Interne Liaison Interne

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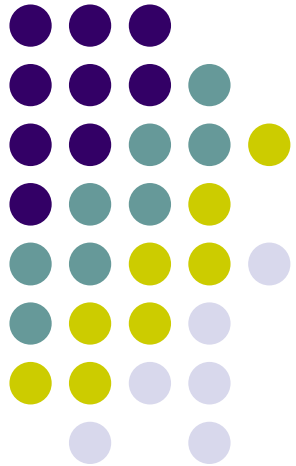
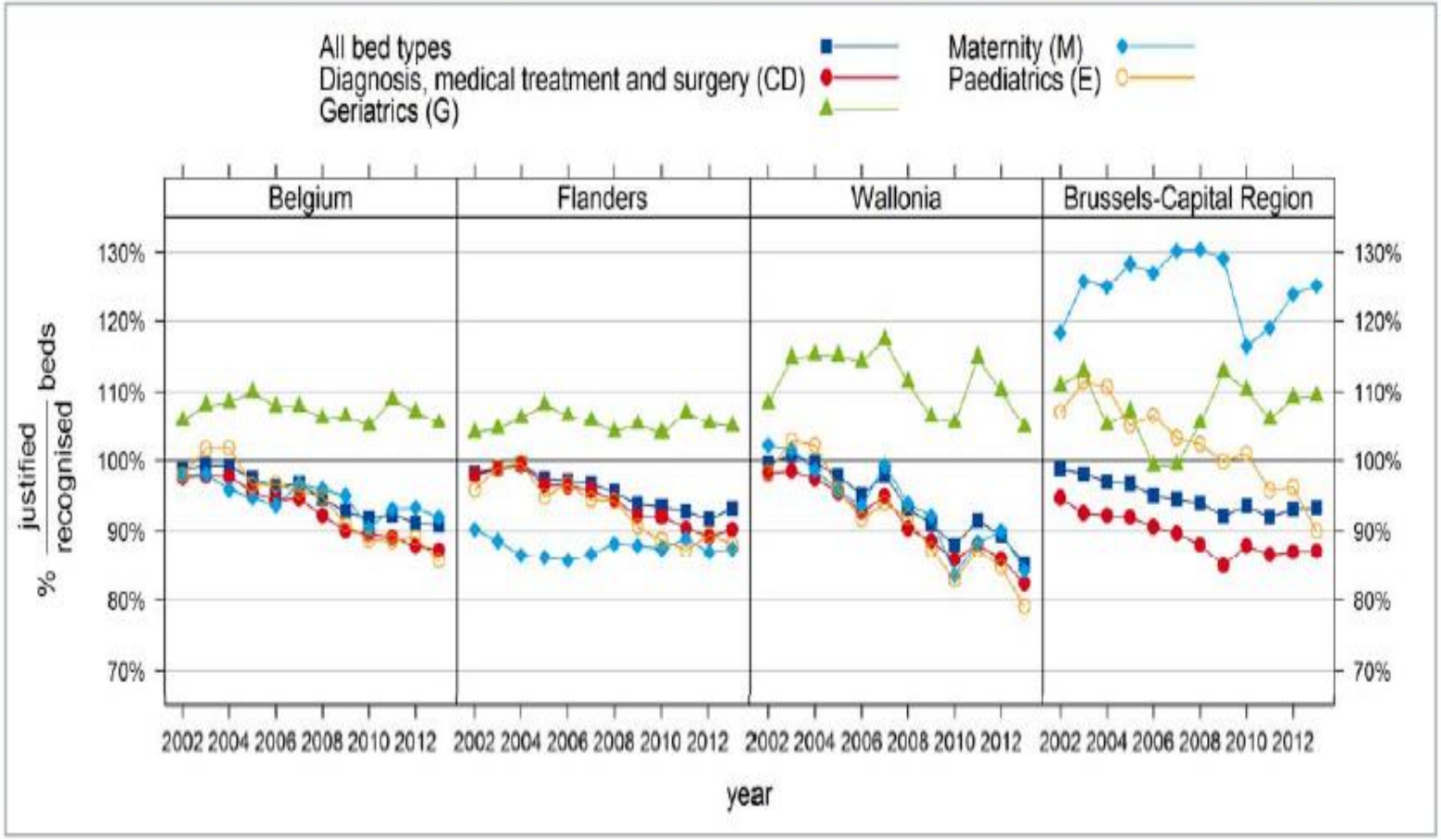


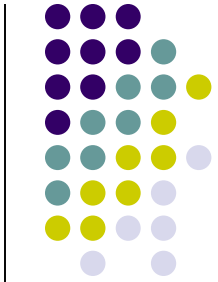
G-beds in Belgium

Figure 2 – Comparison of the number of justified and accredited beds for Belgium and the three regions per bed type, 2002-2013



Source: FOD-SPF[31]

IGCT = Internal Geriatric Consultation Teams



- ZGP – PSSA
  - Internal (external) geriatric liaison
- Financing of the IGCT
- Operationalization of ZGP-PSSA
- Conclusion

Het zorgprogramma voor de Geriatrische Patiënt

KB 2007, 2014

Art. 40. Onze Minister van Volksgezondheid is belast met de uitvoering van dit besluit.

Gegeven te ...*Brussel, 29 januari 2007*.

Art. 40. Notre Ministre de la Santé publique est chargé de l'exécution du présent arrêté.

Donné à .*Bruxelles, le 29 janvier 2007*.

Van Koningswege:

De Minister van Volksgezondheid,

Par le Roi:

Le Ministre de la Santé publique,

Rudy Demotte

De geriatrische patiënt

- Populatie **ouder dan 75 jaar**, met tevens:
  - **Fragiliteit** en beperkte homeostase
  - Actieve **polypathologie**
  - **Atypische** klinische **beelden**
  - Verstoorde **farmacokinetica**
  - Gevaar voor **functionele** achteruitgang
  - Gevaar voor deficiënte **voeding**
  - Neiging tot inactiviteit en bedlegerigheid, toegenomen risico op opname in een instelling en afhankelijkheid bij de activiteiten van het dagelijkse leven
  - **Psychosociale** problemen

KB ZGP, 2007; 2014

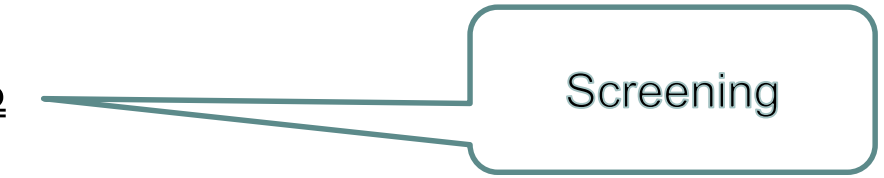
Geriatrie in elk ziekenhuis

AZ + dienst G = ZGP

Art. 2

Screening

- **Elke** 75 plusser opgenomen in ZH en er verblijvend
  - ~~1 van de criteria?~~
  - ~~Al of niet opname in het ZGP?~~
  - Door een teamlid van de afdeling waar opgenomen
  - Gevalideerd screeningsinstrument
  - Vermelding in patiëntendossier
  - Indien geen beroep op ILT -> reden vermelden in patiëntendossier



Art. 4

De geriatrische zorg

- **Pluridisciplinair**
  - Diagnostisch
  - Therapeutisch
  - Revalidatie
  - Opvolging
- **Opsporen** van de geriatrische patiënten en waarborgen van de **continuïteit van de zorg**
  - In samenspraak met
    - de huisarts
    - de andere zorgverstrekkers
- **Hoofddoel:**
  - Optimaal herstel van de **functionele performantie**
  - Een zo groot mogelijke
    - zelfredzaamheid
    - levenskwaliteit

KB ZGP, 2007; 2014

Inhoud

1. Erkende Dienst G (KB 23-10-1964)
2. Geriatrische raadpleging Art. 14
3. Geriatrische ~~dagziekenhuis~~ daghospitalisatie Art. 15
4. Interne Liaison Art. 16
5. Externe Liaison Art. 20

Wordt op zijn minst in zijn **GEHEEL** aangeboden op één van de vestigingen van het ziekenhuis.

Art. 6-7

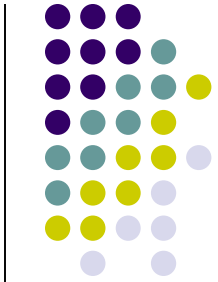
Vereiste deskundigheid

Pluridisciplinair ~~geriatrisch~~ team van het zorgprogramma:

- Minstens één voltijds geriater ~~of internist met bijzondere bekwaming~~
- Minstens 2 verpleegkundigen met beroepstitel of bekwaamheid geriatrie
- Sociaal assistent of verpleegkundige~~, optie sociale vrplgk~~ gespecialiseerd in de sociale gezondheidszorg
- Kinesitherapeut
- Ergotherapeut
- Logopedist
- Dieetleer
- ~~Psycholoog~~Licentiaat/master in de psychologie, bij voorkeur oriëntatie klinische psychologie.
- Zorgkundige

Art. 12

IGCT = Internal Geriatric Consultation Teams



- ZGP – PSSA
  - Screening
  - Internal (external) geriatric liaison
- Financing of the IGCT
- Operationalization of IGCT
  - Screening
  - CGA
- IGCT models
- Conclusion

Onderdelen:
4. De interne liaison

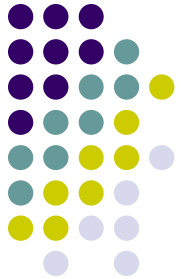
- De pluridisciplinair geriatrisch deskundigheid ter beschikking stellen voor **alle** in het ZH opgenomen geriatrische patiënten
- **Pluridisciplinair team**: samenstelling (alle leden behalve soc. dienst)
  - minstens ~~4~~2FTE
  - N = functie van aantal ~~theoretische~~ patiënten75 plussers opgenomen in het ZH.

Art 16-18

- ~~Eén **referentieverpleegkundige** geriatrische zorg~~
  - ~~(met opleiding/ervaring in ger. zorg)~~
- ~~per verpleegeenheid / chirurgisch daghospitaal~~

Art 19

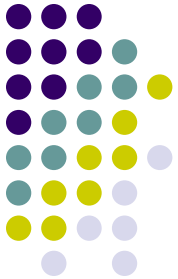
Onderdelen:
4. De interne liaison



- Functie:
  - **Evaluatie** van patiënten met pos. geriatrisch profiel na screening
  - **Verslag** naar HA + patiëntendossier; patiënt wordt hiervan verwittigd
  - Geven van **aanbevelingen** aan het zorgteam en de behandelende geneesheer-specialist tijdens de hospitalisatie; aanbevelingen worden genoteerd in het patiëntendossier
  - Opstellen van aanbevelingen voor de HA om heropname te vermijden; aanbevelingen zijn beschikbaar in het patiëntendossier;
  - **Verspreiden van de geriatrische kennis** in het ziekenhuis;

- Geen zorgtaken
- Meeting 1x/week; ter beschikking in patiëntendossier + voor zorgteam

IGCT = Internal Geriatric Consultation Teams



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Financiering

- Interne Geriatrische Liaison
  - Aantal patiënten **75+ die niet op dienst G verblijven** of hebben verbleven worden geëxtraheerd uit MZG 2011
  - Het aantal gefactureerde dagen op een bed G wordt gebruikt om de **bezettingsgraad op de G** te berekenen.
  - Het gemiddeld aantal **erkende G-bedden** wordt gebruikt voor de berekening van de gemiddelde bezettingsgraad 2011 op G.

Financiering

- Interne Geriatrische Liaison

- Berekening van deze financiering:
  - Aantal verblijven in klassieke hospitalisatie van patiënten ≥75 j DIE EXCLUSIEF BEHANDELD WORDEN OP NIET GERIATRISCHE eenheden
  - VERMINDERD met verschil tussen « reële aantal verblijven op G » en het « aantal verblijven dat overeenstemt met een bezettingsgraad van 85% ».

Financiering

- Interne Geriatrische Liaison
  - Loonkost 58,000€/FTE
  - 2 FTE voor eerste 1000 verblijven; 0,25 FTE per begonnen schijf van 500 bijkomende verblijven boven de 1000;
  - Financiering voor minimum 2 FTE en maximum 6 FTE.

ILT nomenclatuur

- ILT consult
  - 599045
  - Honorarium voor het onderzoek door de geneesheer-specialist in de geriatrie, uitgevoerd bij één op een andere dienst dan G (300) opgenomen rechthebbende, vanaf 75 jaar, op voorschrift van de geneesheer-specialist niet-geriater, die het toezicht uitoefent
  - 2 maal per hospitalisatie
  - 43,26 €

- ILT overleg

ILT nomenclatuur

- ILT consult

- ILT overleg
  - 597623
  - Honorarium voor deelname aan en leiding van een multidisciplinair teamoverleg door de geneesheer-specialist in de geriatrie voor een op een andere dienst dan G (300) opgenomen rechthebbende, vanaf 75 jaar
  - Honorarium: 10,81 €
  - Indien ≥ 1 x 599045 tijdens hetzelfde verblijf
  - Max 1x/week, gedurende heel het verblijf

Onderdelen:

5. De externe liaison

- De geriatrische principes en pluridisciplinaire deskundigheid
  - voor de huisarts,
  - voor de CRA,
  - Voor de andere zorgverstrekkers.
- Doel:
  - Optimale samenwerking zorgprogramma en thuiszorg
  - Continuïteit van de zorg optimaliseren
  - Onnodige heropnames voorkomen
  - Synergieën en samenwerkingsnetwerken ontwikkelen.

