KCE REPORT 245S

Federaal Kenniscentrum voor de Gezondheidszorg
Centre Fédéral d'Expertise des Soins de Santé
Belgian Health Care Knowledge Centre

COMPREHENSIVE GERIATRIC CARE IN HOSPITALS: THE ROLE OF INPATIENT GERIATRIC CONSULTATION TEAMS

APPENDIX

KCE REPORT 245S
HEALTH SERVICES RESEARCH

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COMPREHENSIVE GERIATRIC CARE IN HOSPITALS: THE ROLE OF INPATIENT GERIATRIC CONSULTATION TEAMS

APPENDIX

MIEKE DESCHODT, VEERLE CLAES, BASTIAAN VAN GROOTVEN, KOEN MILISEN, BENOIT BOLAND, JOHAN FLAMAING, ALAIN DENIS, FRANÇOIS DAUE, LUT MERGAERT, CARL DEVOS, PATRIEK MISTIAEN, KOEN VAN DEN HEEDE

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COLOPHON

Title:	Comprehensive geriatric care in hospitals: the role of inpatient geriatric consultation teams – Appendix
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First wave of focus groups: interview guide

Participants receive the SWOT in advance of the group. They have had a chance to read the result of the first four groups.

A - Introduction 10'

- Intro by facilitator
- tour de table
- rules of the game

B - Warming up 15' (total 25') – what surprised them?

- Collect spontaneous reactions on what surprised them in the results of the first round. What was new or unexpected, as a result / idea? Or because it seems more or less important than they had expected.
- Facilitator makes sure every participant expresses him- or herself.

C – Brainstorm – matching strengths with opportunities – 20' (total 45')

Basis is poster with SWOT. Purpose is to find ideas on how to enhance the impact of liaison teams.

Participants are asked in a first round to identify matches between strengths and opportunities to enhance the impact. Each identified match is put on a post-it and on a flip. The reason why is explained and briefly discussed.

After this round, each match is discussed more in detail. Ideas are asked on how this could work in practice, how this could be worked out to enhance the impact even further.

At the end of the exercise, the type of impact pursued by each idea is identified and put on a post-it. These impacts are displayed on a separate flip chart.

D – Brainstorm – converting weaknesses and threats into strengths and/or opportunities – 30' (total 75')

Basis is poster with SWOT. Purpose is to find ideas on how to enhance the impact of liaison teams.

Participants are asked to find ideas how weaknesses and threats could be converted into a strength or an opportunity to enhance the impact. Each identified conversion is put on a post-it and on a flip. The reason why is explained and briefly discussed.

In a next step, each conversion is discussed more in detail. Ideas are asked on how this could work in practice, how this could be worked out to enhance the impact even further.

At the end of the exercise, the type of impact pursued by each idea is identified and put on a post-it. These impacts are added on the impact flip chart.

Short break

E – Review of impacts – 20' (total 95')

Impacts are reviewed in group.

Participants are asked to identify missing types of impact which are then added to the already identified impacts.

Impacts are clustered on the flip or white board.

F – Validation of SWOT - 30' (total 125')

Review of SWOT as formulated.

Review of formulation, consistency, completeness, importance.

Second wave of focus groups: interview guide

Participants receive the SWOT in advance of the group. They have had a chance to read the result of the first four groups.

A - Introduction 10'

- Intro by facilitator
- tour de table
- rules of the game

B - Warming up 15' (total 25') – what surprised them?

- Collect spontaneous reactions on what surprised them in the results of the first round. What was new or unexpected, as a result / idea? Or because it seems more or less important than they had expected.
- Facilitator makes sure every participant expresses him- or herself.

C – Brainstorm – matching strengths with opportunities – 20' (total 45')

Basis is poster with SWOT. Purpose is to find ideas on how to enhance the impact of liaison teams.

Participants are asked in a first round to identify matches between strengths and opportunities to enhance the impact. Each identified match is put on a post-it and on a flip. The reason why is explained and briefly discussed.

After this round, each match is discussed more in detail. Ideas are asked on how this could work in practice, how this could be worked out to enhance the impact even further.

At the end of the exercise, the type of impact pursued by each idea is identified and put on a post-it. These impacts are displayed on a separate flip chart.

D – Brainstorm – converting weaknesses and threats into strengths and/or opportunities – 30' (total 75')

Basis is poster with SWOT. Purpose is to find ideas on how to enhance the impact of liaison teams.

Participants are asked to find ideas how weaknesses and threats could be converted into a strength or an opportunity to enhance the impact. Each identified conversion is put on a post-it and on a flip. The reason why is explained and briefly discussed.

In a next step, each conversion is discussed more in detail. Ideas are asked on how this could work in practice, how this could be worked out to enhance the impact even further.

At the end of the exercise, the type of impact pursued by each idea is identified and put on a post-it. These impacts are added on the impact flip chart.

Short break

E – Review of impacts – 20' (total 95')

Impacts are reviewed in group.

Participants are asked to identify missing types of impact which are then added to the already identified impacts.

Impacts are clustered on the flip or white board.

F – Validation of SWOT - 30' (total 125')

Review of SWOT as formulated.

Review of formulation, consistency, completeness, importance.

2. SEARCH STRING AND RESULTS OF DATABASE SEARCH

2.1. Search string and results of database search

Medline			CINAHL			EMBASE		
Number	**Keywords**	**Results**	**Number**	**Keywords**	**Results**	**Number**	**Keywords**	**Results**
1	exp Geriatrics/	26408	1	MH "Geriatrics"	2414	1	'geriatrics'/exp	42356
2	geriatr*.tw.	30939	2	geriatr*	26205	2	geriatr*:ab,ti	49864
3	oncogeriatr*.tw.	47	3	oncogeriatr*	7	3	oncogeriatr*:ab,ti	146
4	orthogeriatr*.tw.	79	4	orthogeriatr*	40	4	orthogeriatr*:ab,ti	225
5	gerontolog*.tw.	4837	5	gerontolog*	23971	5	gerontolog*:ab,ti	8153
6	Elderly.ti,ab.	159054	6	Elderly	43894	6	elderly:ab,ti	223946
7	geriatric.ti,ab.	25466	7	geriatric	22612	7	geriatric:ab,ti	39205
8	"mini-mental state".ti,ab.	8036	8	“mini-mental state”	2358	8	'mini-mental state examination’/exp	11668
9	alzheimer.ti,ab.	18616	9	alzheimer	2240	9	alzheimer:ab,ti	112823
10	"alzheimer’s".ti,ab.	70092	10	alzheimer’s	16153	10	alzheimers:ab,ti	1268
11	mmse.ti,ab.	5738	11	mmse	1549	11	mmse:ab,ti	11802
12	caregivers.ti,ab.	22696	12	caregivers	24727	12	caregivers:ab,ti	32101
13	falls.ti,ab.	26298	13	falls	13607	13	falls:ab,ti	36508
14	Adl.ti,ab.	5626	14	adl	2120	14	adl:ab,ti	8766
15	Frailty.ti,ab.	3353	15	Frailty	1240	15	frailty:ab,ti	5130
16	Gds.ti,ab.	1809	16	Gds	521	16	gds:ab,ti	3102
17	Ageing.ti,ab.	22288	17	Ageing	3779	17	ageing:ab,ti	31166
18	"hip fractures".ti,ab.	4455	18	"hip fractures"	4282	18	'hip fractures':ab,ti	6259

19	elders.ti,ab.	5387	19	elders	4428	19	elders:ab,ti	7210
20	Frail.ti,ab.	5215	20	Frail	4589	20	frail:ab,ti	7605
21	Mci.ti,ab.	9379	21	Mci	1037	21	mci:ab,ti	16329
22	Demented.ti,ab.	6787	22	Demented.ti,ab.	1106	22	demented:ab,ti	9282
23	"cognitive impairment".ti,ab.	24797	23	cognitive impairment"	5937	23	'cognitive impairment':ab,ti	39262
24	"postmenopausal women".ti,ab.	25428	24	"postmenopausal women"	4257	24	'postmenopausal women':ab,ti	33986
25	comorbidities.ti,ab.	22483	25	MH “Comorbidity”	21327	25	comorbidities:ab,ti	42909
26	dementia.ti,ab.	17349	26	dementia	26563	26	dementia:ab,ti	87549
27	aging.ti,ab.	103253	27	aging	31781	27	aging:ab,ti	134710
28	older.ti,ab.	240078	28	older	71607	28	older:ab,ti	325161
29	"daily living".ti,ab.	17349	29	"daily living"	20075	29	'daily living':ab,ti	24745
30	"cognitive decline".ti,ab.	8824	30	"cognitive decline"	1943	30	'cognitive decline':ab,ti	13912
31	"cognitive impairment".ti,ab.	24797	31	"cognitive impairment”	5937	31	'cognitive impairment':ab,ti	39262
32	"cognitive functioning".tw.	6733	32	"cognitive functioning"	1666	32	'cognitive functioning':ab,ti	9761
33	"old people".ti,ab.	2757	33	"old people"	552	33	'old people':ab,ti	4864
34	exp Geriatric assessment/	18121	34	MH “Geriatric assessment+ “	9652	34	'geriatric assessment'/exp	8681
35	exp aging/	196096	35	MH “Aging+”	21400	35	'aging'/exp	188329
36	exp frail elderly/	6548	36	MH “Frail elderly”	3261	36	'frail elderly'/exp	5320
37	alzheimers.ti,ab.	70092	37	alzheimers	33	37	'alzheimer disease'/exp	121374
38	exp Alzheimer disease/	66581	38	MH "Alzheimer's Disease"	14408	38	'cognition disorders'/exp	93578

39	exp cognition disorders/	61571	39	MH "Cognition disorders"	11920	39	'dementia'/exp	223680
40	exp dementia/	118671	40	MH "Dementia+"	33813	40	'daily life activity'/exp	54340
41	exp Activities of daily living/	50557	41	MH "Activities of daily living+"	29351	41	'very elderly'/exp	19635
42	exp "aged, 80 and over"/	603734	42	MH "Aged, 80 and over"	110800	42	'health services for the aged'	165
43	Health Services for the Aged/	14818	43	MH "Health Services for the Aged"	4232	43	'geriatric nursing'/exp	11379
44	Geriatric Nursing/	12206	44	"geriatric nursing"	525	44	gemu:ab,ti	26
45	GEMU.tw.	22	45	GEMU.tw.	6	45	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36 or 37 or 38 or 39 or 40 or 41 or 42 or 43 or 44	1178915
46	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36 or 37 or 38 or 39 or 40 or 41 or 42 or 43 or 44 or 45	1336504	46	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36 or 37 or 38 or 39 or 40 or 41 or 42 or 43 or 44 or 45	313202	46	'patient care management'	429
47	Patient Care Management/	2296	47	"Patient Care Management/"	1211	47	'patient care team'	462

48	Patient Care team/	51857	48	Patient Care team/	636	48	'geriatric assessment'/exp	8681
49	Geriatric Assessment/	18121	49	MH "Geriatric Assessment+"	9652	49	'referral and consultation'	343
50	"Referral and Consultation"/	50966	50	MH "Referral and Consultation+"	16750	50	'consultation team':ab,ti	136
51	consultation team?.tw.	121	51	consultation team?	20	51	'liaison team':ab,ti	90
52	liaison team?.tw.	61	52	liaison team?	6	52	'comprehensive geriatric assessment':ab,ti	1429
53	(comprehensive adj3 geriatric adj3 assessment?).tw.	821	53	(comprehensive adj3 geriatric adj3 assessment?)	40	53	cga:ab,ti	3451
54	CGA.tw.	2333	54	CGA	118	54	multidisciplinary:ab,ti	63206
55	multidisciplinary.tw.	39318	55	multidisciplinary	30427	55	interdisciplinary:ab,ti	28266
56	interdisciplinary.tw.	18789	56	interdisciplinary	9460	56	'care team':ab,ti	6738
57	care team?.tw.	6000	57	care team?	1980	57	'evaluation team':ab,ti	149
58	evaluation team?.tw.	164	58	evaluation team?	87	58	'support team':ab,ti	800
59	support team?.tw.	643	59	support team?	370	59	'management team':ab,ti	1149
60	management team?.tw.	1068	60	management team	316	60	46 or 47 or 48 or 49 or 50 or 51 or 52 or 53 or 54 or 55 or 56 or 57 or 58 or 59	109939
61	47 or 48 or 49 or 50 or 51 or 52 or 53 or 54 or 55 or 56 or 57 or 58 or 59 or 60	171880	61	47 or 48 or 49 or 50 or 51 or 52 or 53 or 54 or 55 or 56 or 57 or 58 or 59 or 60	64792	61	'guideline adherence'/exp	305327
62	exp Guideline Adherence/	20200	62	MH "Guideline Adherence"	3540	62	'program evaluation'/exp	1658
63	exp "Outcome and Process Assessment (Health Care)"/	706280	63	MH "Process Assessment (Health Care)+"	4745	63	'quality indicator':ab,ti	1428

64	n/a		64	MH "Outcomes (Health Care)+"	169868	64	'organizational efficiency'/exp	721
65	exp Program Evaluation/	55077	65	MH "Program Evaluation"	18246	65	'program evaluation':ab,ti 'program effectiveness':ab,ti 'program appropriateness':ab,ti 'program sustainability':ab,ti 'program sustainabilities':ab,ti	2726 783 2 100 0
66	exp Quality Indicators, Health Care/	12650	66	“Quality indicators”	1271	66	‘protocol compliance’:ab,ti ‘policy compliance’:ab,ti ‘policies compliance’:ab,ti	318 49 3
67	exp Efficiency, Organizational/	17696	67	MH "Organizational Efficiency+"	19229	67	‘institutional adherence’:ab,ti ‘guideline adherence’:ab,ti	5 872
68	(indicator adj3 quality).tw.	1988	68	(indicator adj3 quality)	20	68	‘outcome assessment’:ab,ti ‘process assessment’:ab,ti	2759 150
69	(program? adj3 (evaluation? or effectiveness or appropriateness or sustainability or sustainabilities)).tw.	9187	69	(program? adj3 (evaluation? or effectiveness or appropriateness or sustainability or sustainabilities))	40	69	61 or 62 or 63 or 64 or 65 or 66 or 67 or 68	315309
70	(compliance adj2 (protocol? or policy or policies)).tw.	458	70	(compliance adj2 (protocol? or policy or policies))	15	70	45 and 60	20784
71	(adherence adj2 (institutional or guideline?)).tw.	1464	71	(adherence adj2 (institutional or guideline?))	6	71	69 and 70	1364

72	((outcome? or process) adj2 assessment?).tw.	7608	72	((outcome? or process) adj2 assessment?)	58	72	71 and [1999-2014]/py		1246
73	62 or 63 or 64 or 65 or 66 or 67 or 68 or 69 or 70 or 71	805902	73	62 or 63 or 64 or 65 or 66 or 67 or 68 or 69 or 70 or 71 or 72	210807	73	72 and ([dutch]/lim [english]/lim [french]/lim)	OR OR	1125
74	46 and 61	37411	74	46 and 61	17882	74	73 NOT ('letter'/it 'editorial'/it)	OR	**1101**
75	73 and 74	5986	75	73 and 74	2848				
76	limit 75 to yr="1999 - Current"	5017	76	limit 75 to yr="1999-Current"	2582				
77	limit 76 to (dutch or english or french)	4747	77	limit 76 to (dutch or english or french)	2518				
78	letter.pt.	834177	78	Publication type: letter or editorial	289080				
79	editorial.pt.	351667	79	77 not (78)	**2476**				
80	77 not (78 or 79)	**4631**							
Total references including duplicates			**8208**						
Total references after duplicates removed			**7279**						

