References: Interdisciplinary Care

REF ID: 1322

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Topic 2: Prevention

Care track. time to tackle suboptimal medication prescribing for the elderly?(2002). ***Joint Commission Benchmark, 4*****(3), 8-9.**

Journal Article, Tables/Charts

Pharmacist interventions and multidisciplinary teams offer needed individualized careHealth Services Administration JournalsUSA Journals.Evidence-Based PracticeGerontologic CareQuality AssuranceAgedClinical IndicatorsDrugs, Prescription/st [Standards]Drugs, PrescriptionJoint Commission on Accreditation of Healthcare Organizations/st [Standards]Medical OrdersMedication Errors/pc [Prevention and Control]Multidisciplinary Care TeamPharmacy and PharmacologyPhysiciansProfessional Practice, Evidence-BasedResearchUnited States Agency for Healthcare Research and Quality

REF ID: 1336

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Andrews, B. C., Kaye, J., Bowcutt, M., & Campbell, J. (2001). Redesigning geriatric healthcare: How cross-functional teams and process improvement provide a competitive advantage. ***Health Marketing Quarterly, 19*****(2), 33-48.**

Evaluation Studies. Journal Article

This study examines the consequences of adding a geriatric subacute unit to the traditional health care mix offered by a nonprofit hospital. Historically, geriatric health care offerings have been limited to either acute care units or long-term care facilities. The study's findings demonstrate that the addition of a subacute unit that is operated by an interdisciplinary team is a competitively rational move for two reasons. First, it provides a continuum of care that integrates services and departments, thereby reducing costs. Second, it provides a supportive environment for patients and their families. As a consequence patients have a higher probability of returning home than patients who are assigned to more traditional modes of care.Activities of Daily LivingAgedAged, 80 and overDepression/cl [Classification]FemaleGeorgiaGeriatric Nursing/og [Organization & Administration]Geriatric Nursing/st [Standards]Hospital RestructuringHospital Units/og [Organization & Administration]Hospital Units/st [Standards]Hospitals, University/og [Organization & Administration]Hospitals, Voluntary/og [Organization & Administration]HumansMiddle AgedOrganizational InnovationOutcome and Process Assessment (Health Care)/mt [Methods]Patient Care Team/og [Organization & Administration]Quality Indicators, Health CareQuality of LifeResearch DesignSubacute Care/og [Organization & Administration]Subacute Care/st [Standards]

REF ID: 1339

Level VI: Opinion

Topic 4.2: Management-Behavior Therapy

Topic 4.3: Management-Medication

Arean, P. A., & Cook, B. L. (2002; 2002). Psychotherapy and combined psychotherapy/pharmacotherapy for late life depression. ***Biological Psychiatry, 52*****(3), 293-303.**

Over the past 20 yrs, numerous studies have investigated the efficacy of psychotherapy for treating late life depression and, to a lesser degree, the efficacy of psychotherapy combined with antidepressant medication. Of the intervention studies, cognitive-behavioral therapy and interpersonal psychotherapy combined with antidepressant medication have the largest base of evidence in support of their efficacy for late life depression. To a lesser degree, there is support for stand-alone interpersonal psychotherapy, brief dynamic therapy, and life review treatments. The

purpose of this review is to present data on the acute and long-term effects of cognitive-behavioral therapy, interpersonal psychotherapy, brief dynamic therapy, and combined antidepressant medication and psychotherapy to discuss the generalizability of these interventions, and to discuss future research directions and the need for increased opportunities for this area of research. (PsycINFO Database Record (c) 2006 APA, all rights reserved)psychotherapy, combined psychotherapy/psychopharmacology, major depression, cognitive behavioral therapy, brief dynamic therapy, interpersonal therapy, psychoeducation, reminiscence therapyDrug TherapyInterdisciplinary Treatment ApproachMajor DepressionPsychotherapyBrief PsychotherapyCognitive TherapyGeriatric PatientsInterpersonal PsychotherapyPsychodynamicsPsychoeducationReminiscence

REF ID: 1350

Level VI: Opinion

Topic 3: Assessment

Beltz, S. K. (2000). Comprehensive, in-hospital geriatric assessment plus an interdisciplinary home intervention after discharge reduced length of subsequent readmissions and improved functioning... commentary on nikolaus T, specht-leible N, bach M et al. A randomized trial of comprehensive geriatric assessment and home intervention in the care of hospitalized patients. AGE AGEING 1999 oct;28(6):543-50. *Evidence-Based Nursing, 3*(3), 83.