Art.20

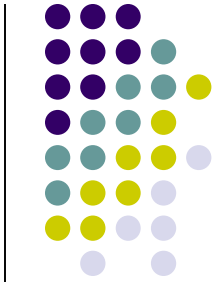
- ~~Minstens halftijds soc. vrplgk /assistent met de functie van ontslagmanager~~
  - Opdrachten m.b.t. continuiteit van de zorg (Art. 27 en 28) uitvoeren.
  - Het zorgprogramma maakt afspraken met de soc. dienst om ontslag voor te bereiden

Art.21

- Formele samenwerking met
  - ≥ 1 geïntegreerde diensten voor thuisverzorging
  - Huisartsenkringen
  - Rust- en Verzorgingstehuizen
  - Centra voor dagverzorging

Art. 22

IGCT = Internal Geriatric Consultation Teams



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ISAR

		Hospital use only
1. Before the illness or injury that brought you to the Emergency, did you need someone to help you on a regular basis?	☐ YES ☐ NO	1 0
2. Since the illness or injury that brought you to the Emergency, have you needed more help than usual to take care of yourself?	☐ YES ☐ NO	1 0
3. Have you been hospitalized for one or more nights during the past 6 months (excluding a stay in the Emergency Department)?	☐ YES ☐ NO	1 0
4. In general, do you see well?	☐ YES ☐ NO	0 1
5. In general, do you have serious problems with your memory?	☐ YES ☐ NO	1 0
6. Do you take more than three different medications every day?	☐ YES ☐ NO	1 0

TOTAL: _____

TRST

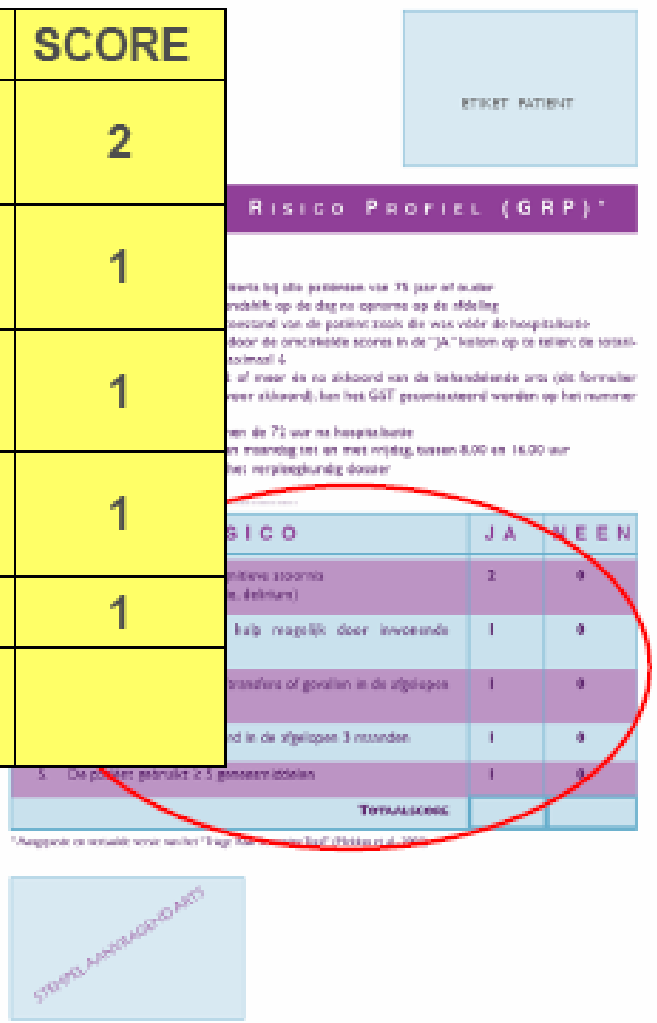
TRST

1. Cognitive impairment
2. Five or more medications
3. Difficulty walking / transferring, or recent falls
4. ED use in the last 30 days or hospitalization in the last 3 months
5. ED staff concerns

(i.e., depression; incontinence; inadequate supports; substance abuse; neglect / abuse; nutritional issues; etc.)

GRP

RISICO		SCORE
1.	Aanwezigheid van een cognitieve stoornis (b.v. desoriëntatie, dementie, delirium)	2
2.	Alleenwonend *of* geen hulp mogelijk door inwonende partner/familie	1
3.	Moeilijkheden bij stappen of transfers *of* gevallen in het voorbije jaar	1
4.	Hij/zij werd gehospitaliseerd in de afgelopen 3 maanden	1
5.	De patiënt gebruikt ≥ 5 geneesmiddelen	1
Totaal		



VIP

	ja	nee
Woont U samen met iemand anders?	0	1
Telefoneert U naar mensen buiten Uw familie?	0	1
Wast en kleedt U zichzelf zonder de minste hulp?	0	1
Totaalscore		

Screening instruments

- Summary
  - Fair sensitivity
  - Poor specificity
  - Outcome dependent
    - Readmission
    - Functional decline
    - Institutionalisation
    - Geriatric profile
  - Setting dependent
    - ED – Hospital
    - Community - Residential

False positives ↑
Unnecessary ILT evaluation intervention

Specificity ↑
Two step aproach?
Mini-CGA?

SEGA

LUIK A :	**Beschrijving geriatrisch profiel en risicofactoren**		
	0	**1**	**2**
Leeftijd	74 jaar of minder	Tussen 75 en 84 jaar	85 jaar of meer
Herkomst	Thuis	Thuis met hulp	RO / RVT
Geneesmiddelen (soorten)	3 of minder	4 tot 5	6 of meer
Cognitieve functies	Normaal	Weinig aangetast	Belangrijke aantasting (acute verwardheid, dementie)
Gemoedstoestand	Normaal	Soms angstig	Vaak bedroefd en depressief
Perceptie van gezondheid (algemeen)	Beter	Goed	Minder goed
Val gedurende de laatste 6 maanden	Geen	Eén en niet ernstig	Ernstige val of reden voor opname
Voeding	Normaal, stabiel gewicht Normaal voorkomen	Verlies van eetlust en/of gewichtsverlies (3 kg/3 maand)	Duidelijk ondervoed (BMI< 21)
Geassocieerde ziekten (co-morbiditeit)	Geen buiten de reden van opname	Van 1 tot 3	Meer dan 3, of CVA of kanker of ernstig COPD, of ernstig hartfalen
ADL opstaan/stappen, (mobiliteit)	Autonoom	Met steun	Niet mogelijk
ADL continentie (urinair en/of faecaal)	Autonoom	Accidentele incontinentie	Incontinentie
ADL voeding (nemen van maaltijden)	Autonoom	Hulp bij bereiding	Hulp bij het eten
iADL (maaltijd, telefoon,medicatie)	Autonoom	Hulp	Afhankelijk
/ 26			

SHERPA score

	Risk score
Fall in the previous year	
No	0
Yes	2
MMSE <15/21	
No	0
Yes	2
Bad self-perceived health	
No	0
Yes	1.5
Age (years)	
<75	0
75–84	1.5
>84	3
Pre-admission IADL score	
6–7	0
5	1
3–4	2
0–1–2	3

G8

2. G8

	Items	Mogelijke antwoorden	Score
A	Bent u afgelopen 3 maanden minder gaan eten als gevolg van verminderde eetlust, spijsverteringsproblemen, problemen bij kauwen en/of slikken?	**0** = belangrijk verlies van eetlust **1** = matig verlies van eetlust **2** = geen verlies van eetlust	.....
B	Gewichtsafname gedurende de 3 afgelopen maanden	**0** = gewichtsafname groter dan 3 kg. **1** = weet niet **2** = gewichtsafname tussen 1 en 3 kg. **3** = geen gewichtsafname	.....
C	Mobiliteit	**0** = aan bed of stoel gebonden **1** = in staat zelfstandig uit bed/stoel te komen, maar gaat niet naar buiten **2** = gaat zelfstandig naar buiten	.....
E	Neuropsychologische problemen	**0** = ernstig dement of depressief **1** = licht dement of depressief **2** = geen psychologische problemen	.....
F	BMI: (gewicht in kg) / (lengte in m2)	**0** = BMI <19 **1** = 19 ≤BMI < 21 **2** = 21 ≤ BMI < 23 **3** = BMI ≥23	.....
H	Neemt de patiënt meer dan 3 geneesmiddelen?	**0** = ja **1** = neen	.....
P	Vindt de patiënt dat hij gezonder is, of minder gezond, dan de meeste mensen van zijn leeftijd?	**0,0** = minder gezond **0,5** = weet niet **1,0** = even gezond **2,0** = gezonder	.....
	Leeftijd	**0** = > 85 **1** = 80 - 85 **2** = < 80	.....
	Totaalscore (0-17)		.....

GFI

Mobiliteit Kunt u zonder enige hulp van iemand anders zelfstandig deze taak uitvoeren? (gebruik maken van hulpmiddelen als stok, rolator, rolstoel, geldt als zelfstandig) 1. boodschappen doen 2. buitenshuis rondlopen (rondom huis of naar de buren) 3. aan- en uitkleden 4. toiletbezoek	ja nee
Lichamelijke fitheid 5. Welk rapportcijfer geeft u zichzelf voor uw lichamelijke fitheid? (1 staat voor heel slecht en 10 staat voor uitstekend)	0 tot 10
Visus 6. Ondervindt u problemen in het dagelijks leven door slecht zien?	ja nee
Gehoor 7. Ondervindt u problemen in het dagelijks leven door slecht horen?	ja nee
Voeding 8. Bent u in de afgelopen 6 maanden veel (6 kg) afgevallen zonder dit zelf te willen? (of 3 kg in één maand)	ja nee
Co-morbiditeit 9. Gebruikt u momenteel 4 of meer verschillende soorten medicijnen?	ja nee
Cognitie 10. Heeft u klachten over uw geheugen (of is patiënt bekend met een dementie)?	nee / soms ja
Psychosociaal 11. Ervaart u wel eens een leegte om zich heen? 12. Mist u wel eens mensen om zich heen? 13. Voelt u zich wel eens in de steek gelaten? 14. Heeft u zich de laatste tijd somber of neerslachtig gevoeld? 15. Heeft u zich de laatste tijd nerveus of angstig gevoeld?	nee soms / ja

Scoring: range 0 tot 15
Vraag 1 t/m 4: zelfstandig (ja) = 0; niet-zelfstandig (nee) = 1
Vraag 5: 0-6 = 1; 7-10 = 0
Vraag 10: nee en soms = 0; ja = 1
Vraag 11 t/m 15: nee = 0; soms en ja = 1

Edmonton frail scale

The Edmonton Frail Scale:				Score: ___/17
Frailty domain	Item	0 point	1 point	2 points
Cognition	Please imagine that this pre-drawn circle is a clock. I would like you to place the numbers in the correct positions then place the hands to indicate a time of 'ten after eleven'	No errors	Minor spacing errors	Other errors
General health status	In the past year, how many times have you been admitted to a hospital?	0	1–2	≥2
	In general, how would you describe your health?	'Excellent', 'Very good', 'Good'	'Fair'	'Poor'
Functional independence	With how many of the following activities do you require help? (meal preparation, shopping, transportation, telephone, housekeeping, laundry, managing money, taking medications)	0–1	2–4	5–8
Social support	When you need help, can you count on someone who is willing and able to meet your needs?	Always	Sometimes	Never
Medication use	Do you use five or more different prescription medications on a regular basis?	No	Yes	
	At times, do you forget to take your prescription medications?	No	Yes	
Nutrition	Have you recently lost weight such that your clothing has become looser?	No	Yes	
Mood	Do you often feel sad or depressed?	No	Yes	
Continence	Do you have a problem with losing control of urine when you don't want to?	No	Yes	
Functional performance	I would like you to sit in this chair with your back and arms resting. Then, when I say 'GO', please stand up and walk at a safe and comfortable pace to the mark on the floor (approximately 3 m away), return to the chair and sit down'	0–10 s	11–20 s	One of >20 s patient unwilling, or requires assistance

ILT approach

STEP 1: CASE-FINDING

- using a screening tool
- performed by primary nurse of non-geriatric ward

STEP 2: PRESCREENING AND CGA[†]

- of patients with a positive screening tool
- performed by nurse and geriatrician of the geriatric consultation

STEP 3: TARGETED IN-DEPTH EVALUATION

- performed by all members of the geriatric consultation team
- other disciplines consulted on an "on call" basis

STEP 4: FORMULATING ADVICE AND RECOMMENDATIONS

- based on findings of geriatric consultation team
- detailed electronic report and oral clarification , communication to GP

STEP 5: FOLLOW-UP VISIT

- one-time only
- to check for additional problems

Scientific reseach ILT ZGP- PSSA
FOD/SPF 2008

CGA based care models for hospitalized older persons

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Dept. CHROMETA, KU Leuven, Belgium

Comprehensive Geriatric Assessment (CGA)

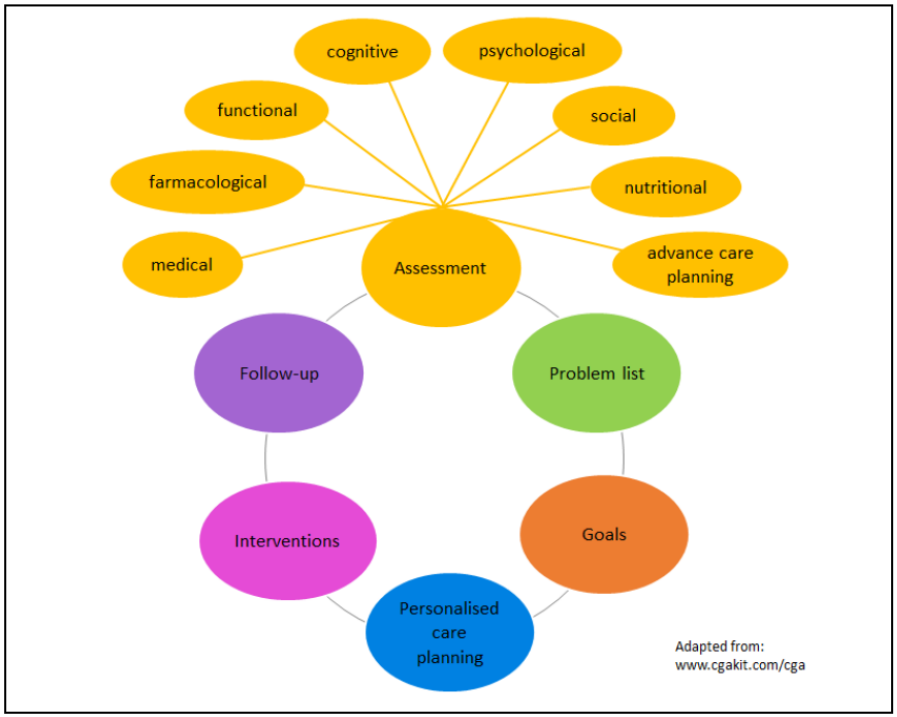

Figure 2: Schematic representation of the CGA process (geriatric care)

Definition (Rubenstein 1991)

*'A **multidimensional interdisciplinary** diagnostic process intended to determine a frail older person's medical, psychosocial and functional capabilities in order to develop an overall plan for treatment and long-term follow-up.'*

"one size fits all"

