



ComPacks

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<http://www.archi.net.au/e-library/build/moc>

Model of Care concept Angela Littleford and Judith Carl.

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Executive Summary

As the population ages and the incidence of chronic disabling conditions rises, so does the need for long term care services.

Over-reliance on high cost technologies to support the aged and those with chronic illness will not be sustainable in the long term. New models of care that provide opportunities for innovative and interdisciplinary care within the community setting are a key strategy for reducing the projected need for high cost care.

ComPacks is a joint discharge program between multidisciplinary health teams and non health community case managers.

It is designed to assist patients to leave hospital and return to functionality in a timely manner. The focus is on maximising patient independence and capacity in line with their preferences and goals while helping to manage demand across the health system.

ComPacks clients are patients whose hospital length of stay may have been extended, or is at risk of being extended, because of difficulties or concerns about the availability of community support services needed to allow the person to leave hospital. ComPacks is not open to patients who are awaiting placement in a nursing home or who require intensive (more than 56 hours per month) of support services.

ComPacks aims to optimise patient access to the community services they need for a safe and supported return home. The program brokers the use of specialist community case managers to assess a patient before they leave hospital and then work collaboratively with the patient and their carers, hospital based staff and service providers.

The Case Managers uses their expert knowledge, skills and service links to broker short term care and support services for clients for up to six weeks after they leave hospital. As many clients need longer-term support the Case Managers must also negotiate seamless transition to ongoing (extended) support services for clients and their carers.

Services funded by ComPacks are wide ranging and include domestic assistance, personal care, social support, centre based care, respite care and health care related assistance.

The ComPacks model has been tested across Sydney's tertiary hospitals and is now being implemented across all area health services. It builds on work undertaken in the Northern Sydney Central Coast Area Health Service.

ComPacks is proving to be successful at delivering a better utilisation of available resources and better matches between the clients' needs and the services available. It is having a positive effect on reducing length of stay in hospitals.

Older people and those with chronic illness are being supported to achieve optimum functionality and to live independently.

Why Implement this Model?

- Patients prefer to be cared for at home or in the community.
- ComPacks can significantly reduce the time patients stay in hospital.
- It facilitates reduced adverse events.
- It can provide high quality care at much less cost.

The model has been tested across Sydney's tertiary hospitals and is being implemented across all area health services.

Richard's Story Prior to ComPacks

Richard's Story

Richard's Story

Richard is 76 years old and has been hospitalised following a fall. He has mild dementia and no family support.

This is his story.

This is a real story... only the names have been changed.

I was in hospital for six weeks after my fall and I wanted to go home. The nurses and hospital social worker said I needed some help around the house organised before they would let me go home.

I didn't think I needed anyone. I told them I could look after myself but I agreed to have some help with the cleaning to keep them quiet. Apparently there was a long waiting list for Home and Community Care Services so it took six weeks to get something organised.

I finally went home but about a month later I started to feel sick again. I decided to take some of the pills that the doctor had given me a while ago to see if it would help me shake whatever bug I had.

I got into a bit of a mess. I started to feel confused and forgot things. The telephone wasn't working properly but I couldn't figure out how to fix it. I forgot to pay the electricity bill and they came to cut it off.

I must have fallen again. Luckily for me my neighbour Bill found me. They put me in hospital but I seemed to get worse while I was there. I kept forgetting more things. After four weeks they said I had to go into a nursing home. I was in hospital for three months until they found me a place.

Richard's functionality has significantly reduced in hospital and he is no longer able to carry out daily living tasks. Richard will never return to his own home.



Richard, 76 years old, is in hospital following a fall. He has dementia, no family support and is fiercely independent.

Home and Community Care Services have no vacancies so Richard stays in hospital for a further six weeks.

Home and Community Care Services helps with household tasks but Richard refuses any additional help.

What's wrong with this story?

- The hospital discharge planner is unable to access appropriate support for Richard so he can return home. He has to stay in hospital for far longer than is necessary for both him and the hospital.
- Richard returns home without support. His health deteriorates again to a level where he is required to go back in to hospital.
- Richard's hospital stay severely reduces his functionality and his dementia worsens. This substantially impacts on his ability to look after himself at home.
- Richard is prematurely admitted to a residential nursing home when he could have lived in his own home, as was his wish, for a much longer period.

Richard spends too long in hospital and returns home without proper support.

This puts him in a downward spiral. His functionality deteriorates in hospital to the point where he becomes too unwell to go home.