Journal Article, Commentary, Tables/Charts

QUESTION: Is an in-hospital, comprehensive geriatric assessment alone or combined with an interdisciplinary home intervention after discharge more effective than usual care? Design: Randomised, (allocation concealed}*, unblinded, controlled trial with follow up at 1 year. Setting: A university affiliated geriatric hospital in Heidelberg, Germany and patient homes. Patients: 545 patients (mean age 81 y, 73% women) who were admitted from home with acute illness and had multiple chronic conditions or functional deterioration after convalescence, or were at risk of nursing home placement. Patients with terminal illness or severe dementia were excluded. Follow up at 1 year was 94%. Intervention: 181 patients were allocated to comprehensive, geriatric assessment plus in-hospital and post-discharge treatment at home by an interdisciplinary team, which consisted of 3 nurses, a physiotherapist, an occupational therapist, and a social worker (home intervention group). The in-hospital, comprehensive assessment addressed activities of daily living, cognition, social situation, and perceived health. The team provided additional treatment while the patient was in hospital (eg, additional training in dressing or walking). Before discharge, the team made 1 home visit to assess the patient's home and prescribe technical aids as necessary. After discharge, the team provided treatment that home services could not, or could not immediately, provide. 179 patients were allocated to comprehensive assessment alone, and 185 were allocated to usual care, which comprised an assessment of activities of daily living and cognition. Main outcome measures: Main outcomes were mortality, hospital readmission, nursing home placement, functional status (Barthel index), and direct costs (staff, use of community services, hospital and physician visits, and nursing home days). Main results: Analysis was by intention to treat. The 3 groups did not differ for mortality at 1 year (table). Among the survivors (n=420), the home intervention group had shorter stays during geriatric hospital readmissions ($p < 0.05$), shorter nursing home placements ($p < 0.05$), and better instrumental functioning ($p < 0.05$) (table). The home intervention group did not differ from the assessment and usual care groups for number of hospital readmissions or admissions to nursing homes. The average annual net savings per person in the home care group was US $4000. Conclusion: Among elderly patients in hospital with acute illness, comprehensive geriatric assessment plus an interdisciplinary home visit after discharge reduced the duration of subsequent hospital readmissions and improved functional status, but did not affect mortality, readmission rate, or nursing home placements when compared with comprehensive assessment alone or usual care. *Information provided by author. [Original article accession number: 2000021894 (clinical trial, research, tables/charts)]Core Nursing JournalsNursing JournalsUK & Ireland Journals.Activities of Daily Living/ev [Evaluation]After CareAgedAged, 80 and OverBarthel IndexClinical Assessment ToolsCognition/ev [Evaluation]Community LivingComparative StudiesDescriptive

StatisticsFemaleGeriatric AssessmentGerontologic CareHome Health Care/ec [Economics]Home Health CareIntervention TrialsLength of StayMaleMarital StatusMortality/ev [Evaluation]Multidisciplinary Care TeamProspective StudiesPsychological TestsQuality of LifeQuestionnairesRandom AssignmentReadmissionSelf ReportSocioeconomic FactorsTreatment Duration

REF ID: 1323

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Topic 2: Prevention

Berkowitz, R., Blank, L. J., & Powell, S. K. (2005). Strategies to reduce hospitalization in the management of heart failure. *Lippincott's Case Management, 10*(6 Suppl), S1-15.