↓

individualized care

CGA based care models for older persons

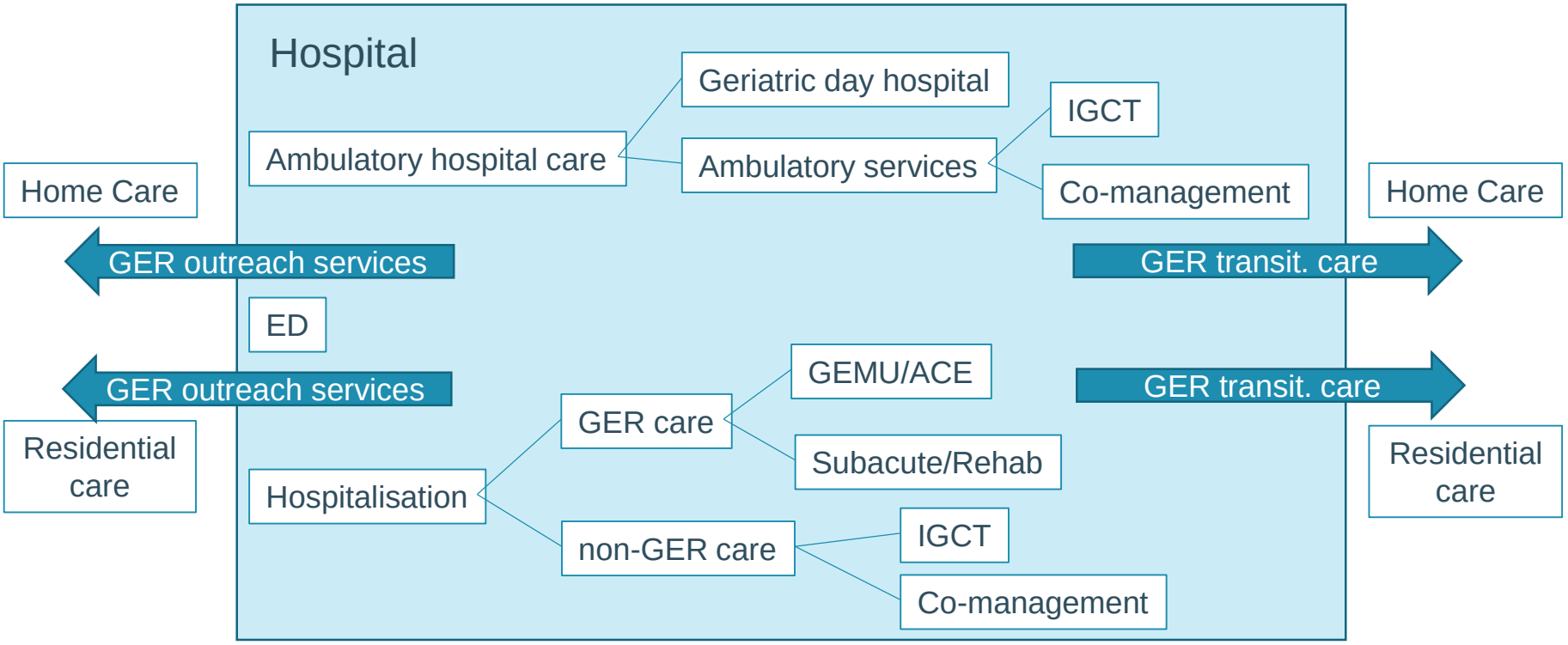

Image.eu

- Geriatric care models in 8 EU countries

	Total N = 178	Belgium N = 69	Denmark N = 22	Estonia N = 13	Greece N = 47	Iceland N = 4	Ireland N = 11	Malta N = 3	Slovenia N = 9
Response rate	50%	72%	100%	72%	27%	67%	50%	75%	96%
Acute geriatric units, n (%)	92 (51.6)	69 (100)	16 (72.7)	0	1 (2.1)	1 (25.0)	4 (36.4)	0	1 (11.1)
Number of beds, median (Q1-Q3)	50 (28-78)	60 (36-86)	20 (26-34)	NA	60	20	33 (16-56)	NA	16
Mean length of stay, median (Q1-Q3)	13 (10-17)	14 (12-17)	7 (5-8)	NA	30	15	13 (10-18)	NA	7
Geriatric rehabilitation unit, n (%)	41 (23)	21 (30.4)	5 (22.7)	2 (15.4)	2 (4.3)	3 (75.0)	7 (63.6)	0	1 (11.1)
Number of beds, median (Q1-Q3)	22 (10.5-30)	24 (20.5-31)	15 (8-20.5)	5 (5-5)	-	17 (4-80)	20 (13-34)	NA	30
Geriatric consultation team, n (%)	97 (54.5)	69 (100)	13 (59.1)	3 (23.1)	2 (4.3)	1 (25.0)	8 (72.7)	1 (33.3)	0
Members									NA
- Geriatrician	95 (97.9)	68 (98.6)	0	2 (66.7)	2 (100.0)	1 (100.0)	8 (100.0)	1 (100)	
- Nurse	85 (87.6)	67 (97.1)	9 (69.2)	3 (100.0)	1 (50.0)	1 (100.0)	4 (50.0)	0	
- Occupational therapist	62 (63.9)	55 (79.7)	4 (30.8)	1 (33.3)	0	0	2 (25.0)	0	
- Speech therapist	50 (51.5)	46 (66.7)	1 (7.7)	2 (66.7)	0	0	1 (12.5)	0	
- Physiotherapist	46 (47.4)	33 (47.8)	8 (61.5)	2 (66.7	1 (50.0)	0	2 (25.0)	0	
- Dietician	45 (46.4)	41 (59.4)	1 (7.7)	1 (33.3)	1 (50.0)	0	1 (12.5)	0	
- Psychologist	40 (41.2)	39 (56.5)	0	1 (33.3)	0	0	0	0	
- Social worker	36 (37.1)	32 (46.4)	0	3 (100.0)	0	1 (100.0)	0	0	
Geriatric co-management, n (%)	52 (29.2)	28 (40.6)	14 (63.6)	3 (23.1)	2 (4.3)	0	2 (18.2)	3 (100)	0
Members						NA			NA
- Geriatrician	45 (86.5)	27 (96.4)	13 (92.9)	1 (33.3)	0		2 (100.0)	2 (66.7)	
- Internal medicine physician	15 (28.8)	9 (32.1)	3 (21.4)	2 (66.7)	0		0	1 (33.3)	
- Nurse	39 (75)	21 (75.0)	11 (78.6)	3 (100.0)	1 (50.0)		1 (50.0)	2 (66.7)	
- Physiotherapist	32 (61.5)	14 (50.0)	10 (71.4)	2 (66.7)	2 (100.0)		2 (100.0)	2 (66.7)	
- Occupational therapist	31 (59.6)	19 (67.9)	7 (50.0)	2 (66.7)	0		1 (50.0)	2 (66.7)	
- Social worker	22 (42.3)	15 (53.6)	0	3 (100.0)	2 (100.0)		1 (50.0)	1 (33.3)	
- Dietician	15 (28.8)	10 (35.7)	2 (14.3)	1 (33.3)	1 (50.0)		1 (50.0)	3 (100.0)	
- Speech therapist	15 (28.8)	10 (35.7)	1 (7.1)	2 (66.7)	0		1 (50.0)	1 (33.3)	
- Psychologist	13 (25)	9 (32.1)	0	1 (33.3)	1 (50.0)		1 (50.0)	1 (33.3)	
Emergency department, n (%)	173 (97.2)	68 (98.6)	22 (100)	13 (100)	45 (95.7)	4 (100)	10 (90.9)	3 (100)	8 (88.9)
Geriatrician at the ED	100 (57.8)	48 (70.6)	17 (77.3)	1 (7.7)	4 (8.5)	3 (75.0)	8 (80.0)	1 (33.3)	0
Boxes for older people at ED	9 (5.2)	4 (5.9)	1 (4.5)	0	3 (6.4)	0	1 (10.0)	0	0
Number of boxes, median (Q1-Q3)	2 (1-4)	2.5 (1.25-4.5)	5 (5-5)	NA	1 (1- ...)	0	1 (1-1)	NA	NA
Systematic screening ("yes")	62 (35.8)	45 (66.2)	5 (22.7)	0	5 (10.6)	1 (25.0)	6 (60.0)	0	0
Ambulatory services, n (%)									
Geriatric day clinic	62 (34.8)	53 (76.8)	5 (22.7)	0	0	1 (25.0)	3 (27.3)	0	0
Memory clinic	100 (56.2)	62 (89.9)	12 (54.5)	1 (7.7)	14 (29.8)	2 (50.0)	8 (72.7)	0	1 (11.1)
Falls prevention clinic	86 (48.3)	55 (79.7)	16 (72.7)	4 (30.8)	1 (2.1)	1 (25.0)	7 (63.6)	1 (33.3)	1 (11.1)
Transitional care programs, n (%)	107 (60.1)	52 (75.4)	15 (68.2)	10 (76.9)	16 (34.0)	3 (75.0)	6 (54.5)	2 (66.7)	3 (33.3)

Legend: Percentage of hospitals that have implemented the care model = **0 – 24%,** 25 – 49%, ≥50%

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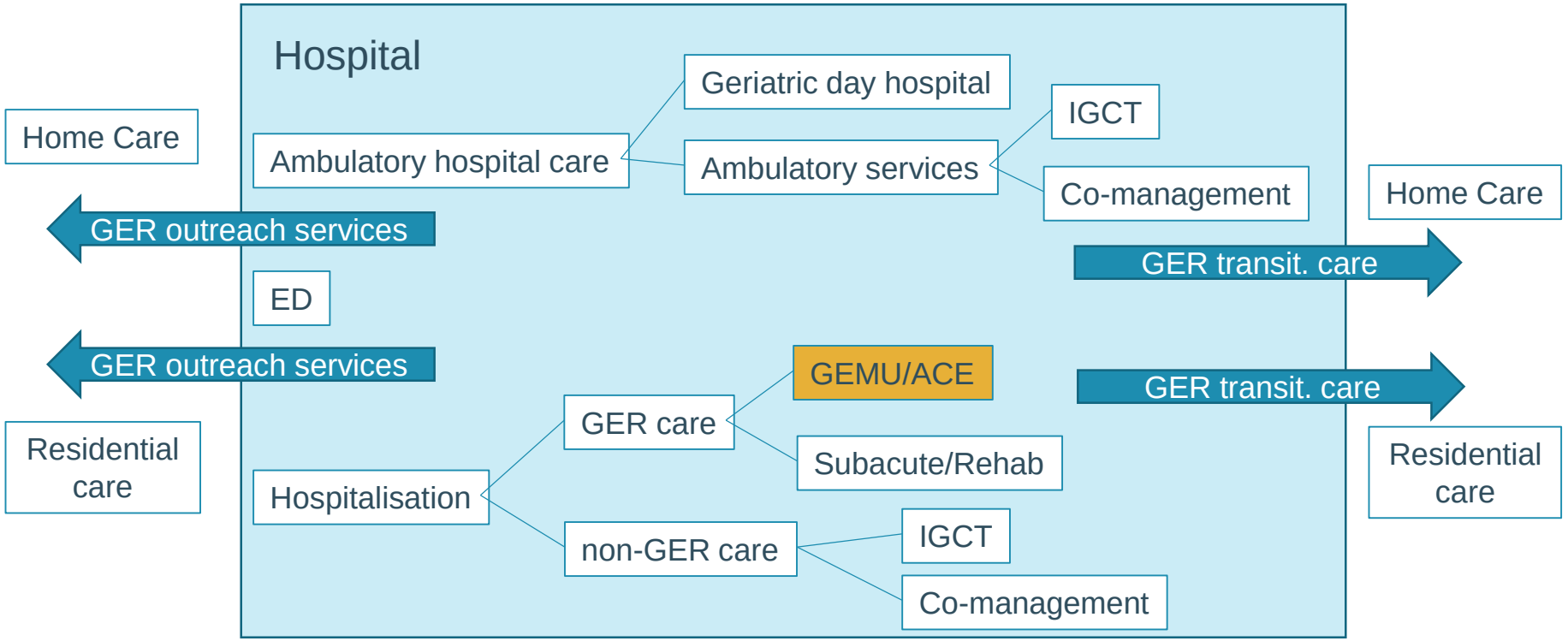
CGA based care models for older persons



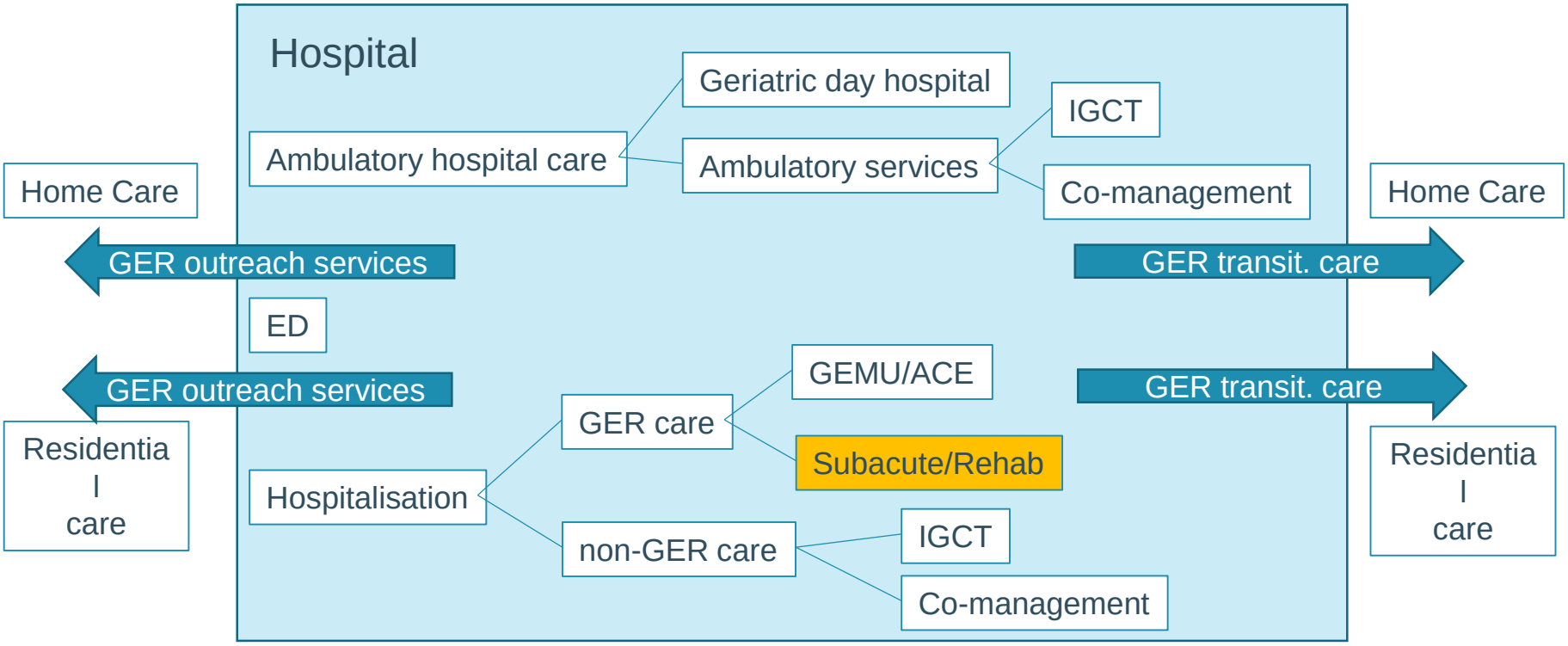
Cochrane Review CGA vs. CC (medical pts)

