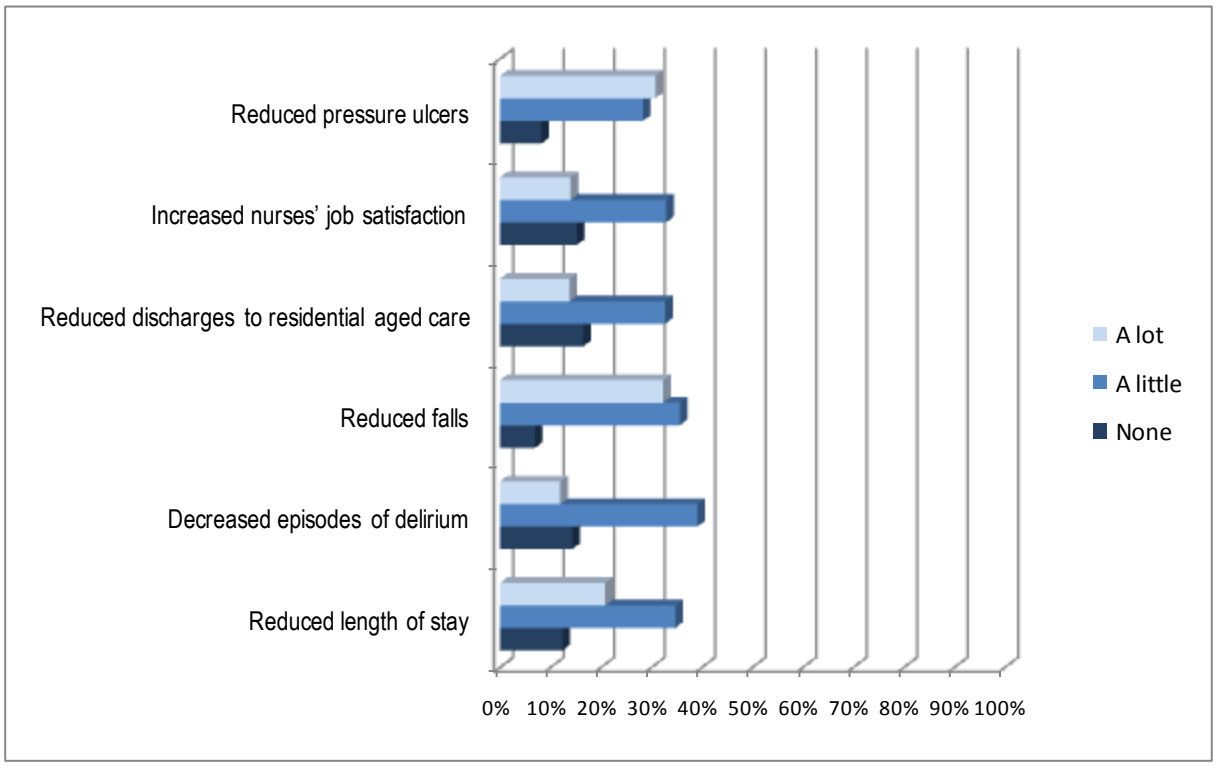
Appendix 4. Survey Report

Impact of LSOP program in your health service* - LSOP Project Officers and Executive Sponsors Survey



