Statewide Older People Clinical Network

Level 6 Area Geriatric Service
Geriatric Consultation Liaison Team
MODEL OF CARE

October 2013

Government of South Australia
SA Health

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Acknowledgements

The Geriatric Consultation Liaison Team workgroup was convened in October 2011, as a workgroup of the Statewide Older People Clinical Network Steering Committee. The workgroup was formed to develop a Model of Care for Geriatric Consultation Liaison Teams in Area Geriatric Services in South Australia.

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This document was endorsed by the members of SA Health's Portfolio Executive on 19 September 2013.

Abbreviations

AAA	Acute Assessment Area
ACAT	Aged Care Assessment Team
ACE	Acute Care of the Elderly
AGS	Area Geriatric Service
AMU	Acute Medical Unit
CA-LHN	Central Adelaide Local Health Network
CGA	Comprehensive Geriatric Assessment
ED	Emergency Department
FMC	Flinders Medical Centre
FTE	Full Time Equivalent
GCLT	Geriatric Consultation Liaison Team
GEM	Geriatric Evaluation and Management
GP	General Practitioner
LHN	Local Health Network
LMHS	Lyell McEwin Health Service
NA-LHN	Northern Adelaide Local Health Network
OPMHS	Older Persons Mental Health Services
RACF	Residential Aged Care Facility
RAH	Royal Adelaide Hospital
SA-LHN	Southern Adelaide Local Health Network
TCP	Transition Care Program
TQEH	The Queen Elizabeth Hospital

Disclaimer

This document has been developed by the Older People Clinical Network. The document is intended to be used to support the reform of health services within allocated budgets. The formation and development of Area Geriatric Services is considered optimal practice. It is expected the Local Health Networks will implement all recommendations that can be implemented without additional funding. It is the role of the Local Health Networks to determine which of the recommendations requiring the allocation of funding (from within the allocated LHN budget) they will implement and when. It is accepted, given the fixed allocation of funding, that there will be recommendations that may not be implemented within the timeframe to 2016. It is also accepted that optimal patient and system outcomes will not be achieved where Area Geriatric Services cannot be fully implemented.

Summary

The Geriatric Consultation Liaison Team is designed to improve access for those referring older people to specialist geriatric services; provide consultation out to patients who are not in specialist geriatric inpatient units; arrange admission for older people into specialist geriatric inpatient units; and connect older people into community based specialist geriatric services.

The Geriatric Consultation Liaison Team will bring together existing disparate assessment, liaison and patient finding roles into a central team operating under the governance of the Local Health Network's Area Geriatric Service, to:

- Serve as a Point of Contact into the AGS for Level 4 (country) Area Geriatric Services, for General Practitioners, other referring specialists, and other service providers (where the patient has no General Practitioner).
- Provide a response by telephone for information or by consultation where a patient requires review.
- Facilitate direct admission from community into an Area Geriatric Service Acute Care of the Elderly unit or Geriatric Evaluation & Management unit.
- Screens people 80 years and over in the Emergency Department and in the Acute Medical Unit to assess their need for Area Geriatric Services. (Unless screening is undertaken by Emergency Department discharge liaison staff).
- Identify and support the transfer of inpatients into Acute Care of the Elderly units or Geriatric Evaluation and Management units.
- Support the discharge of patients:
    - To Area Geriatric Service community outpatient and outreach services;
    - To the Transition Care Program and other subacute services including Rehabilitation, Pyschogeriatrics and Palliative Care; and
    - Back to Country Health SA- Health Network (CHSA-HN) services.
- Provide access to a consultation/liaison service to enable patients in non-Area Geriatric Service units to receive timely access to specialist geriatric services.
- Provide education and advice to all staff in the care of older people, using the 12 Domains of the Care of Older People Toolkit [1] – as the standard reference.
- Provide education and advice to all staff, and services as a champion of the 10 principles of Dignity in Care [2].

The Geriatric Consultation Liaison Team provides these services to all patients in metropolitan hospitals, including country people in metropolitan hospitals.

The following recommendations are made as a guide to the implementation of level 6 Geriatric Consultation Liaison Team services:

- Each metropolitan Local Health Network forms an Area Geriatric Service based Geriatric Consultation Liaison Team service that includes a point of contact, resourced by senior clinicians.
- Each metropolitan Local Health Network communicates to internal and external stakeholders how to access Area Geriatric Services through the Geriatric Consultation Liaison Team service point of contact.
- Each metropolitan Local Health Network supports geriatrician approved direct admission of patients into Area Geriatric Service wards.
- Each metropolitan Area Geriatric Service Geriatric Consultation Liaison Team establishes a program of education sessions for the benefit of the Local Health Network workforce on the content of the 12 Domains of the Care of Older People Toolkit [1] and the 10 Principles of Dignity in Care [2].
- The Local Health Networks work with the Older People Clinical Network on research strategies to determine if and how older patients in hospital should be screened to identify those who would benefit from access to Area Geriatric Services.