Acute medical ward or inpatient rehabilitation (CGA = ward based or mobile team)

Outcome	N studies	MD (continuous data) RR (categorical data)	95% CI
Living & at home (discharge)	11	RR = 1.05	0.01 – 1.10
Living & at home (3-12m)	16	RR = 1.06	1.01 – 1.10
Nursing home admission (discharge)	12	RR = 0.89	0.81 – 0.98
Nursing home admission (3-12m)	14	RR = 0.80	0.72 – 0.89
Dependence (in ADL or decline ADL)	14	RR = 0.97	0.89 – 1.04
Activities of daily living	7	MD = 0.04	- 0.06 – 0.15
Mortality (discharge)	11	RR = 1.04	0.82 – 1.32
Mortality (3-12m)	21	RR = 1.0	0.93 – 1.07
Readmission	13	RR = 1.02	0.94 – 1.11
Costs	17	MD = 234 £	-144 – 605
LOS / Cognitive function	17 / 5	MD (heterogeneity)	(no meta-analysis)

Ellis et al. Cochrane Database of Systematic Reviews, 2017; Issue 9

CGA based care models for older persons



Interventions to improve the outcomes of frail people having surgery

- Interventions were applied pre- and postoperatively
  - exercise therapy (n = 4),
  - multicomponent geriatric care protocols (n = 5),
  - blood transfusion triggers (n = 1);
- **Exercise therapy**, applied pre-, or post-operatively
  - **improvements in functional outcomes**
  - **improved quality of life**.
- **Multicomponent protocols**
  - poor compliance
  - difficulties in implementation.
- **Transfusion** triggers
  no impact on mortality or other outcomes

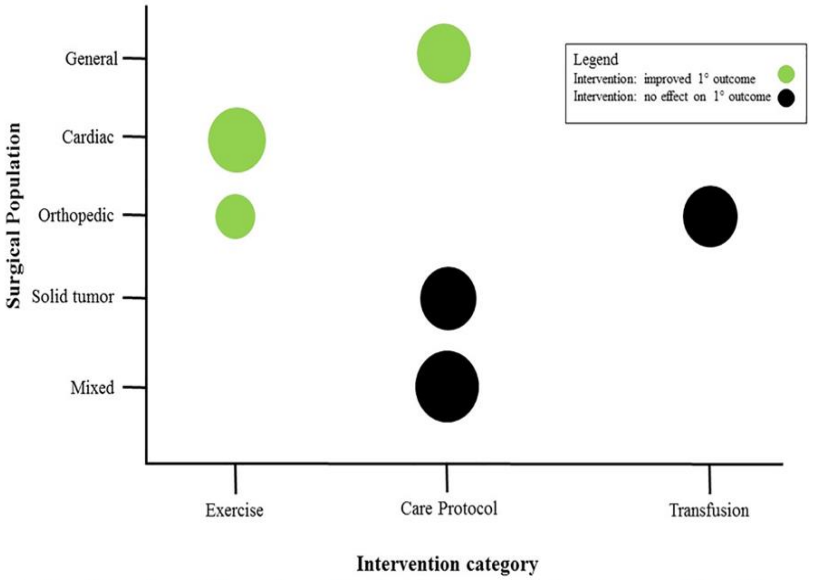


Fig 2. Summary of study outcomes by intervention type and surgical population. The size of each circle is proportional to the number of participants in each grouping.

Effects of Geriatric Team Rehabilitation After Hip Fracture

- Interdisciplinary geriatric team rehabilitation
  - increased **ADL/physical function** (SMD, 0.32; 95 % CI, 0.17-0.47)
  - increased **mobility** (SMD, 0.32; 95% CI, 0.12-0.52) compared with conventional care.

  - no increase the chance of living in one's own home after discharge (RR, 1.07; 95% CI, 0.99-1.16) or
  - no increase in survival (RR, 1.02; 95% CI, 0.99-1.06) compared with conventional care.
  - All results were rated as GRADE 3.

Non-pharmacological interventions for the improvement of post-stroke activities of daily living and disability amongst older stroke survivors

- Software Engine for the Assessment and Optimisation of Drug and Non-Drug Therapies in Older Persons (**SENATOR**) [http://www.senatorproject.eu].

- Optimal Evidence-Based Non-Drug Therapies in Older Persons (**ONTOP**) project
- 72 primary articles spanning 14 types of non-pharmacological intervention

- **Physiotherapy and occupational therapy techniques** improved **ADL**.
- No evidence was found to support use of any non-pharmacological approach to benefit disability.

Stewart C, Subbarayan S, Paton P, Gemmell E, Abraha I, Myint PK, et al. (2018) Nonpharmacological interventions for the improvement of post-stroke activities of daily living and disability amongst older stroke survivors: A systematic review. PLoS ONE 13(10): e0204774

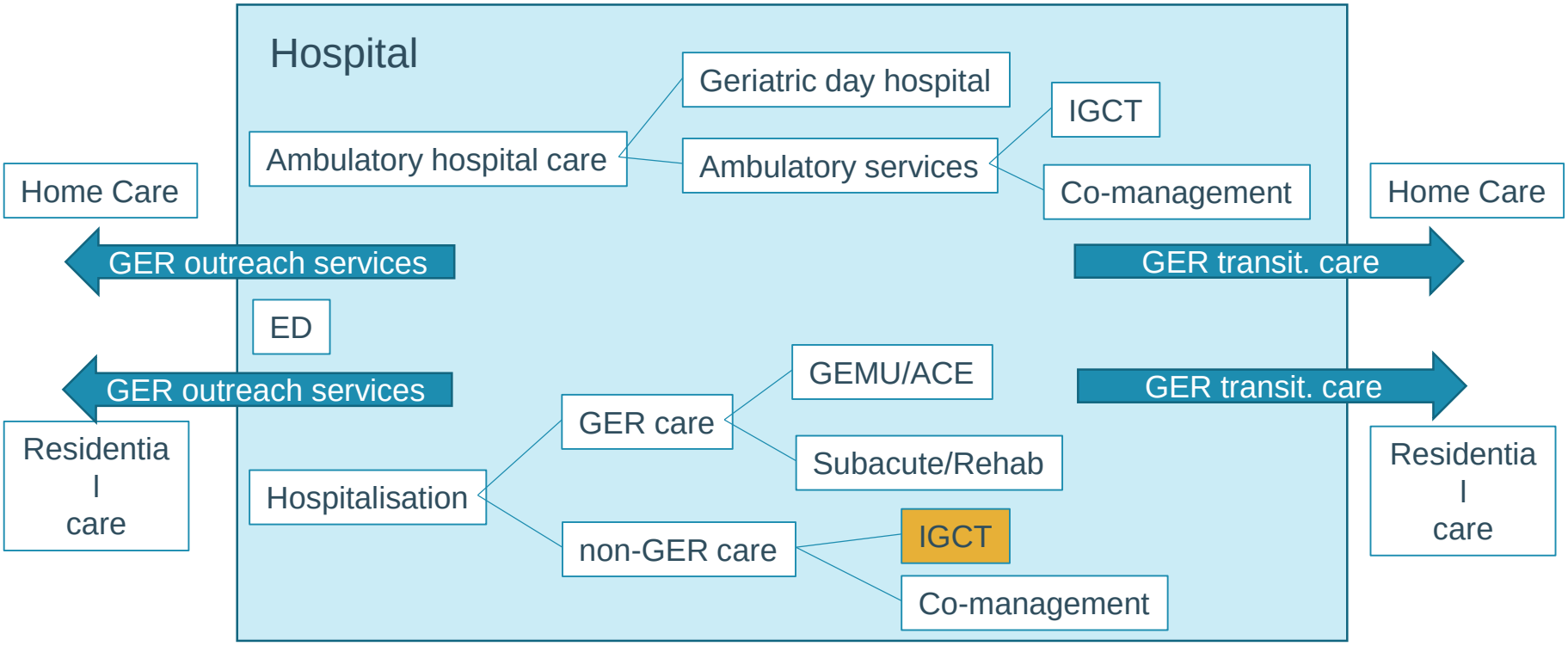
Effects of Postacute Multidisciplinary Rehabilitation Including Exercise in **Out-of-Hospital Settings** in the Aged

- 6MWD,
  - walked an average of **23 m** more (95% CI: -1.34 to 48.32; I^2: 51%).

- Rehabilitation did not lower
  - the 3-month risk of unplanned hospital readmission (risk ratio: 0.93; 95% CI: 0.73-1.19; I^2: 34%).

- The risk of bias was present, mainly due to the non-blinded outcome assessment in 3 studies, and 7 studies scored this unclearly.

CGA based care models for older persons



Structure and processes of interdisciplinary geriatric consultation teams in acute care hospitals: A scoping review.

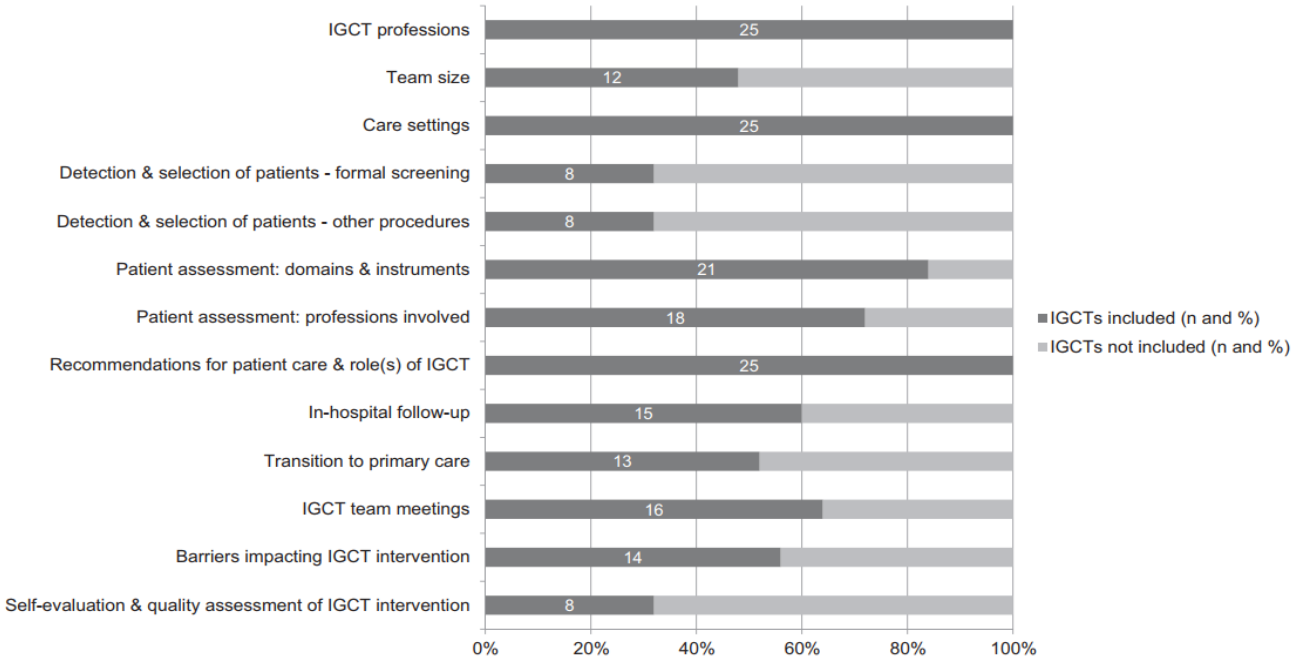


Fig. 2. Number of teams reporting on the different structure and process domains of IGCT care.