Richard feels ill again four weeks later and self-medicates. He is unable to keep track of household chores.



Richard is readmitted one week later following another fall. He spends four weeks in hospital where his dementia and confusion worsens.



Three months later, Richard is discharged to a residential nursing home.

Background to the Model

Our population is ageing and this is placing greater demand on hospital services.

Older people recover medically before they recover functionality. Following an illness they need support to return to independent living.

Hospitals are no place to regain functionality. Older people are at greater risk of adverse events in hospital.

There is a growing body of evidence that demonstrates care in the community delivers good health outcomes for some patients at lower cost than hospital treatment.

There is strong patient and community support for such care.

Despite additional funding the community care sector has become increasingly complex and access to services has declined.

Our population is ageing and therefore demands that the health system creates effective models of care, particularly for the older person.

The ageing of the population is resulting in an increasing number of older people being admitted to hospital.

A large body of evidence also shows that once hospitalised, the older person is at greater risk of becoming deconditioned. (Creditor 1993, Inouye 1993, Counsell 2000). Older people have much higher rates of adverse events in hospital such as falls, medication errors and infections (Palmer 1998).

Hospitalisation and bed rest usually thrust older people into disability as ageing reduces muscle mass and strength. Without voluntary contraction, muscle strength decreases by 5% per day (Creditor 1993). It is important that an older person's length of stay is not prolonged so they can avoid deconditioning and loss of function. Older people recover medically before they recover functionality. After any episode of acute illness the older person requires support to return to optimal function.

Older people face many challenges to live independently as they often have complex needs associated with higher incidents of chronic disabling conditions and co-morbidities.

The community care sector has become very complex. Despite increased funding to both the health and community care sectors, access to services has declined and referral processes and actions can be unclear and confusing for some patients. This has resulted in hospital staff and service intake staff having to spend significant time securing support for patients leaving hospital. This in turn leads to significant delays for people leaving hospital, reducing the capacity of the hospital to care for other patients. Alternatively patients go home without appropriate support, increasing the chance that they will need to return to hospital.

For many elderly people, admission to hospital and concomitant use of community support services are integral to their ongoing community independence (Grimmer 2004). Innovative approaches that focus on supporting older people as they return to the community are essential.

All of the above factors, as well as technological and pharmaceutical advances, are driving innovation for the delivery of health and community care. Older people, those with chronic illnesses, and their families and carers want community based interdisciplinary care at home.

Significantly lower costs have been associated with delivering care within the community while at the same time patient and carer satisfaction are reported to be much higher (Caplan 2006). Research also shows that using a systematic approach to provide the right assistance to offset the impacts of impairments resulting from chronic conditions and ageing, can slow rates of decline and reduce institutional and certain in-home personnel costs (Mann 1999).

The focus of this care is to provide a 'continuum of care' that is characterised by effective integration of services that tracks the patient's movement between care settings from hospital admission to return of function within the community. Research shows that when a patient's needs are recognised, and appropriate information, follow up resources and services are provided as they leave hospital, their recuperation and ability to continue to live in the community are optimised (Grimmer 2004).

It is important that successful integration of hospital admissions and return to independent community living are achieved to maximise the capacity of both the health and community services sector. This requires hospital staff, community services, patients and their families to plan for a patient's ongoing health and social needs.

Richard's Story Under ComPacks

Richard's new Story

Richard is 76 years old and has been hospitalised following a fall. He has mild dementia and no family support.

This is his story under ComPacks.

This is a real story... only the names have been changed.

I had been in hospital for six weeks when someone called a Case Manager came to see me about leaving hospital.

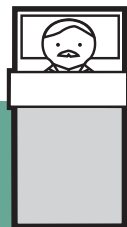
He said I was well enough to leave hospital but the staff were worried that I might not be safe at home because I get a bit confused and forgetful sometimes. I live alone and don't have any friends or relatives around to help me.

The Case Manager said he could arrange for me to go to a hostel. I got a bit upset and told him that I couldn't go to a hostel because I might never get to go back home. There was no way I was going to leave my home I told him.

The Case Manager was very reassuring and said that his job was to help me to do what I wanted to do. I agreed to let him just pop in and see me a few times once I got home. That seemed like a good idea and it is nice to have visitors.