1. Introduction

South Australia has an ageing population [3]. Older people are significant consumers of health services and older people have a higher risk of functional decline [4] and the development of geriatric syndromes when unwell and when in hospital [5]. Specialist health services need to be well organised and provided efficiently in order to appropriately meet their needs.

The Geriatric Consultation Liaison Team (GCLT) is designed to improve access for General Practitioners (GPs) and specialists (including those from country location) referring older people to specialist geriatric services, provide consultation out to patients who are not in specialist geriatric inpatient units and to connect patients into inpatient and community based specialist geriatric services. These connections are required to make sure patients receive the right service, by the right team, at the right time in the right location. In doing so, health services will support older people to maintain their optimal level of function and therefore optimise their level of independence and maintain their dignity.

The Health Services Framework for Older People 2009-2016 [6] proposes the formation of integrated Regional Older People's Health Services (referred to here as Area Geriatric Services (AGS)) for each of the Local Health Networks (LHN), with Level 6 Area Geriatric Services (AGS) in the three metropolitan LHNs linked to the Level 4 services within Country Health SA-Health Network (CHSA-HN). The GCLT is an essential component of an AGS.

An AGS does not provide all health services to older people, an AGS provides specialist health care services by an interdisciplinary team, under the leadership of a geriatrician, that includes screening, comprehensive assessment and management to acute and subacute services within the AGSs and services into other non-AGS acute and subacute services through the AGS GCLT. The AGS leads teaching, training and research in geriatric health [7].

This document does not cover orthogeriatrics. A separate Model of Care needs to be developed for this specialist service.

2. Purpose

The purpose of this document is to describe current practice in each LHN, the evidence for the optimal GCLT model of care and the future state model of care.

3. Why reform current practice?

This Model of Care considers Level 6 (metropolitan) AGSs. Each of the metropolitan LHNs currently has some form of GCLT service, but services are variable across the three LHNs, meaning the consumer may be advantaged or disadvantaged depending on where they are receiving their service.

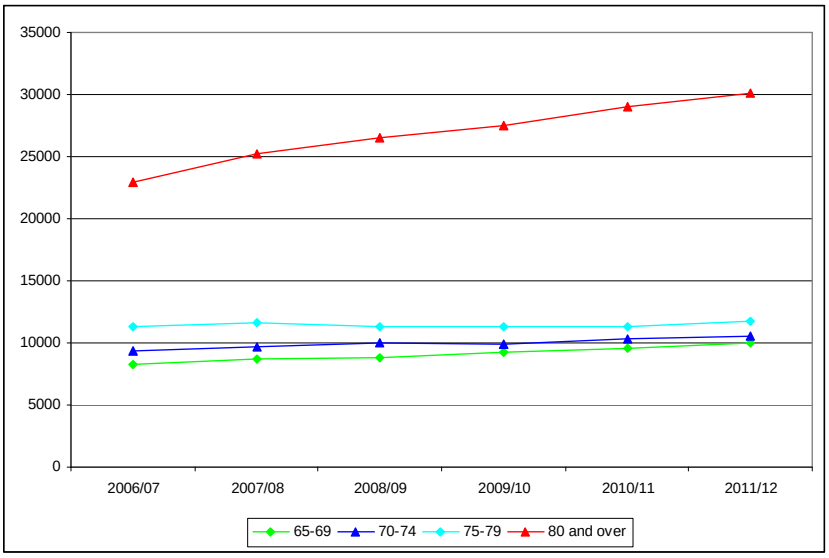
It is expected that GCLTs will be formed by bringing together existing disparate assessment, liaison and patient finding roles into a centralised team under governance of the AGS. This should improve the efficiency of consultation / liaison roles for older people.

The increasing demand for acute health services by those aged 80 years and over also strongly supports the need for change.

3.1 Trends in admitted activity

The number of overnight separations for people in each of the age categories 65-69, 70-74, 75-79 years has remained consistent over the previous six years, but the number of overnight separations for people aged 80 years and over has increased each year [8] (Table 1).