3. OVERVIEW OF INCLUDED GREY LITERATURE

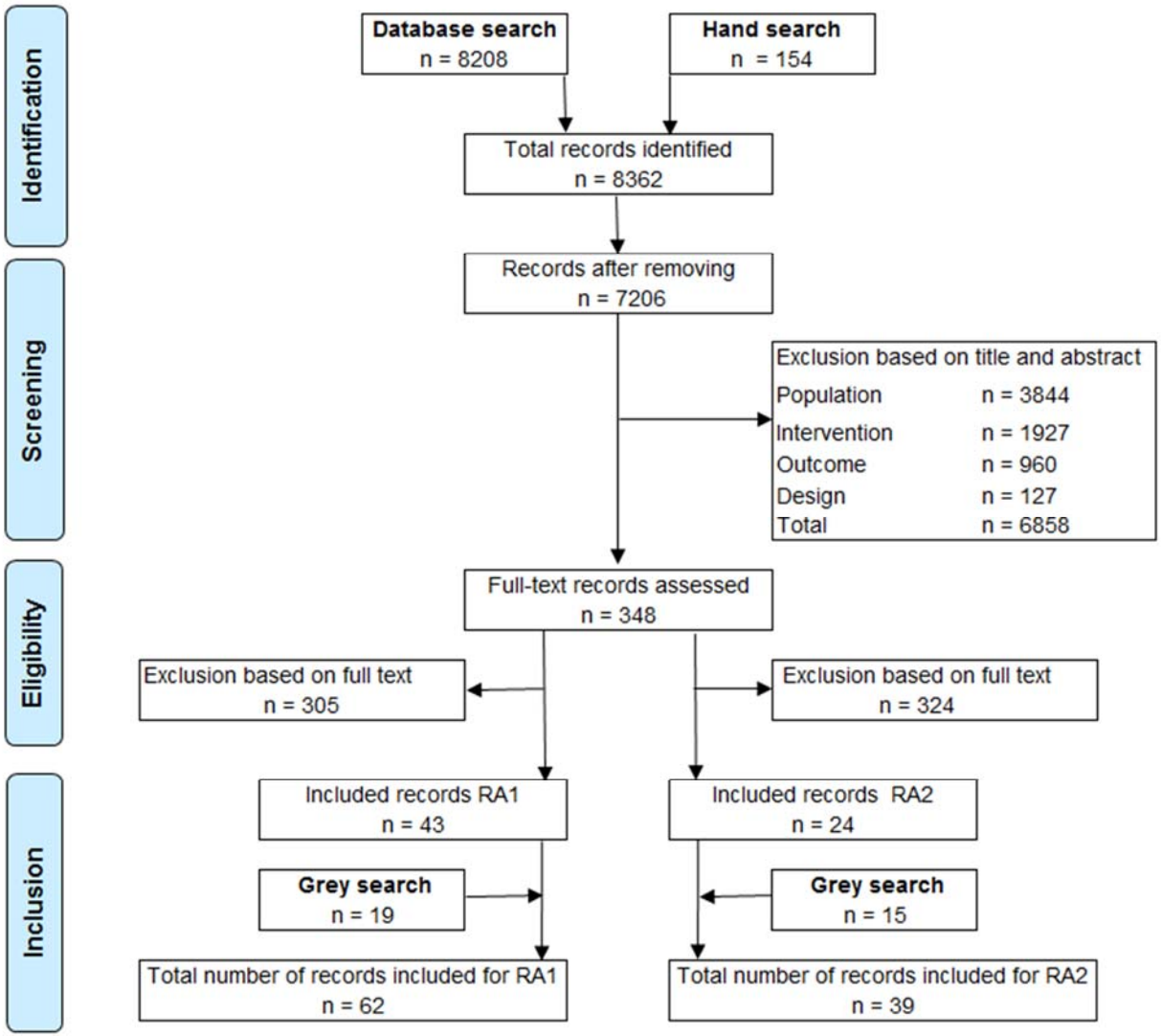
Country	Organisation/Author	Included documents	Chapter 4	Chapter 5
Canada	Canadian Association on Gerontology (CAG) (www.cagacg.ca)	/		
	Regional Geriatric Programs of Ontario (http://rgps.on.ca/)	Lewis D. Organization design for geriatrics: an evidence based approach. Regional Geriatric Programs of Ontario, Ontario, Canada. [1] http://rgps.on.ca/files/RGPHandbookFINAL.pdf	+	-
	The Canadian Geriatrics Society (http://www.canadiangeriatrics.ca/)	/		
	Senior Friendly Hospitals (http://seniorfriendlyhospitals.ca)	Ontario LHINs. Senior Friendly Hospital Care Acros Ontario. Summary Report and Recommendations, September 2011 [2]	+	-
		Wong K, Tsang A, Liu B, Schwartz R. The Ontario Senior Friendly Hospital Strategy - Delirium and functional decline indicators. A Report of the Senior Friendly Hospital Indicators Working Group, November 2012 [3]	-	+
		Home page http://seniorfriendlyhospitals.ca [4]	+	-
France	Inspection générale des affaires sociales (IGAS) (http://www.igas.gouv.fr)	Rousseau AC & Bastianelli JP. Les equips mobiles gériatriques au sein de la filière de soins. Rapport n° 2005 053, Mai 2005 [5]	+	-
	Société Française de Gériatrie et Gérontologie (www.sfgg.fr)	/		
	Ministère de la Santé et des Solidarités Ministère de la Santé, de la Famille et des Personnes Handicapées	Circulaire DHOS/O2/DGS/SD. 5D/2002/157 du 18 mars 2002 relative à l'amélioration de la filière de soins gériatriques [6]	+	+
		Circulaire N°DHOS/02/2007/117 relative à la filière de soins gériatriques, le 28 mars 2007 [7]	+	+
		Circulaire N°195/DHOS/01/2007/65 relative à la prise en charge des urgences, le 13 février 2007 [8]	+	

	Ministère des Affaires Sociales et de la Santé, France	Les schémas régiounaux d'organisation des soins (SROS) (http://www.sante.gouv.fr/les-schemas-regionaux-d-organisation-des-soins-sros.html) [9]	+	-
	Montalan MA, Vincent B.	Performance des organisations transversables hospitalières: proposition d'un outil d'évaluation du capital immatérial des équips mobiles de gériatrie.[10]	-	+
Germany	Deutsche Gesellschaft für Gerontologie und Geriatrie (http://www.dggg-online.de/englisch.php)	/		
Taiwan	The Hong Kong Geriatrics Society (www.hkgs.org)	/		
The Netherlands	Nederlandse Vereniging voor Klinische Geriatrie (www.nvkg.nl)	Richtlijn Comprehensief Geriatrisch Assessment (CGA), 2013 [11]	+	-
		Richtlijn Comprehensief Geriatrisch Assessment bij consult en medebehandeling - Addendum behorende bij de richtlijn CGA, 2013 [12]	+	+
		Home page www.nvkg.nl [13]	+	-
		Indicatorenset NVKG [14]	-	+
	Samenwerkende ouderenorganisaties (http://seniorvriendelijkziekenhuis.nl/project.html)	Methodologisch document Keurmerk Seniorvriendelijk Ziekenhuis, 2013 [15]	+	
		Kwaliteitsaspecten Keurmerk Seniorvriendelijk Ziekenhuis, 2013 [16]	+	+
		Home page http://seniorvriendelijkziekenhuis.nl/project.html [17]	+	-
	VMS Veiligheidsprogramma (www.vmszorg.nl/Themas/Kwetsbare-ouderen)	Kwetsbare ouderen. 2009.0104 [18]	+	+
	Koninklijke Nederlandse Maatschappij tot bevordering der Geneeskunde (KNMG)	Sterke medische zorg voor kwetsbare ouderen – KNMG-standpunt (2010) [19]	+	-

	(http://knmg.artsennet.nl/Publicaties/KNMGpublicatie/76604/Sterke-medische-zorg-voor-kwetsbare-ouderen-1.htm)			
	Inspectie voor de Gezondheidszorg - Ministerie van Volksgezondheid, Welzijn en Sport (www.rijksoverheid.nl/ministeries/vws/documenten-en-publicaties)	Kwaliteitsindicatoren 2014. Basisset ziekenhuizen (http://www.igz.nl/zoeken/document.aspx?doc=Basisset+Kwaliteitsindicatoren+Ziekenhuizen+2014&docid=6076) [20]	-	+
	Nederlandse Zorgauthoriteit. (http://www.nza.nl/regelgeving/tarieven/ziekenhuiszorg/tarievenDBCDOT/tarieven-prestaties-DBC-DOT/)	Tarieventabel DBC-zorgproducten en overige producten per 1 juni 2014 [21]	+	-
		Regeling prestaties en tarieven medisch specialistische zorg [22]	+	-
	Centrale Samenwerkende Ouderenorganisaties (CSO) (http://ouderenorganisaties.nl/cso/)	http://ouderenorganisaties.nl/cso/download/zorg-en-welzijn/eindrapport-1e-project-delier.pdf [23]	-	+
	te Velde BP, Betten W. (2011)	Geriatrische zorg vanuit Patiëntenperspectief. Kwaliteitscriteria voor zorg aan kwetsbare ouderen [24]	-	+
	CZ zorgverzekering (http://www.cz.nl/)	http://www.cz.nl/~/media/zorgaanbieder/mimoduleouderenzorgtoelichtingtransmuraal.pdf [25]	-	+
	Verenso specialisten ouderengeneeskunde (http://www.verenso.nl/)	http://www.verenso.nl/wat-doen-wij/praktijkvoering/prestatie-indicatoren-grz/ [26]	-	+
UK	British Geriatrics Society (www.bgs.org.uk/)	/		
	British Society of Gerontology (http://www.britishgerontology.org/)	/		
	Royal College of Physicians (www.rcplondon.ac.uk/)	Acute care toolkit 3. Acute medical care for frail older people, March 2012 [27]	+	-
USA	American Geriatrics Society	/		

	(http://www.americangeriatrics.org/)			
	Gerontological Society of America (www.geron.org)	/		
	Joint Commission International (http://www.jointcommission.org/)	http://www.jointcommissioninternational.org/assets/3/7/ILM-Index-Measure-Codes-Descriptions.pdf [28]	-	+
	Agency for Healthcare Research and Quality (http://www.qualitymeasures.ahrq.gov/)	http://www.qualitymeasures.ahrq.gov/browse/index.aspx?alpha=A – American Geriatric Society [29]	-	+

4. FLOWCHART OF THE STUDY IDENTIFICATION AND SELECTION



5. DATA CHARTING FORMAT FOR RESEARCH AIM 1

General information

- First author, identification number (ID) of paper, language of paper
- Reviewer name (MD or VC)
- Complete reference, source of reference
- Study design (multi center RCT, single center RCT, multi center nRCT, single center nRCT, pre-post intervention study, prospective observational study, retrospective observational study, case-series/case-study, descriptive study (survey/qualitative/other), other (specify), remarks regarding study design
- Study setting: country, state/city, general hospital characteristics (name, number of beds), IGCT (name, year of establishment)
- Aims of the study
- General remarks

Composition of IGCT

- Disciplines/members of IGCT (physician (G = geriatrician), nurse, occupational therapist, physical therapist, social worker, pharmacist, other (specify), type of member for each (core member, available on call, not clearly indicated)
- Head count, full-time equivalents, educational requirements (in general and/or for each discipline)
- Criteria for establishment and/or composition of IGCT (evidence/experience/hospital characteristics/law – specify)

Operational aspects of IGCT

- Study population (sample size, lost to follow-up/response rate, inclusion criteria, exlcusion criteria, focus on older patients with a geriatric risk profile (yes/no/not clearly indicated), specify geriatric profile (if applicable), age (years, median, standard deviation or n(%))
- Intervention hospital units (general hospital units/ED/ICU/other, specify)
- Detection of high-risk patients (screening): screening performed (yes/no/not clearly indicated), population screened (age limit, hospital units,…), discipline responsible, timeframe, screening criteria used (with cut-off), result of positive screening
- Other type of case-finding (if no screening is performed or in addition to a screening procedure)
- Patient assessment: domain (medical, functional, psychological, social, other), specify instrument used and discipline responsible, remarks)
- Multi/interdisciplinary team meetings: frequency, attending members, agenda)
- Role of IGCT members (advisory role, advisory + implementation role, different role/team member, not clearly indicated)
- Recommendations for high-risk patients: content, communication, mandatory for requesting unit (yes/no/not clearly indicated)
- Collaboration: with GRNs, with primary care (yes, specify/no)
- In-hospital follow-up of patients (yes, specify/no)
- Other activities of IGCT (besides patient consultation)

- CGA process: according to author (yes/no/not clearly indicated), according to reviewer (yes/no/doubt, specify)
- Caseload of IGCT
- Operational problems encountered by IGCT (in general)
- Financing of IGCT

Studied outcomes of IGCT

- Outcomes evaluation: domain, definition, operationalization, effect (effect, non-effect, negative-effect, several effects, not applicable)
- Other evaluations of IGCT (yes, specify/no)
- Quality of care dimensions assessed (as defined by the Institute of Medicine, USA): safe, effectiveness, patient-centered, timely, efficiency, equitable

6. CONTENT VALIDATION – RESULTS

Concise description of the questionnaire item	Number of experts	Relevant item[2]	Clearly formulated item[3]	I-CVI[4]	P_c[5]	k*[6]	Evaluation[7]
Part 1: General information about you and your hospital							
1. Identification contact person							
a. Name	15	10	15	.67	.092	.633	Good
b. Profession	15	15	15	1.00	.000	1.00	Excellent
c. Email	15	12	15	.80	.014	.797	Excellent
2. Identification hospital							
a. Name	15	13	15	.87	.003	.866	Excellent
b. Location	15	14	15	.93	.000	.933	Excellent
c. Hospital type	15	13	14	.87	.003	.866	Excellent
3. Hospital figures							
ai. Hospital beds, general	15	15	14	1.00	.000	1.00	Excellent
aii. Hospital admissions, general	15	14	13	.93	.000	.933	Excellent
biii. Hospital admissions, aged ≥ 75 years	15	15	13	1.00	.000	1.00	Excellent
biv. Length of stay, aged ≥ 75 years	15	14	14	.93	.000	.933	Excellent
cv. Geriatric unit, existence	15	15	15	1.00	.000	1.00	Excellent
cvi. Geriatric unit, beds	15	15	14	1.00	.000	1.00	Excellent
cvii. Geriatric unit, admissions	15	15	14	1.00	.000	1.00	Excellent
cviii. Geriatric unit, length of stay	15	14	14	.93	.000	.933	Excellent
dix. Geriatricians, head count	15	14	14	.93	.000	.933	Excellent
dx. Geriatricians, full-time equivalents	15	14	14	.93	.000	.933	Excellent
e. Emergency department, existence	15	14	15	.93	.000	.933	Excellent

Part 2: General information about the IGCT							
4. Year of establishment	15	13	14	.87	.003	.866	Excellent
5. Motivation for establishment	15	13	15	.87	.003	.866	Excellent
6. Team composition							
a. Disciplines	15	15	9	1.00		1.00	Excellent
b. Head count + full-time equivalents per discipline	15	14	12	.93	.000	.933	Excellent
c. Total head count + Full-time equivalents	15	14	11	.93	.000	.933	Excellent
d. Team composition, underlying motivation	15	14	15	.93	.000	.933	Excellent
e. Team composition, educational requirements	15	13	13	.87	.003	.866	Excellent
7. IGCT availability							
a. Days	12	11	11	1.00	.000	1.00	Excellent
b. Hours/day	15	12	14	.80	.014	.797	Excellent
c. Units + frequency	15	14	13	.93	.000	.933	Excellent
8. GRNs							
a. Existence	15	15	15	1.00	.000	1.00	Excellent
b. Implementation units	14	12	13	.86	.006	.856	Excellent
c. Collaboration with IGCT	14	12	13	.86	.006	.856	Excellent
Part 3: Detection and selection of frail older patients							
9. Screening, performance	15	15	12	1.00	.000	1.00	Excellent
10. Screening, population	15	15	13	1.00	.000	1.00	Excellent
11a. Screening, team responsible	15	15	13	1.00	.000	1.00	Excellent
11b. Screening, discipline responsible	15	11	15	.73	.042	.772	Good
12a. Screening, timeframe	15	12	14	.80	.014	.797	Excellent
12b. Screening, repeated	15	11	14	.73	.042	.722	Good

13a. Screening, type of instrument	15	14	15	.93	.000	.933	Excellent
13b. Screening, name of instrument	15	14	15	.93	.000	.933	Excellent
14. Screening, action if positive result	15	14	13	1.00	.000	1.00	Excellent
15. Screening, result added to patient file	15	14	13	.93	.000	.933	Excellent
16. No screening							
16a. Reasons	14	14	14	1.00	.000	1.00	Excellent
16b. Other selection procedure - how	14	12	11	.86	.006	.856	Excellent
16c. Other selection procedure – by whom	14	11	13	.79	.022	.781	Excellent
Part 4: IGCT assessment and recommendations							
17. Assessment							
17a. Items	15	15	11	1.00	.000	1.00	Excellent
17b. Result added to patient file	15	15	15	1.00	.000	1.00	Excellent
18. Team meetings							
18a. Existence	15	15	13	1.00	.000	1.00	Excellent
18b. Frequency	15	15	15	1.00	.000	1.00	Excellent
18c. Hours/week	15	14	13	.93	.000	.933	Excellent
18d. Members attending	15	13	14	.87	.003	.866	Excellent
19a. Recommendations, most frequent	15	14	13	.93	.000	.933	Excellent
19b. Recommendations, use of guidelines/protocols	15	13	15	.87	.003	.866	Excellent
20a. Recommendations, communication – how	15	14	12	.93	.000	.933	Excellent
20b. Recommendations, communication – to whom	15	10	8	.71	.061	.696	Good
Part 5: Implementation of IGCT recommendations							
21. Recommendations, direct implementation by IGCT - existence	15	15	12	1.00	.000	1.00	Excellent
22. Recommendations, direct implementation by IGCT – types	15	14	13	.93	.000	.933	Excellent

23. Recommendations, implementation mandatory	15	15	13	1.00	.000	1.00	Excellent
24. In-hospital follow-up of patients	15	15	15	1.00	.000	1.00	Excellent
25. Communication to primary and residential care	15	15	11	1.00	.000	1.00	Excellent
Part 6: IGCT performance							
26a. Work load, requests	14	11	13	.79	.022	.781	Excellent
26b. Work load, patients assessed	15	13	14	.93	.001	.929	Excellent
27a. Adherence to recommendations, overall percentage	15	11	15	.73	.042	.722	Good
27b. Adherence to recommendations, improvement actions	15	13	15	.87	.003	.866	Excellent
28. Performance evaluation							
28a. Use of quality criteria/indicators	15	14	15	.93	.000	.933	Excellent
28b. Annual report	15	15	14	1.00	.000	1.00	Excellent
28c. Other strategies	15	14	14	.93	.000	.933	Excellent
28d. Subjective rating	15	10	14	.67	.092	.633	Good
29a. Financing, basis	15	14	12	.93	.000	.933	Excellent
29b. Financing, payment criteria	15	10	10	.67	.092	.633	Good
30. Additional information of IGCT team	15	15	15	1.00	.000	1.00	Excellent
Number of items of the questionnaire	69						
S-CVI$_{Ave}$[9]	0.91						
S-CVI$_{UA}$[10]	0.35						

[2] *Number of experts with agreement that the item is clearly formulated*
[3] *Number of experts giving a relevance rating 3 or 4*
[4] *Item content validity index (I-CVI) = number giving a rating of 3 or 4 / number of experts. The items with I-CVI of more than .78 are shown in bold*
[5] *Probability of a chance agreement (P_C) = [N! / A! (N - A!] x 0.5^N where N = number of experts and A = number of experts agreeing on good relevance of the item (rating 3 and 4)*
[6] *Modified kappa statistic for agreement on relevance (k*) = [I-CVI – P_c] / [1 – P_c]*
[7] *Evaluation criteria for kappa: fair = k* of .40 - .59; good = k* of .60 - .74 and excellent = k* > .74*
[9] *Average scale content validity index (S-CVI$_{Ave}$) = mean of I-CVI*
[10] *Scale content validity index universal agreement (S-CVI$_{UA}$) = number of experts giving a rating 3 or 4 / number of items*
Items that were deleted in the final questionnaire based on recommendations of the experts and/or their I-CVI are shown in italics

7. FINAL QUESTIONNAIRE – ENGLISH VERSION

PART 1: Identification of you and your hospital

1. Identification of the contact person

Your participation in this questionnaire is non-anonymous. After survey participation, you might receive a request for further contact with our research team to discuss your answers or to request additional information and details regarding your IGCT

a. Full name
b. Profession
c. Are you directly involved in your hospital's IGCT activities? (Yes/No)
d. E-mail

2. Identification of the hospital

a. What is the name of your hospital?
b. What is the full address of your hospital?
c. Is your hospital a multi-site (more than one campus) hospital? (Yes/No)

3. Type of hospital: *Choose one of the following answers*

a. University hospital
b. Non-university hospital
c. Other, specify

PART 2: Establishment of the IGCT

4. In which year was your IGCT established?

PART 3: Composition of the IGCT

5. Current composition of your IGCT (I)

a. Indicate **for each discipline** mentioned in the table whether the discipline is:
- o Represented as a core member of the IGCT
- o Available when necessary ('on call')
- o Not available.