Evaluation Studies. Journal Article

Progressive and debilitating heart failure (HF) affects almost 5 million, mostly elderly, individuals in the United States. As the elderly population grows in coming decades, the prevalence of HF is expected to increase substantially. In addition to its human toll, HF yields a substantial economic burden, with direct and indirect cost estimates ranging from $27 to $56 billion annually. It is associated with an unacceptably high rehospitalization rate--50% within 6 months--which not only drives burgeoning costs but also provides a signal that current management approaches to HF are less than optimal. Evidence-based treatment approaches, which include the use of beta-blockers, angiotensin-converting enzyme inhibitors, spironolactone, and nesiritide, may offer opportunities for reducing mortality and rehospitalization rates in HF. Yet, because of inadequate discharge guidance and follow-up, many patients with HF are caught in a "revolving door" process that ultimately culminates in exacerbation and rehospitalization. Hospital-based disease management programs have consistently been shown to optimize care and reduce rehospitalization rates in patients with HF. The Hackensack University Medical Center HF program is discussed as an example of a successful HF program. This program represents a multidisciplinary, multifaceted approach to care that emphasizes case management. The core goal of this program is to provide a continuum of care that extends through hospitalization and into the patients' home environment.Aftercare/og [Organization & Administration]AgedAlgorithmsCase Management/og [Organization & Administration]Continuity of Patient Care/og [Organization & Administration]Cost of IllnessDecision TreesDisease ManagementHeart Failure, Congestive/ec [Economics]Heart Failure, Congestive/ep [Epidemiology]Heart Failure, Congestive/pp [Physiopathology]Heart Failure, Congestive/pc [Prevention & Control]Home Care Services/og [Organization & Administration]Hospital MortalityHumansLength of Stay/sn [Statistics & Numerical Data]New Jersey/ep [Epidemiology]Outcome Assessment (Health Care)Patient Care Team/og [Organization & Administration]Patient DischargePatient Readmission/sn [Statistics & Numerical Data]Program EvaluationQuality Indicators, Health CareSeverity of Illness IndexTotal Quality Management/og [Organization & Administration]United States/ep [Epidemiology]

REF ID: 1311

Level V: Case report

Topic 3: Assessment

Bonnono, C., Criddle, L. M., Lutsep, H., Stevens, P., Kearns, K., & Norton, R. (2000). Emergi-paths and stroke teams: An emergency department approach to acute ischemic stroke. *Journal of Neuroscience Nursing, 32*(6), 298-305.

Journal Article, Case Study, Critical Path, Forms

In patients with early acute ischemic stroke (AIS), studies have shown improved recovery rates when thrombolytic therapy is appropriately initiated. However, in clinical practice, there are several barriers to rapid patient evaluation and drug administration. To facilitate the management of this population, an AIS clinical pathway, Emergi-path, was developed. Initiated at the time of the patients' arrival to the emergency department, Emergi-path provides a step-by-step guide for early care of AIS patients. A citywide stroke team plays an integral role in this process by responding to stroke codes.

Implementation of an AIS pathway and activation of an organized team of stroke specialists can facilitate rapid evaluation and treatment of this high-risk population.Core Nursing JournalsNursing JournalsPeer Reviewed JournalsUSA Journals.AgedCerebral Hemorrhage/ci [Chemically Induced]Cerebral Ischemia/co [Complications]Cerebral Vascular Accident/di [Diagnosis]Cerebral Vascular Accident/et [Etiology]Cerebral Vascular Accident/ra [Radiography]Cerebral Vascular Accident/dt [Drug Therapy]Critical PathDiagnosis, NeurologicEarly InterventionEmergency ServiceHospitalsMaleMiddle AgeMultidisciplinary Care TeamOregonTime FactorsTissue Plasminogen Activator/ae [Adverse Effects]Tissue Plasminogen Activator/ct [Contraindications]Tissue Plasminogen Activator/tu [Therapeutic use]Treatment Outcomes

REF ID: 1338

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Bristow, P. J., Hillman, K. M., Chey, T., Daffurn, K., Jacques, T. C., & Norman, S. L. et al. (2000). Rates of in-hospital arrests, deaths and intensive care admissions: The effect of a medical emergency team. [see comment]. ***Medical Journal of Australia, 173*****(5), 236-240.**