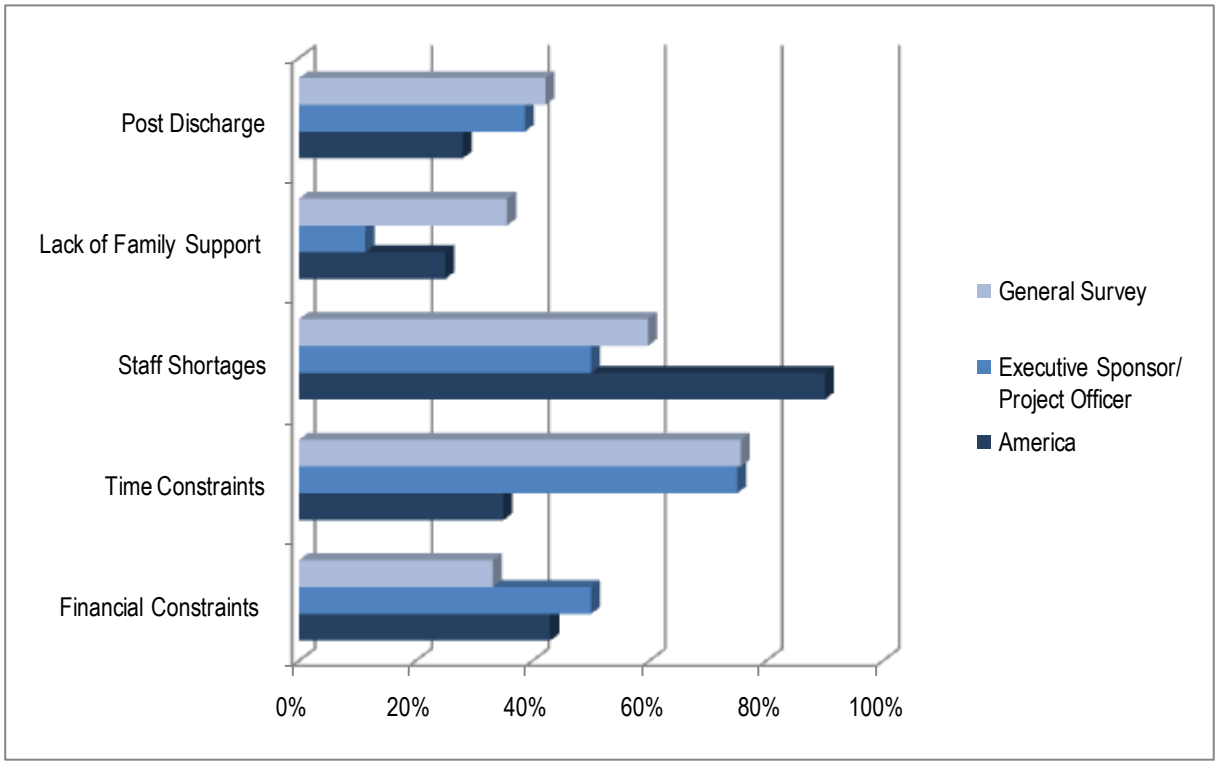
*Responses reflect all hospitals that completed this question
Note: The usual response to all of these questions was 'Don't know' (79%)