Note: Make sure each person is listed only once in the category that most approaches the description of his/her discipline, or in the category 'other' if the discipline is not mentioned in the list

Discipline	Availability
Internal medicine physician	Core member/available when necessary / not available
Geriatric medicine physician	Core member/available when necessary / not available
(Geronto)psychiatrist	Core member/available when necessary / not available
General nurse	Core member/available when necessary / not available
Nurse with additional geriatric training	Core member/available when necessary / not available
Nurse practitioner	Core member/available when necessary / not available
Clinical nurse specialist	Core member/available when necessary / not available
Psychiatric nurse	Core member/available when necessary / not available
Occupational therapist	Core member/available when necessary / not available
Physical therapist	Core member/available when necessary / not available
Psychologist	Core member/available when necessary / not available
Speech therapist	Core member/available when necessary / not available
Dietician	Core member/available when necessary / not available
Social worker	Core member/available when necessary / not available
Pharmacist	Core member/available when necessary / not available
Other	Core member/available when necessary / not available

b. Please **specify 'other' disciplines** of the previous question **(discipline + type of availability)**

Note: Skip this question if 'other disciplines' is not applicable for your IGCT

- o Other discipline 1
- o Other discipline 2

- Other discipline 3
- Other discipline 4
- Other discipline 5

6. Current composition of your IGCT (II)

a. If a discipline is represented as **core member** in your IGCT, **specify** the number of people **(head count)** and the number of full time equivalents **(FTE) per discipline**

Note: 1 FTE = 100% = full-time employee. Please fill out the value '0' if an answer category is not applicable (e.g. a discipline in the list that is not a core member of your IGCT)

Discipline	Head count	FTE
Internal medicine physician		
Geriatric medicine physician		
(Geronto)psychiatrist		
General nurse		
Nurse with additional geriatric training		
Nurse practitioner		
Clinical nurse specialist		
Psychiatric nurse		
Occupational therapist		
Physical therapist		
Psychologist		
Speech therapist		
Dietician		
Social worker		

Pharmacist
Other

b. Please **specify** the **head count and FTE** for the '**other discipline(s)** that are represented as core members in your IGCT' of the previous question

Note: Skip this question if 'other disciplines' is not applicable for your IGCT

- o Other discipline 1
- o Other discipline 2
- o Other discipline 3
- o Other discipline 4
- o Other discipline 5

c. Specify the **total head count** and **FTE** of IGCT core members:

- o Total head count
- o Total FTE

7. Additional training

a. Is an additional training required to function as a core member of the IGCT? (e.g. working experience in geriatrics, special courses/education,…)

- o Yes >> Go to question 8
- o No

b. Please **specify** the **type of additional training** required to function as a core member of your IGCT

Check all that apply

- o Working experience in geriatrics
- o Special courses/education in geriatrics
- o Other, please specify

PART 4: Availability of the IGCT

8. Availability of your IGCT

a. During the **week:** *Check all that apply*

- o Monday – Friday
- o Saturday
- o Sunday

- o Official holidays

b. During **the day:** *Choose one of the following answers*

- o 24 hours per day
- o Day time hours only, please specify the hours of availability
- o Other, please specify

c. Specify for each **unit how often IGCT consultation** is provided.

- o General surgical units Regularly / rarely / never
- o General non-surgical units Regularly / rarely / never
- o Intensive care unit Regularly / rarely / never
- o Emergency department Regularly / rarely / never
- o Psychiatry unit Regularly / rarely / never
- o Other Regularly / rarely / never

d. Please **specify for the 'other units/departments of the previous question**: the types of units/departments & frequency of consultation by IGCT

PART 5: Geriatric resource nurses (GRNs)

9. Are GRNs available on nongeriatric units in your hospital?

- o Yes
- o No *>> Go to question 12*

10. **Which type of hospital units currently have GRNs?** *Check all that apply*

- o General surgical units
- o General non-surgical units
- o Intensive care unit
- o Emergency department
- o Psychiatry unit
- o Other, specify

11. a) Is there a formal collaboration between your IGCTs and GRNs on nongeriatric units?

- o Yes
- o No >> *Go to question 12*

b) Please **specify** the **types of formal collaboration** between your IGCT and GRNs on nongeriatric units

Our IGCT and GRNs formally collaborate for: *Check all that apply*

- o Screening of high-risk patients
- o Assessment of high-risk patients
- o Formulation and/or communication of recommendations for IGCT patients
- o Education and/or coaching of the care team of the nongeriatric unit
- o Participations in IGCT team meetings
- o Other, specify

PART 6: Detection and selection of frail older patients

12. In your hospital, are older patients screened for having a geriatric risk profile?

- o Yes
- o No >> *Go to question 19*

13. Who is being screened? Choose one of the following answers

- o We aim to screen all patients with a minimum age of …
- o Only specific groups of older patients are being screened, please specify

14. Who performs the screening?

a. **Which team** is **mainly responsible** for performing the screening? *Choose one of the following answers*

- o The care team of the unit where the patient is hospitalized
- o The IGCT
- o Other, specify

b. Which discipline(s) is/are mainly responsible for performing the screening? *Check all that apply*

- o Physician
- o Nurse

- o Geriatric resource nurse
- o Occupational therapist
- o Social worker
- o Other, specify

15. Timeframe of the screening
    a. **When** is the **screening performed?** *Choose one of the following answers*
    - o Usually within … hours after hospital admission
    - o There are no requirements regarding the timing of the screening
    - o Other, please specify

    b. Is the screening **repeated?** *Choose one of the following answers*
    - o No, every older patient is screened once
    - o Yes, the screening is repeated for all older patients every … days
    - o Yes, the screening is systematically repeated for a selection of older patients based on certain signs or symptoms, namely (please specify)
    - o Yes, the screening is repeated for a selection of older patients but not systematically

16. a) Performance of the screening – What type of screening instrument is used in your hospital?
    - o An internationally recognized screening instrument for the detection of patients at risk is used *>> Go to question 16b) and skip question 16c)*
    - o A self-developed screening instrument is used *>> Go to question 16c)*
    - o A combination of both types of screening instruments is used *>> Go to question 16b)*

    b) Please specify the **name(s) of the instrument(s) used**

    Note: If more than 1 screening instrument is used, please check all instruments that apply

    - o Care Complexity Prediction Instrument (COMPRI) *(Huyse et al. 2001)*
    - o Hospital Admission Risk Profile (HARP) *(Sager et al. 1996)*
    - o Identification for Senior's At Risk (ISAR) *(McCusker et al. 1999)*
    - o Rowland questionnaire *(Rowland et al. 1990)*
    - o Runciman questionnaire *(Runciman et al. 1996)*
    - o Triage Risk Screening Tool (TRST) *(Meldon et al. 2003)*

o Other, specify

c) Please specify the **features of** this **self-developed screening instrument** (e.g. the items included, cut-off used for a positive screening,…)

17. How is a positive screening acted upon?
    - o An IGCT assessment is automatically performed for all patients with a positive screening
    - o An IGCT assessment is performed when deemed necessary by the IGCT
    - o An IGCT assessment is performed when deemed necessary by the care team of the unit where the patient is hospitalized
    - o Other, please specify

18. Are the results of a screening added to the patient's file?
    - o Yes >> Go to question 20
    - o No >> Go to question 20

19. No systematic screening of older persons is performed in your hospital

    a. What are the **reasons** for **not performing** a systematic screening of older patients? *Check all that apply.*
    - o We are unsure about which screening instrument is most appropriate to detect at risk patients
    - o We are not convinced about the added value of the use of screening instruments to detect patients at risk
    - o It is too time-consuming to perform a screening to detect patients at risk
    - o Other, specify

    b. Specify **how and by whom** (e.g. team and discipline responsible) **patients are selected** for an **IGCT intervention**

PART 7: IGCT assessment

20. Indicate for each item how often the item is assessed by your IGCT

Item	Frequency of assessment
a) MEDICAL DOMAIN	
Medical history	Regularly / Rarely / Never
Actual medical problems	Regularly / Rarely / Never
Medication review	Regularly / Rarely / Never
Review of results from laboratory tests & diagnostic procedures	Regularly / Rarely / Never
Physical examination	Regularly / Rarely / Never
Item	**Frequency of assessment**
b) FUNCTIONAL DOMAIN	
Basic activities of daily living	Regularly / Rarely / Never
Instrumental activities of daily living	Regularly / Rarely / Never
Mobility	Regularly / Rarely / Never
Pain	Regularly / Rarely / Never
Sleeping disorders	Regularly / Rarely / Never
Fatigue	Regularly / Rarely / Never
Nutritional status	Regularly / Rarely / Never
Swallowing function	Regularly / Rarely / Never
Vision	Regularly / Rarely / Never
Hearing	Regularly / Rarely / Never
c) COGNITION/PSYCHOLOGICAL DOMAIN	
Orientation	Regularly / Rarely / Never

Depression	Regularly / Rarely / Never
Delirium (acute confusional state)	Regularly / Rarely / Never
Dementia	Regularly / Rarely / Never
d) SOCIAL DOMAIN	
Place of residence	Regularly / Rarely / Never
Available professional care	Regularly / Rarely / Never
Available informal care	Regularly / Rarely / Never
Caregiver burden	Regularly / Rarely / Never

21. If **other domains/items are assessed** by your IGCT, indicate **which items and how often** each item is assessed (e.g. regularly, rarely, never)

22. Are the results of the baseline assessment added to the patient's file?
    - o Yes
    - o No

PART 8: IGCT team meetings

23. Are team meetings organized within the IGCT to discuss patients for whom consultation is provided?
    - o Yes
    - o No *>> Go to question 24*

24. Specify the frequency of these team meetings: … times per week

Note: If the team meeting is organized once per month, enter 0,25.

PART 9: IGCT recommendations for consulted patients

25. Give a list of the five (domains of) recommendations that are the most frequently made by your IGCT

1.
2.
3.
4.
5.

26. Are guidelines or protocols used to determine the IGCT recommendations?
    - o Yes
    - o No >> *Go to question 26*

27. Please **upload the guidelines used** to determine the IGCT recommendations

Please upload at most 10 files (file type Word (.doc, .docx) ou Pdf (.pdf))

28. How does your **IGCT communicate its recommendations** to the care team of the unit where the patient is hospitalized? *Check all that apply*
    - o Added to the patient's file
    - o Written or printed on paper
    - o Send by email or other electronic means
    - o IGCT member visits the unit where the patient is hospitalized (e.g. direct contact with the care team)
    - o Telephone contact between an IGCT member and a member of the unit where the patient is hospitalized
    - o IGCT member attends the multidisciplinary team meeting of the unit where the patient is hospitalized
    - o Other, please specify

29. Who implements the recommendations made by the IGCT?
    - o The care team of the unit where the patient is hospitalized implements the recommendations (e.g. the IGCT has an advisory role only) >> *Go to question 29*
    - o The IGCT directly implements all its recommendations
    - o Recommendations are partly implemented by the IGCT, and partly by the care team of the unit where the patient is hospitalized

30. Indicate which recommendations are directly implemented by the IGCT. *Check all that apply.*
    - o Medical diagnostic recommendations (e.g. ordering additional laboratory tests or diagnostic procedures)
    - o Medical therapeutic recommendations (e.g. starting or stopping of medication prescriptions)
    - o Functional recommendations (e.g. assisting in activities of daily living, executing a physical rehabilitation program)
    - o Social recommendations (e.g. organizing home care services to help the patient after hospital discharge)
    - o Cognitive recommendations (e.g. requesting further diagnostic procedures for dementia, implementation of measures for the management of delirium)
    - o Nutritional recommendations (e.g. changing the patient's diet)
    - o Other, specify

PART 10: Follow-up of consulted patients

31. Which statement best describes the follow up of IGCT patients during their hospital stay?
    - o No follow up is provided. The IGCT performs an assessment only (with or without formulating recommendations)
    - o Follow up is only provided by the IGCT on demand of the unit where the patient is hospitalized
    - o Follow up is automatically provided by the IGCT until the IGCT decides that follow-up is no longer necessary
    - o Follow up is automatically provided by the IGCT until the patient is discharged from the hospital
    - o Other, specify

32. Are the IGCT assessment and recommendations available for primary health care providers (home care or residential care)?
    - o Yes, both the IGCT assessment and recommendations are available
    - o Only the IGCT assessment is available
    - o Only the IGCT recommendations are available
    - o No, the assessment and recommendations are not available

PART 11: IGCT activities

33. Specify the total **number of patients assessed** by your IGCT in 2013.

34. How would you **rate** the **overall adherence** to the **recommendations** of your IGCT?
    - o Bad
    - o Poor
    - o Good
    - o Excellent

Adherence: the extent to which recommendations made by the IGCT are implemented.

35. Does your IGCT take any actions to improve the adherence to its recommendations?
    - o Yes, please specify the actions taken
    - o No

36. Evaluation of the IGCT performance
    a. Does your IGCT **use quality criteria** or indicators to evaluate its performance?
    - o Yes
    - o No *>> Go to question 34c)*

    b. Please **upload documents regarding these quality criteria/indicators** (e.g. overview of the criteria/indicators, scoring procedures used, results of this type of performance evaluation,...)

    c. Is an **annual report** describing the performance of your IGCT available?
    - o Yes
    - o No *>> Go to question 34e)*

    d. **Please upload** the **most recent annual report** available

    Please upload at most 10 files (file type Word (.doc, .docx) ou Pdf (.pdf))

    e. Do you use **other methods** to evaluate the performance of your IGCT?
    - o Yes, please specify the methods used
    - o No

PART 12: General information about your hospital

Important: *Please ask for advice of an employee at the management level of your hospital, before filling out these questions*

37. General figures
    a. Total number of hospital beds
    b. Total number of hospital admissions in 2013

Note: including hospital beds/admissions on maternity units, pediatric units and at the day care hospital

38. Figures for patients aged 75 years or older: total number of hospital admissions in 2013
    Note: including admissions at the emergency department and at the day care hospital

39. a) Does your hospital have (a) geriatric unit(s)?
    - o Yes
    - o No >> *Go to question 38*

    Note: if your hospital is located on multiple geographical sites/campuses (multi-site hospital), please take into account the geriatric units at all campuses

    b) Geriatric unit:
    - o What is the total number of geriatric beds on all geriatric units?
    - o What was the total number hospital admissions on all geriatric units in 2013?

    Note: if your hospital is located on multiple geographical sites/campuses (multi-site hospital), please take into account the geriatric units at all campuses

40. Geriatricians
    c. Give the total number (head count) of geriatricians working in your hospital
    d. Give the total number of FTE of geriatricians working in your hospital
    Note: 100% = 1 FTE = 1 full time employee

41. Is there an emergency department in your hospital? (Yes/No)

PART 13: Financing of your IGCT

Important: *Please ask for advice of the financial department or an employee at the management level of your hospital, before filling out these questions*

42. The financing of our IGCT is based on: *Choose one of the following answers*
    - o Project grants. Please specify the annual amount received
    - o Structural reimbursement resources as part of a general payment system

- o A combination of project grants and structural reimbursement resources. Please specify the amount of project grants received & the percentage it represents in the total financing of your IGCT
- o I don't know

43. On which of the following payment criteria is the financing of the IGCT based? *Check all that apply*
    - o Salary (number of actual FTEs and time allocation)
    - o Fixed payment per pathology (standardized cost, e.g. Diagnostic Related Group (DRG) system)
    - o Fixed payment per patient (standardized cost as part of the full cost per patient; capitation)
    - o Variable payment (separately per IGCT intervention; fee for service)
    - o Quality payment (based on reaching quality targets; pay for performance)
    - o Networking payment (based on degree of mutual cooperation; e.g. bundled or global payment)
    - o Other payment criteria, please specify
    - o I don't know

PART 14: Additional information

44. Is there anything else you want to add concerning the organization, operationalization and financing of IGCTs in your hospital/country?