The Case Manager was true to his word and when I got home he did pop into see me most days. He suggested I get some rails put in the bathroom and down the stairs to help me to get up and down without falling. I thought that was a good idea – I didn't want to go to hospital again. The Case Manager organised it all and in a couple of days the rails were up. They were a tremendous help. It is much easier to wash, to go into the garden and out to check the mail box.

He then said that he might be able to find someone to help me with the housework and he could arrange for me to get a hot meal each day. That sounded good because the housework was getting a bit much.



Richard, 76 years old, is in hospital following a fall. He has dementia, no family support and is fiercely independent.



Home and Community Care Services have no vacancies so Richard stays in hospital for a further six weeks.



Home and Community Care Services helps with household tasks but Richard refuses any additional help.

What is good about this story?

- Richard is able to maintain his independence and continue to live at home.
- The Case Manager spent time with Richard to build trust and identify what services would be most useful to him.
- He is able to access mainstream services for Richard through negotiation and management.
- The support to remain independent is financially affordable for Richard and sustainable in the longer term.
- The Case Manager liaises with Richard's GP to ensure co-ordination of care.

Having that sort of help is a big relief and I didn't have to organise anything. The Case Manager fixed it all up for me and I just give them some money from my pension. Someone helps me with that as well now because I get a bit confused about when bills have to be paid.

After I had been home about four weeks I got a cold. I decided to take some old pills in the cupboard. The Case Manager came to visit me and offered to talk to my GP and try and get some better pills.

When I go to the doctor now he asks what I have been doing and who is helping me. If I don't call in every few weeks, the doctor's nurse rings to see what I am up to.

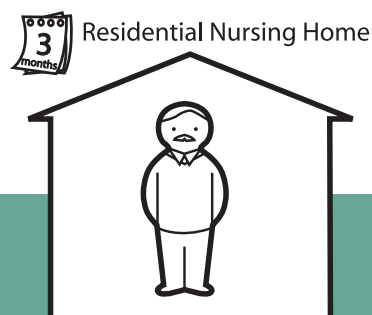
It is six months since I went to hospital and with the help with my meals and other things I am keeping well and managing at home by myself. I have lots of visitors so I have company most days. Home is where I want to be.



Richard feels ill again four weeks later and self-medicates. He is unable to keep track of household chores.



Richard is readmitted one week later following another fall. He spends four weeks in hospital where his dementia and confusion worsens.



Three months later, Richard is discharged to a residential nursing home.

What are ComPacks?

- Brokered service using expert case managers.
- Case Manager uses funding packages to obtain support to allow a patient to leave hospital.
- Time limited – six week maximum.
- Client focused service delivery.
- Link to long term sustainable community support for patients and carers.
- Collaboration between community and hospital based staff.

ComPacks is a joint discharge program between multidisciplinary health teams and non health community case managers.

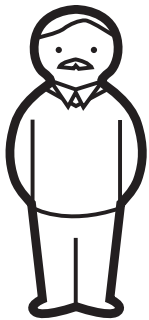
It is designed to assist patients to leave hospital and return to functionality in a timely manner. The focus is on maximising patient independence and capacity in line with their preferences and goals.

ComPacks aims to optimise patient access to the community services they need for a safe and supported return home. The program brokers the use of specialist community case managers to work in partnership with hospital based staff. Assessment, care planning and evaluation are undertaken collaboratively between service providers, the patient and carers.

Eligibility

ComPacks clients are patients whose hospital length of stay may have been extended, or is at risk of being extended, because of difficulties or concerns about the availability of community support services needed to allow the person to leave hospital.

Other patients who may be referred for ComPacks assistance are those who may wish to return home rather than take up a residential care option. Clients include those with short term home support needs, those who are Home and Community Care (HACC) eligible, and current clients of community care services including those who require a short term increase in services.

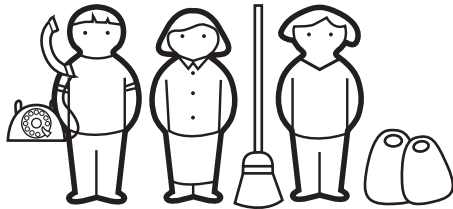


Eligible for ComPacks	Not eligible for ComPacks
<ul style="list-style-type: none"> • Assessed as requiring the support of two or more community services to facilitate leaving hospital. 	<ul style="list-style-type: none"> • Recipient of a Community Aged Care Package (CACP) (except where additional short term support is required).
<ul style="list-style-type: none"> • Assessed as having a clinical need that can be jointly met in the community. 	<ul style="list-style-type: none"> • Need more than 56 hours of service per calendar month.
<ul style="list-style-type: none"> • Referred by ASET staff in an emergency department as requiring in-home care and support. 	<ul style="list-style-type: none"> • Waiting for nursing home placement.
	<ul style="list-style-type: none"> • Waiting for Attendant Care funding.