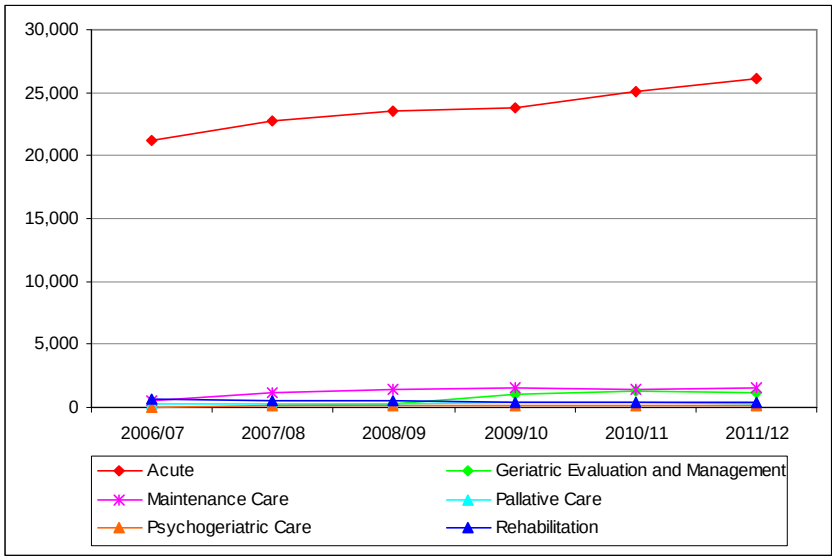
Table 1. Overnight separations for people aged 65 years and over in SA's major and general metropolitan hospitals (NHS RGH FMC MH LMHS RAH TQEH)



Source: ISAAC

For those aged 80 and over the activity in overnight separations is predominantly for acute activity [8] (Table 2).

Table 2. Overnight separations by Episode of Care Type for people aged 80 years and older in SA's major and general metropolitan hospitals (NHS RGH FMC MH LMHS RAH TQEH)



Source: ISAAC

The AGS's Acute Care of the Elderly (ACE) and Geriatric Evaluation and Management (GEM inpatient units will not be able to accommodate and should not need to accommodate all older people admitted to hospital. However, older people not admitted to specialist AGS units, should have access to specialist geriatric services through the GCLT.

3.2 Description of an Area Geriatric Service

An AGS provides the clinical governance for all specialist older people's health services within an LHN. Each AGS is responsible for measuring and managing their budget, clinical, service, teaching and research performance.

To aid in the description of an AGS, a conceptual model of a Level 6 (metropolitan) AGS is presented in Figure 1. The conceptual model reflects AGS acute services (coded red), subacute services (coded orange) and community services (coded green). For an AGS to function there needs to be some dedicated acute service, more subacute than acute services and substantial capacity in community based services.

The conceptual model illustrates how older people who are living in the community, at home with community support or in residential aged care, connect though their General Practitioner (GP) (or other service provider) to access specialist community, subacute or acute inpatient AGSs.

Each AGS should have an identifiable point of access, with a single contact number, based at the AGS's 'hub' within the LHN's general hospital, and resourced by the Geriatric Consultation Liaison Team (GCLT). The role of the GCLT is to improve access for those referring older people to specialist geriatric services; actively screen older people in the Emergency Department and non AGS units to determine their need for

AGSs, provide consultation out to patients who are not in specialist geriatric inpatient units; arrange admission for older people into specialist geriatric inpatient units (GEM and ACE); and connect older people into community based specialist geriatric services (TCP, Maintenance, Case Management, Community Outreach and Community Outpatient Services).

As depicted in the conceptual model (Figure 1), the AGS works closely with Rehabilitation, Palliative Care, Older Persons Mental Health Services and the South Australian Dental Service.

The AGS works closely with non-AGS community based services and Residential Aged Care providers to collaborate in the provision of care and connect in the transition of care.

Mostly older people's interaction with the AGS will be intermittent, and their interaction with primary health care, through their GP, and community care, possibly through a Home Care package [9] or other community services, will be ongoing. The AGS collaborates with the GP during the intermittent episodes of AGS involvement, and the GP, as the central point of co-ordination of care, maintains the collaboration with the community service provider(s). In the absence of a GP, the AGS collaborates with the community service provider(s).

The AGS is described slightly differently for Country Health-SA, but both Level 6 AGSs (metro) and Level 4 AGSs (country) have an access point through which referrals and communication can take place [7].

To understand the component parts of an Area Geriatric Service in greater detail, this document should be read in conjunction with:

- Description of an Area Geriatric Service [7]
- Acute Care of the Elderly Unit Model of Care [10]
- Geriatric Evaluation & Management Unit Model of Care [11]
- Community Geriatric Services Model of Care [12]

3.3 Role of GCLT in the context of an AGS

The GCLT provides the Point of Contact into the AGS for GPs and specialists (including those from country location) referring older people to specialist geriatric services.

An AGS, with access to AGS governed GCLT services, can provide access to specialist geriatric services to older people in the community or in non-AGS inpatient wards, and when required, arrange for admission of older people into specialist geriatric inpatient units.