45. Please complete your bank account details to enable transferring the financial compensation
    a. Bank account (IBAN)
    b. Bank account (BIC)
    c. Address of your bank
    d. Specific details concerning bank transfer

8. FINAL QUESTIONNAIRE – FRENCH VERSION

PARTIE 1: Identification de votre hôpital et vous-même

1. Votre identification

Votre participation à ce questionnaire n‟est pas anonyme. Après votre participation à l‟enquête, vous pourriez recevoir une demande d‟un contact avec notre équipe de recherché afin de pouvoir discuter avec vous l‟interprétation de certaines réponses ou de vous demander de bien vouloir fournir quelques informations complémentaires concernant votre EGLI

   a. Nom
   b. Profession
   c. Participez-vous directement aux activités au sein de l‟EGLI de votre hôpital? (Oui/Non)
   d. Adresse courrielle (@)

2. Identification de l'hôpital
   a. Quel est le nom de votre hôpital?
   b. Quel est l‟adresse postale complète de votre hôpital?
   c. Est-ce que votre hôpital est multi-site (plus d‟un campus)? (Oui/Non)

3. **Type d'hôpital:** Seulement une réponse possible
   a. Universitaire
   b. Non-universitaire
   c. Autre, specifiér

PARTIE 2: Initiation de l'EGLI

4. En quelle année votre EGLI a-t-elle initiée?

PARTIE 3: Composition de l'EGLI

5. Composition actuelle de votre EGLI (I)
   a. Indiquez pour chaque discipline mentionnée dans la table si la discipline:
   o Fait partie constitutive de l‟EGLI

- o Est disponible en cas de nécessité (de garde sur appel)
- o N‟est pas disponible

Remarque: Veuillez ne lister chaque personne qu‟une seule fois dans la catégorie qui reflète le mieux sa discipline, ou dans la catégorie “autre” si sa discipline n‟est pas mentionnée dans notre liste

Discipline	Disponibilité
Médecin interniste	Partie constitutive de l‟EGLI / disponible en cas de nécessité / pas disponible
Gériatre	Partie constitutive de l‟EGLI / disponible en cas de nécessité / pas disponible
Psycho-gériatre / Psychiatrist	Partie constitutive de l‟EGLI / disponible en cas de nécessité / pas disponible
Infirmier	Partie constitutive de l‟EGLI / disponible en cas de nécessité / pas disponible
Infirmier avec competence en gériatrie	Partie constitutive de l‟EGLI / disponible en cas de nécessité / pas disponible
Infirmier clinicien	Partie constitutive de l‟EGLI / disponible en cas de nécessité / pas disponible
Infirmier clinician specialisé	Partie constitutive de l‟EGLI / disponible en cas de nécessité / pas disponible
Infirmier en psychiatrie	Partie constitutive de l‟EGLI / disponible en cas de nécessité / pas disponible
Ergothérapeute	Partie constitutive de l‟EGLI / disponible en cas de nécessité / pas disponible
Kinésithérapeute	Partie constitutive de l‟EGLI / disponible en cas de nécessité / pas disponible
Psychologue	Partie constitutive de l‟EGLI / disponible en cas de nécessité / pas disponible
Logopède	Partie constitutive de l‟EGLI / disponible en cas de nécessité / pas disponible
Diététicien	Partie constitutive de l‟EGLI / disponible en cas de nécessité / pas disponible
Assistant social	Partie constitutive de l‟EGLI / disponible en cas de nécessité / pas disponible
Pharmacien	Partie constitutive de l‟EGLI / disponible en cas de nécessité / pas disponible
Autre	Partie constitutive de l‟EGLI / disponible en cas de nécessité / pas disponible

b. Veuillez **préciser le(s) ‘autre(s)’ discipline(s)** de la question précédente **(discipline + type de disponibilité)**

Remarque: Passez à la question suivante si „d"autres disciplines" n"est pas applicable pour votre EGLI

- o Autre discipline 1
- o Autre discipline 2
- o Autre discipline 3
- o Autre discipline 4
- o Autre discipline 5

6. Composition actuelle de votre EGLI
   a. Si une discipline est **partie constitutive** de votre EGLI, merci de **préciser** le nombre de collègues **(personnes)** et le nombre d'équivalents temps plein **(ETP)** par discipline

Remarque: 1 ETP = 100% = un employé à temps plein. S'il vous plaît remplir la valeur '0 'si une catégorie de réponse n'est pas applicable (une discipline dans la liste qui ne fait pas partie constitutive de votre EGLI)

Discipline	Personnes	ETP
Médecin interniste		
Gériatre		
Psycho-gériatre / Psychiatrist		
Infirmier		
Infirmier avec competence en gériatrie		
Infirmier clinicien		
Infirmier clinician specialisé		
Infirmier en psychiatrie		
Ergothérapeute		
Kinésithérapeute		
Psychologue		

Logopède
Diététicien
Assistant social
Pharmacien
Autre

b. Veuillez préciser **le nombre de personnes et d'ETP** pour **le(s) 'autres' discipline(s)** qui font partie constitutive de votre EGLI de la question précédente
Remarque: Passer cette question si „d"autres disciplines" n"est pas applicable pour votre EGLI

- o Autre discipline 1
- o Autre discipline 2
- o Autre discipline 3
- o Autre discipline 4
- o Autre discipline 5

c. Indiquez **le nombre total de personnes et d'ETP** pour les disciplines qui font partie constitutive de votre EGLI

- o Total personnes
- o Total ETP

7. Formation supplémentaire
   a. Une formation supplémentaire est-elle requise pour faire partie constitutive de votre EGLI ? (p.ex. experience professionnelle en gériatrie, participation à des cours ou des formations,…)
   - o Qui >> Passez à la question 8
   - o Non

   b. Veuillez **préciser l"expérience ou/et la formation requise(s)** pour faire partie constitutive de votre EGLI.
   Plusieurs réponses possibles
   - o Experience professionnelle en gériatrie
   - o Des cours ou des formations en gériatrie

o Autre, veuillez spécifier

PARTIE 4: Disponibilité de l'EGLI

8. Disponibilité de votre EGLI

a. Durant **la semaine:** *Plusieurs réponses possibles*

o Lundi au Vendredi
o Samedi
o Dimanche
o Jours fériés

b. Durant **la journée:** *Seulement une réponse possible*

o 24 heures par jour
o Pendant la journée seulement, veuillez spécifier les heures de disponibilité
o Autre, veuillez spécifier

c. Merci de présicer **pour chacun des services** ci-dessous **la fréquence à laquelle** une **consultation par l'EGLI** est fournie

o Unités de chirurgie générales Régulièrement / occasionnellement / jamais
o Unités non chirurgicales Régulièrement / occasionnellement / jamais
o Unités intensives Régulièrement / occasionnellement / jamais
o Salle d"urgence Régulièrement / occasionnellement / jamais
o Psychiatrie Régulièrement / occasionnellement / jamais
o Autres Régulièrement / occasionnellement / jamais

d. S'il vous plaît **préciser pour les «autres unités / départements de la question précédente:** les types d'unités /départements et la fréquence de consultation par l'EGLI

PARTIE 5: Geriatric resource nurses (GRNs)

9. Dans votre hôpital, y a-t-il des infirmières relais en gériatrie disponibles dans les unites non gériatriques?
   - o Oui
   - o Non *>> Passez à la question 12*

10. Quelles unités de votre hôpital disposent actuellement d'IRG? *Plusieurs réponses possibles*
   - o Unités de chirurgie générales
   - o Unités non chirurgicales
   - o Unités intensives
   - o Salle d"urgence
   - o Psychiatrie
   - o Autres, veuillez préciser

11. Y a-t-il un mode de collaboration explicite entre votre EGLI et les IRG dans les unites non gériatriques?
   - o Oui
   - o Non *>> Passez à la question 12*

b) Veuillez s"il vous plait préciser ce(s) mode(s) de collaboration explicite entre votre EGLI et les IRG dans les unites non gériatriques

Notre EGLI et les IRG ont une collaboration explicite pour: Plusieurs réponses possibles
   - o Le dépistage des patients avec un profil de risque gériatrique
   - o L"évaluation des patients avec un profil de risqué gériatrique
   - o La formulation et/ou communication des recommendations pour des patients suivis par l"EGLI
   - o L"éducation et/ou l"encadrement de l"équipe soignante de l"unité non gériatrique
   - o Participation des IRGs dans la reunion de l"EGLI
   - o Autre(s), veuillez spécifier

PARTIE 6: Détection et sélection des patients ages fragiles

12. Dans votre hôpital, les personnes âgées sont-elles dépistées sur le plan d'un profil de risqué gériatrique?
    - o Oui
    - o Non >> *Passez à la question 19*

13. Quels sont les patients qui sont dépistés? *Seulement une réponse possible*
    - o Nous visons de dépister tous les patients qui sont âgés d"au moins …. ans
    - o Nous dépistons seulement des groups spécifiques des patients âgés, veuillez préciser

14. Qui réalise ce dépistage?

a. **Quelle équipe** est-elle **principalement responsable** de la réalisation de ce **dépistage**? *Seulement une réponse possible*
    - o L"équipe soignante de l"unité où le patient est hospitalisé
    - o L"EGLI
    - o Autre, spécifier

b. **Quelle(s) discipline(s) sont principalement responsible(s)** de la réalisation de ce dépistage? *Plusieurs réponses possibles*
    - o Médecin
    - o Infirmière
    - o Infirmière relais de gériatrie (IRG)
    - o Ergothérapeute
    - o Assistant social
    - o Autre, spécifier

15. Calendrier du dépistage

    a. **Quand le dépistage** est-il **réalisé?** *Seulement une réponse possible*
    - o Généralement endéans …. heures après l"admission à l"hôpital
    - o Il n"y a pas d"exigence concernant le moment de ce dépistage
    - o Autre, veuillez spécifier

b. Ce dépistage **est-il répété?** *Seulement une réponse possible*

- o Non, chaque personne âgée est dépistée une seule fois
- o Oui, le dépistage est répété pour l'ensemble des patients âgés, et ce tous les …. jours
- o Oui, le dépistage est répété pour un sous-groupe de personnes âgées, sur la base de certains symptômes et signes, en particulier (merci de les préciser ici)….
- o Oui, le dépistage est répété pour un sous-groupe des personnes âgées, mais pas de façon systématique

16. a) Réalisation du dépistage – Quel type d'outil de dépistage est utilize dans votre hôpital?
    - o Un outil de dépistage, reconnu internationalement, pour la detection des personnes à risque est utilisé. >> *Passez à la question 16b) et ne remplissez pas la question 16c)*
    - o Un outil de dépistage, que nous avons développé nous-mêmes, est utilisé >> *Passez à la question 16c)*
    - o Une combinaison d'outil(s) officiel(s) et développé(s) par nous-mêmes est utilisé. >> *Passez à la question 16b)*

    b) Veuillez **préciser le(s) nom(s) d'outil de dépistage** utilisé

    Remarque: Cocher chaque outil utilisé

    - o Care Complexity Prediction Instrument (COMPRI) (Huyse et al. 2001)
    - o Hospital Admission Risk Profile (HARP) (Sager et al. 1996)
    - o Identification for Senior's At Risk (ISAR) (McCusker et al. 1999)
    - o Rowland questionnaire (Rowland et al. 1990)
    - o Runciman questionnaire (Runciman et al. 1996)
    - o Triage Risk Screening Tool (TRST) (Meldon et al. 2003)
    - o Autre(s), veuillez spécifier

    c) Veuillez décrire **les caractéristiques** de **l'outil de dépistage** que vous avez développé (p.ex. ses variables, le seuil utilisé, …)

17. Quelles sont les suites d'un dépistage positif?
    - o Une intervention de l'EGLI est automatiquement assurée pour tous les patients dont le screening est positif
    - o Une intervention de l'EGLI est réalisée lorsque l'EGLI le juge nécessaire
    - o Une intervention de l'EGLI est réalisée lorsque l'équipe soignante de l'unité où le patient est hospitalisé le trouve nécessaire
    - o Autre, spécifier

18. Are the results of a screening added to the patient's file?
    - o Oui >> Passez à la question 20
    - o Non >> Passez à la question 20

19. Il n'y a pas de dépistage systématique des personnes âgées dans votre hôpital
    e. Quelles sont **les raisons** pour lesquelles un dépistage des personnes âgées **n'est pas** réalisé systématiquement? *Plusieurs réponses possibles*
    - o Nous ne savons pas quel outil de dépistage est le plus approprié pour détecter les patients âgés à risque
    - o Nous ne sommes pas convaincus de la valeur ajoutée apportée par les outils de dépistage pour dépister des patients âgés à risqué
    - o Le dépistage des patients âgés à risqué demande trop de temps
    - o Autre, veuillez spécifier

    f. Merci de **préciser comment et par qui** (l'équipe et la discipline responsable) les patients sont **sélectionnés** pour l"intervention par l"EGLI

PARTIE 7: IGCT assessment

20. Veuillez indiquer la fréquence avec laquelle chacun des domaines est évalué par votre EGLI

Item	Fréquence de l'évaluation
SUR LE PLAN MÉDICAL	
Antécédents médicaux	Régulièrement / occasionnellement / jamais
Problématiques médicaux actuelles	Régulièrement / occasionnellement / jamais
Revue des médicaments actuels	Régulièrement / occasionnellement / jamais
Revue des résultats de laboratoire et des tests diagnostiques	Régulièrement / occasionnellement / jamais
Examen clinique	Régulièrement / occasionnellement / jamais
SUR LE PLAN FONCTIONNEL	
Activités de la vie journalière	Régulièrement / occasionnellement / jamais
Activités instrumentales de la vie journalière	Régulièrement / occasionnellement / jamais
Mobilité	Régulièrement / occasionnellement / jamais
Douleur	Régulièrement / occasionnellement / jamais
Troubles du sommeil	Régulièrement / occasionnellement / jamais
Fatigue	Régulièrement / occasionnellement / jamais
Nutrition	Régulièrement / occasionnellement / jamais
Dysphagie	Régulièrement / occasionnellement / jamais
Vision	Régulièrement / occasionnellement / jamais
Audition	Régulièrement / occasionnellement / jamais
SUR LE PLAN COGNITIF/PSYCHOLOGIQUE	
Orientation	Régulièrement / occasionnellement / jamais
Dépression	Régulièrement / occasionnellement / jamais

Delirium (confusion aiguë)	Régulièrement / occasionnellement / jamais
Dementia	Régulièrement / occasionnellement / jamais
SUR LE PLAN SOCIAL	
Lieu de vie	Régulièrement / occasionnellement / jamais
Disponibilité d'aides professionnelles	Régulièrement / occasionnellement / jamais
Disponibilité de proches aidants	Régulièrement / occasionnellement / jamais
Le fardeau des proches aidants	Régulièrement / occasionnellement / jamais

e) Si **d'autres domaines sont évalués** par votre EGLI, veuillez indiquér **le contenu** de ces domains **et la fréquence** avec laquelle chaque domaine est évalué (règulièrement, occasionnellement, jamais)

21. Les résultats de l'évaluation de base sont-ils indiqués dans le dossier du patient ?
    - o Oui
    - o Non

PARTIE 8: Réunions de l'EGLI

22. Des réunions de l'EGLI sont-elles organisées pour discuter des patients pour lesquels une consultation par l'EGLI a été réalisée?
    - o Oui
    - o Non >> *Go to question 24*

23. Veuillez préciser la fréquence de ces reunions de l'EGLI: …. fois par semaine
    Remarque: Si une réunion de l'EGLI est organisée une fois par mois, veuillez indiquér 0,25

PARTIE 9: EGLI recommandations pour des patients consultés

24. Veuillez lister les 5 (domaines de) recommandations les plus fréquemment données par votre EGLI

25. A) Utilisez-vous des protocols/guides de bonne pratique pour choisir les recommandations de l'EGLI?
    - o Oui
    - o Non *>> Go to question 26*

    b) S"il vous plaît **fournissez les protocols/guides de bonne pratique utilisées** pour choisir les recommandations de l"EGLI
    Please upload at most 10 files (file type Word (.doc, .docx) ou Pdf (.pdf))

26. **Comment** votre **EGLI communiqué-t-elle ses recommendations** à l"équipe soignante de l"unité où le patient est hospitalisé? *Plusieurs réponses possibles*
    - o Intégrées dans le dossier du patient
    - o Écrites sur un document (manuscrit ou imprimé)
    - o Envoyées par courriel/réseau interne
    - o Transmises oralement lors de passage par des membres de l"EGLI à l"unité où le patient est hospitalisé
    - o Transmises par contact téléphonique entre un membre de l"EGLI et l"unité où le patient est hospitalisé
    - o Participation d"un member de l"EGLI à la réunion multidisciplinaire de l"unité où le patient est hospitalisé
    - o Autres, veuillez préciser