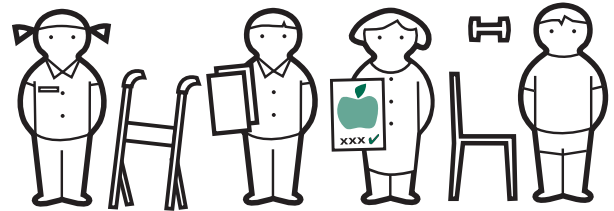
Criteria for managing demand for ComPacks

- Patients who are not otherwise able to be discharged.
- Patients have a history of, or are at risk of hospital readmission.
- Patients who need short term intensive case management and require ongoing long term service support.
- Patients who require short term case management and service support and may require linkage and referral for ongoing services.

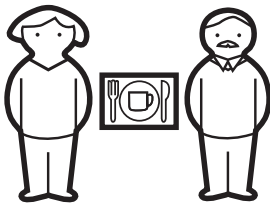
Services Provided Under ComPacks



Domestic Assistance may include cleaning, washing and ironing, help with shopping, transport to appointments and general household support such as helping with telephone calls. Meals can also be provided for people who are unable to prepare their own meals or maintain an adequate nutritional intake. Domestic assistance may also include helping with household accounts and paperwork such as bill paying and banking.



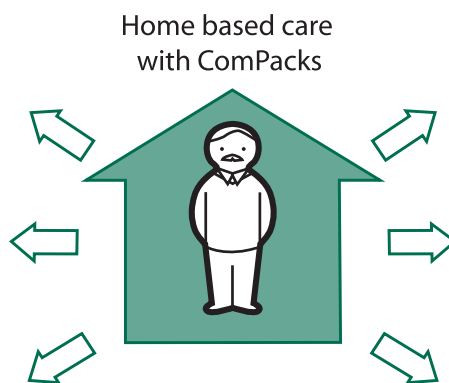
Health Care Services may include: falls management; Aged Care Assessment Team (ACAT); dementia support services; equipment; rehabilitation; home modifications and maintenance; medication review and education; allied health services such as physiotherapy and occupational therapy, dietician, podiatry and speech pathology; community nursing; continence management; bilingual services; and interpreters.



Personal Care includes assistance with performing essential self care tasks such as bathing, dressing, eating and personal grooming.



Respite Care is used to assist carers.



Centre Based Care may include participation in structured group activities that are aimed at developing, maintaining or supporting independent living and social interaction as well as organised day trips.



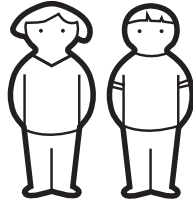
Social Support may include the provision of friendly visiting services or accommodation advice. Transport assistance can be made available for medical appointments, community services and/or to facilitate socialisation to improve independence.

Keys to Success

Key Aspects of Successful ComPacks Services

- Be client focussed.
- Enable the client to be at home and independent.
- Provide timely responsive care.
- Be flexible in providing care as it is essential the care fits the client's needs.
- Raise awareness and educate community about the services available.
- Provide seamless transition into the community and extended support services.

Community Case Manager



Community case management is pivotal and includes assessment, care planning, implementation, monitoring, advocacy, evaluation and closure.

The Case Manager uses their expert knowledge, skills and service links to broker short term care and support services for patients for up to six weeks after they leave hospital. As many clients need longer-term support the Case Manager must also negotiate a seamless transition to ongoing (extended) support services for the patient.

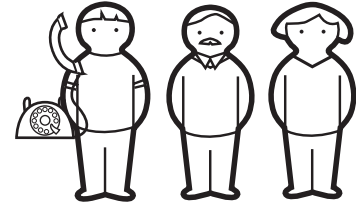
The Case Manager builds on the knowledge and skills of the patient and their carers, allowing them to learn at a structured pace and utilise personal preferences and social goals to achieve their optimal level of independence and wellbeing within their community.

Joint case management

The ability to jointly case manage some clients is a key success factor of the ComPacks program. It is particularly valuable for clients requiring speciality community health services such as mental health, palliative care, community acute/post acute care, drug and alcohol and community nursing.