IGCT meta-analysis

- 12 prospective cohort studies
- N = 4546
- IGCT
  - Mortality (6m): -34 % (-15 to -48 %)
  - Mortality (8m): -48 % (-15 to -69 %)
  - Functional status: NS
  - Readmission: NS
  - LOS: NS
- Heterogeneity
- Non-compliance

IGCT UZ Leuven RCT

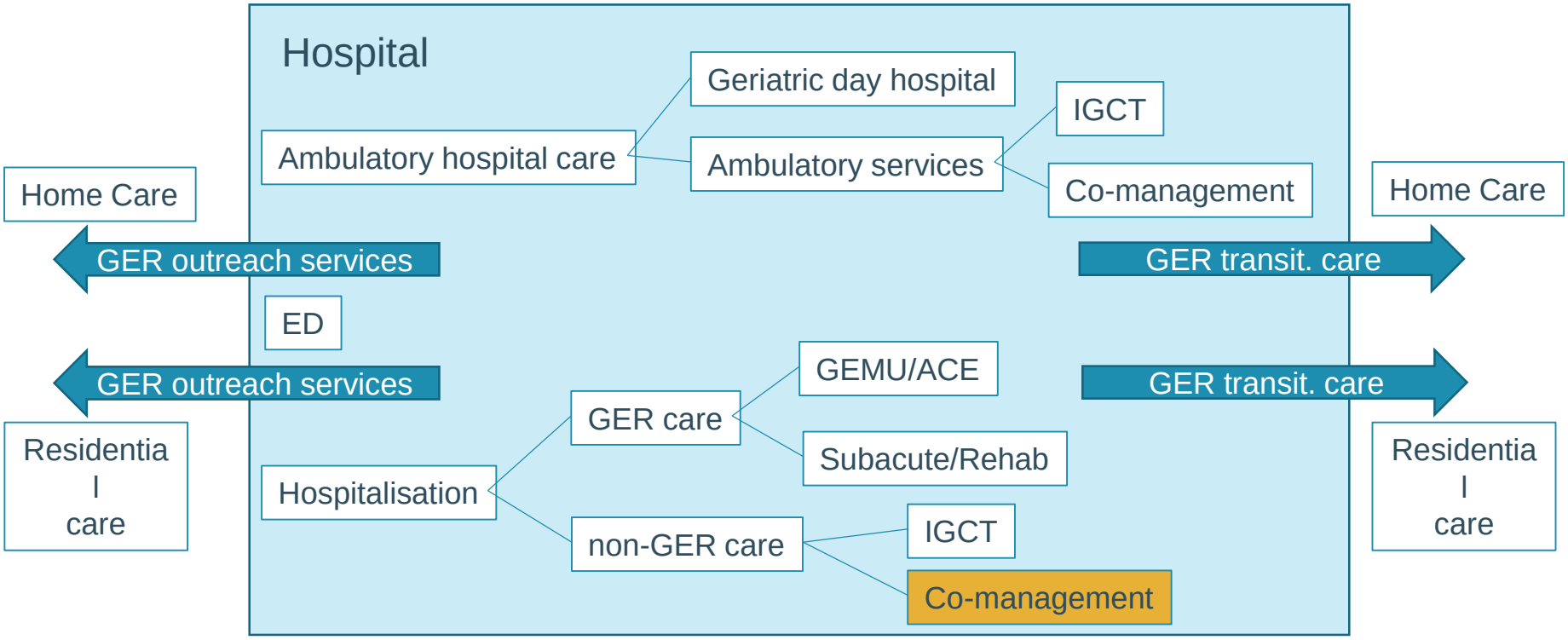
- RCT
- N = 171 ≥ 65 y with traumatic hip fracture
- Intervention group
  - More pain therapy
  - More occupational therapy
- Compliance
  - 30 % non- and 10 % partial adherence to advices
- GST effect on outcomes:
  - Mortality, Function, LOS, Readmission, NH admission: NS

IGCT RCT UZ Leuven

- RCT
- N = 171 ≥ 65 y with traumatic hip fracture
- GST effect on outcome
  - Delirium controls (CAM)
    - OR: 1.92 (95% CI 1.04 – 3.54)
  - Cognitive decline controls (MMSE)
    - OR: 2.16 (95% CI (1.1 to 4.25)

Deschodt M, JAGS 2012; 60:733-739

CGA based care models for older persons



CGA and postop complications GI surgery

- Prediction of **postoperative complications**:
  - **Charlson Comorbidity Index** [CCI] ≥3; OR=1.31, 95% CI [1.06, 1.63], *P*=0.01,
  - **Polypharmacy** (≥5 drugs/day); OR=1.30, 95% CI [1.04, 1.61], *P*=0.02
  - **Activities of daily living** (ADL) **dependency** (OR=1.69, 95% CI [1.20, 2.38], *P*=0.003)

Xue DD, Clin Interv Aging.

CGA in surgical oncology

Table 3 — Geriatric assessment components and association with surgical outcomes.

Outcomes	POC		Postoperative mortality		Discharge to a nonhome facility		Other outcomes
	Rates	Predictors	Rates	Predictors	Rates	Predictors	
Preoperative assessment of cancer in the elderly participants *et al.* [9]	37.8% ≥1 overall 30-d complication 16% (n = 75) ≥1 major 30-d complication	IADL (or 1.4; 95% CI 1.0–2.0) moderate–severe brief fatigue inventory (OR = 1.5; 95% CI 1.2–2.1) American Society of Anesthesiologists Score (OR = 2.0; 95% CI: 1.1–3.5)	3.5% overall 30-d mortality	None			Longer LOS: decreased ADL 2.0 (1.4–2.9)
Fukuse *et al.* [1]	16.7%	Decreased mini-mental state examination (P = 0.03); decreased ADLs) (P = 0.04) no ORs reported					
Kothari *et al.* [3]	13% major 30-d complication	Dependency with IADL "shopping" (P = 0.01); geriatric depression scale "have you dropped activities and interests?" (P = 0.04)	1.6% 30-d mortality	None	10% discharge to nonhome location	Dependency in IADLs (P = 0.003); geriatric depression score "do you feel worthless the way you are now?"	Longer LOS: nutrition NSI NHC: illness that made patients change the way they ate (P = 0.04); unintentional ≥10 pound weight loss in 6 mo (P = 0.01); not always able to feed or shop for oneself (P = 0.03)
Kristjannson *et al.* [5]	60% overall complications (78% severe)	Worse frailty score (OR = 3.7; 95% CI: 1.7–7.9)	2% 30-d mortality	None			Readmissions higher for worse frailty score
Tan *et al.* [10]	Surgical complications n = 16 (19%) Medical complications; n = 16 (19%) Major complications (n = 22); 27%	Worse frailty score (OR = 3.5; 95% CI: 1.1–10.8) Worse frailty score (OR = 3.5; 95% CI: 1.1–10.8) Worse frailty score (OR = 4.1; 95% CI: 1.4–11.6)					
Badgwell *et al.* [11]	90-d overall complications (48%) n = 53	No predictors	90-d mortality 3% (n = 3)	None	Discharge status to SNF 10%	ECOG (<2): OR 4.5 (1.03–19.7); weight loss ≥10%: OR 6.5 (1.4–29.8); ASA>2: OR 5.1 (1.2–22.8)	30-d readmissions 24% (no predictors); increased LOS: weight loss ≥10% (OR = 4.0; 95% CI 1.1–14.4); polypharmacy (OR = 2.4; 95% CI 1.1–5.5)
	90-d major complications (21%)	No predictors					

CI = confidence interval; ECOG = Eastern Cooperative Oncology Group; NSI NHC = Nutritional Screening Initiative Nutritional Health Checklist; OR = odds ratios; SNF = Skilled Nursing Facility.

Feng MA. J Surg Res. 2015 Jan;193(1):265-72.

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1-year mortality in elderly patients with a hip fracture following integrated **orthogeriatric treatment**

	Univariate analysis			Multivariate analysis		
	OR	95 % CI	*p* value	OR	95 % CI	*p* value
Male gender	1.48	1.05–2.10	0.026	1.68	1.13–2.45	0.011
Age in years	1.07	1.04–1.09	<0.001	1.06	1.02–1.09	0.001
Fracture type	1.04	0.73–1.41	0.926			
VMS frailty delirium[a]	2.16	1.55–3.02	<0.001			
VMS frailty prior fall[b]	0.60	0.15–2.42	0.474			
VMS frailty malnutrition[c]	2.56	1.77–3.70	<0.001	2.01	1.34–3.02	<0.001
VMS frailty physical limitations[d]	4.61	2.83–7.53	<0.001	2.35	1.32–4.20	0.004
Dementia	2.22	1.55–3.19	<0.001			
ASA 3[e]	4.19	2.26–7.77	<0.001	2.43	1.25–4.74	0.009
ASA 4–5[e]	16.23	8.12–32.42	<0.001	7.05	3.20–15.52	<0.001
CCI 1–2[f]	2.65	1.59–4.40	<0.001	1.46	0.83–2.57	0.191
CCI 3–4[f]	3.73	2.16–6.47	<0.001	1.59	0.85–2.96	0.149
CCI 5[f] or more	7.74	3.95–15.47	<0.001	2.71	1.23–5.93	0.013
Barthel Index preoperative	0.89	0.86–0.92	<0.001	0.96	0.92–1.01	0.091
Parker Mobility Score preoperative	0.82	0.77–0.87	<0.001			
Residential home[g]	2.19	1.40–3.44	0.001			
Skilled nursing home[g]	2.77	1.85–4.16	<0.001			

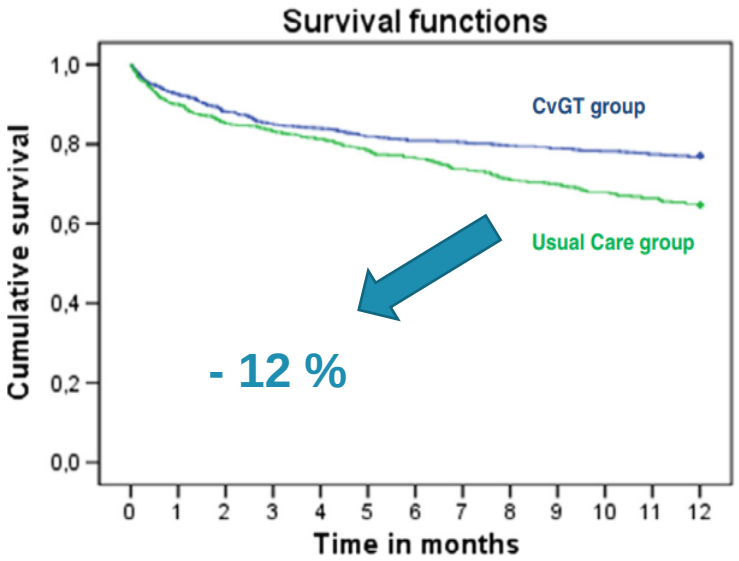

Fig. 2 Kaplan-Meier survival curve over 1 year following hip fracture treatment

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Cochrane Review CGA vs. CC (surgical pts)

7 studies in hipfracture - 1 study in onco-surgery* patients

Outcome	N studies	MD (continuous data) RR (categorical data)	95% CI
Major complication	1	RR = 0.74	0.60 – 0.92
	1*	RR = 1.16	0.80 – 1.67
Delirium	3*	RR = 0.75	0.60 – 0.94
Mortality	5	RR = 0.85	0.68 – 1.05
LOS	5	MD (heterogeneity)	(no meta-analysis)
Readmission	3*	RR = 1.00	0.76 – 1.32
Discharge to increased level of care	5	RR = 0.71	0.55 – 0.92
Total cost at 1y	1	MD = -5154 €	-13.288 – 2980

Eamer et al. Cochrane Database of Systematic Reviews, 2018; Issue 1

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Effectiveness of in-hospital **geriatric co-management**: a systematic review and meta-analysis

- Twelve studies and 3,590 patients were included from six randomised and six quasi-experimental studies.
- Geriatric co-management
  - **improved functional status**
  - **reduced** the number of **complications** in three of the four studies
    (high risk of bias and outcomes heterogeneous and could not be pooled).
  - **reduced the length of stay** (pooled mean difference, -1.88 days [95% CI, -2.44 to -1.33]; 11 studies)
  - may **reduce in-hospital mortality** (pooled odds ratio, 0.72 [95% CI, 0.50–1.03]; 7 studies).
  - no effect
    - number of patients discharged home (5 studies),
    - post-discharge mortality (3 studies)
    - readmission rate (4 studies).

Comprehensive Geriatric Assessment for Prevention of Delirium After Hip Fracture:

- Reduction in delirium overall
  - **RR = 0.81**, (CI = 0.69-0.94).
  - Post hoc subgroup analysis
    - **team-based intervention group** (RR = 0.77, 95% CI = 0.61-0.98)
    - not the ward-based group.
- No significant effect was observed on any secondary outcome.

Economic evaluations of comprehensive geriatric assessment in surgical patients

- **loss of function**
  - odds ratio 0.92 ([CI]: 0.88-0.97).
- **length of stay**
  - mean difference: −1.17(CI: −1.63 to −0.71)
- **mortality**
  - risk ratio: 0.78 (95% CI: 0.67-0.90).

- **All studies decreased cost and improved health outcomes in a cost-effective manner.**

Geriatricians in perioperative medicine: developing subspecialty training

Table 1 British Geriatric Society's curriculum for Perioperatve Medicine for Older People

Perioperative Medicine for Older People
To know how to risk assess, optimise and manage the older elective and emergency surgical patient throughout the surgical pathway

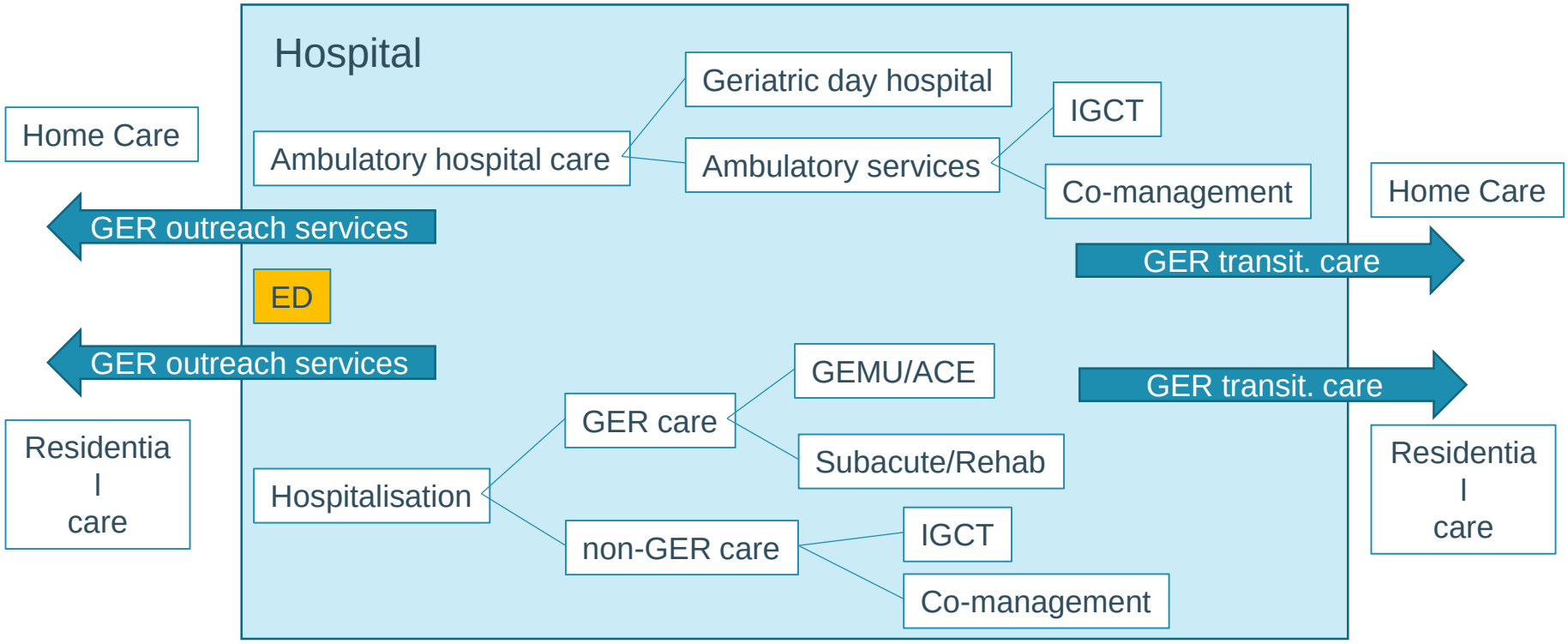
Knowledge
Demographics and political landscape relevant to the older surgical patient
National reports and policy drivers relevant to the older surgical patient
Models and pathways of care for older surgical patients
Risk assessment of perioperative morbidity and mortality (including use of tools e.g. PPOSSUM and investigations e.g. Cardiopulmonary exercise testing)
Modification of risk including the use of organ specific national and international guidelines (e.g. European Society Cardiology)
Use of inter-disciplinary and cross-speciality interventions to improve postoperative outcome (e.g. therapy delivered pre-habilitation)