Impact of LSOP program in your health service* - LSOP General Survey



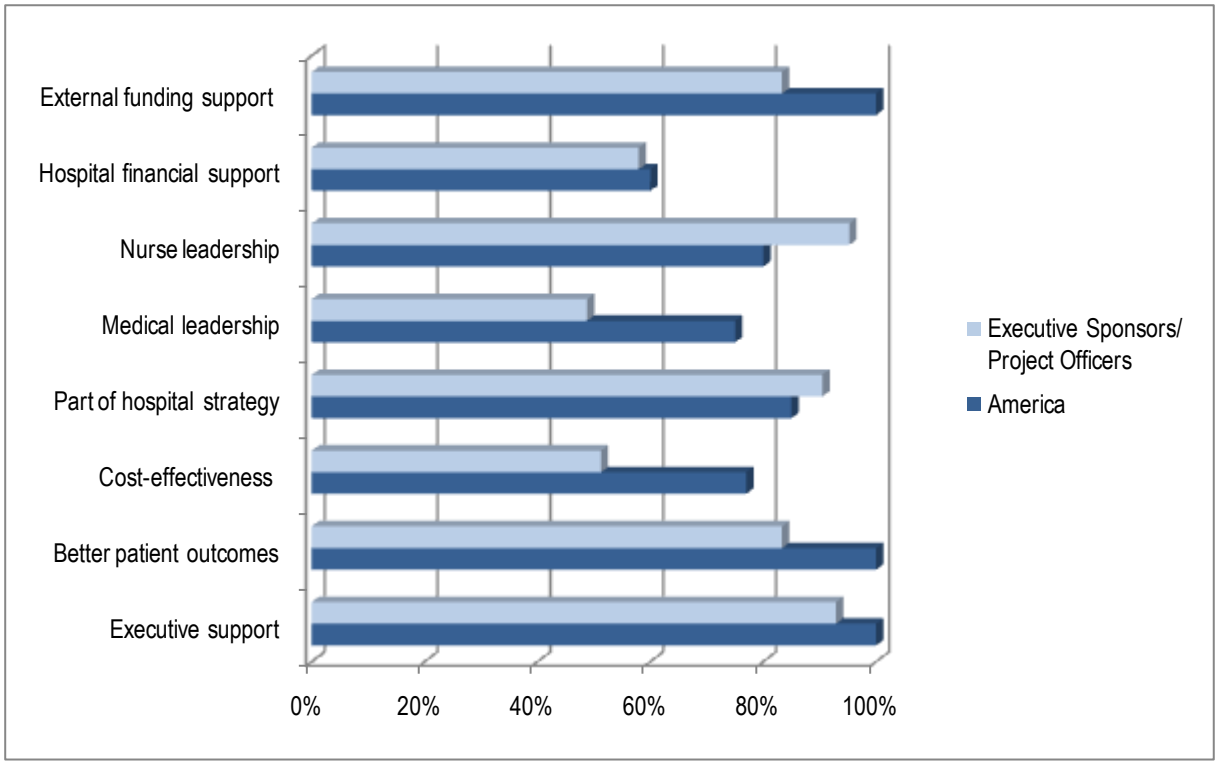
Appendix 4. Survey Report

Most pressing issues currently faced in caring for the elderly*



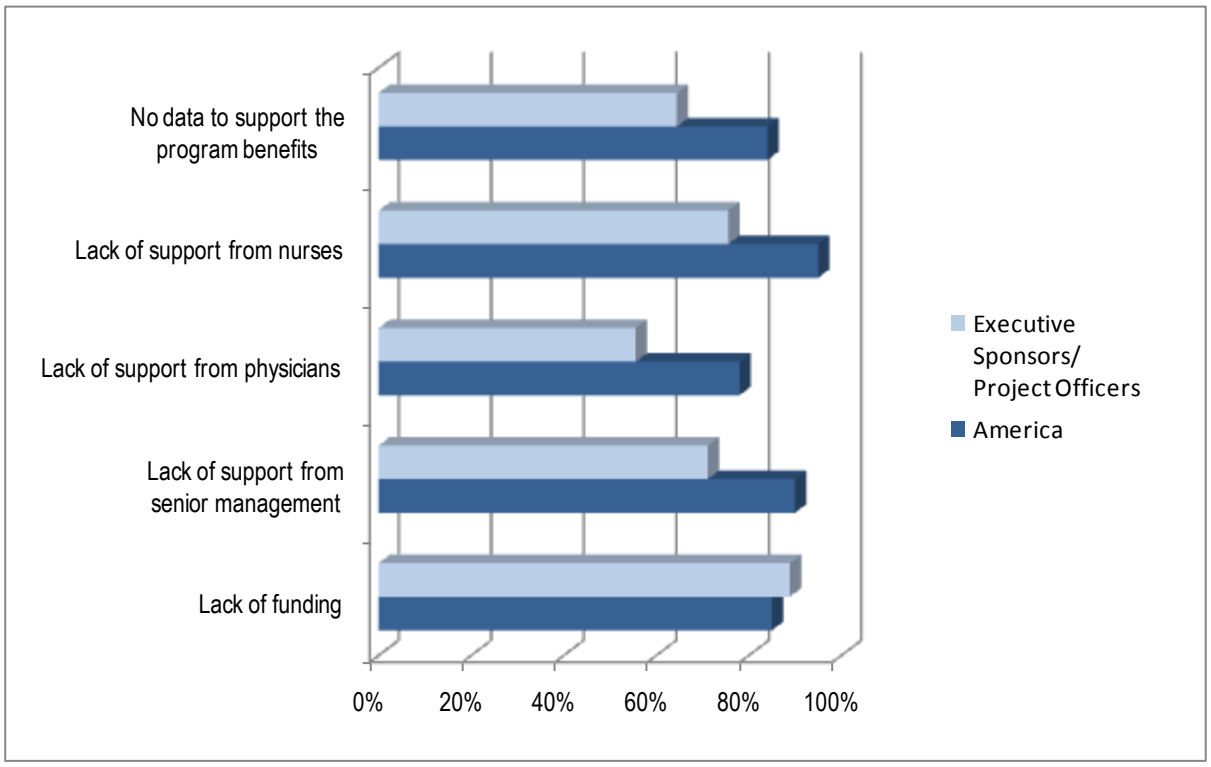
*Proportion of survey response identifying this as a pressing issue