27. Quelles sont les personnes qui mettent en pratique les recommandations émises par l'EGLI?
    - o Ce sont des membres de l"équipe soignante de l"unité où le patient est hospitalisé qui appliquent les recommandations émises par l"EGLI (càd que notre EGLI n"a q"un role de consultance, d"avis) *>> Passez à la question 29*
    - o Ce sont des membres de notre EGLI qui applique tous les recommandations émises
    - o Les recommandations sont mises en pratique en partie par l"EGLI et en partie par l"unité où le patient est hospitalisé

28. Indiquez quelles recommandations sont directement mises en pratique par l'EGLI. *Plusieurs réponses possibles*
    - o Recommandations diagnostiques (ex.: prescriptions d"analyse de laboratoire ou d"autres tests diagnostiques)
    - o Recommandations thérapeutiques (ex.: débuter ou suspendre des médicaments)
    - o Recommandations fonctionnelles (ex. : aides dans les activités de la vie journalière, proposition d"un programme de réadaptation)
    - o Recommandations sociales (ex.: organisér des services d"aides au domicile pour aider le patient après son sortie de l"hôpital)
    - o Recommandations cognitives (ex.: demande d"une evaluation diagnostique pour déclin congitif/suspicion de démence; réalisation de mesures de gestion d"un patient en delirium/confusion aiguë)
    - o Recommandations nutritionnelles (ex. : adaptation de l"alimentation du patient)

- o Autre(s), veuillez spécifier

PARTIE 10: Le suivi des patients consultés par l'EGLI

29. Quelle affirmation décrit le mieux le suivi des patients par l'EGLI, durant leur séjour hospitalier?
    - o Il n"y a pas de suivi assure. Notre EGLI assure uniquement l"évaluation (en formulant ou non des recommandations)
    - o Un suivi sera assuré par notre EGLI uniquement sur demande de l"unité où le patient est hospitalisé
    - o Un suivi est assuré automatiquement par notre EGLI jusqu"à ce que l"EGLI décide que ce suivi n"est plus nécessaire
    - o Un suivi est assuré automatiquement par notre EGLI jusqu"à ce que le patient soit sorti de l"hôpital
    - o Autre, veuillez spécifier

30. **L'évaluation et les recommandations** émises par l"EGLI, sont-elles **disponibles pour** les soignants dans les **soins de santé primaires** (soins de santé à domicile ou résidentiel)?
    - o Oui, l"évaluation et les recommandations de l"EGLI leur sont disponibles
    - o Seule l"évaluation de l"EGLI est disponible
    - o Seule les recommandations de l"EGLI sent disponibles
    - o Non, ni l"évaluation ni les recommandations sont disponibles

PARTIE 11: Activités de l'EGLI

31. Spécifiez le nombre total de patients évalués par votre EGLI en 2013

32. Comment qualifieriez-vous l'adhérence/compliance générale aux recommandations émises par votre EGLI?
    - o Mauvaise
    - o Pauvre
    - o Bonne
    - o Excellente

Adhérence/compliance: niveau auquel les recommandations émises par l"EGLI sont concrétisées

33. Votre EGLI a-t-elle un plan d'action pour augmenter la compliance à ces recommandations?
    - o Oui, merci de préciser les strategies

o Non

34. Évaluation de la performance de l'EGLI

a. Votre EGLI utilize-t-elle **des indicateurs ou des critères de qualité** pour évaluer sa performance?
o Oui
o Non *>> Passez à la question 34c*

b. Veuillez, s"il vous plaît, nous transmettre les documents qui reprennent ces critères/indicateurs de qualité (p.ex. vue d"ensemble de critères/indicateurs; mesures et échelles utilisées, résultats de ce mode d"évaluation des activités de l"EGLI,…)

c. Existe-ti-il un rapport d'activité annuel de votre EGLI?
o Oui
o Non *>> Passez à la question 34e*

d. Veuillez nous transmettre le dernier rapport annuel

S"il vous plait ne fournissez plus que 10 fichiers (format Word (.doc, .docx) ou Pdf (.pdf))

e. D'autres méthodes sont-elles utilisées pour évaluer l"activité de votre EGLI?
o Oui, veuillez décrire les autres methods par lesquelles vous suivez/évaluez les activités de votre EGLI
o Non

PARTIE 12: Information générale concernant votre hôpital

Important: *Pouvons-nous vous recommander de demander des informations auprès votre department administratif ou votre Direction, avant de répondre aux questions suivantes?*

35. Chiffres généraux
a. Numbre de lits total

b. Nombre total d'admissions à l'hôpital 2013

Remarque: inclure les lits/admissions dans les services/unites de maternité, de pédiatrie, et des hôpitaux de jour

36. Statistiques pour les patients âgés de 75 ans et plus: nombre total d"admissions à l"hôpital en 2013

Remarque: inclure les admissions dans la salle d"urgence et dans les hôpitaux de jour

37. a) Votre hôpital, dispose-t-il d'une/plusieurs sale(s)/unité(s) gériatrique(s)?
    - o Oui
    - o Non *>> Passez à la question 38*

Remarque: si votre hôpital est situé sur plusieurs sites, veuillez inclure dans ce calculation les unités de gériatrie de tous les sites

b) Unité(s) gériatrique(s) What is the total number of geriatric beds on all geriatric units?
- o a. Quel est le nombre total de lits sur l"ensemble des unités gériatriques de votre hôpital?
- o b. Quel était le nombre total de patients admis dans les unités gériatriques de votre hôpital en 2013?

Remarque: si votre hôpital est situé sur plusieurs sites, veuillez inclure dans ce calculation les unités de gériatrie de tous les sites

38. Gériatres
    a. Donnez le nombre total (personnes) de gériatres qui travaillent dans votre hôpital
    b. Donnez le nombre total d"équivalents temps plein (ETP) de gériatres qui travaillent dans votre hôpital

Remarque: 1 ETP = 100% = un employé à temps-plein

39. Votre hôpital dispose-t-il d'une sale d'urgence? (Oui/Non)

PARTIE 13: Financement de l'EGLI

Important: *Pouvons-nous vous recommander de demander des informations auprès votre department administratif/financier ou votre Direction, avant de répondre aux questions suivantes?*

40. Le financement de notre EGLI est basé sur: *Seulement une réponse possible*
    - o Des subsides spécifiques. Veuillez nous en préciser le montant annuel
    - o Un financement structurel, dans le cadre du système de financement général
    - o Une combinaison de subsides spécifiques et d"un financement structurel (dans ce cas, veuillez préciser la proportion du financement total de l"EGLI que representent ces subsides)
    - o Je ne sais pas

41. Sur quelles bases le financement de l'EGLI est-il réalisé? *Plusieurs réponses possibles*
    - o Salaire (nombre d"ETP reel)
    - o Paiement fixe par problème de santé (coût standardisé par exemple, système DRG: Diagnostic Related Group)
    - o Paiement fixe par patient (coût standardisé partie du coût total par patient)
    - o Paiement variable (spécifique pour l"intervention par l"EGLI; honoraire spécifique)
    - o Paiement sur base de qualité (basé sur l"atteinte de cible de qualité; paiement à la performance)
    - o Paiement en réseau (basé sur un degree de cooperation mutuelle; ex.: paiement global)
    - o Autrès critères de financement, veuillez spécifier
    - o Je ne sais pas

PARTIE 14: Informations supplémentaires

42. Auriez-vous d'autres commentaires à ajouter concernant l'organisation, la conduit et le financement de l'EGLI dans votre hôpital, et dans votre pays?

43. Veuillez indiquer **vos coordonnées bancaires** pour que nous puissions vous faire parvenir **les honorares** lies à votre collaboration
    a. Détail bancaire (IBAN)
    b. Détail bancaire (BIC)
    c. L"adresse de votre banque
    d. Communication spécifique

NOUS VOUS REMERCIONS VIVEMENT POUR VOTRE COLLABORATION

9. INTERNATIONAL SURVEY – SAMPLE SELECTION

Country	Contacted[1]	Scope of IGCT implementation[2]	Grey literature	Sample decision – country level[3]	Sample decision – hospital level (IGCT best-practices)
Canada	n/a	n/a	• No legislative framework • Accreditation program 'Seniorfriendly Hospitals' [15, 16, 30] (n = 1)	Exclusion • Regional level implementation only • No legislative framework • IGCT concept not included in accreditation program 'Seniorfriendly Hospitals' • No best-practice IGCTs identified • Primary studies regarding IGCT identified (n = 3) (research context only)	n/ap
France	• French Society for Geriatrics and Gerontology: WG 'IGCT' (*Salles, N.*)[4] • University Hospitals, Grenoble (Couturier, P.)[5] • University Hospitals, Angers (Beauchet, O.)[5] • University Hospitals, Rouen (*Chassagne, P.*)[5] • University Hospitals, Poitiers (Paccalin, M.)[5] • Broca Hospital, Paris (Hanon, O.)[5] • Charles Foix Hospital, Ivry-sur-Seine (Belmin, J.)[5] • University Hospitals, Lille (Puisieux, F.)[5]	National level	• Legislative framework (n = 3) • 2014: Les schémas régionaux d'organisation des soins (SROS) [9] • 2007: Circulaire relative à l'amélioration de la filière de soins gériatrique (DHOS/02/2007/117) [7] • 2003: Circulaire relative à la prise en charge des urgences (DHOS/01/2003/195) [8] • Research report (n = 1) [5]	Inclusion • National level implementation (n ≥ 200 hospitals) • Legislative framework and grey literature available • Best-practice IGCTs identified (n = 25) • Primary studies regarding IGCT identified (n = 6) • Questionnaire translation to overcome language barrier (French)	(n = 25) • University hospitals: Brest; Paris (Saint-Antoine; Ambroise-Paré/ Boulogne Billancourt); Strasbourg; Toulouse; Limoges; Grenoble; Rouen; Montpellier; Bordeaux; Périqueux; Dax Côte D'Argent; Mont-de-Marsan • Nonuniversity hospitals: Provins; Broca-Cochin, Paris; Haguenau; Sélestat; Colmar; Niort; Melle; Saint-Maixent l'École; Pau; Roubaix; Seclin; Arras

	• Hospital, La Roche-sur-Yon (Bourdet, I.)[5]				
Germany	• European Academy of Nursing Science (*Meyer, G.*)[5] • European Delirium Association (Thomas, C.; Kreisel, S.)[5] • German Society for Gerontology and Geriatrics (general contact address; *Thiesemann, R.)*[4,5] • German Society for Geriatrics (general contact address; Kwetkat, A.)[4] • Institute for Biomedicine in older adults, Nuremberg (Sieber, C.)[5]	Small-scale level	• No legislative framework • No guidelines/research reports	Exclusion • Language barrier (German) • Small-scale implementation only • No legislative framework or grey literature available • No best-practice IGCTs identified • Only n = 1 primary study regarding IGCT identified	n/ap
Taiwan	n/a	n/a	• No legislative framework • No guidelines/research reports	Exclusion • Language barrier (Taiwanese) • No information on scope of IGCT implementation • No legislative framework or grey literature available • No best-practice IGCTs identified • Primary studies regarding IGCT identified (n = 6) (research context only)	n/ap
The Netherlands	• University Hospital, Utrecht (*Schuurmans, M.)*[5] • University Hospital, Amsterdam (*de Rooij, S.*)[5] • Orbis Hospital, Sittard (*Habets, H.*)[5] • Radboud University, Nijmegen (*Maier, A.; van Achterberg, T.; van Asselt, D.*)[5]	National level	• No legislative framework • Guideline (n = 1) • 2013: Nederlandse Vereniging voor Klinische Geriatrie [11, 12]	Inclusion • National level implementation (n ≥ 57 hospitals) • Grey literature available • Best-practice IGCTs identified (n = 26) • Only n = 1 primary study regarding IGCT identified • No language barrier	(n = 26) • University hospitals: Nijmegen (UMC Radboud); Maastricht (MUMC+); Amsterdam (VUmc; AMC); Groningen (UMCG); Leiden (LUMC)

					• Nonuniversity hospitals: Leiden & Utrecht (Diaconessenhuis); Gorinchem (Beatrix H); Rotterdam (Haven H); Ede (H Gelderse Vallei); Capelle-aan-de-Ijssel (Ijsselland H); Arnhem (Rijnstate H); Deventer; Sittard-Geleen (Orbis H); Terneuzen (ZorgSaam H); Haarlem (Kennemer H); Amsterdam (Slotervaart H); Woerden (Zuwe Hofpoort H); Apeldoorn (Gelre H); Leeuwarden; Leidschendam (Antoniushove); Den Haag (Bronovo H); Tilburg (TweeSteden H); Winterswijk (Regional H Queen Beatrix); Dordwijk (Albert Schweitzer H)
United Kingdom (UK)	• European Delirium Association (Page, V.)[5] • British Geriatrics Society (*Conroy, S.*)[4]	Small-scale level	• No legislative framework • Guideline (n = 1) • 2012 : Royal College of Physicians [27]	Exclusion • Small scale implementation only • No legislative framework • Only n = 1 guideline available (insufficiently detailed to ensure an IGCT concept is discussed) • No best-practice IGCTs identified • Only n = 2 primary studies regarding IGCT identified	n/ap

				• Consultation-based geriatric care models are mostly monodisciplinary (geriatrician only)	
United States of America (USA)	• **American Geriatrics Society: SIG 'Acute hospital' (Palmer, RM.)[4], 'Geriatrics Consultative Services' (Bowman, EH.)[4], 'HELP' (Wierman, H.)[4]** • **American Delirium Society (*Kamholz, B.*)[5]** • **University of Rochester, New York (Friedman, B.)[5]** • **Rush University, Chicago (Foreman, M.)[5]** • **Harvard Medical School (Inouye, S.)[5]** • **University of California, San Francisco (*Covinsky, K.*; Pierluissi, E.)[5]** • **Indiana University (*Counsell, S.*)[5]** • **University of Alabama (Flood, K.)[5]** • **University of Seattle (Unutzer J.)[5]** • **Mayo Clinics (Hanson, GJ.)[5]**	**Small-scale level**	• **No legislative framework** • **No guidelines**	**Exclusion** • **Small scale implementation only** • **No legislative framework or grey literature available** • **No best-practice IGCTs identified** • **Out-dated care model (due to lack of evidence on IGCT effectiveness), focus on ACE-unit and GRN care models** • **Primary studies regarding IGCT identified (n = 23) (only n = 5 published > 1999)**	**n/ap**

n/a: no data/contact persons available
n/ap: not applicable
[1] Contacts of whom a response was received are indicated in italics.
[2] National level (IGCTs are broadly implemented in hospitals throughout the country), regional level (IGCTs are only implemented in specific regions of the country), small-scale level (IGCTs are only implemented in a limited number of hospitals).
[3] Final decision (inclusion/exclusion), underlying arguments provided as 'bullet points'. Based on thorough discussion of the research team and KCE.[4] Representative or working group of a professional organization for geriatrics and gerontology.
[5] International colleagues of (a) member(s) of the research team and contact persons identified by international colleagues.

10. SEMI-STRUCTURED INTERVIEWS USA

Part 1: Request for interview participation

Title: Research project on 'Inpatient geriatric consultation teams (IGCT): criteria for organization and observation of quality' (KCE study 2013-14, Belgium) - request for interview participation

Text: Dear,

The Belgian Health Care Knowledge Centre (KCE) is currently conducting a **study on** the **development of criteria for the organization and monitoring of the quality of internal geriatric consultation teams (IGCTs)** in Belgian hospitals. This study is jointly conducted by the University of Leuven, Centre for Health Services and Nursing Research and the Université Catholique de Louvain, Institut de Recherche Santé et Société, with coordination and funding of the KCE.

An IGCT or inpatient geriatric consultation team is defined as: *"a multidisciplinary team which assesses frail older patients hospitalized on nongeriatric units, and subsequently discusses and recommends a plan of treatment. They are intended to advice and sensitize healthcare professionals in their contacts with older patients, to familiarize them with important aspects of geriatric medicine, and to provide multidisciplinary expertise".*

The majority of initial studies on the development, operationalization and effectiveness of the IGCT care model have been conducted in the USA between 1975 and 1995. However, a scoping review and contacts with international colleagues (in the context of this KCE study) suggest that the IGCT care model is currently no longer widespread implemented in the USA.

Given your position as a leading clinician, researcher and/or policymaker in the USA's field of geriatrics, **we would like to invite you to participate in a semi-structured interview**. The **purpose** of the interviews is **threefold:**

- To determine the scope of implementation of IGCT in the USA (national level, regional level or small-scale implementation). If applicable, information will be requested about the underlying arguments for no longer widespread using the IGCT care model in the current USA's geriatric clinical practice.
- To determine which types of care models are currently being used for the care of older patients with a geriatric risk profile who are hospitalized on nongeriatric units, as an alternative to the IGCT care model. In particular, information will be requested on the level of implementation of care models including geriatric resource nurses.
- To obtain more detailed information regarding the structure, process and outcomes of these alternative care models, including information on the performance of screening and assessment to identify and comprehensively evaluate older patients with a geriatric risk profile.

Interview participation will be **non-anonymous** and will take **approximately 45 minutes**. A **financial compensation** of **€100** will be rewarded for your participation. Interviews will be conducted **using Skype**, by Dr Mieke Deschodt, a Belgian researcher with foreknowledge of the USA field of geriatric medicine and the IGCT concept.