Joint case management allows each Case Manager to use their specialised skills and knowledge to meet the client's assessed clinical needs and goals. It is also an effective way to provide specialised expertise at an affordable cost.

Assessment



A patient assessment ideally takes place before the patient leaves hospital to allow both health professionals and family members to attend.

Usually the Case Manager visits the patient in hospital but it can be done in exceptional cases by telephone.

See the Models of Care website for the assessment tool.

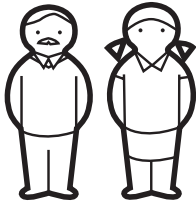
Client Agreements



The need for and level of services are identified taking into account short and long term patient goals and carer needs. Required services are recorded in a plan that is agreed to by the patient and the Case Manager. Client agreements include:

- a description of the ComPacks program including the maximum duration of any ComPacks
- contact details of the Case Manager
- services to be received
- the referrals determined at the initial assessment - any subsequent needs that are identified during the course of the ComPacks and needing referral are documented separately
- information about client rights and responsibilities and complaints mechanisms.

Carer Involvement



Carers are often the key component in supporting ComPacks clients at home. Particularly in the first two weeks carers need to be closely involved.

Often carers are stressed by an expectation to take on personal care for someone who has left hospital and frequently are unsure about what is required of them. They need preparation before the client comes home and information about medications, equipment or community service.

The intensive case management support of ComPacks can help carers and families to gain confidence to manage the client's ongoing support needs.

Brokerage Funding and Client Fees



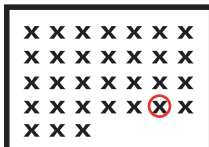
ComPacks funding helps case managers to purchase services and/or equipment that are not available from existing Home and Community Care (HACC) or other government funded services. Funds cannot be used to substitute for available mainstream services.

Funds must be used to buy high quality services with due regard to their cost effectiveness. Purchase of equipment is restricted to low cost safety equipment/items.

As mainstream services begin, clients are expected to pay fees, contributions, or donations that may apply subject to the standard income tests. In cases where a client may be unable to pay a fee, the role of the Case Manager is to negotiate a reduction or waiver of any fee.

Exiting ComPacks

EXIT



Planning for exit from ComPacks is key. It is expected that after a maximum period of six weeks patients will no longer require intensive community case management.

If a client requires ongoing community service support, referrals and linkages must be made. If there is a waiting list for the required service, clients must be placed on the list and arrangements made for support from family or privately purchased services until the other services become available.

Clients must also be provided with information about both the services they have been referred to and the range of services available.

Monitoring and Evaluation



The ComPacks service is monitored during the six week period of service delivery to ensure that the client's needs are being met at the expected level and quality.

Evaluation and assessment of the ComPacks service is undertaken collaboratively between service providers, the patient and their carer.

Implementing ComPacks

Process Map

Visit the online version of this process map on the ARCHI website at www.archi.net.au/eli-brary/build/moc

Here you will be able to access more information on each of the steps in implementing the model. You will have access to tools and templates as well as hints and lessons learned by others who have implemented the model.

	Planning Where are you now?	
Governance	Identify leaders. Develop a process map. Establish a steering committee.	
Patient Journey	Map the patient journey.	
Policies and Protocols	Understand current systems. Identify gaps in existing policies and procedures that may limit the service establishment. Identify eligibility criteria and referral points.	
People	Stakeholder analysis. Identify partnerships with key stakeholders.	
Resources	Conduct a resource survey to identify what is needed to establish ComPacks.	
Communication	Develop Communication Plan.	

Preparation Make it happen	Operationalise Make it stick
Develop a governance plan. Develop key performance indicators.	Monitor and evaluate against Key Performance Indicators (KPIs).
Identify changes that need to occur to improve the patient journey. Include the perspective of carers and family.	Document 'new' patient journey's that ComPacks has enhanced. Review patient and carer stories
Develop policies, protocols and guidelines that articulate how ComPacks is implemented and operates. Develop the operational structure. Establish the referral processes. Develop agreements with community service providers. HACC Service Response Form. Create links with rehabilitation and chronic disease management services.	Ongoing review of policies, protocols and guidelines. Community and Aged Care Services - Client Service Agreement Community and Aged Services Home Occupational Health and Safety Assessment Client Diary Form Client Diary Costs Form
Appoint a project officer Develop competencies for staff Provide training to staff Establish linkages between community service providers, clinicians, and other staff.	Develop and implement a monitoring and review process Interagency Peer Support Group
Deliver required resources Implement third party agreements	Monitor use of resources and modify as required
Tell people about the project at every opportunity Identify how results will flow back to key stakeholders	Ensure there is a feedback and review process

Benefits

Reduced Length of Stay

A 2004 evaluation of the ComPacks Service showed the greatest gains are in reduced length of stay (LOS).