Key factors supporting the enhancing care of older patients programs



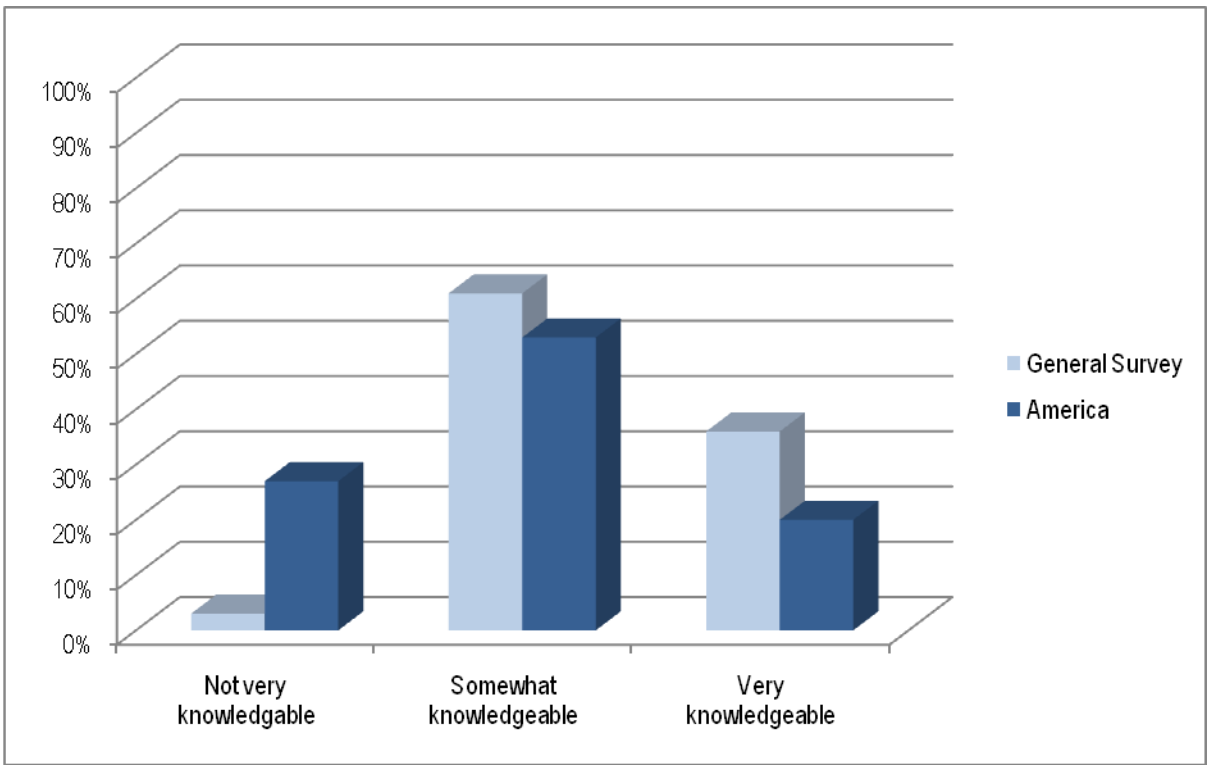
Appendix 4. Survey Report

Factors likely to limit sustainability of enhancing care of older patients programs*