Skills
Clinical assessment with appropriate use of investigations and tools to preoperatively risk assess for perioperative morbidity and mortality
Communication of risk with health professionals and patients/relatives
Timely medical optimisation of comorbidity and geriatric syndromes
Appropriate allocation of postoperative resources (e.g. use of level 2 and 3 care)
Decision making regards rehabilitation, and timely and effective discharge pertinent to the surgical patient
Liaison with patients, anaesthetists and surgeons to ensure shared decision making
Application of ethical and biomedical approaches to ensure appropriate ceilings for escalation of care

Behaviours
Objectively assess the risk-benefit ratio of surgery for older patients without value-laden judgement
Develop confidence in the added value of the geriatrician's role in shared decision making
Appreciate the importance of collaboration between geriatricians, anaesthetists and surgeons in promoting high quality care

Specific learning methods
Attend clinics where comprehensive geriatric assessment methodology is used to improve outcomes
Participate in routine nurse led preassessment and high risk anaesthetic led preassessment of older surgical patients
Liaison work on surgical wards
Attend surgical ward multidisciplinary team meetings
Attend training days and conferences relevant to the older surgical patient (e.g. POPS training day, AAGBI training day, Age Anaesthesia Association meetings)

CGA based care models for older persons



Elderly on the ED

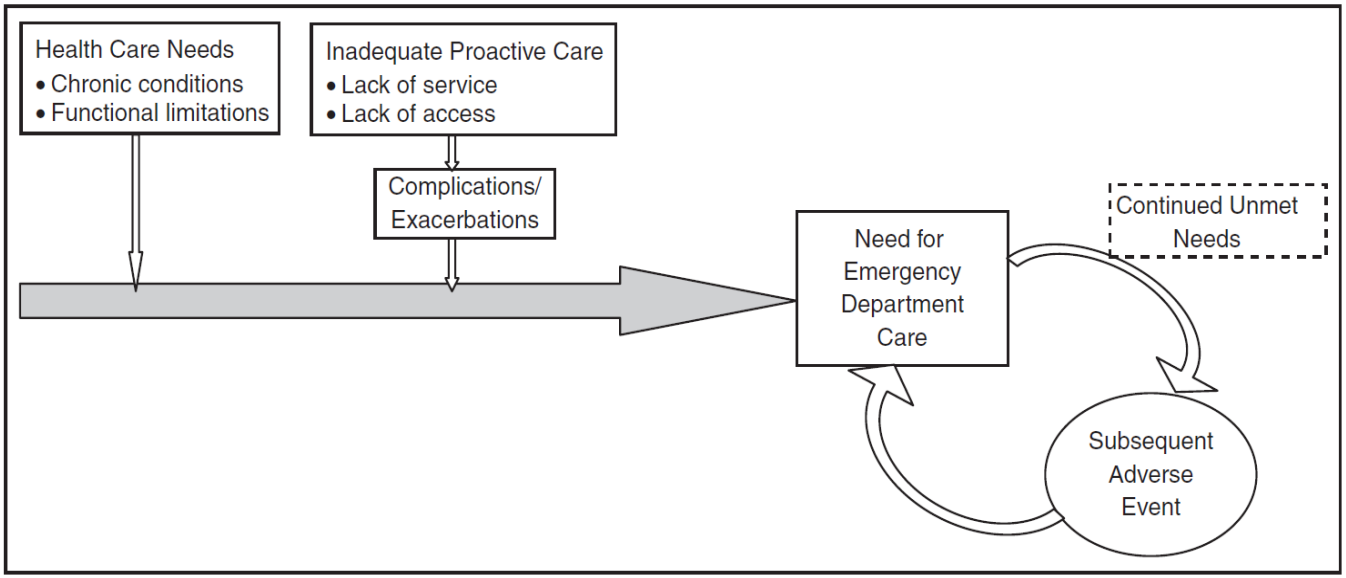


Figure 1. Conceptual model illustrating factors that influence emergency department use by older adults
Source: Adapted from Andersen (1995) and McCusker et al. (2003).

Gruneir et al, 2010

Geriatric ED care models

Geriatric screening

CGA based care models

Geriatric ED

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Screening of the frail patient in the emergency department

- Clinical Frailty Scale, Deficit Accumulation Index, Identification of Seniors At Risk and The Study of Osteoporotic Fracture frailty index

- **Frailty** successfully **predicts**
  - increased risk of hospitalization,
  - nursing home admission,
  - mortality and
  - prolonged length of stay after an initial emergency department visit.

- **Frailty does not predict**
  - increased risk of 30 day emergency department revisit.

Frailty identification in the ED

Key points

- Risk stratification is a useful first step in identifying a cohort of older people accessing urgent care settings at especial risk of harm.
- Several risk-stratification tools exist, but little is known about their acceptability in practice (acceptability, completion rates).
- Although most commonly used tools are relatively quick to use (less than 10 minutes), little over 50% of potentially eligible people are screened using existing tools.

Can **consultant geriatrician led CGA** in the ED reduce hospital admission rates?

Table 3. The results of the included studies

Study	*n*	Change in same-day admissions rate (before intervention, during intervention)	Readmissions rate	Length of stay
Ellis *et al.* [15]	749	15.7% (98.6%, 82.9%)[a], $P < 0.0005$	No significant effect ($P = 0.82$)	No significant effect ($P = 0.78$)
Arendts *et al.* [16]	5,265	2.6% (74.4%, 72%), $P = 0.046$	Not reported	Not reported
Conroy *et al.* [17]	15,930	8.4% (69.6%, 61.2%), $P < 0.001$	(expressed as risk ratios) 7 days: 0.71 (0.42–1.1); 30 days: 0.74 (0.55–1.00); 90 days: 0.77 (0.63–0.93)	(Expressed as mean days) Before: 8.9 Intervention: 11.1
Wright *et al.* [19]	6406	19.7% (87.7%, 68%), $P < 0.001$	Not reported	Fall in median stay of 2 days Reduction in mean stay of 18.2% ($P < 0.001$)
Sophia and Bashir [18]	84	9% (55%, 46%)	Not reported	Fall in mean stay from 12 to 3 days

[a]Ellis *et al.* measured their results at a different point in the care pathway to the other studies, explaining the high 'before intervention' admission rate and rendering direct comparison of their results inexact. The rate corresponds to patients transferred to a subunit within the ED rather than the overall ED population.

The impact of **geriatric focused nurse assessment and intervention** in the ED

- **No impact** on
  - hospitalization,
  - readmissions,
  - LOHS and
  - ED revisits.
- Risk screening and comprehensive **geriatric assessment extending into primary care** may reduce readmission rates but not affect hospitalization.
- An **increase in ED visits** in the intervention group at 30 days post-intervention was noted.

UNPLANNED READMISSION PREVENTION BY GERIATRIC EMERGENCY NETWORK FOR TRANSITIONAL CARE (URGENT)

Screening: RAI ED screener.

IGCT nurse in the ED

Primary outcome: ED readmission ↓: NS

- Low acceptance rate of primary care case management

Secondary outcome: ED LOS

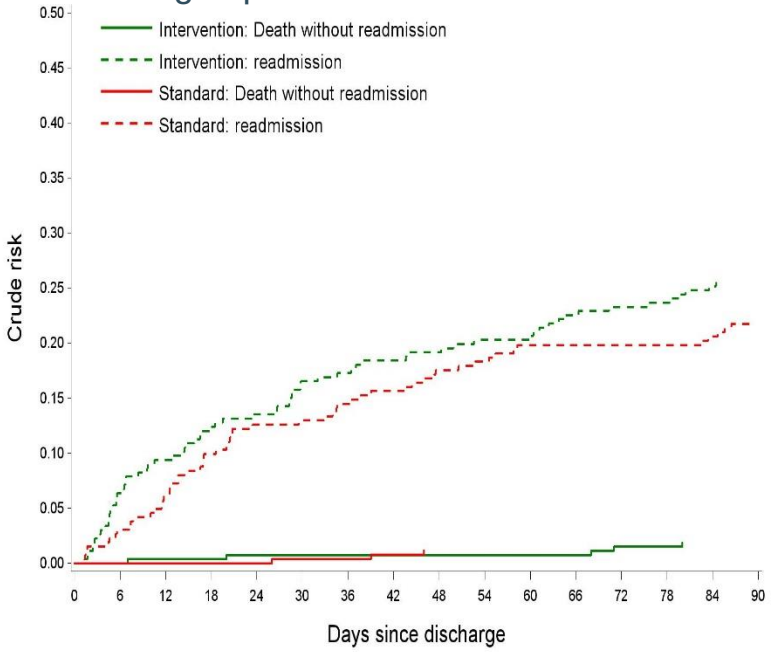
- **All patients: - 6 h. (19 -> 12 h): p= 0,0003**
- **Hospitalized: - 6 h. (20 -> 14 h): p= 0,0002**
- Discharged: - 5 h. (15 ->10 h): NS

CGA:

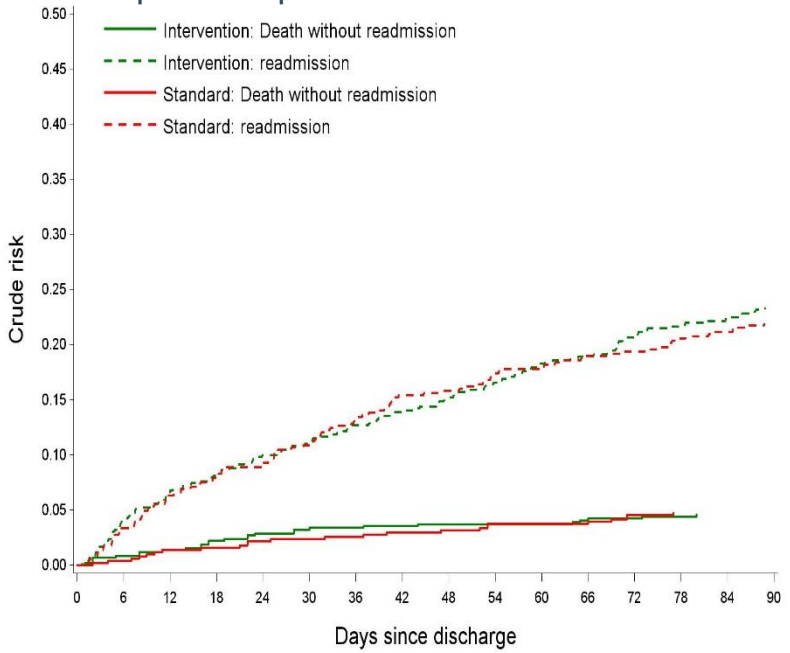
Geriatric domain	Variables within the comprehensive geriatric assessment
Functional	❖ Activities of daily living (Katz index [35]) ❖ Fall History [34] ❖ Taking stairs ❖ Pain [34] ❖ Nutritional status: Appetite and weight loss [34] ❖ Alcohol use and smoking ❖ Medication intake ❖ Dyspnea [34]
Cognitive	❖ Screening for cognition: three-item word memory and clock drawing (mini-cog [36]) ❖ Orientation in time and place ❖ Attention ❖ Depressive symptoms (3-item screening tool for depression [38]) ❖ Screening for delirium (Confusion Assessment Method [37])
Social	❖ Age ❖ Gender ❖ Living situation (alone, together, other) [34] ❖ Formal care at home (e.g. nurse, meals on wheels, cleaning help, physiotherapist) ❖ Informal care at home (e.g. help from family, friends) ❖ Caregiver burden [34]
Medical	❖ Triage priority level (Emergency Severity Index [25]) ❖ Reason for admission ❖ Treating discipline on the ED ❖ Diagnosis ❖ Polypharmacy ❖ ED and hospital use in the last months

UNPLANNED READMISSION PREVENTION BY GERIATRIC EMERGENCY NETWORK FOR TRANSITIONAL CARE (URGENT)

Time to unplanned ED readmission discharged patients



Time to unplanned ED readmission hospitalized patients



Deviendt E. Submitted for publication

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Geriatric ED

- **Characteristics**:
  - Sepatate beds for geriatric patients (4-12)
  - Strict criteria→ screening
  - CGA
  - Adapted infrastrucute
  - Geriatrician available
  - Interdisciplinary team and collaboration
  - Focus on discharge planning, referral en continuity of care
- **Specific characteristics**
  - Caregiver involvement (Salvi et al. 2008 & Ellis et al. 2012)
  - Adapted trajectories ex radiology, lab, 'frailty pathway' (Salvi et al. 2008; Conroy et al 2013)

Geriatric ED

- **Outcomes**:

Outcome	Salvi 2008	Ellis 2012	Parteja-Sierra 2013	Conroy 2013
Readmission	3m&6m NS	7d&1m NS	/	7d&1m NS 3m S
Hospitalisation	NS	S	S	S
LOHS	NS	NS	S	NS
Mortality	6m NS	12m NS	/	/