Journal Article. Multicenter Study

OBJECTIVES: To evaluate the effectiveness of a medical emergency team (MET) in reducing the rates of selected adverse events. DESIGN: Cohort comparison study after casemix adjustment. PATIENTS AND SETTING: All adult (> or = 14 years) patients admitted to three Australian public hospitals from 8 July to 31 December 1996. INTERVENTION STUDIED: At Hospital 1, a medical emergency team (MET) could be called for abnormal physiological parameters or staff concern. Hospitals 2 and 3 had conventional cardiac arrest teams. MAIN OUTCOME MEASURES: Casemix-adjusted rates of cardiac arrest, unanticipated admission to intensive care unit (ICU), death, and the subgroup of deaths where there was no pre-existing "do not resuscitate" (DNR) order documented. RESULTS: There were 1510 adverse events identified among 50 942 admissions. The rate of unanticipated ICU admissions was less at the intervention hospital in total (casemix-adjusted odds ratios: Hospital 1, 1.00; Hospital 2, 1.59 [95% CI, 1.24-2.04]; Hospital 3, 1.73 [95% CI, 1.37-2.16]). There was no significant difference in the rates of cardiac arrest or total deaths between the three hospitals. However, one of the hospitals with a conventional cardiac arrest team had a higher death rate among patients without a DNR order. CONCLUSIONS: The MET hospital had fewer unanticipated ICU/HDU admissions, with no increase in in-hospital arrest rate or total death rate. The non-DNR deaths were lower compared with one of the other hospitals; however, we did not adjust for DNR practices. We suggest that the MET concept is worthy of further study.AdolescentAdultAgedAustralia/ep [Epidemiology]Cohort StudiesComparative StudyEmergenciesEmergency Service, HospitalFemaleHeart Arrest/ep [Epidemiology]Hospital MortalityHumansIntensive Care Units/sn [Statistics & Numerical Data]MaleMiddle AgedOdds RatioOutcome Assessment (Health Care)Patient Care Team/og [Organization & Administration]Patient Transfer/sn [Statistics & Numerical Data]PrevalenceResearch Support, Non-U.S. Gov'tRisk Adjustment

REF ID: 79

Level I: Systematic Reviews

Topic 1: Risks

Topic 3: Assessment

Topic 4: Management

Britton, A., & Russell, R. (2005). Multidisciplinary team interventions for delirium in patients with chronic cognitive impairment. ***The Cochrane Library.(Oxford),*** **(4)**

Software, Research, Systematic Review

A substantive amendment to this systematic review was last made on 17 December 2003. Cochrane reviews are regularly checked and updated if necessary. Background: Delirium is common in hospitalized elderly people. Delirium may affect 60% of frail elderly people in hospital. Among the cognitively impaired, 45% have been found to develop delirium and these patients have longer

lengths of hospital stay and a higher rate of complications which, with other factors, increase costs of care. The management of delirium has commonly been multifaceted, the primary emphasis has to be on the diagnosis and therapy of precipitating factors, but as these may not be immediately resolved, symptomatic and supportive care are also of major importance. Objectives: The objective of this review is to assess the available evidence for the effectiveness, if any, of multidisciplinary team interventions in the coordinated care of elderly patients with delirium superimposed on an underlying chronic cognitive impairment in comparison with usual care. Search strategy: The trials were identified from a last updated search of the Specialized Register of the Cochrane Dementia and Cognitive Improvement Group on 3 July 2003 using the terms delirium and confus* . The Register is regularly updated and contains records of all major health care databases and many ongoing trial databases. Selection criteria: Selection for possible inclusion in this review was made on the basis of the research methodology - controlled trials whose participants are reported as having chronic cognitive impairment, and who then developed incident delirium and were randomly assigned to either coordinated multidisciplinary care or usual care. Data collection and analysis: Nine controlled trials were identified for possible inclusion in the review, only one of which met the inclusion criteria. At present the data from that study cannot be analysed. We have requested additional data from the authors and are awaiting their reply. Main results: No studies focused on patients with prior cognitive impairment, so management of delirium in this group could not be assessed. There is very little information on the management of delirium in the literature despite an increasing body of information about the incidence, risks and prognosis of the disorder in the elderly population. Authors' conclusions: The management of delirium needs to be studied in a more clearly defined way before evidence-based guidelines can be developed.Insufficient data are available for the development of evidence-based guidelines on diagnosis or management. There is scope for research in all areas - from basic pathophysiology and epidemiology to prevention and management.Though much recent research has focused on the problem of delirium, the evidence is still difficult to utilize in management programmes. Research needs to be undertaken targeting specific groups known to be at high risk of developing delirium, for example the cognitively impaired and the frail elderly. As has been highlighted by Inouye 1999, delirium has very important economic and health policy implications and is a clinical problem that can affect all aspects of care of an ill older person.Delirium, though a frequent problem in hospitalized elderly patients, is still managed empirically and there is no evidence in the literature to support change to current practice at this time. [CINAHL Note: The Cochrane Collaboration systematic reviews contain interactive software that allows various calculations in the MetaView.]Evidence-Based PracticeGerontologic CarePsychiatry/PsychologyAgedAged, HospitalizedClinical TrialsCognition Disorders/co [Complications]Delirium/th [Therapy]InpatientsMultidisciplinary Care Team