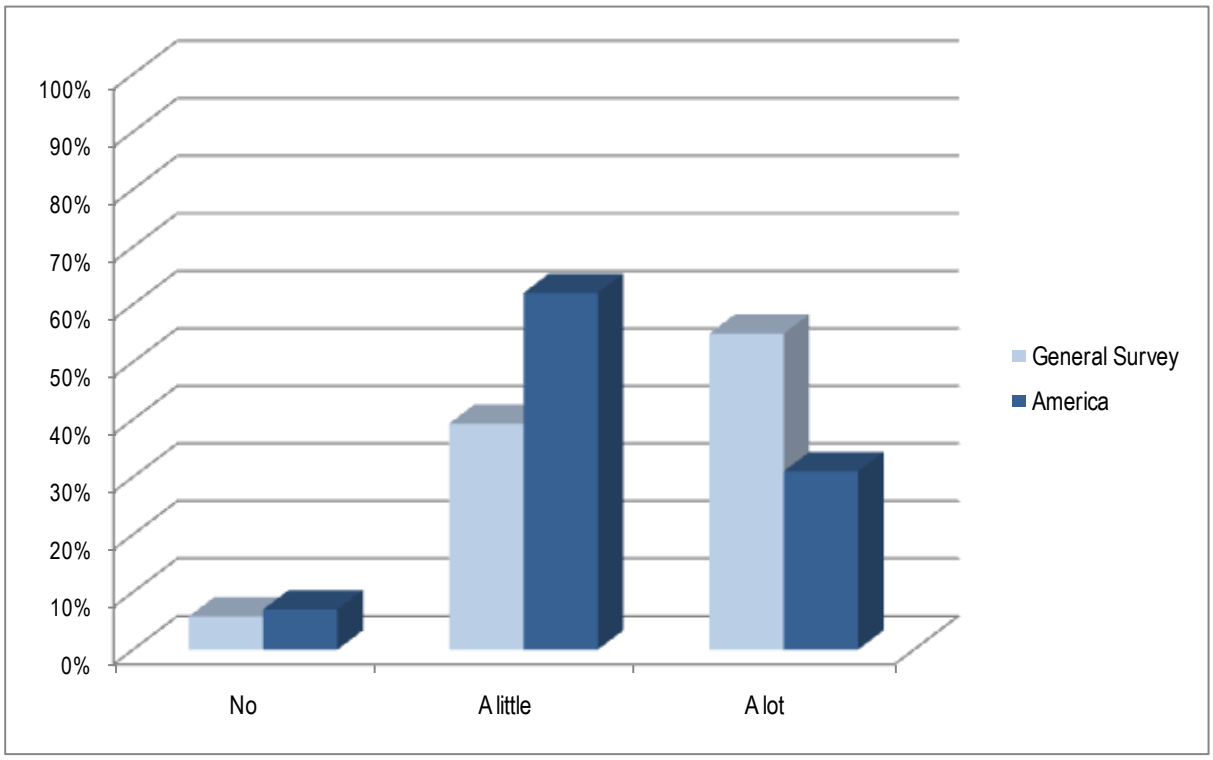
*Responses reflect all hospitals that completed this question

How knowledgeable do you consider yourself to be about basic principles surrounding the care of older adults?