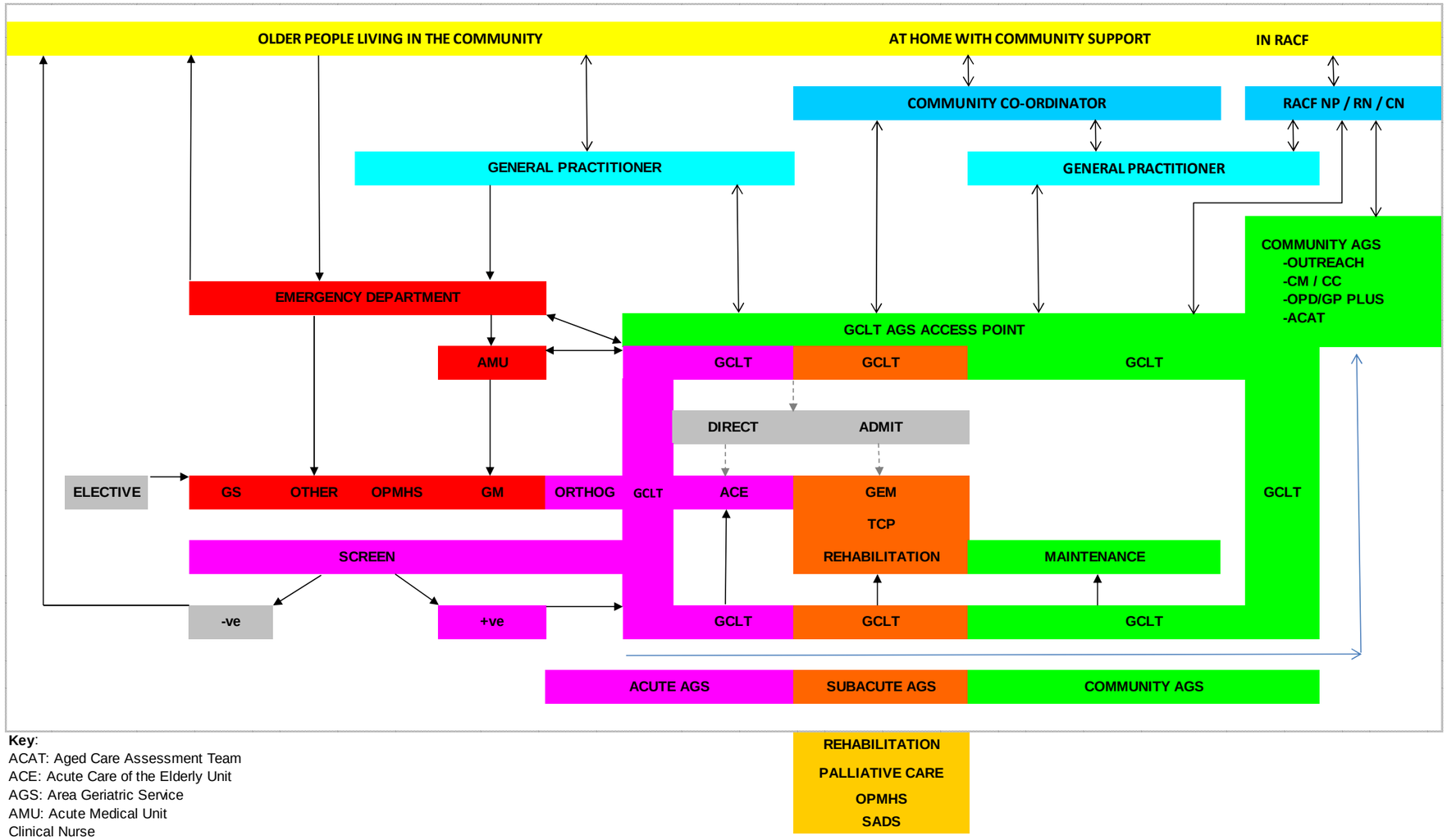
It is well understood that LHNs are in different stages of implementation of AGSs. Each component of the service is required to form an efficient AGS. Each component of the

service is required to be fully resourced to support the proper function of the AGS. The distribution of resources across the AGS needs to recognise the need for capacity in community, subacute and acute components of the service.

The role of the GCLT in the context of the AGS is presented in the L6 AGS conceptual model (Figure 1). A full description of an AGS is provided in Description of an Area Geriatric Service document [7].

The conceptual model reflects acute services in red, subacute in orange and community services in green. For an AGS to function, there needs to be some dedicated acute service (coded red), more subacute than acute services (coded orange) and substantial capacity in community based services (coded green).