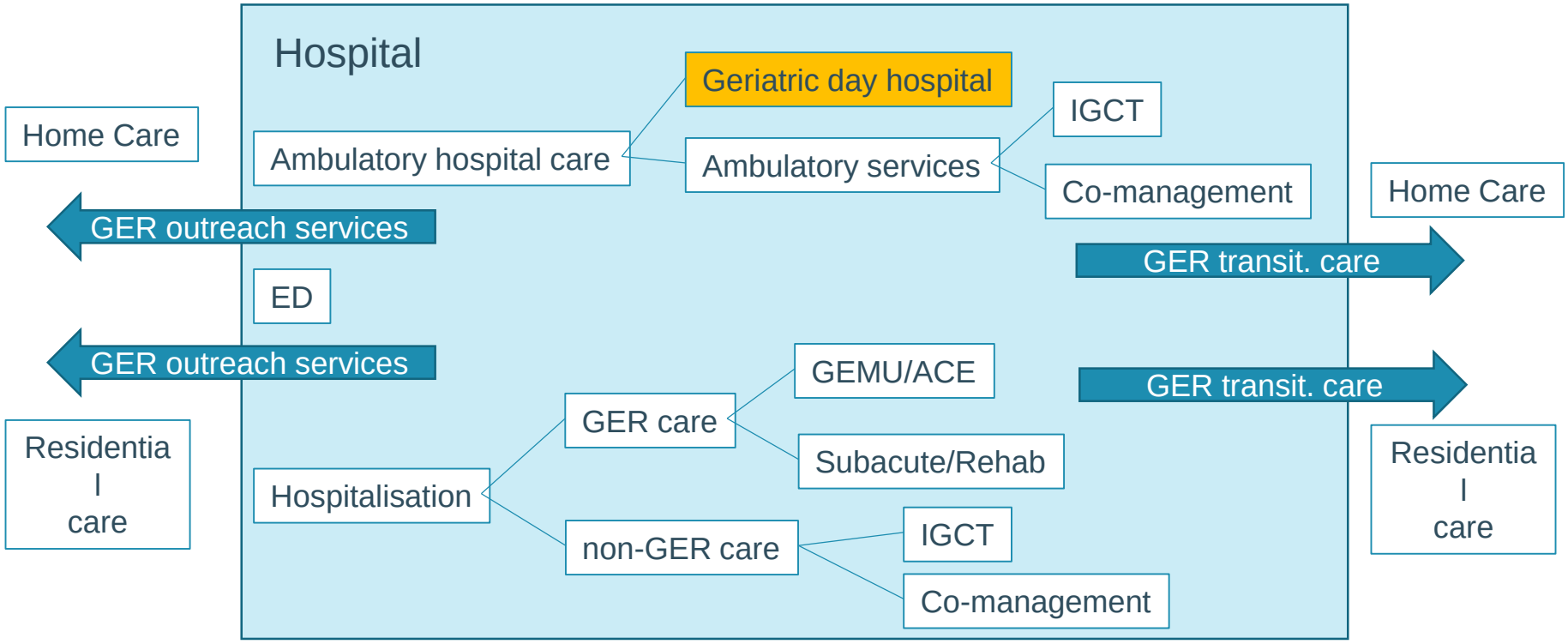
Salvi et al. 2008; Ellis et al. 2012; Parteja-Sierra et al. 2013; Conroy et al. 2013

ED pathways

Key aspects of interventions that warrant further research

- Comprehensive assessment and screening of elderly patients attending the ED may be effective in to preventing hospital admission and ED attendance.
- Follow up of patients after discharge (from ED or acute setting) may reduce ED attendance and readmission rates.
- Senior staff who are appropriately trained to manage and treat or refer complex patients appears to aid in preventing hospital admission.
- Interventions that are trialled away from the time pressured environment of the ED may be effective.
- Providing 'holding' areas for patients discharged directly from the ED to allow staff sufficient time to plan the discharge care of patients may reduce the proportion of unscheduled ED return visits.
- Further research regarding patient centred education within the ED for specific chronic diseases needs to be conducted.
- There is a need for high quality prospective studies in the UK setting.

CGA based care models for older persons

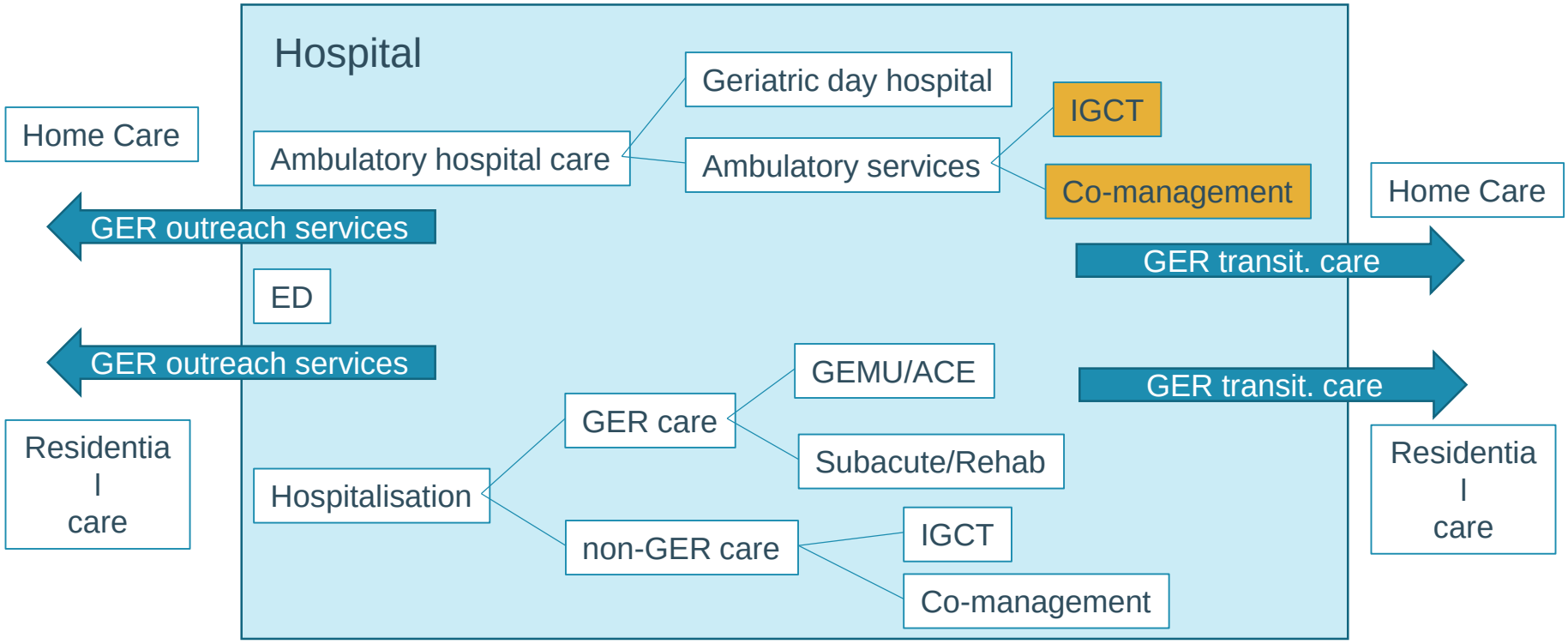


GDH

	Death	Death or ADL↓	Death or poor outcome*	Death or institutionalisation	ADL↓	Institutionalisation
Other treatment	NS	NS	NS	NS	NS	NS
Comprehensive care	NS	NS	NS	NS	NS	NS
Domiciliary care	NS	NS	NS	NS	NS	NS
No comprehensive care	NS	NS	**-28 %**	**-37 %**	**-49 %**	NS

* institutional care, dependency, deterioration in physical function

CGA based care models for older persons



International Society of Geriatric Oncology Consensus on Geriatric Assessment in Older Patients With Cancer

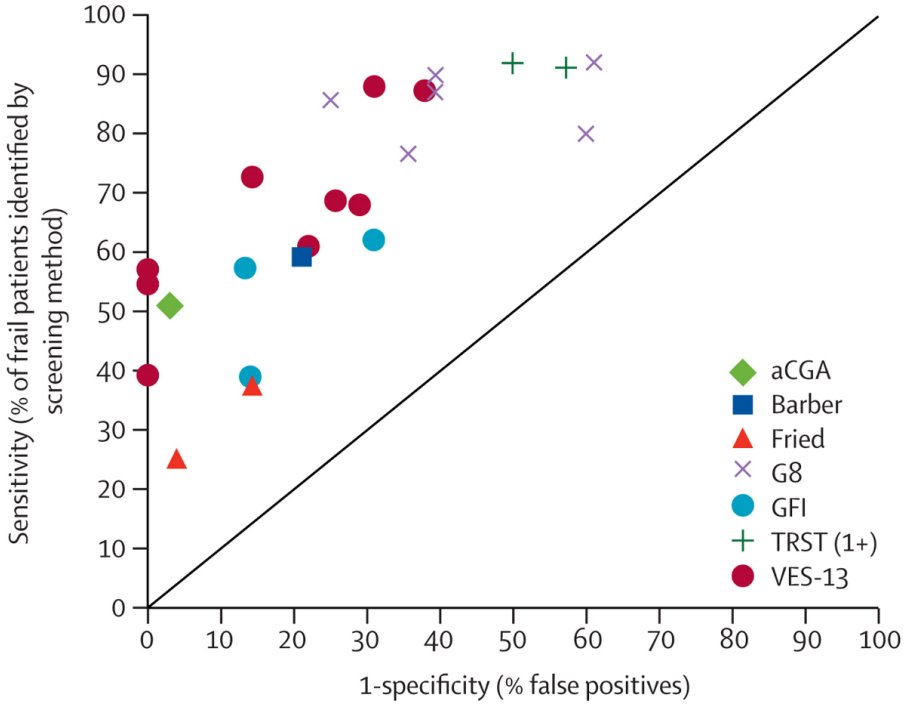
Table A2. Reasons to Perform GA Based on Statements in Former Publications

Literature Search Results
GA can reveal/detect previously unknown and potentially reversible geriatric problems not found by routine oncology care[15,22,23,25,28,32-34,44]
GA can predict toxicity/adverse effects from cancer treatment or decrease in QOL, enabling more targeted use of preventive measures[15,18-21,23,25,32,41]
GA has important prognostic information that can be helpful in estimating life expectancy, which is of paramount importance when making treatment decisions[15,18,19,22-24,26,28-34,44,75]
GA can influence/improve treatment decisions[15,16,21,23,25,27,32]
GA allows targeted interventions, which can improve QOL and compliance with therapy[15,23,22,32]
GA is a systematic procedure to appraise objective health, including multimorbidity and functional status, which interfere with cancer prognosis and treatment choices in older patients[15,23,30]

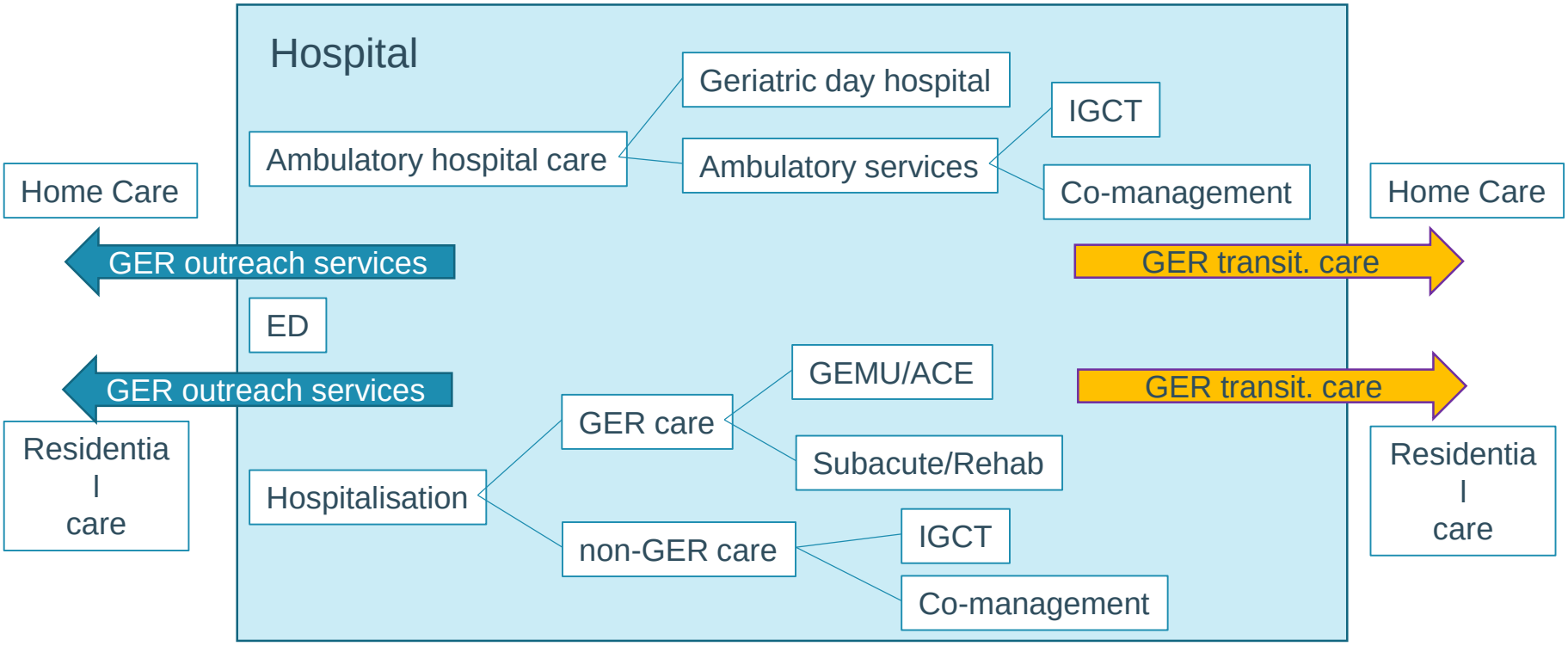
Abbreviations: GA, geriatric assessment; QOL, quality of life.