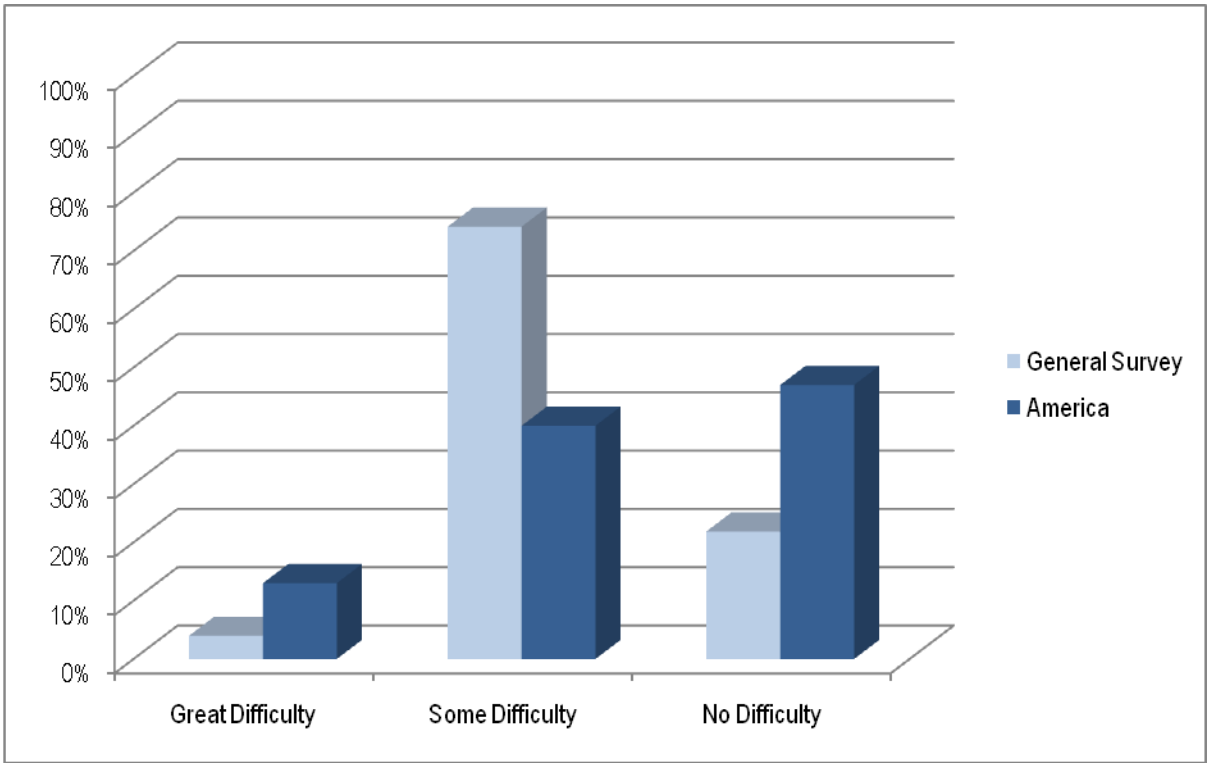


Appendix 4. Survey Report

Has your knowledge regarding care of older patients improved in the past 3 years?