Figure 1. Conceptual Model of a Level 6 Area Geriatric Service



Key:
ACAT: Aged Care Assessment Team
ACE: Acute Care of the Elderly Unit
AGS: Area Geriatric Service
AMU: Acute Medical Unit
Clinical Nurse
CM/CC: Case Management / Care Co-ordination
GCLT: Getriatric Consultation Liaison Team (includes Access Point)
GEM: Geriatric Evaluation and Management
GM: General Medicine
GS: General Surgery
GP+: GP Plus Clinics
NP: Nurse Practitioner
OPD: Outpatient Department
OPMHS: Older People Mental Health Service
ORTHOG: Orthogeriatrics
OTHER: Refers to all other clinical units patients might be admitted under
RACF: Residential Aged Care Facility
RN: Registered Nurse
SADS: South Australian Dental Service

4. Current State Model of Care

The current state role and function of the GCLTs have developed as a result of local influences, including how far each LHN has progressed implementation of the full complement of AGSs.

4.1 SA-LHN

The SA-LHN spans three hospitals and each has a different model of Geriatric Consultation and Liaison.

At the Repatriation General Hospital (RGH), Flinders Medical Centre (FMC) and Noarlunga Health Services (NHS), geriatric medical consultation to patients not admitted to a geriatrics unit is accessed by directly liaising with a Geriatrics Registrar, supported by a rostered geriatrician. Typical issues include the evaluation and management of geriatric syndromes, particularly dementia and delirium, behavioural disturbance and assessment of decision-making capacity. At RGH, this Registrar also provides general medical support to Psychogeriatrics and Rehabilitation services.

Additionally at RGH, a Level 3 GEM Triage Nurse (fulltime weekdays) screens all medical admissions to the RGH and liaises closely with the other medical and allied health teams to identify and 'pull' suitable candidates for the RGH GEM service. The 'Guidelines for GEM Admissions' form, and the support of the duty Geriatrician, is used by the triage nurse to support decision making. The GEM Triage Nurse also assists the other medical and allied health teams with future and discharge planning of the patients, regardless of the involvement of GEM. Direct admission, from FMC's Acute Medical Unit or the community, to the GEM unit can be arranged in liaison with the GEM medical team and GEM Triage Nurse.

At FMC, patients are identified and 'pulled' to ACE by the ACE Allied Health Team Leader at the daily General Medicine handover meeting. This role is predominantly focused on the identification of patients that would benefit most from a multidisciplinary comprehensive geriatric assessment and management, with little other liaison role. The ACE Allied Health team, on occasion, consults on patients with complex management related to geriatrics syndromes admitted under non-geriatric units. Additionally, a Clinical Practice Consultant reviews the ongoing management of any patient with dementia-related behavioural disturbance requiring one to one nursing, liaising with the treating team with geriatrician support.

At NHS, patient admissions to GEM are identified by referral from other teams at FMC, RGH or NHS.

The Community Geriatrics Service (CGS) is a small interdisciplinary team based at the RGH servicing southern Adelaide that provides assessment and support to older community patients and their carers with complex care needs. CGS has a role in facilitating discharge and hospital avoidance by providing timely follow up, linking and

advocating for services to support them at home and access to specialist geriatrics assessment in the community. Should community clients need inpatient admission, CGS also facilitate direct admission to the most appropriate unit, frequently ACE or GEM. CGS is supported by a rostered community geriatrician, available for outpatient review or home/residential aged care facility visits. The majority of referrals are from general practitioners trying to support their patients at home, with others from geriatricians and acute hospital services.

4.2 CA-LHN

The Queen Elizabeth Hospital (TQEH) has a GEM Liaison Team within the Aged & Extended Care Services. The team is led by the Geriatrician on duty, and is staffed by a Geriatrics Registrar (1 FTE) who may work as the Liaison and Community Registrar during a 6 month block, a Clinical Practice Consultant (0.8FTE) and 3 Clinical Nurses (2.5 FTE) who work only in the inpatient setting but are separate from the GEM ward nursing staff. The GEM Liaison Team operates weekdays from 8am to 5pm.

The GEM Liaison Team has five main functions:

- To identify patients who could benefit from admission to the GEM Unit. The GEM Liaison Team manages the waiting list for the GEM Unit and prioritises patients for admission to the unit;
- To provide access to a Geriatric Consultation service for patients not admitted to the GEM Unit;
- To provide all patients access to other Area Geriatric Services;
- To provide all patient access to other subacute services;
- To provide education and support in the care and management of older people to TQEH staff.

The GEM Liaison Team will identify patients by age, screening all patients aged 70+ and Aboriginal people aged 50+ who are admitted to the Acute Medical Unit. The team will also identify patients by attending the discharge planning meetings on other wards.

The team will take referrals from other units, who can contact the GEM Liaison Team nurses or the Geriatric Liaison Registrar directly. The nurses will assess the patient and report their findings to the Geriatrician and Geriatrics Liaison Registrar at their daily meeting. Where necessary the Geriatrician or Geriatrics Liaison Registrar will visit the patient on the ward and decide if the patient is to be admitted to the GEM unit, or remain on the treating team's ward, under the care of the treating team, and receive daily Geriatrics consultation with oral and written advice on interdisciplinary patient management, or referred to other Area Geriatric Services such as Community Geriatric Services or Outpatient Clinics or referred to other subacute services including Rehabilitation, Palliative Care or Psychogeriatrics.