If you are willing to participate, please contact Dr Deschodt to arrange a date and time for the interview. We would like to **conduct** the **interview before September 12, 2014.** Furthermore, you are **encouraged** to **recommend** other leading clinicians, researchers and/or policymakers in the USA's field of geriatrics, who might provide us useful information and insights.

Please do not hesitate to contact us to obtain additional information.

Thank you in advance for your valuable participation.

With kind regards,

Prof. Koen Milisen (RN, PhD), Prof. Johan Flamaing (MD, PhD), Mieke Deschodt (RN, PhD), Veerle Claes (RN, MSc)
Center for Health Services and Nursing Research, KU Leuven
mieke.deschodt@kuleuven.be, +32 16 37 76 92, Skype name: miekedeschodt

Prof. Benoit Boland (MD, PhD)
Institut de Recherche Santé et Sociéte (IRSS), Université Catholique de Louvain (UCL)

Koen Van den Heede (RN, PhD), Patriek Mistiaen (RN, PhD)
Belgian Healthcare Knowledge Center (KCE, www.kce.fgov.be)

Part 2: Format for semi-structured interviews

1. Introduction

- Data collection: ask for agreement of participant regarding:
  - Non-anonymous data-collection, analysis and reporting
  - Recording of interview

2. Short introduction about the context and purposes of the interview

- **Study** of **Belgian Health Care Knowledge Centre** on the development of criteria for the organization and monitoring of the quality of internal geriatric consultation teams (IGCTs) in Belgian hospitals.

- **Jointly conducted** by the University of Leuven and Université Catholique de Louvain, with coordination and funding of the KCE.

- Threefold purpose of the interviews
  - To request information about the implementation of the inpatient geriatric consultation team (IGCT) model for older hospitalized patients in the US

- To determine which types of care models are currently being used for the care of older patients with a geriatric risk profile who are hospitalized on nongeriatric units, as an alternative to the IGCT care model
- To obtain more detailed information regarding the structure, process and outcomes of the above-mentioned alternative care models

3. Core questions interviews USA

Q1: What are your **current main professional activities** as a leading clinician, researcher and/or policymaker in the USA's field of geriatrics?

Q2: Have you been previously involved in research or implementation projects regarding the IGCT care model?

Q3: On which level is the **IGCT care model currently implemented** in hospitals **in the USA?**

- A national level: IGCTs are broadly implemented in hospitals throughout the USA
- A regional level: IGCTs are only implemented in specific regions/states of the USA
- A small-scale level: IGCTs are only implemented in a limited number of hospitals

Q4: Does the USA (or specific states) have **legislative framework** on the organization, operationalization, financing and/or evaluation of IGCT care models?

Q5: What are the **underlying arguments** for **no (longer) widespread using** the **IGCT care model** in the **current** USA's geriatric clinical practice?

Q6: How is the **in-hospital care** for **older patients** (with a **geriatric risk profile) currently organized** in the USA?

Ask more information on

- The existence and types of acute geriatric units
- Care models that are currently used to organize the care for older patients with a geriatric risk profile who are hospitalized on nongeriatric units (e.g. as an alternative to the IGCT model)
- Geriatric resource nurse models

Alternative care models for patients with a geriatric risk profile hospitalized on nongeriatric units (repeat for each model)

i. Establishment

Q7: When was the use of the (name) care model approximately **initiated in the USA?**

Q8: What was/were the **underlying motivation(s)** for using the (name) care model?

ii. Structure

Q9: Which disciplines of healthcare workers function as **key providers** in the (name) care model?

Q10: On which types of nongeriatric units is the (name) care model mainly being implemented?

iii. Process

Q11: At **which type(s) of older patients** is the (name) care model focused?

Q12: How are **patients** that might benefit from the (name) care model **detected/selected** in clinical practice?

Q13: Is the performance of a **comprehensive geriatric (baseline) assessment** for individual patients included in the (name) care model?

iv. Level of implementation, legislation/grey literature & best-practice examples

Q14: On which level is the (name) care model currently implemented in hospitals in the USA?

- A national level: the (name) care model is broadly implemented in hospitals throughout the USA
- A regional level: the (name) care model is only implemented in specific regions/states of the USA
- A small-scale level: the (name) care model only implemented in a limited number of hospitals

Q15: Could you recommend us **grey literature** (e.g. guidelines, position statements, research reports, …) on the organization, operationalization, financing and/or evaluation of the (name) care model **in the USA?**

Yes/no, further question to specify if 'yes'

v. Evaluation

Q16: Is the **quality of care** provided through the (name) care model in the USA **evaluated? If yes, how?**

1. Conclusion
   - Any additional information or questions that the interviewee would like to add?
   - Request to provide bank account details by email, to enable transferring the financial compensation for participation

11. SCOPING REVIEW – SUMMARY AND REPORT OF RESULTS

Table 1 – Patient assessment and recommendations by IGCTs

Country	Study	Medical assessment							Functional assessment									Mental assessment			Social assessment			IGCT role
		Acute medical problems	Medical history	Medication review	Laboratory tests	Skin condition	Physical examination	Osteoporosis	Activities of daily living	Fall risk/history	Mobility & balance	Risk for pressure sores	Hearing and vision	Nutritional status	Pain	Incontinence	Sleep disturbances	Cognitive assessment	Delirium	Depression	Living conditions	Care uses & needs +	Finances	
Canada	Gayton et al. (1987)[31]																							Advice & implementation
	Hogan et al. (1987, 1990)[32, 33]	x	x	x	x				x															n/a
France	Bloch et al. (2007)[34]		x						x		x							x			x	x		n/a
	Cudennec et al. (2006, 2007)[35, 36]				x	x			x	x	x	x	x	x	x			x		x	x	x		Advice only
	Couturier (2008, 2009)[37, 38], Morin (2012)[39], Steenpass (2012)[40]	x	x	x			x		x		x		x	x	x			x	x		x	x	x	Advice only
Germany	Kircher et al. (2007)[41]								x	x								x		x	x	x	x	Advice & implementation

Taiwan	Shyu et al. (2005, 2008, 2010, 2013a, 2013b)[42-46], Tseng et al. (2012)[47]		x	x		x	x	x	x		x		x				x					x		Advice & implementation
The Netherlands	Buurman et al. (2010)[48]			x			x	x	x	x		x	x	x	x	x	x	x	x					n/a
UK	Clift et al. (2012)[49]						x						x	x			x					x		n/a
	Harvey et al. (2009)[50]																							Advice & implementation
USA	Allen et al. (1986)[51], Becker et al. (1987)[52], Cohen et al. (1992)[53], Saltz et al. (1988)[54], Mc Vey et al. (1989)[55]	x	x	x		x		x							x		x		x		x	x	x	Advice only
	Arbaje et al. (2010)[56]			x				x	x						x	x	x	x	x			x		Advice & implementation
	Barker et al. (1985)[57]	x	x	x				x									x				x	x		n/a

Blumenfield et al. (1982)[58]																							Advice & implementation
Borok et al. (1994)[59], Reuben et al. (1995, 1996)[60, 61]		x	x	x	x	x					x				x		x		x	x			Advice & implementation
Campion et al. (1983)	x		x												x		x						Advice only
Dellasega et al. (2001)[62]	x		x				x	x				x			x		x	x					n/a
Fallon et al. (2006)[63]	x		x				x		x		x				x	x	x		x				n/a
Inouye et al. (1993a, 1993b)[64, 65]	x		x		x	x	x					x	x			x							Advice only
Winograd et al. (1987, 1988, 1993)[66-68]		x				x	x								x								Advice & implementation
Miracle et al. (1992)[69]			x	x		x	x		x						x		x		x				n/a
Sennour et al. (2009)[70]	x	x	x		x		x		x		x				x		x						Advice & implementation

	Thomas et al. (1993)[71]	x	x	x					x								x				x	x	n/a	
	Tucker et al. (2006)[72]									x	x		x				x	x	x				Advice & implementation	
Summary statistics[1]		42	42	63	17	17	29	13	67	29	33	8	25	21	21	21	13	79	25	50	29	54	17	A: 21, A+I: 42

Legend

n/a: data not available

[1] Reporting total percentage of IGCTs performing baseline assessment for a specific item. IGCT role: reporting total percentage of IGCTs with an advisory role only (A) and both an advisory and implementation role (A+I)

Table 2 – Operational problems and financing of IGCT

Country	Study	Operational problems	Financing of IGCT
Canada	Gayton et al. (1987)[31]	n/a	n/a
	Hogan et al. (1987, 1990)	n/a	Research grant
France	Bloch et al. (2007)[34]	• No IGCT availability during weekends • ED: limited time for profound assessment	n/a
	Cudennec et al. (2006, 2007)[35, 36]c	• Follow-up of recommendations • Infrastructure and working procedures at hospital level • Attitudes of CTU towards geriatric patients/care	n/a
	Couturier (2008, 2009)[37, 38], Morin (2012)[39], Steenpass (2012)[40]	Follow-up of recommendations: negative effect of not focusing on a limited amount of priority recommendations	n/a
Germany	Kircher et al. (2007)[41]	n/a	• Research grant • Governmental and university funds
Taiwan	Shyu et al. (2005, 2008, 2010, 2013a, 2013b)[42-46], Tseng et al. (2012)[47]	n/a	• Research grant • Hospital funds
The Netherlands	Buurman et al. (2010)[48]	n/a	n/a
UK	Clift et al. (2012)[49]	n/a	Governmental funds (IGCT establishment only)
	Harvey et al. (2009)[50]	n/a	n/a
USA	Allen et al. (1986)[51], Becker et al. (1987)[52], Cohen et al. (1992)[53], Saltz et al. (1988)[54], Mc Vey et al. (1989)[55]	Follow-up of recommendations • Negative effect of not using direct discussion of the recommendations with the CTU • Low adherence to recommendations for care after home discharge if patient does not have a social network	• Research grant • Hospital funds
	Arbaje et al. (2010)[56]	n/a	n/a
	Barker et al. (1985)[57]	• Availability of supportive services and financing at hospital level	Hospital funds

	• Attitudes of CTU towards geriatric patients/care	
Blumenfield et al. (1982)[58]	• Responsibility for patient care (IGCT or CTU) • Time constraints (attendance at team meetings, implementation of recommendations) • Infrastructure at hospital level • Lack of leadership within IGCT	n/a
Borok et al. (1994)[59], Reuben et al. (1995, 1996)[60, 61]	n/a	n/a
Campion et al. (1983)[73]	Responsibility for patient care (IGCT or CTU)	n/a
Dellasega et al. (2001)[62]	Follow-up of recommendations	n/a
Fallon et al. (2006)[63]	n/a	n/a
Inouye et al. (1993a, 1993b)[64, 65]	• Time constraints (identification of at-risk patients, implementation of recommendations, attendance at team meetings) • Support from nursing management • Communication between IGCT and CTU	n/a
Winograd et al. (1987, 1988, 1993)[66-68]	Follow-up of recommendations	Research grants
Miracle et al. (1992)[69]	n/a	n/a
Sennour et al. (2009)[70]	Time constraints (high IGCT caseload)	• Hospital funds • Governmental social security system (Medicare)
Thomas et al. (1993)[71]	Follow-up of recommendations	n/a
Tucker et al. (2006)[72]t	• Delay in referral to IGCT • Attitudes of CTU towards geriatric patients/care	n/a

n/a = not available; CTU = care team of unit where patient is hospitalized

12. LONG LIST QUALITY INDICATORS

Table 3. Long list of quality indicators (n = 155)

Reference	Level	Example
Cognition (n = 4)		
Loh et al. 2000 [74]	Process	Percentage of admissions to a geriatric ward that have an assessment of cognitive function (Abbreviated Mental Test Score, Mini-Mental State Examination or Information Orientation Score)
Payot et al. 2007 [75]	Process	Si une personne âgée vulnérable admise en unité de courte durée gériatrique est évaluée pour une atteinte cognitive, ALORS le taux de vitamine B12 et celui de la thyréostimuline (TSH, thyroid-stimulating hormone) doivent être déterminés. [If a vulnerable elder admitted at a short term geriatric unit is evaluated for cognitive impairment, THEN the levels of vitamin B12 and the thyroid stimulating hormone (TSH) should be determined]
Terrell et al. 2009 [76]	Process	IF an older adult presents to an emergency department and is found to have cognitive impairment, THEN an emergency department care provider should document whether there has been an acute change in mental status from baseline (or document an attempt to do so).
Tropea et al. 2011 [77]	Process	Numerator Number of patients 65 years of age and older admitted to hospital who have had their cognition assessed using a validated tool within 24 h of admission Denominator Number of inpatients 65 years of age and older
Continuity and coordination of care (n = 29)		
Wenger et al. 2007 [78]	Process	IF an outpatient vulnerable elder was referred to a consultant and revisited the referring physician, THEN the referring physician's medical record should acknowledge the consultant's recommendations, include the consultant's report, or indicate why the consultation did not occur
Wenger et al. 2007 [78]	Process	IF a vulnerable elder is treated at an emergency department or admitted to a hospital, THEN there should be documentation (during the emergency department visit or within the first 2 days after admission) of communication with a continuity physician, of an attempt to reach a continuity physician, or that there is no continuity physician
Wenger et al. 2007 [78]	Process	IF a vulnerable elder is discharged from a hospital to home and survives 6 weeks or longer after discharge, THEN a physician visit or telephone contact should be documented within 6 weeks of discharge, and the medical record should document acknowledgment of the recent hospitalization
Wenger et al. 2007 [78]	Process	IF a vulnerable elder is discharged from a hospital to home or nursing home, THEN there should be a discharge summary in the outpatient or nursing home medical record
Arora et al. 2007 [79]	Process	IF a vulnerable elder is discharged from the hospital, THEN the hospital record should contain an assessment of: level of independence, need for home health services, and patient and caregiver readiness for discharge time and location
Kroger et al. 2007 [80]	Process	IF a vulnerable elder is discharged from a hospital to home or to a nursing home, THEN there should be a discharge summary in the medical record (doctor's office, local community service centre (CLSC) or long term care facility) within 6 weeks
Kroger et al. 2007 [80]	Process	IF a vulnerable elder is deaf or does not speak English, THEN an interpreter or translated materials should be employed to facilitate communication between the vulnerable elder and the health care provider
Kroger et al. 2007 [80]	Process	If a vulnerable elder is assessed, then language barriers, needs of persons with disabilities (including sensory impairment) or ethnic, cultural and religious preferences should be taken into account

Reference	Level	Example
Kroger et al. 2007 [80]	Process	All vulnerable elders with complex medication regimens who are returning to community living should be evaluated whether they are able to maintain a self-medication programme
McGory et al. 2009 [81]	Process	If an elderly patient is undergoing elective or nonelective inpatient surgery, then the following discharge planning issues should be assessed: Home environment and possible needs for medical equipment at home prior to discharge. Social support and possible needs for home health services prior to discharge. Patient acceptance of possible nursing home or skilled nursing facility placement prior to discharge.
McGory et al. 2009 [81]	Process	If an elderly patient undergoes elective or nonelective inpatient surgery and is being discharged, then assessment prior to discharge in the following areas should be performed to compare to preoperative level of function and determine appropriate discharge plan: Nutrition (Mini Nutritional Assessment), Cognition (3-Item Recall or Mini Mental State Exam), Ambulation ability (Timed Up and Go), Functional status (activities of daily living), Presence of delirium.
Payot et al. 2007 [75]	Process	Si une personne âgée vulnérable souffrant de démence est soutenue par un proche aidant, ALORS le médecin ou un professionnel compétent doit avoir une discussion avec le patient si c'est possible ou avec son aidant à propos de la sécurité, de ses besoins en services de soutien, des ressources disponibles en communauté pour les personnes atteintes de démence et des stratégies de résolution de conflits liés à la progression de la maladie. [If a vulnerable elder with dementia is supported by a caregiver, THEN the doctor or a qualified professional should have a discussion with the patient if possible, or with the caregiver about the safety, the needs for supportive services, available resources in the community for people with dementia, and resolving strategies for conflicts related to the progress of the disease]
NVKG 2013 [12]	Process	Percentage van de patiënten waarbij het gemeten (instrumental) activities of daily living functioneren bij het begin van de behandeling terug is te vinden in de brief/het bericht aan de verwijzer. [Percentage of patients for whom the measured (instrumental) activities of daily living at the start of treatment is mentioned in the letter to the referrer.]
NVKG 2013 [12]	Structure	Welke disciplines dienen volgens de afspraken binnen de vakgroep persoonlijk aanwezig te zijn bij het multidisciplinair overleg in uw ziekenhuis? [Which disciplines should be personally present in the multidisciplinary consultation meeting in your hospital according to the protocol of the department?]
NVKG 2013 [12]	Process	Worden de tijdens het multidisciplinair overleg geformuleerde behandeldoelen vastgelegd? [Are the formulated treatment goals registered during the multidisciplinary meeting?
NVKG 2013 [12]	Structure	Is duidelijk wie verantwoordelijk is voor de uitvoering van de geformuleerde behandeldoelen? [Is it clear who is responsible for the implementation of the formultated treatment goals?]
NVKG 2013 [12]	Process	Worden de uitkomsten van het multidisciplinair overleg structureel met patiënt dan wel wettelijk vertegenwoordiger besproken? [Are the results of the multidisciplinary meeting structurally discussed with the patient or legal representative?]
NVKG 2013 [12]	Process	Het percentage van de patiënten, bij wie geïndividualiseerde schriftelijke informatie en adviezen zijn meegegeven aan de patiënt of diens mantelzorger.[The percentage of patients for whom individualized written information and advice was given to the patient or his caregiver]