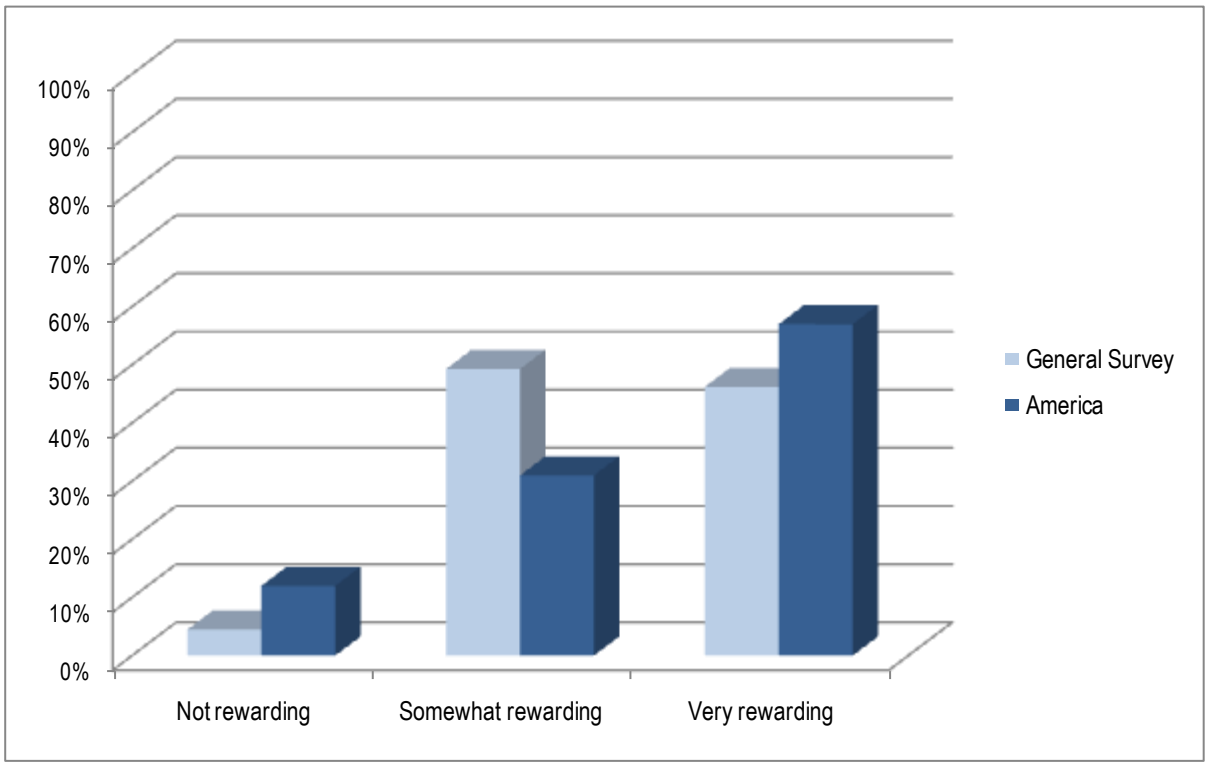


Overall, how much difficulty do you experience caring for the older adults in your work area?