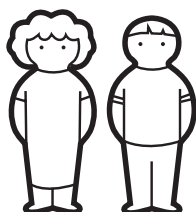
Example: Rehabilitation patients (ANDRG Z60A code)

- 47 patients with average reduction in LOS of 14.3 days.
- Net reduction of 736 days of hospital care.
- Average cost of hospital care is \$350 per day.
- Average cost of ComPacks services is \$30 per day - more than 90% cheaper than hospital care.
- Saving of \$235,520 in operating costs.

The most frequent DRG groups on discharge to ComPacks were found to be those groups with catastrophic or severe complications with an average number of medical diagnoses of seven per patient.

For people who stay in hospital for more than 21 days there was a LOS reduction of 8.9 days.

Patient and carer



- Able to recover functionality outside of hospital.
- Increased confidence about leaving hospital.
- Improved access to services, as skilled community Case Managers are aware of the available services and waiting lists.*
- Freed from dealing with a multitude of services and providers often with different and sometimes mutually exclusive entry criteria.
- Reduced risk of adverse events from hospital admission.

* The 2004 ComPacks evaluation showed 83% of people got access to the services they needed. Referral for services through ComPacks improved from 24% to 82% and only 2% of the need for services for mobility, dementia, falls and pain management were not met.

Hospital



- Reduced length of stay in hospital.
- Reduced adverse events from hospital admission.
- Reduced readmissions.
- Increased patient and staff satisfaction.
- Greater cost effectiveness.
- Improved, co-ordinated, interaction with other health care providers and community services.

Service providers



- Improved, co-ordinated interaction with a specialised hospital service.
- Appropriate care for their patients in the comfort of their own home.

Success story: Alison



Alison is 34 years old. She has Multiple Sclerosis and leg ulcers. She is wheel chair bound, is morbidly obese, and is unable to get around in her home. Alison recently fractured her ankle.

Alison's mother is her main carer but requires significant support herself. In hospital Alison saw a dietician and physiotherapist. After she left hospital Alison was unable to attend follow up clinics and home visits were not possible. She had no exercise routine. The Multiple Sclerosis Society (MSS) had started home modifications for Alison when she went back in to hospital with cellulitis.

This time when she left hospital a Community Options Service jointly case managed Alison with the MSS. Alison was assessed as needing rehabilitation, diet, carer support, dressings, as well as general housework and shopping support. The MSS Case Manager gave advice on the appropriate dressings for the leg ulcers and ComPacks paid for them. A private physiotherapist was engaged to establish an exercise program and a carer package was secured to provide shopping and home cooking services consistent with Alison's dietary needs. A ramp was installed to help Alison access her home.

After six weeks...

Alison lost 40 kilos and her ulcers were healed. She continued her exercises for her upper and lower body and was able to leave her home and look after her personal care by herself. Her Case Manager had arranged for continued support with shopping, cooking and domestic help for her mother and herself.

Success story: Veronica



Veronica is an 87 year old lady who goes to a Rehabilitation Unit after fracture of her femur. Veronica has an independent and coping nature and lives alone with supportive nieces and neighbours.

After Veronica left hospital she received ComPacks services to help her with daily personal care, meal preparation, weekly domestic assistance, Webster packs for medication and a Medi-alert system. The ComPacks Case Manager arranged transport to Veronica's out-patient appointments until she regained her restricted licence. Modifications were also made to her bathroom to prevent falls.

Within three weeks Veronica only received daily meal preparation and support.

After six weeks...

Veronica had regained her independence and only retains the Medi-alert.

Resources

For more information about CAPAC visit the Models of Care section of the ARCHI website

www.archi.net.au

Here you will find an electronic copy of this document, resources and have the opportunity to participate in online discussion groups.

Aged and Community Services – Australia CMSA, 2006. Case Management and Community Care, A Discussion Paper, Consultation Draft, Aged and Community Services Australia, Case Management Society of Australia – accessed on 31 July 2006 at <http://www.cmsa.org.au/FinalcaseManagementDiscussionPaper.pdf>.

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Notes