Reference	Level	Example
NVKG 2013 B [11]	Process	Percentage patiënten bij wie de geriater in medebehandeling is geweest en waarbij schriftelijke overdracht van de belangrijkste bevindingen van de geriater naar de huisarts of vervolgbehandelaar heeft plaatsgevonden. [Percentage of patients for whom a geriatrician was comanaging the patients and for whom written transfer of the main findings of the geriatrician to the doctor or followup therapist occurred.]
NVKG 2013 B [11]	Structure	Zijn er schriftelijke werkafspraken over de verantwoordelijkheden voor de uitvoering van de adviezen in het behandelplan voor patiënten bij wie de geriater in medebehandeling is geweest. Zo ja, met welke vakgroepen zijn er werkafspraken? [Are there written agreements on the responsibilities for the implementation of the recommendations in the treatment plan for patients for whom the geriatrician was comanaging the patient? If so, with whicht departments are there arrangements?]
NVKG 2013 [12]	Process	Hoeveel basiselementen van het comprehensive geriatric assessment zijn in het dossier zijn terug te vinden? (Er wordt 1 punt gescoord per onderwerp.) **Inhoud comprehensive geriatric assessment:** Medische voorgeschiedenis; Medicatie review; Anamnese; Tractusanamnese; Functionele anamnese; Sociale anamnese; Heteroanamnese; Algemeen lichamelijk onderzoek; Oriënterend neurologisch onderzoek; Oriënterend psychiatrisch onderzoek; Functioneel onderzoek; Meetinstrumenten: a. Mini-Mental State Examination, b. Kloktekentest, c. Activities of daily living/instrumental activities of daily living; Laboratoriumonderzoek; Electrocardiogram; Behandelplan [How many basic elements of the comprehensive geriatric assessment in the file can be found? (One point scored per topic.) Content comprehensive geriatric assessment: Medical history; Medication review; Patient history; Review of medical systems; Functional history; Social history; Heteroanamnesis; General physical examination; Neurological exam; Exploratory psychiatric examination; Functional research; Measuring instruments: a. Mini-Mental State Examination, b. Clock Drawing Test, c. Activities of daily living / instrumental activities of daily living; laboratory testing; Electrocardiogram; Treatment plan]
NVKG 2013 [12]	Process	Percentage van de patiënten waarbij de 4 assen (somatische as, psychische as, sociale as en functionele as) van het comprehensive geriatric assessment zijn beschreven. A) in het multidisciplinair overleg, B) in de brief aan verwijzer [Percentage of patients for whom the 4 axes (somatic axis, psychological axisl, social axis, and functional axis) of the comprehensive geriatric assessment are described. A) in the multidisciplinary consultation, B) in the letter to the referrer]
NVKG 2013 [12]	Process	Percentage van de patiënten waarbij in de brief/het bericht aan verwijzer de volgende specifieke elementen uit de heteroanamnese worden vermeld. • Een (gestructureerd) interview over de cognitieve functies, het gedrag en psychiatrische symptomatologie. • Een heteroanamnestische indruk van het functioneren. • Het in kaart brengen van de sociale situatie en de zorgconsumptie. • Een indruk van het systeem en de caregivers' burden. [Percentage of patients for whom the letter / message to the referrer mentiones the specific elements of the heteroanamnesis. • A (structured) interview on cognitive status, behavior and psychiatric symptomatology. • A heteroanamnestic impression of functioning. • The mapping of the social situation and the care consumption. • An impression of the system and the caregivers' burden.]

Reference	Level	Example
Senior Friendly Hospital [16]	Structure	Het ziekenhuis heeft in samenwerking met de ketenpartners (o.a. thuiszorg, wijkverpleegkundige, huisarts) een ketenprotocol opgesteld en geïmplementeerd waarmee de continuïteit in de zorg voor en in de begeleiding van (kwetsbare) ouderen wordt geborgd. Een voorbeeld is de transmurale zorgbrug tussen de 1e en 2e lijn. In dit ketenprotocol wordt aandacht besteed aan: (1) tijdige informatieoverdracht (zoals verwijsbrief bij polibezoek en opname en binnen 24 uur huisarts geïnformeerd); (2) voortzetten en bespreken van het eerder uitgesproken en ingezette beleid t.a.v. behandelbeperkingen; (3) de verdeling van taken en verantwoordelijkheden na ontslag; (4) contact met de patiënt/mantelzorger: binnen 1 week na ontslag. [The hospital has established and implemented a protocol with healthcare partners (e.g. home care, primary care nurse, general practitioner) to ensure the continuity in the care and guidance of (vulnerable) older persons. An example is the transmural care bridge between primary cae and hospital care. This protocol focuses on: (1) timely transfer of information (such as a referral letter for outpatient clinic visits and admissions and general practitioner informed within 24 hours); (2) Pursueing and discussing the earlier and initiated policy regarding treatment limitations; (3) the distribution of tasks and responsibilities after discharge; (4) contact with the patient / caregiver: within 1 week after discharge.]
CZ zorgverzekering [25]	Process	Kwetsbare patiënten krijgen altijd 1 (multidisciplinair) zorgplan, 1 coördinator (casemanager geriatrie), 1 contactpersoon voor de patiënt. Bij voorkeur is de hoofdbehandelaar de klinisch geriater of een oudereninternist. Doorverwijzing naar andere specialisten wordt alleen via de klinisch geriater/ oudereninternist georganiseerd. [Vulnerable patients always receive one (multidisciplinary) care plan, one coordinator (geriatric case manager), one contact person. The primary treatment provider is preferably a clinical geriatrician or internal medicine physician with geriatric experise. Referral to other specialists is only offered through the clinical geriatrician / internal medicine physician with geriatric expertise.]
CZ zorgverzekering [25]	Process	De uitkomsten van het assessment worden tijdens een multidisciplinair overleg besproken door de behandelend specialist en een klinisch geriater of een specialist ouderengeneeskunde. Voor kwetsbare ouderen/ ouderen met een verhoogd risico op functieverlies (“Identification of Seniors At Risk-Hospitalized Patients” (ISAR-HP) ≥ 1) wordt een multidisciplinair behandelplan opgesteld, waarbij ook de ondersteuning van de mantelzorg wordt betrokken. Ouderen met een risico voor functieverlies beginnen binnen 48 uur na ziekenhuisopname met een multidisciplinaire reactiverende behandeling om onnodig functieverlies te voorkomen. [The results of the assessment are discussed at a multidisciplinary meeting by the primary treatment provider and a clinical geriatrician or internal medicine physician with geriatric expertise. For frail elderly / older people with an increased risk for functional decline ("Identification of Seniors at Risk Hospitalized Patients" (ISAR-HP) ≥ 1) a multidisciplinary treatment plan, including care givers’ support. Within 48 hours after hospital admission older people at risk for functional decline begin a multidisciplinary reactivating treatment to prevent unnecessary functional decline.]
CZ zorgverzekering [25]	Process	Tijdens een multidisciplinair overleg wordt de voortgang met betrekking tot de behandeldoelen van de patiënt en de ervaren belasting van de mantelzorger, besproken. Bij het overleg worden ook andere specialismen (bijvoorbeeld psychiater, maatschappelijk werk, fysiotherapeut) betrokken. [The progress regarding the treatment goals of the patient and the caregiver burden is discussed during a multidisciplinary meeting. Other specialties (eg, psychiatrist, social worker, physiotherapist) are involved in this meeting.]
CZ zorgverzekering [25]	Process	Er is een adequate overdracht van de patient tussen instellingen en tussen instellingen en de zorg in de thuissituatie. Deze overdracht bevat de reguliere medische, farmaceutische en verpleegkundige aspecten (somatisch, cognitief, psychisch) en informatie over de sociale en maatschappelijke omgeving. Alle medische gegevens ontvangt de huisarts bij voorkeur op de ontslagdag van de coördinator van de patiënt of de transmuraal verpleegkundige.

Reference	Level	Example
		[There is an adequate patient transfer between institutions, and between institutions and home care. This transfer includes the regular medical, pharmaceutical and nursing aspects (somatic, cognitive, psychological) and information about the social environment. The primary care physician receives all medical information preferably on the day of discharge, from the coordinator of the patient or the transmural nurse.]
CZ zorgverzekering [25]	Process	Het duidelijk overdragen van informatie van een ziekenhuisarts aan een patient en/of diens mantelzorger kan voorkomen dat ouderen na ontslag alsnog te maken krijgen met functieverlies. Dit kan middels een patientbrief. Het voorkomt heropnames en medicatiefouten. [Clear information transfer from a hospital physician to a patient and / or his caregiver can prevent functional decline in elderly after discharge. This can be by means of a patient letter. It prevents readmissions and medication errors.]
Arora, Johnson et al. 2007 [82]	Process	If a hospitalized elder has a definite or suspected diagnosis of delirium, then an evaluation for potentially precipitating factors must be undertaken and identified causes treated.
McGory et al. 2009 [81]	Process	If an elderly patient undergoes elective or nonelective inpatient surgery, then a daily screening exam for postoperative delirium should be performed for the first 5 inpatient days after surgery
McGory et al. 2009 [81]	Process	If an elderly patient undergoes elective or nonelective inpatient surgery and has a new definite or suspected diagnosis of delirium in the postoperative period, then an evaluation for the following core group of precipitating factors for delirium should be undertaken within 4 h from time of identification of delirium episode: Presence of infection including sepsis, pneumonia, urinary tract infection, wound infection, central line infection, intra-abdominal infection Electrolyte abnormalities (Na, K, BUN, Cr, glucose), hypoxia, uncontrolled pain, urinary retention or fecal impaction, use of sedative -hypnotic drug
Payot et al. 2007 [75]	Process	Si une personne âgée vulnérable atteinte de démence est admise en unité de courte durée gériatrique, ALORS un diagnostic de delirium surajouté doit être recherché et s'il est confirmé, les facteurs précipitants doivent être évalués et traités. [If a vulnerable elder with dementia is admitted to a short term geriatric unit, THEN a superimposed delirium should be assessed and if confirmed, precipitating factors should be evaluated and treated.]
Tropea et al. 2011 [77]	Process	Numerator Number of patients 65 years of age and older who had major surgery, in whom a daily screening examination for delirium is performed for the first 3 days after surgery Denominator Number of patients 65 years of age and older who had major surgery
VMS 2009 [18]	Structure	Is er in uw ziekenhuis een multidisciplinair ziekenhuisbreed protocol voor delirium bij patiënten ≥ 70 jaar? [Does your hospital have a multidisciplinary hospital-wide protocol for delirium in patients ≥ 70 years?]
VMS 2009 [18]	Process	Screent de verpleegkundige binnen 24 uur na opname of er sprake is van (verhoogd risico op) delirium? [Does the nurse screen for (an increased risk of) delirium within 24 hours of admission?]
VMS 2009 [18]	Process	Delirante patiënten worden verpleegd door geriatrisch geschoolde verpleegkundigen. [Delirious patients are cared for by geriatric trained nurses.]
SFH Ontario [83]	Process	Percentage of patients (65 and older) receiving delirium screening using a validated tool upon admission to hospital
SFH Ontario [83]	Outcome	Incidence of delirium in patients (65 and older) acquired over the course of hospital admission
Dementia (n = 8)		

Reference	Level	Example
Feil et al. 2007 [84]	Process	IF a vulnerable elder has dementia, THEN he or she should be screened annually for behavioral symptoms of dementia
Feil et al. 2007 [84]	Process	IF a vulnerable elder with dementia and behavioral symptoms is newly treated with an antipsychotic, THEN there should be a documented risk–benefit discussion
Feil et al. 2007 [84]	Process	IF a vulnerable elder with dementia is physically restrained in the hospital, THEN the target behavioral disturbance or safety concern justifying the use of restraints should be documented in the medical record (discussed between the internal geriatric consultation team and requesting unit) and communicated to the patient, caregiver, or guardian
Arora, Johnson et al. 2007 [82]	Process	If a vulnerable elder has dementia, then he or she should be screened for depression during the initial evaluation.
Kroger et al. 2007 [80]	Process	If a patient has early stage dementia, then his performance in productive activities, leisure and everyday activities as well as his ability to drive a car should be evaluated
Kroger et al. 2007 [80]	Process	If a patient has intermediate stage dementia, then his performance in communicating and personal care should be evaluated
Kroger et al. 2007 [80]	Process	If a patient has advanced stage dementia, then his performance in swallowing and his positioning should be evaluated
Kroger et al. 2007 [80]	Process	All care-givers of patients with dementia must be asked about their needs for support services
Depression (n = 3)		
Nakajima & Wenger 2007 [85]	Process	ALL vulnerable elders should have documentation of a screen for depression during the initial primary care evaluation and annually
Nakajima & Wenger 2007 [85]	Process	IF a vulnerable elder presents with sad mood, feeling down, insomnia or difficulties with sleep, apathy or loss of interest in pleasurable activities, complaints of memory loss, unexplained weight loss of 5% or more in the previous month or 10% or more in the previous year, or unexplained fatigue or low energy (and the symptom has not previously been documented as a chronic condition), THEN the patient should be asked about depression, treated for depression, or referred to a mental health professional within 2 weeks of presentation
Nakajima & Wenger 2007 [85]	Process	IF a vulnerable elder receives a diagnosis of a new depression episode, THEN the medical record should document on the day of diagnosis the presence or absence of suicidal ideation and psychosis
Falls and mobility problems (n = 10)		
Chang et al. 2007 [86]	Process	ALL vulnerable elders should have documentation that they have been asked annually about the occurrence of recent falls.
Chang et al. 2007 [86]	Process	IF a vulnerable elder reports a history of two or more falls (or 1 fall with injury) in the previous year, THEN there should be documentation of a basic fall history (circumstances, medications, chronic conditions, mobility, alcohol intake) within 3 months of the report (or within 4 weeks of the report if the most recent fall occurred in the previous 4 weeks)
Chang et al. 2007 [86]	Process	IF a vulnerable elder reports a history of two or more falls (or 1 fall with injury) in the previous year, THEN there should be documentation of orthostatic vital signs (blood pressure and pulse) within 3 months of the report (or within 4 weeks of the report if the most recent fall occurred in the previous 4 weeks)
Chang et al. 2007 [86]	Process	IF a vulnerable elder reports a history of two or more falls (or 1 fall with injury) in the previous year, THEN there should be documentation of a basic gait, balance, and strength evaluation within 3 months of the report (or within 4 weeks of the report if the most recent fall occurred in the previous 4 weeks).
Chang et al. 2007 [86]	Process	IF a vulnerable elder demonstrates poor balance or proprioception or excessive postural sway and does not have an assistive device, THEN an evaluation or prescription for an assistive device should be offered within 3 months.

Reference	Level	Example
Arora et al. 2007 [79]	Process	IF a vulnerable elder falls during hospitalization, THEN presence or absence of prodromal symptoms and review of medications or drugs potentially contributing to the fall should be documented within 24 hours
Brand et al. 2011 [87]	Outcome	Fall during hospitalization
Tropea et al. 2011 [77]	Process	Numerator Number of patients 65 years of age and older who fall during hospitalisation in whom presence or absence of prodromal symptoms and review of medications or drugs potentially contributing to the fall is documented Denominator Number of patients 65 years of age and older who fall during hospitalisation
VMS 2009 [18]	Process	Screent de verpleegkundige binnen 24 uur na opname of er sprake is van verhoogd risico op vallen? [Does the nurse screen for an increased risk of falls within 24 hours of admission?]
VMS 2009 [18]	Process	Stelt de hoofdbehandelaar bij een verhoogd valrisico een multidisciplinair multifactorieel interventieplan op? [In case of an increased risk of falls, does the primary treatment provider compose a multidisciplinary multifactorial intervention plan?]
Functional status (n = 9)		
Brand et al. 2011 [87]	Outcome	Functional decline (premorbid to discharge): Decline in ability to communicate
Brand et al. 2011 [87]	Outcome	Functional decline (premorbid to discharge): Decline in instrumental activities of daily living function
Brand et al. 2011 [87]	Outcome	Functional decline (premorbid to discharge): Decline in bladder or bowel continence
Kroger et al. 2007 [80]	Process	ALL vulnerable elders should receive an assessment of their level of physical activity at least once a year and, if necessary be provided with counselling about appropriate resources
Tropea et al. 2001 [77]	Process	Numerator Total number of patients aged 65 years and older for whom there is documented objective assessment of physical function (including self-care) using a validated tool within 24 h of admission Denominator Total number of patients aged 65 years and older
McGory et al. 2009 [81]	Process	If an elderly patient is undergoing nonelective inpatient surgery, then the patient's baseline ability to ambulate should be documented
JCI - International Hospital Inpatient Quality Measures [28]	Outcome	The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint
SFH Ontario [83]	Process	Percentage of patients (65 and older) receiving assessment of activities of daily living function with a validated tool at both admission and discharge
SFH Ontario [83]	Outcome	Percentage of patients (65 and older) with no decline in activities of daily living function from hospital admission to hospital discharge as measured by a validated tool
Hearing and vision (n = 3)		
Yueb & Shekelle 2007 [88]	Process	ALL vulnerable elders should have an evaluation of hearing status as part of the initial evaluation
Rowe & MacLean 2007 [89]	Process	IF a vulnerable elder has sudden-onset severe visual changes, THEN he or she should see an eye care professional within 24 hours.