Members of the GEM Liaison Team attend a weekly meeting with the hospital's Consultation Liaison Psychiatrist to identify patients requiring access to Area Geriatric Services.

The team will also take referrals from the community. The patient can be referred by their General Practitioner who will fax a referral to the hospital. The patient will then receive a visit from the Community Geriatrics Registrar who will determine which service(s) the patient needs. If that service is a GEM Unit admission, the Community Geriatrics Registrar will work with the GEM Liaison Team to arrange direct admission into the GEM unit.

The TQEH has an orthogeriatric liaison service described in the Orthogeriatric Model of Care (under development).

The Royal Adelaide Hospital (RAH) has a Geriatric Consultation Service (GCS) staffed with a Consultant Geriatrician and a Registered Nurse. The Consultants have a roster of days that they are assigned to the GCS; the nurse is full time in the dedicated GCS position. The GCS respond to requests for patient review and undertake their own case finding.

The GCS has 3 main functions:

- To identify patients who should be transferred to the Acute Geriatric Ward at the RAH;
- To identify patients who should be transferred to the medical rehabilitation ward or the stroke rehabilitation ward at Hampstead;
- To advise and assist with the discharge planning of patients from any ward at the RAH.

The RAH has an orthogeriatric liaison service described in the Orthogeriatric Model of Care (under development).

4.3 NA-LHN

The NA-LHN has a Geriatrics Registrar in training (as of September 2012, soon to be appointed) located at the LMHS and two part time Associate Nurses (1.0 FTE) located with the GEM unit at Modbury Hospital who, with the support of the GEM Clinical Services Co-ordinator, comprise the Geriatric Liaison Team. The Geriatric Liaison Team staff operate within the governance of the Area Geriatric Service which belongs to the NA-LHN's Subacute Services stream. The Geriatric Liaison service operates Monday to Friday 7 to 3.30pm.

The GEM Liaison Team has five main functions:

- To identify patients at the LMHS or at Modbury Hospital who could benefit from admission to the Modbury Hospital GEM Unit. The GEM ward CSC works with the

GEM Associate Nurses to manage the waiting list for the GEM Unit and prioritises patients for admission to the unit;

- To provide access to a Geriatric Consultation service for patients at the LMHS who will not be admitted to the GEM Unit;
- To provide all patients access to other Area Geriatric Services;
- To provide all patients access to other subacute services;
- To provide education and support in the care and management of older people to NA-LHN staff.

The target population are patients aged 65+ and Aboriginal people aged 55+ who are medically stable, have no major behavioural issues, were mobilising prior to admission, do not need high level residential aged care, are not awaiting placement and preferable have been in hospital less than 7 days.

Internal Modbury Hospital referrals are mostly made by the Transition Care Unit staff who operate throughout the hospital (ED, AMU and wards). Internal LMHS referrals are mostly made by the ED Liaison Nurses and the Home Link nurses (1.0FTE Medical and 1.0FTE Surgical).

Referrals are made into the Geriatric Liaison Team using the Oacis referral page. No specific screening tool is used.

5. Evidence to support change

5.1 Policy

The Health Services Framework for Older People 2009-2016 [6] makes no specific reference to geriatric liaison services.

A number of key policy documents have been identified that support the role of geriatric consultation liaison. The Australian and New Zealand Society for Geriatric Medicine [13] state that "to provide effective acute care services to older people, a hospital requires… a multidisciplinary consultancy service, led by a trained geriatrician working closely with nursing and allied health staff, with a process to facilitate early referral…" (p.1).

The British Geriatrics Society [14] has made a number of recommendations regarding geriatric liaison services, including the need for a 24/7 single point of access and urgent response out into the community, and greater use of geriatric liaison services in acute medical units to increase the proportion of older people able to be managed in the community setting. They suggest the Older Persons Assessment and Liaison team (OPAL) (p.26) as an example of how such as service has improved patient outcomes.

Western Australia's Aged Care Network [15], identifies capacity in geriatric consultation and liaison as a gap in service provision in relation to delirium treatment and

management, stating… "There is limited and inconsistent access to consultation, liaison and advice from geriatricians and psychiatrists of old age. Management of patients with delirium occurs in a range of settings, especially emergency departments and acute medical and surgical wards. Mostly, these are not equipped to properly manage the care of older people with delirium. Care is provided mainly by medical and nursing staff without expertise in the care of older people. Medical and nursing staff often have limited skills and training in managing delirium and the associated problematic behaviours" (Appendix 2, p. 39)

5.2 Literature

The literature examines the role of different models of GCLT in a variety of settings over many decades with mixed results.