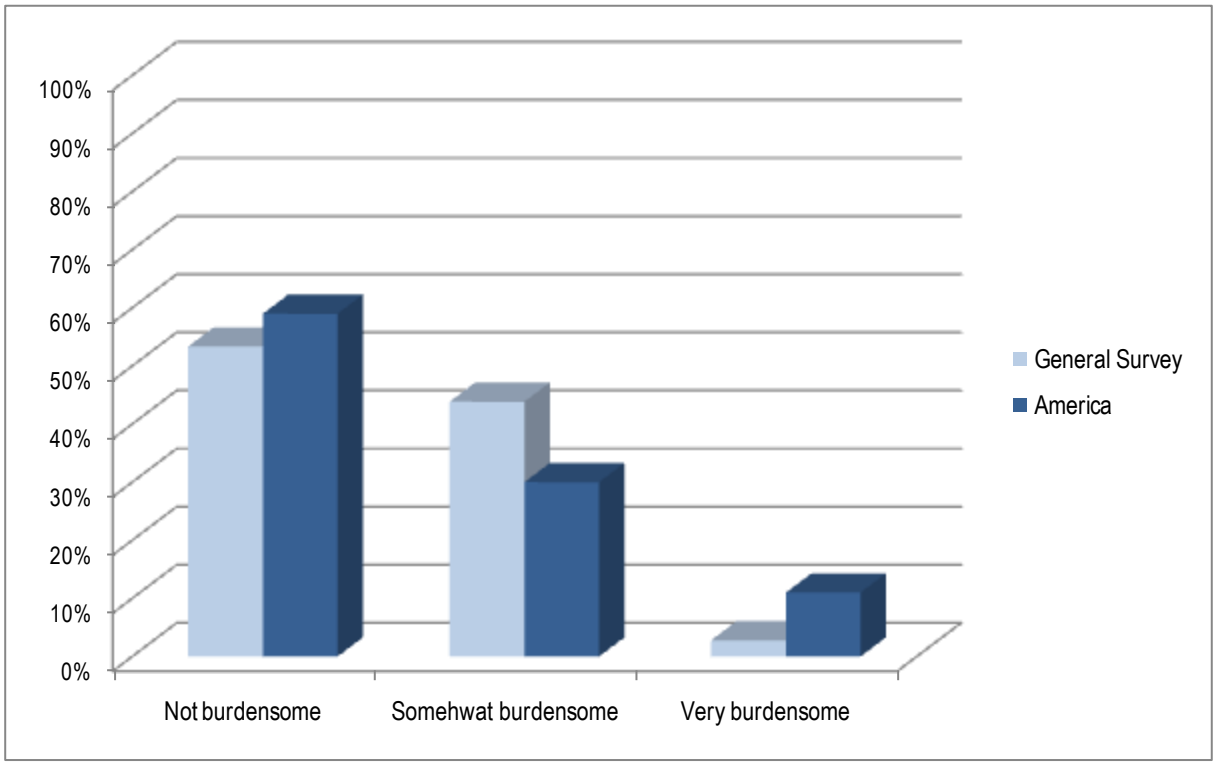


Appendix 4. Survey Report

How rewarding is your work with older adults



How burdensome do you find your work with older adults?



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Appendix 5
Advisory Group Membership

Appendix 5. Advisory Group Membership

COAG Long Stay Older Patients' Initiative Advisory Group - Membership	
Name	**Role**
Ms Susan Race (Chair)	Manager, Ambulatory and Continuing Care, DHS
Prof David Ames	Director, National Ageing Research Institute
Dr Caroline Brand	Director, Clinical Epidemiology and Health Service Evaluation Unit
Dr Michael Brignell	Geriatrician, Head of Aged Care, Western Health
Ms Karen Bull	Manager, Peninsula Health
Ms Annette Davis	Pharmacist, Northern Health
Ms Anne Franzi-Ford	Manager, Volunteer Coordinator, Peter MacCallum Cancer Institute
Ms Liz Hamilton	Executive Director, Bendigo Health Care Group
Ms Sue Hendy	Executive Director, Council Of The Ageing
A/Prof Keith Hill	-- LaTrobe University
A/Prof Peter Hunter	President, Australia and New Zealand Geriatric Medicine
Ms Maree Jeffs	Consumer Representative
Ms Christine Lloyd	Education Officer, Geriatric Medicine Training Project
A/Prof Michael Murray	Director of Medicine, St Vincent's Health
Prof Rhonda Nay	Gerontic Nursing, LaTrobe University
Ms Gill Pierce	Senior Policy Advisor, Carers Victoria
Ms Elizabeth Rand	Manager, Cognitive and Dementia Management Services, Bayside Health
Dr Andrew Perrignon	Chief Executive Officer, Northern Health
Ms Diane Petchell	Director Health Strategies, Commonwealth Department of Health and Ageing
Dr Mark Santini	General Practitioner
Ms Alison Stewart	Manager, Nutrition and Dietetics within Continuing Care, Southern Health
Dr Kwong Teo	Victorian Chair, Australasian Faculty of Rehabilitation Medicine
Mr Wayne Weaire	Director, Delatite Community Health Service, Benalla and District Memorial Hospital
Ms Carolina Weller	PhD Candidate, Department of Epidemiology and Preventative Medicine, Monash University
Ms Janne Williams	Director, Allied Health, Southern Health
Dr Kwong Teo	Victorian Chair of Australian Rehabilitation Medicine
Ms Jude Czerenkowski	A/Manager, Assessment, Aged Care Branch, Rural and Regional Health Care Services, DHS
Ms Ann-Maree Conners	Regional DHS Manager, Loddon Mallee
Dr Darren Harris	Manager, Funding Policy, Funding Health and Information Policy, DHS
Ms Sue O'Sullivan	Senior Project Officer, Access and Metropolitan Performance, Statewide Emergency Program, DHS
Ms Diana Quin	A/Manager, Victorian Quality Council
Ms Nicole Doran	Manager, Sub-Acute Services, DHS
Ms Charlotte Dart	Senior Project Officer, Health Independence Programs, DHS
Ms Belinda Gilsenan	Senior Project Officer, Sub Acute Services, DHS
Ms Tania Cossich	Senior Project Officer, Sub Acute Services, DHS
Ms Suzanne Corcoran	Senior Project Officer, COAG LSOP DHS – Loddon Mallee