Reference	Level	Example
Rowe & MacLean 2007 [89]	Process	IF a vulnerable elder has new-onset eye pain, grossly visible corneal lesions, or severe purulent discharge, THEN he or she should undergo a basic eye examination within 72 hours
Medication (n = 5)		
Kroger et al. 2007 [80]	Process	IF a vulnerable elder is prescribed a new drug, THEN the prescribed drug should have a clearly defined indication documented in the record
Kroger et al. 2007 [80]	Process	ALL vulnerable elders should have a drug regimen review at least annually
Payot et al. 2007 [80]	Process	IF a vulnerable elder presents with symptoms of a cognitive disorder, THEN the physician should review the patient's medication list (prescriptions, over the counter or supplements) for initiation of medications that might correspond chronologically to the onset of dementia symptoms
CZ visietekst [25]	Process	Bij ontslag is de medicatie van de patiënt op orde en gecontroleerd. De medicatie sluit aan bij het 1e lijns voorschrijfbeleid. Aandacht voor transfer van medicatie-overzicht aan de huisarts en de apotheker. [At discharge the medication of the patients is organized and checked. The medication is consistent with the prescription policy in prrmamery care. Attention should be given to transfer of the medication overview to the general practitioner and pharmacist]
CZ visietekst [25]	Process	Bij alle kwetsbare ouderen vindt een medicatiereview plaats. [Medication review is conducted in all vulnerable elders]
Osteoporosis (n = 2)		
Grossman & MacLean 2007 [90]	Process	ALL vulnerable elders at an initial primary care visit should be counseled about intake of calcium and vitamin D and weightbearing exercise
Grossman & MacLean 2007 [90]	Process	IF a vulnerable elder has osteoporosis, THEN he or she should be prescribed calcium and vitamin D supplements
Pain (n =3)		
Etzioni et al. 2007 [91]	Process	IF a vulnerable elder presents for an initial evaluation, THEN a quantitative and qualitative assessment for persistent pain should be documented (if cognitively impaired, a standardized pain scale, behavioral assessment or proxy report of pain should be used)
Etzioni et al. 2007 [91]	Process	IF a vulnerable elder with persistent pain is treated with opioids, THEN one of the following should be prescribed or noted: stool softener, laxative, increased fiber, stool-softening foods, or documentation of the potential for constipation or why bowel treatment is not needed
IGZ 2014 [20]	Outcome	Percentage gestandaardiseerde pijnmetingen bij postoperatieve patiënten [Percentage standardized measurements of pain in postoperative patients]
Pressure ulcers (n = 2)		
Bates-Jensen & MacLean 2007 [92]	Process	IF a vulnerable elder who is admitted to a hospital is unable to reposition himself or herself or has limited ability to do so, THEN risk assessment for pressure ulcers using a standardized scale should be performed upon admission, and if the patient is found to be at risk, the assessment should be repeated at least every 48 hours thereafter
Brand et al. 2011 [87]	Outcome	Pressure ulcer (new or worsening)

Reference	Level	Example
Substance abuse (n = 2)		
Kroger et al. 2007 [80]	Process	ALL vulnerable elders should be screened at least once to detect problem drinking and hazardous drinking by taking a history of alcohol use or by using standardized screening questionnaires
Kroger et al. 2007 [80]	Process	ALL vulnerable elders should be screened at least once to detect whether they use tobacco regularly
Screening (n = 7)		
NVKG 2013 [12]	Process	Wordt er een vorm van triage gehanteerd, waarbij aan de hand van vaste criteria vastgesteld wordt of een verwezen patiënt inderdaad in aanmerking komt voor een comprehensive geriatric assessment door de klinisch geriater? [Is any form of triage used, where by means of of predetermined criteria is determined if a referred patient is indeed eligible for a comprehensive geriatric assessment by the clinical geriatrician?]
NVKG 2013 B [11]	Structure	Is er een protocol waarin is vastgelegd welke interventies geïnitieerd dienen te worden op basis van de uitkomst van de in het ziekenhuis gehanteerde screeningsintrumtent voor functieverlies bij kwetsbare ouderen. [Is a protocol available specifying which interventions should be initiated based on the outcome of the screening instrument used in the hospital for detection of functional decline in frail elderly.]
SFH 2013 [16]	Outcome	Bij minimaal 80% van de in het ziekenhuis opgenomen patiënten van 70 jaar en ouder is de uitkomst vastgelegd in het patiëntendossier van de screening op: verhoogd risico op delirium, vallen, ondervoeding en bestaande fysieke beperkingen. [At least for 80% of hospitalized patients aged 70 years and older the result of the screening for increased risk of delirium, falls, malnutrition and existing physical limitations, are recorded in the patient file.]
SFH 2013 [16]	Structure	Op alle in de screening geconstateerde risico's worden interventies ingezet; dit is protocollair vastgelegd. [Interventions are implemented for all risks identified by the screening procedure; this is defined by protocol.]
CSO 2008 [23]	Process	Bij acute opname van een oudere vindt screening plaats op de aanwezigheid van een delier; Signalering bij het ontwikkelen van een delier gedurende een opname; Verpleegkundigen moeten alert zijn op veranderingen in het functioneren van de patiënt en signalen van de naaste. [When an elder is acutely admitted, screening for delirium is conducted. Alarming in case of development of a delirium during an admission; Nurses should be alert to changes in the patient functioning and signals from relatives]
CZ zorgverzekering [25]	Process	Alle 75-plussers die in het ziekenhuis worden opgenomen, worden bij opname actief gescreend op kwetsbaarheid via de vragenlijst "Identification of Seniors At Risk-Hospitalized Patients" (ISAR-HP). [All hospitalized patietns aged 75 years or over are actively screened for frailty using the questionnaire "Identification of Seniors at Risk Hospitalized Patients" (ISAR-HP).]
CZ zorgverzekering [25]	Process	Als er een verhoogd risico op functieverlies bestaat, dient een geriatrisch assessment plaats te vinden. [In case of an increased risk for functional decline, a geriatric assessment should be conducted.]
Sleep disorders (n = 2)		
Martin et al. 2007 [93]	Process	ALL vulnerable elders should be screened annually for sleep problems
Martin et al. 2007 [93]	Process	IF a vulnerable elder reports a sleep problem, THEN a targeted sleep history should be documented within 6 months
Nutrition (n = 5)		

Reference	Level	Example
Gnanadesigan et al. 2007 [94]	Process	ALL non-wheelchair-bound vulnerable elders should have their height, weight, and body mass index documented within 3 months of the initial primary care visit
Reuben et al. 2007 [95]	Process	IF a vulnerable elder has involuntary weight loss of 10% or more in 1 year or less or hypoalbuminemia (<3.5 g/dL), THEN he or she should be evaluated for potentially reversible causes of poor nutritional intake including assessment of dental status (e.g., dentition, gumhealth, dental referral), food security (e.g., financial status, social work referral), food-related functional status (e.g., ability to feed, prepare meals), appetite and intake (e.g., 72-hour calorie count, dietician referral), swallowing ability (e.g., bedside swallowing study, swallowing study referral), and dietary restrictions (e.g., low-salt or low-protein diet)
Reuben et al. 2007 [95]	Process	IF a vulnerable elder has involuntary weight loss of 10% or more in 1 year or less or hypoalbuminemia (<3.5 g/dL), THEN he or she should be evaluated for potentially relevant comorbid conditions, including assessment of medications associated with decreased appetite, depression, cognitive impairment, thyroid function, screen for cancer, diabetes mellitus, and malabsorption
Kroger et al. 2007 [80]	Process	IF a community-dwelling vulnerable elder has documented involuntary weight loss (greater than or equal to 10% of body weight) or hypoalbuminemia (< 3.5 g/dl), THEN he or she should receive an evaluation for potentially relevant co morbid conditions, including medications that might be associated with decreased appetite (for example, digoxin, fluoxetine, anticholinergics), depressive symptoms, and cognitive impairment and for potentially reversible causes of poor nutritional intake
Tropea et al. 2011 [77]	Process	Numerator Number of patients 65 years of age and older for whom evaluation of nutritional status is documented within 72 h of admission Denominator Number of patients 65 years of age and older
Urinary incontinence (n = 5)		
Fung et al. 2007 [96]	Process	ALL vulnerable elders should have documentation of the presence or absence of urinary incontinence during the initial evaluation
Fung et al. 2007 [96]	Process	IF a vulnerable elder has a postvoid residual greater than 300 cc, THEN he or she should have a serum creatinine within 72 hours and (if no reversible causes found) be referred to a clinician with urological expertise within 2 months (also see benign prostatic hyperplasia, for supporting evidence)
Fung et al. 2007 [96]	Process	IF a vulnerable elder has new urinary incontinence or established urinary incontinence with bothersome symptoms, and the urinary incontinence is treated with medication or surgery, THEN classification of the type of or suspected reason(s) for urinary incontinence should be documented.
Fung et al. 2007 [96]	Process	IF a vulnerable elder has clinically significant urinary retention, and a long-term (>1 month) urethral catheter is placed, THEN there should be documentation of justification for its use
Kroger et al. 2007 [80]	Process	IF a vulnerable elder has a new urinary incontinence that persists for more than 1 month or urinary incontinence at the time of a new evaluation, THEN a clinical conduct based on evidence and including targeted history, physical exam, diagnostic tests and discussion of treatment options should be offered
Recommendations (n = 3)		
Kroger et al. 2007 [80]	Process	IF the elements of a comprehensive geriatric assessment are performed, THEN follow-up should assure the implementation of recommendations

Reference	Level	Example
Department of Health 2011 [97]	Outcome	Left without being seen rate
Rouseau & Bastianelli 2005	Outcome	Taux de suivi des recommandations de l'equipe mobile [Adherence rate to the recommendations of the mobile team]
Team composition (n = 4)		
Ministère de la Santé et des Solidarités 2007	Structure	Composition de l'équipe médicale en équivalent plein temps [Composition of the medical team in full time equivalents]
Ministère de la Santé et des Solidarités 2007	Structure	Composition de l'équipe non médicale en équivalent plein temps [Composition of the non-medical team in full time equivalents]
Rouseau & Bastianelli 2005 [5]	Structure	Existence d'une procedure d'intervention formalisee de l'equipe mobile [Existence of a formal intervention procedure for the mobile team]
Rouseau & Bastianelli 2005 [5]	Structure	Intervention d'une 'equipe' (geriatre + infirmier diplomé d'état (IDE) + assistantes sociales…) [Intervention of a 'team' (geriatrician + registered nurse + social worker…)]
SFH [16]	Structure	In het ziekenhuis is een multidisciplinair geriatrieteam beschikbaar dat ingeschakeld wordt voor poliklinische en klinische behandeling van kwetsbare ouderen (direct of via intercollegiaal consult). [A multidisciplinary geriatric team is available in the hospital that is activated for outpatient and inpatient treatment of vulnerable elders (directly or through peer consultation).]
SFH [16]	Structure	Dit geriatrieteam met vaste samenstelling en regulier multidisciplinair overleg bestaat uit minimaal een klinisch geriater of internist ouderengeneeskunde en een geriatrieverpleegkundige of verpleegkundig specialist geriatrie. Een geriatrie fysiotherapeut dient in ieder geval op consultbasis beschikbaar te zijn. [The geriatric team with fixed composition and regular multidisciplinary meetings consists out of a clinical geriatrician of internal medical physician with geriatric expertise and a geriatric nurse of geriatric clinical nurse specialist. A geriatric physiotherapist should be available at least on a consultative basis.]
Patient characteristics (n = 4)		
Rouseau & Bastianelli 2005 [5]	Structure	Age moyen des patients vus par l'equipe mobile [Average age of patients seen by the mobile team]
Rouseau & Bastianelli 2005 [5]	Structure	Score moyen d'autonomie des patients vus par l'equipe mobile [Average autonomy score of patients seen by the mobile team]
Rouseau & Bastianelli 2005 [5]	Structure	Score moyen de gravité a l'entree aux urgences de patients vus par l'equipe mobile [Average severity score for patients admitted at the emergency department seen by the mobile team]
Rouseau & Bastianelli 2005 [5]	Structure	Pourcentage de personnes agees de plus de 75 ans a aux urgences [Percentage of patients aged 75 years or older admitted at the emergency department]
IGCT activity (n = 17)		
Department of Health 2011	Process	Time to initial assessment

Reference	Level	Example
Rouseau & Bastianelli 2005 [5]	Structure	Utilisation par l'equipe mobile de grilles d'evaluations specifiques des personnes agees [Use of specific evaluation instruments for older people by the mobile team]
Rouseau & Bastianelli 2005 [5]	Outcome	Nombre d'interventions (ou visites) faites par l'equipe mobile [Number of interventions (or visits) by the mobile team]
Rouseau & Bastianelli 2005 [5]	Outcome	Nombre de patients vus par l'equipe mobile [Number of patients seen by the mobile team]
Rouseau & Bastianelli 2005 [5]	Outcome	Duree moyenne de la visite [Average duration of a visit]
Rouseau & Bastianelli 2005 [5]	Outcome	Nombre de diagnostics par patient [Number of diagnoses per patient]
Rouseau & Bastianelli 2005 [5]	Outcome	Delai moyen d'intervention de l'equipe mobile apres appel au secretariat [Average delay between the consultation request and the intervention of the mobile team]
Rouseau & Bastianelli 2005 [5]	Structure	Origine des appels (par discipline ou services) [Origin of the consultation requests (per discipline or service)]

Reference	Level	Example
IGZ [20]	Structure	Teller: aantal medebehandelingen geriatrieteam bij patiënten van 70 jaar en ouder met een heupfractuur; Noemer: aantal opgenomen patiënten van 70 jaar en ouder met een heupfractuur. [Numerator: number of patients with a hip-fracture aged 70 years or older comanaged by the geriatric team; Denominator; number of hospitalized patients aged 70 years or older with a hip-fracture]
Senior Friendly Hospital [16]	Structure	Protocollair is vastgelegd wanneer en door wie het geriatrieteam wordt ingeschakeld. [It is determined by protocol when and by whom the geriatric team can be requested to intervene]
Montalan 2011 [10]	Outcome	Nombre de contacts intra, extrahospitaliers. [Number of inhospital and outhospital contacts]
Montalan 2011 [10]	Outcome	Nombre d'actions de sensibilisation menées. [Number of sensibilisation activities undertaken]
Montalan 2011 [10]	Outcome	Nombre d'échanges avec les professionnels appelants. [Number of exchanges with professionals requesting to intervene]
Montalan 2011 [10]	Outcome	Nombre de réunions pluridisciplinaires. [Number of multidisciplinary meetings]
Montalan 2011 [10]	Outcome	Nombre d'interventions par nature. [Number of interventions per type]
Montalan 2011 [10]	Outcome	Délai de réponse par service et partenaire externe. [Response time per service and external partner]
Montalan 2011[10]	Outcome	Taux de courriers de synthèse envoyés dans les délais. [Rate of reports sent on time]
Other outcomes (n = 16)		
Brand et al. 2011 [87]	Outcome	Discharge to a higher level care
Brand et al. 2011 [87]	Outcome	Death in hospital
The Australian Council on Healthcare Standards 2013	Outcome	Unplanned and unexpected readmissions within 28 days
The Australian Council on Healthcare Standards 2013	Outcome	Unplanned and unexpected readmissions within 14 days
Ministère de la Santé et des Solidarités, 2007	Outcome	Pourcentage de réhospitalisations non programmées survenant dans les 60 jours suivant la sortie des patients évalués par l'équipe mobile en intra hospitalier [Percentage unplanned hospital readmissions withing 30 days of discharge for patients seen by the mobile team in the hospital]
Rouseau & Bastianelli 2005 [5]	Outcome	Pourcentages de mutations internes (autres services aigus) [Percentage of internal transfers (other acute services)]

Reference	Level	Example
Rouseau & Bastianelli 2005 [5]	Outcome	Pourcentages de mutations en SSR geriatriques ou non [Percentage of transfers to geriatric or non geriatric rehabilitation units]
Rouseau & Bastianelli 2005 [5]	Outcome	Pourcentages de mutations en long sejour [Percentage of transfers to long-term care]
Rouseau & Bastianelli 2005 [5]	Outcome	Pourcentages de mutations exteriers en institutions (établissement d'hébergement pour personnes âgées dépendantes etc) [Percentage of external transfers to institutions (nursing homes for older dependents elders etc)]
Rouseau & Bastianelli 2005 [5]	Outcome	Pourcentages de retours a domicile [Percentage of discharges to home]
Rouseau & Bastianelli 2005 [5]	Outcome	Pourcentages de patients venant du domicile et retournant a domicile [Percentage of patients admitted from home and discharged home]
Rouseau & Bastianelli 2005 [5]	Outcome	Duree moyenne de sejour des patients vus par l'equipe mobile [Average duration of hospital stay for patients seen by the mobile team]
Rouseau & Bastianelli 2005 [5]	Outcome	Pourcentages d'hospitalisations evitees aux urgences [Percentage of avoided hospitalizations at the emergency department]
Montalan 2011 [10]	Structure	Existence de documents d'évaluation formalisés. [Existence of standardized assessment instruments]
Montalan 2011 [10]	Outcome	Délai Moyen de Séjour des patients vus par l'equipe mobile gériatrie dans les services. [Average length of stay for patients seen by the mobile geriatric team per service]
Montalan 2011 [10]	Outcome	Nombre d'heures de formation reçues par professionnel [Number of education hours per professional]

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