Inpatient Comprehensive Geriatric Assessment (CGA) has been shown beneficial in a variety of domains however the majority of the studies and benefit is in those patients admitted to a specialised geriatrics unit [16]. Inpatient GCLT has been demonstrated to lead to higher rates of identification of geriatric syndromes [17] and earlier geriatric intervention (ward-based case management & transfer to appropriate geriatric wards) [17]. Whilst an inpatient, GCLT leads to reduced functional decline [18-21], triaging to outpatient services [17], and reduced length of stay [17,20-22] and hospital costs [20]. Following discharge there is a reduction in health-care utilisation [21], institutionalisation [21] and survival [18]. However other literature suggests GCLT may not impact function [23-27], hospital-acquired complications [28], health-care utilisation [23,24,27,29], institutionalisation [24,30] or survival [23,24,26,30].

However there are many difficulties in applying the current evidence to practice today - the literature highlights differences over decades in health-care systems across the world, including models of inpatient care and GCLT, differences in community services, sub-acute and long-term care models and availability, and the rising awareness and uptake of geriatric principles and multidisciplinary involvement in non-geriatric wards over time.

Community GCLT is even more varied in staffing, models and sites of care, and delivery, combined with varying eligibility, outcome measures and low statistical power in the literature, making the evidence even harder to interpret and translate. Whilst a recent meta-analysis has shown some improvement in health-care utilisation, institutionalisation, falls, and physical function, other studies have demonstrated more sobering results [31-33].

Despite these uncertainties, position statements/policy documents (Section 6.1) and worldwide practice supports the role of a GCLT for the hospitalised elderly on the basis of some evidence and face validity. Models of GCLT have variable size of the interdisciplinary team, however at their core remain geriatrician and nursing expertise. Typically, with the support of the treating medical team, patients are identified by a

screening process to identify high-risk individuals for functional decline, or complicated and prolonged admissions. This screening process is essential to target high-risk patients to maximise the benefit and effectively use the limited resource of GCLT [27]. These patients then have a multidisciplinary CGA and recommendations made in consultation with the treating team. The GCLT frequently participates in team conferences, and some models incorporate transition and follow-up visits in the community post-discharge. A significant challenge is the translation of recommendations made by GCLT into practice by referring specialists and primary care physicians.

Whilst the body of literature does not give compelling evidence for the use of GCLT, it may be that team care may improve the process of care (eg. systematic practice such as adherence to guidelines and process quality measures), rather than outcomes [32].

6. Future State Model of Care

The future state describes the agreed model of care for a GCLT service, based on policy and evidence published in the literature.

6.1 Overview

A future state GCLT is a geriatrician led team of clinicians with expertise in the care of older people. The GCLT works across the acute, subacute and community components of an AGS to connect services within the AGS and connect the AGS to other services.

6.2 Target Population

Patients 65 years and older (those younger than 65 years to be considered on a case by case basis), with a priority for those aged 80 years and over, and 50 years and older for Aboriginal people, who:

- Are at risk of functional decline; and/or
- Are at risk of or who have geriatric syndromes (delirium, frailty, falls, fracture); and/or
- Are at risk of prolonged hospitalisation

6.3 Referral in to GCLT

A Level 4 (country) AGS, the patient's GP or treating specialist can refer a community based patient to the AGS through the Level 6 (metropolitan) GCLT Point of Contact. If the patient does not have a GP then the GCLT Point of Contact will accept referrals from other health providers.

The ED team or non-AGS inpatient unit can refer patients to the GCLT.

The GCLT will determine if the person requires AGSs (ie specialist care) and refer them to either an AGS ward, subacute care or community based AGSs.

For inpatients, the GCLT may arrange with the non AGS treating team to provide consultation on the persons care while the person remains admitted in the non-AGS ward.

6.4 Screening

It is optimal to screen all patients aged 80 years and over to identify patients requiring further management by the AGSs. The GCLT should undertake screening of patients 80 years and older in the Acute Medical Unit and/or Emergency Department. There is currently no existing screening tool that can be relied upon by others to screen and refer to the AGS. Therefore, the screening process must be undertaken by skilled geriatrics/gerontology clinicians to determine further assessment and management to avoid unnecessary referrals as well as ensure that those that require access gain access in a timely manner.

6.5 Consultation / Liaison

The focus of the GCLT is in the management of geriatric syndromes that would benefit from CGA such as dementia, delirium and falls. The liaison service provides for close collaborative working relationship with areas where there is a high proportion of frail older people such as the Acute Medical Unit, General Medicine and the Orthopaedic Service. Within these ward areas, the liaison service will be an integral member of the multi-disciplinary team of clinicians providing assessment and management as well as participating in education and quality improvement initiatives within those areas. The consultation service will support requests for advice and management from the rest of the hospital.