REF ID: 1335

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Brooks, N. (2001). Length of stay in community hospitals. ***Nursing Standard, 15*****(27), 33-38.**
Journal Article

AIM: To identify the factors that contribute to variation in length of stay in hospital. METHOD: After a pilot study, an audit was undertaken in 11 community hospitals in a single trust over an eight-week period. Each ward was audited once. During the audit period 202 patients' records were reviewed, of which 71 were GP admissions and 131 were consultant admissions. RESULTS: Patients admitted to community hospitals were older, predominantly female, classed as at risk of malnutrition and had a reduced functional capacity. An increased length of stay could also be due to limited evidence of discharge planning on transfer from acute or residential homes, a lack of information about patients' social circumstances and how the discharge process was progressed, delay from referral to assessment by the multidisciplinary team, and pressure ulcers on admission to hospital. CONCLUSION: Recommendations for practice are: improved documentation, including an integrated discharge care pathway that is transferable across health and social care; multidisciplinary

records; clinical leadership; adapting the current audit tool; and undertaking another audit after the recommendations have been implemented.Age DistributionAgedAged, 80 and overFamily Practice/sn [Statistics & Numerical Data]FemaleGreat BritainHealth Services ResearchHospitals, Community/ut [Utilization]HumansLength of Stay/sn [Statistics & Numerical Data]MaleMedical AuditMiddle AgedPatient Admission/sn [Statistics & Numerical Data]Patient Care TeamPatient Discharge/sn [Statistics & Numerical Data]Quality Indicators, Health CareReferral and Consultation/sn [Statistics & Numerical Data]Research Support, Non-U.S. Gov'tRisk FactorsSex DistributionSpecialties, Medical/sn [Statistics & Numerical Data]State Medicine

REF ID: 1354

Level I: Systematic Reviews

Topic 4.1: Management-General

Cameron, I., Crotty, M., Currie, C., Finnegan, T., Gillespie, L., & Gillespie, W. et al. (2000). Geriatric rehabilitation following fractures in older people: A systematic review. *Health Technology Assessment, 4*(2), 1-105.

Journal Article, Research, Systematic Review

Executive summary available for free by visiting the document URL listed with this record. http://www.cinahl.com/cgi-bin/refsvc?jid=2408&accno=2003065348Biomedical JournalsBlind Peer ReviewedEditorial Board ReviewedExpert Peer ReviewedOnline/PrintUK & Ireland Journals.Evidence-Based PracticeGerontologic CareAgedEarly Patient DischargeFractures/rh [Rehabilitation]Hip Fractures/rh [Rehabilitation]Length of StayMeta AnalysisProspective Payment SystemRehabilitation, Geriatric/ec [Economics]Rehabilitation, GeriatricTreatment Outcomes

REF ID: 1296

Level I: Systematic Reviews

Topic 4.1: Management-General

Cameron, I. D. (2005). Coordinated multidisciplinary rehabilitation after hip fracture. *Disability and Rehabilitation, 27*(18/19), 1081-1090.