Frailty screening methods for predicting outcome of a comprehensive geriatric assessment in elderly patients with cancer

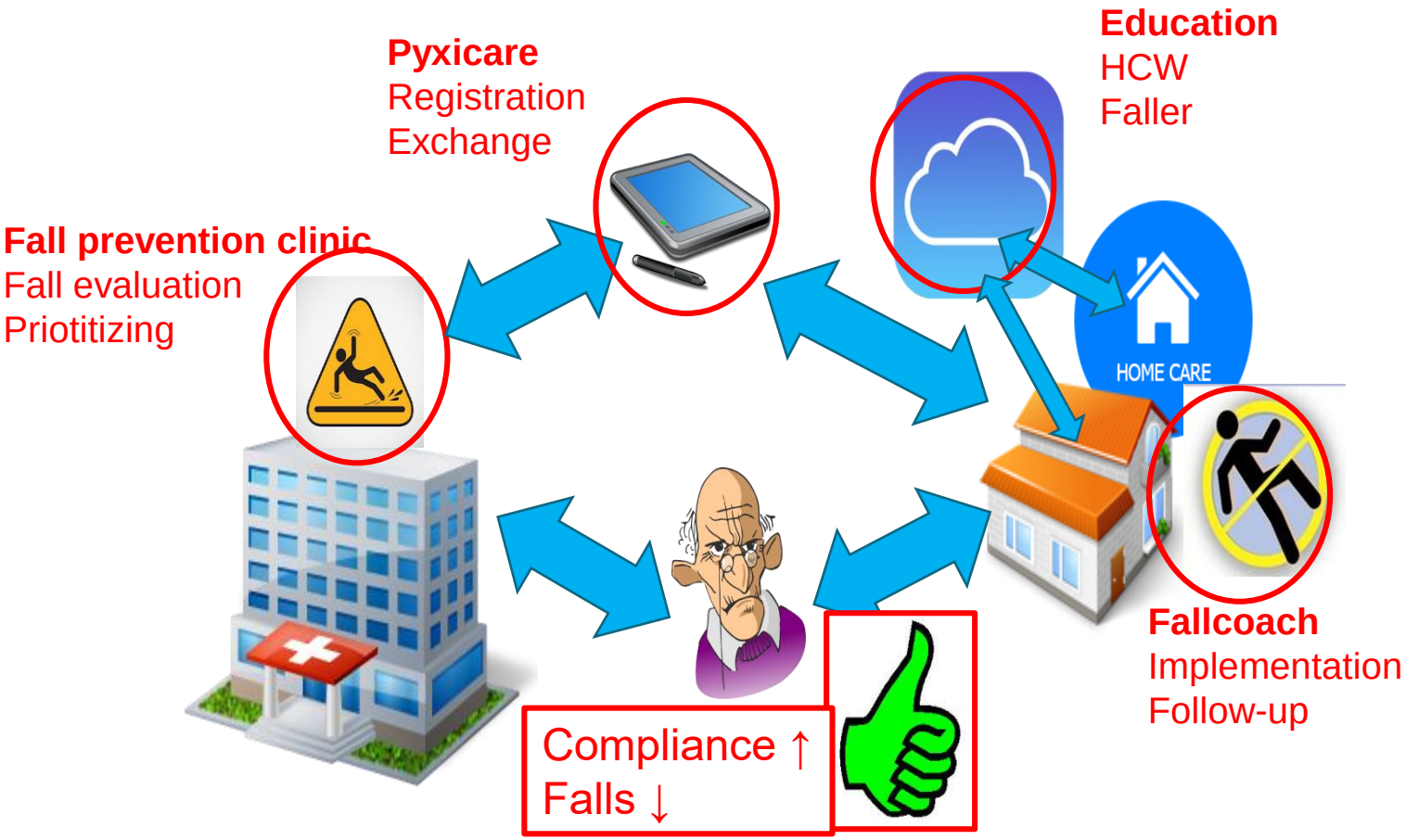
Use CGA



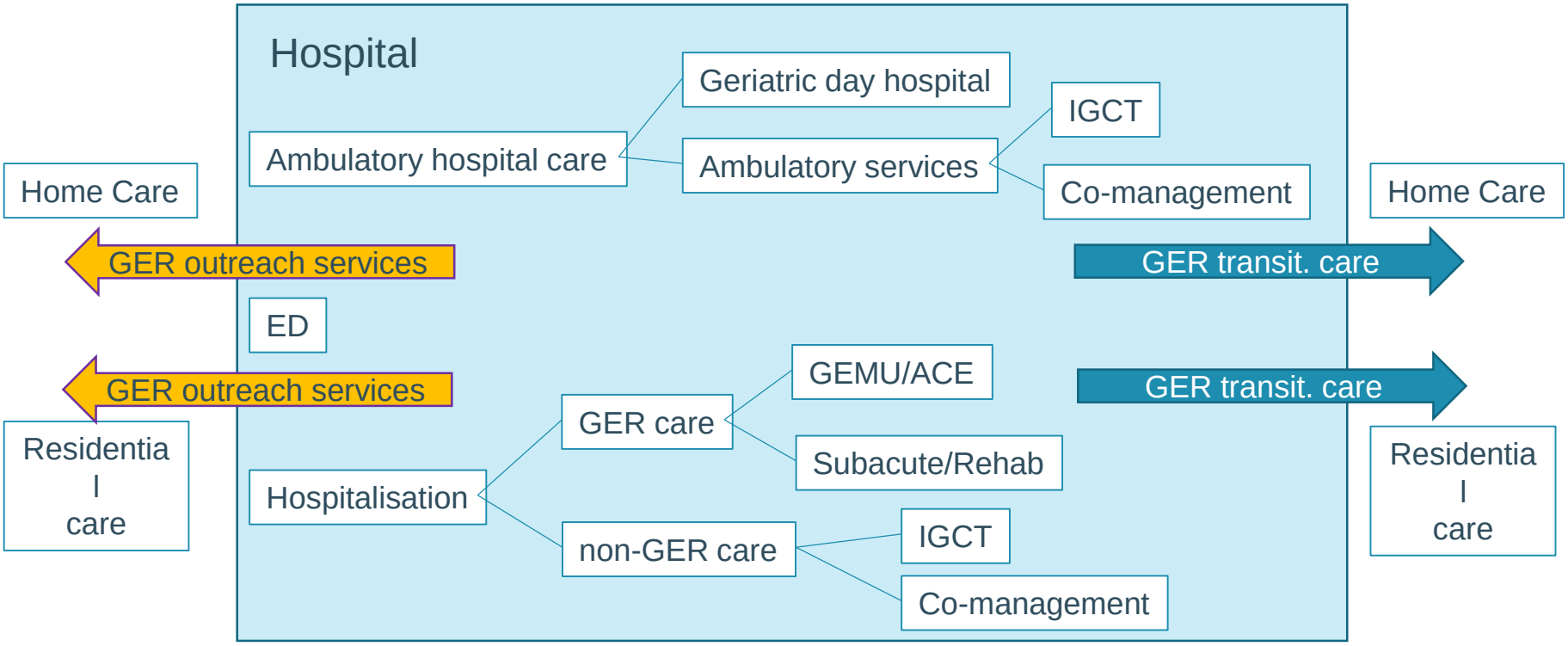
CGA based care models for older persons



Fall-net-interventions



CGA based care models for older persons



Nurse Led Outreach Teams (NLOT) Toronto

Outreach into LTCF

Prevention of ED and hospital admission.

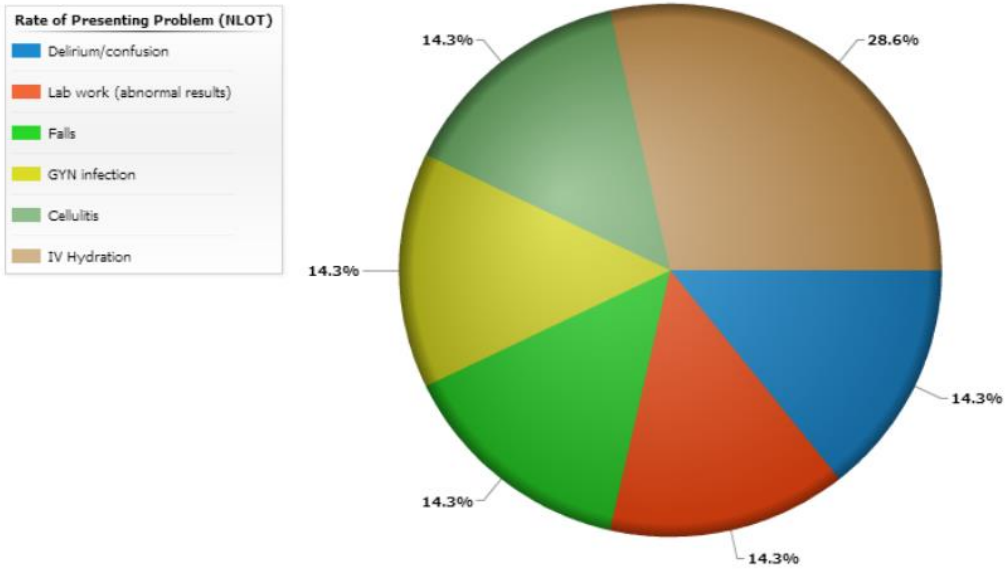


Figure 2. Rate of presenting problem seen by NLOT.

doi:10.3233/978-1-61499-678-1-237

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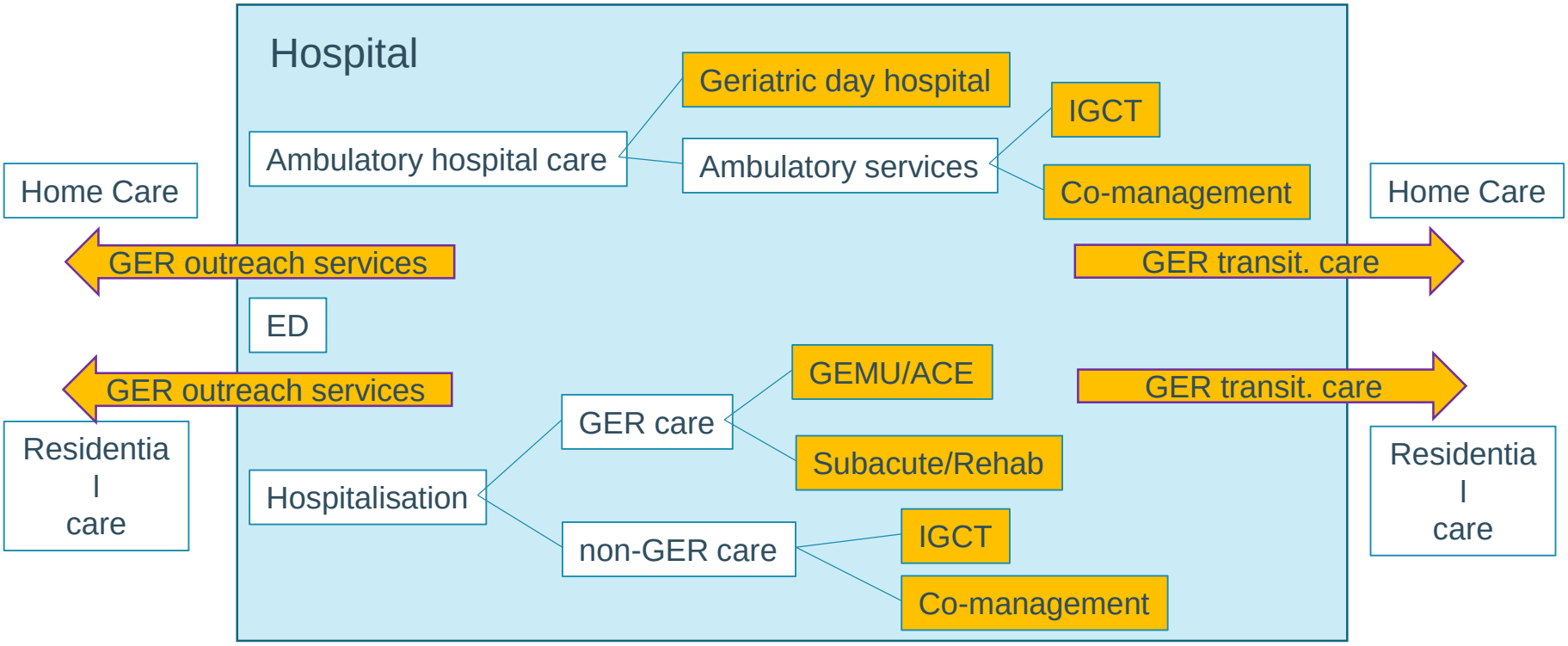
CGA based care models for older persons



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Intentions

Intention to implement … N (%)		Total N = 178	Belgium N = 69	Denmark N = 22	Estonia N = 13	Greece N = 47	Iceland N = 4	Ireland N = 11	Malta N = 3	Slovenia N = 9
Acute geriatric units	In next year? In next 5 years?	4 (4.7) 15 (17.4)	NA	2 (9.1) 0	0 1 (7.7)	0 5 (10.9)	0 1 (33.3)	2 (28.6) 3 (42.9)	0 1 (33.3)	0 4 (50.0)
Geriatric rehabilitation unit	In next year? In next 5 years?	1 (0.7) 16 (11.7)	0 7 (14.6)	0 0	0 1 (9.1)	0 5 (11.1)	0 0	0 1 (25.0)	0 1 (33.3)	1 (12.5) 1 (12.5)
Geriatric consultation team	In next year? In next 5 years?	3 (3.7) 13 (16.0)	NA	1 (11.1) 2 (22.2)	0 0	0 5 (11.1)	0 1 (33.3)	1 (33.3) 1 (33.3)	1 (50.0) 0	0 4 (44.4)
Geriatric co-management	In next year? In next 5 years?	14 (11.1) 32 (25.4)	8 (19.5) 16 (39.0)	2 (25.0) 1 (12.5)	0 0	0 7 (15.6)	0 2 (50.0)	4 (44.4) 2 (22.2)	NA	0 4 (44.4)
Geriatric ED boxes	In next year? In next 5 years?	9 (5.5) 29 (17.9)	1 (1.6) 15 (23.4)	4 (19.0) 4 (19.0)	0 0	1 (2.4) 5 (11.9)	0 1 (25.0)	2 (22.2) 2 (22.2)	0 1 (33.3)	1 (12.5) 1 (12.5)
Geriatric day clinic?	In next year? In next 5 years?	2 (1.1) 12 (10.3)	0 1 (6.3)	1 (5.9) 2 (11.8)	0 0	1 (2.1) 5 (10.6)	0 1 (33.3)	0 1 (12.5)	0 0	0 2 (22.2)
Transitional care programs	In next year? In next 5 years?	8 (11.3) 13 (18.3)	4 (23.5) 4 (23.5)	1 (14.3) 2 (28.6)	0 0	0 2 (6.5)	0 1 (100.0)	2 (40.0) 2 (40.0)	0 1 (100.0)	1 (16.7) 1 (16.7)

Legend: Percentage of hospitals aiming to implement the care model in the next year or 5 years = **0 – 24%, 25 – 49%, ≥50%**

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- National framework / legislation
- Geriatricians and specialized HCW
- Education: training in geriatric medicine

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- **XIIIth EAMA Postgraduate Course in Geriatrics**

  - **Session 1:January 21-25, 2019**
    Principles of Geriatric Care
    Brussels, Belgium
  - **Session 2: June 24-28, 2019**
    Cognition and Behaviour
    Vienna, Austria
  - **Session 3: January 20-24, 2020**
    Evidence-Based Medicine in Geriatrics
    Nice, France
  - **Session 4: June 22-26 2020**
    How to Provide Geriatric Care