6.6 Role of the Geriatric Consultation Liaison Team

The role of the Geriatric Consultation Liaison Team is to:

- Serve as a Point of Contact into the AGS for Level 4 AGSs, for GPs, other referring specialists, and other service providers (where the patient has no GP).
- Provide a response by telephone for information or by consultation where a patient requires review.
- Facilitate direct admission from community into an AGS ACE unit or GEM unit.
- Screens people 80 years and over in the Emergency Department and Acute Medical Unit to assess their need for Area Geriatric Services. (Unless screening is undertaken by Emergency Department discharge liaison staff).
- Identify and support the transfer of inpatients into ACE or GEM units.
- Support the discharge of patients:
    - To AGS community outpatient and outreach services;

    - To the Transition Care Program and other subacute services including Rehabilitation, Pyschogeriatrics and Palliative Care; and
    - Back to LHN services.
- Provide access to a consultation/liaison service to enable patients in non-AGS units to receive timely access to specialist geriatric services.
- Provide education and advice to all staff in the care of older people, using the Care of Older People Toolkit [1] – as the standard reference.
- Provide education and advice to all staff, and services as a champion of the 10 principles of Dignity in Care [2].

The GCLT provides these services to all patients in metropolitan hospitals, including country people in metropolitan hospitals.

6.7 The Team

The GCLT operates as an interdisciplinary team. The essential components of the GCLT are leadership by a Consultant Geriatrician and senior nurse/allied health practitioner who is a specialist in the care of older people. The GCLT may comprise other staff, as determined by the LHN, with the following competencies:

- Training and experience in the care of older people
- Comprehensive knowledge of AGS and non AGSs the AGS must work collaboratively with, including (but not limited to) Rehabilitation, Palliative Care, Older Persons Mental Health Services, SA Dental Services, General Practice and primary and community care providers.
- Knowledge of Comprehensive Geriatric Assessment

It is expected that GCLTs will be formed by bringing together existing disparate assessment, liaison and patient finding roles into a centralized GCLT under the governance of the AGS. This should improve the efficiency of consultation / liaison services for older people.

7. Monitoring and evaluation

Activity will be measured by numbers of new patients, number of patient interactions/contacts, and number of active patients at any point in time. This will allow for longitudinal measurement of GCLT activity and help determine funding and staffing levels for future planning.

The GCLT is a patient-centred, complex, multimodal intervention delivered in a variety of settings. Accordingly one evaluation method is unlikely to capture the outcomes and efficiency of such a service and would require evaluation of smaller components of such a service eg. quantitative analysis of health care utilisation of individuals pre- and post-involvement of AGS, or qualitative analysis of the impact of AGS on quality of life.

8. Teaching and research

Teaching is a critical role of the GCLT to educate referrers and other clinical staff in the principles of geriatrics and the services (and referral points) available. The purpose of a GCLT is not to manage every elderly patient, but to educate and facilitate non-AGS clinicians to have increased knowledge and confidence in the care of the older patient, and to know when and how to refer to AGS for further or ongoing assessment and management.

GCLT team members should continue to have ongoing professional development as part of the GCLT team, as part of their wider AGS, and as part of their profession, including journal reading, conferences and research. It is acknowledged that GCLT is a specialised component of the AGS and interdisciplinary peer education will be essential to refine specialised knowledge and skills.

High priority areas for research include:

1. The utility of current screening tools applied in different settings (eg. the use of a tool designed for use in the ED, applied in the AMU), and the impact on the use of such tools on the referrals and demands on the AGS.
2. The impact of an integrated GCLT service with better access and continuity to post-acute and hospital avoidance services. This could be measured with pre-post- analysis of individual health service utilisation.
3. Patient and carer satisfaction.
4. Qualitative work to understand the benefit of multiperson activity in an interdisciplinary team – benefit to the patient, and benefit to the team member[32].

9. Recommendations

The following recommendations are made as a guide to the implementation of Level 6 GCLT services:

- Each metropolitan LHN forms an AGS based GCLT service that includes a point of contact, resourced by senior clinicians.
- Each metropolitan LHN communicates to internal and external stakeholders how to access AGSs through the GCLT service point of contact.
- Each metropolitan LHN supports geriatrician approved direct admission of patients into AGS wards.
- Each metropolitan AGS GCLT establishes a program of education sessions for the benefit of the LHN workforce on the content of the 12 Domains of *The Toolkit* [1] and the 10 Principles of Dignity in Care [2].

- The LHNs work with the Older People Clinical Network on research strategies to determine if and how older patients in hospital should be screened to identify those who would benefit from access to AGSs.

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