Journal Article, Pictorial, Research, Systematic Review, Tables/Charts

Purpose : To review the topic of coordinated multidisciplinary rehabilitation after hip fracture from a research perspective and to provide information to guide the provision of rehabilitation services for patients with hip fracture. Methods : Literature review including searches of Medline, Embase, Cochrane Collaboration and evidence based clinical guidelines, checking of references of publications and consultation with researchers. Results : The research evidence is heterogeneous and remains inclusive. Programs that assist patients with hip fracture to regain function and return home as soon as feasible are likely to be effective as they appear to increase the percentage of patients who return home and remain there after hip fracture. Rehabilitation programs that achieve this are likely to be cost effective. These programs involve health professionals from multiple disciplines (nurses, allied health professionals and medical practitioners) who work collaboratively, may operate in several settings, and routinely provide specific treatments that are supported by strong evidence of effectiveness. Conclusions : Patients with hip fracture should be offered a coordinated a multidisciplinary rehabilitation program with the specific aim of regaining sufficient function to return to their pre-fracture living arrangements.Allied Health JournalsOnline/PrintPeer Reviewed JournalsUK & Ireland Journals.Evidence-Based PracticeOccupational TherapyPhysical TherapyAgedCochrane LibraryCommunity LivingCost Benefit AnalysisCritical PathDecision Making, ClinicalEarly Patient DischargeEmbaseForecastingFunctional StatusGerontologic CareHip Fractures/ep [Epidemiology]Hip Fractures/rh [Rehabilitation]MedlineMultidisciplinary Care Team/cl [Classification]Multidisciplinary Care TeamPatient SelectionProfessional Practice, Evidence-BasedProspective Payment SystemRecoveryRehabilitation CentersRehabilitation/cl [Classification]Rehabilitation, GeriatricResearch MethodologyResearch PrioritiesResidential CareTreatment DelayTreatment Outcomes

REF ID: 1291

Level I: Systematic Reviews

Topic 4.1: Management-General

Cameron, I. D., Handoll, H. H., Finnegan, T. P., Madhok, R., & Langhorne, P. (2001). Co-ordinated multidisciplinary approaches for inpatient rehabilitation of older patients with proximal femoral fractures.[update of cochrane database syst rev. 2000;(4):CD000106; PMID: 11034674]. ***Cochrane Database of Systematic Reviews,*** **(3), 000106.**

Journal Article. Review

BACKGROUND: Hip fracture is a major cause of morbidity and mortality in older people and its impact, both on the individual and to society, is substantial. OBJECTIVES: To examine the effects of co-ordinated multidisciplinary inpatient rehabilitation, compared with usual (orthopaedic) care, for older patients with hip fracture. SEARCH STRATEGY: We searched the Cochrane Musculoskeletal Injuries Group specialised register (March 2001), MEDLINE (1966 to February 2001), PREMEDLINE (March 28th 2001), and reference lists of articles and books. We also contacted colleagues and trialists. SELECTION CRITERIA: Randomised and quasi-randomised trials of post-surgical care using specialised rehabilitation of mainly older patients (aged 65 years or over) with hip fracture. DATA COLLECTION AND ANALYSIS: Trial assignment to included, excluded and awaiting assessment categories, was by consensus. Two reviewers independently assessed trial quality and extracted data. Limited additional information was sought from most trialists. As well as pooling data from primary outcomes, supplementary analyses were performed to combine clinically relevant outcomes and investigate possible explanatory factors. MAIN RESULTS: In this substantive update, one new trial has been included. The nine included trials involved 1869 patients. The combined outcomes of death or requiring institutional care showed no significant difference between intervention and control groups (relative risk 0.92; 95% confidence interval 0.82 to 1.04). There was considerable heterogeneity in length of stay and cost data. Using death and deterioration in function as a further combined outcome variable yielded a relative risk of 0.92 (95% confidence interval 0.82 to 1.02). This should be interpreted with caution due to heterogeneity. No quality of life measures were reported and the two trials investigating carer burden showed no detrimental effect from the intervention. The review update did not result in any new data for these outcomes. REVIEWER'S CONCLUSIONS: The available trials reviewed had different aims, interventions and outcomes. Combined outcome measures (e.g. death or institutional care) tended to be better for patients receiving co-ordinated inpatient rehabilitation, but the results were heterogeneous and not statistically significant. Future trials of post-surgical care involving inpatient rehabilitation, or other models such as 'early supported discharge' and 'hospital at home' schemes, should aim to establish both effectiveness and cost effectiveness of multidisciplinary rehabilitation overall, rather than attempt to evaluate its components. [References: 34]AgedFemoral Fractures/rh [Rehabilitation]Hip Fractures/rh [Rehabilitation]HumansInpatientsPatient Care TeamRandomized Controlled TrialsTreatment Outcome

REF ID: 1343

Level VI: Opinion

Topic 2: Prevention

Campbell, H. M. (2004). Review: Therapy based rehabilitation services reduce the risk of deterioration in patients who have had a stroke. ***Evidence-Based Nursing, 7*****(4), 117.**

Journal Article, Abstract, Commentary, Tables/Charts

CRITIQUE OF: Original Study: Legg L, Langhorne P, Outpatient Service Trialists. Rehabilitation therapy services for stroke patients living at home: systematic review of randomised trials. LANCET 2004; 363: 352-6

In community dwelling patients who have had a stroke, do therapy based rehabilitation services offered < 1 year after stroke onset or discharge from hospital reduce deterioration in ability to perform activities of daily living (ADL)? METHODS Data sources: Cochrane Controlled Trials Register, Medline, CINAHL, PsycLIT, EMBASE/Excerpta Medica, AMED, Social Science Citation Index, Science Citation Index, bibliographies of relevant articles, and researchers in the field. Trial

searching was completed in November 2001. Study selection and assessment: randomised controlled trials (RCTs) that compared outpatient therapy based rehabilitation services (ie, interventions provided by qualified physiotherapists, occupational therapists, multidisciplinary staff, or under the supervision of qualified therapy staff) with no routine input. Quality of the RCTs was evaluated using criteria including method of generating the random sequence, concealment of allocation, masking of outcome assessment, and intention to treat analysis. Outcomes: risk of deterioration in ability to perform ADL or becoming dependent in ADL by the end of scheduled follow up. Deaths were included as deterioration. MAIN RESULTS 14 RCTs (n = 1617) met the selection criteria. Types of interventions included occupational therapy (8 RCTs), physiotherapy (2 RCTs), and multidisciplinary team services (4 RCTs). Meta-analyses were done using both fixed effects (for binary outcomes) and random effects (for continuous outcomes) models. Overall, the risk of deterioration was lower in the intervention group than the control group (table). The intervention group had higher (better) scores than the control group for ADL (12 RCTs, n = 1180; standardised mean difference [SMD] 0.14, 95% CI 0.02 to 0.25) and extended ADL (9 RCTs, n = 996; SMD 0.17, 95% CI 0.04 to 0.30). CONCLUSION In community dwelling patients who have had a stroke, therapy based rehabilitation services offered </= 1 year after stroke onset or discharge from hospital reduce the risk of patient deterioration in ability to perform activities of daily living.Core Nursing JournalsNursing JournalsOnline/PrintUK & Ireland Journals.Evidence-Based PracticeCerebral Vascular Accident/rh [Rehabilitation]Clinical TrialsCommunity LivingMeta AnalysisMultidisciplinary Care TeamOccupational TherapyOutpatient ServicePhysical TherapyTreatment Outcomes

REF ID: 1313

Level VI: Opinion

Topic 4.1: Management-General

Topic 2: Prevention

Cervo, F. A., Cruz, A. C., & Posillico, J. A. (2000). Pressure ulcers: Analysis of guidelines for treatment and management. *Geriatrics, 55*(3), 55-60, 62.

Journal Article, CEU, Exam Questions, Practice Guidelines, Review Biomedical JournalsBlind Peer ReviewedDouble Blind Peer ReviewedEditorial Board ReviewedExpert Peer ReviewedPeer Reviewed JournalsUSA Journals.AgedDebridement/mt [Methods]Education, Continuing (Credit)MaleMultidisciplinary Care TeamPressure Ulcer/pc [Prevention and Control]Pressure Ulcer/th [Therapy]Wound Healing

REF ID: 117

Level II: Individual experimental study

Topic 3: Assessment

Topic 4: Management

Cole, M. G., McCusker, J., Bellavance, F., Primeau, F. J., Bailey, R. F., & Bonnycastle, M. J. et al. (2002 Oct 1). Systematic detection and multidisciplinary care of delirium in older medical inpatients: A randomized trial. *CMAJ Canadian Medical Association Journal, 167*(7), 753-759.

Clinical Trial. Journal Article. Multicenter Study. Randomized Controlled Trial

BACKGROUND: Delirium is common and often goes undetected in older patients admitted to medical services. It is associated with poor outcomes. We conducted a randomized clinical trial to determine whether systematic detection and multidisciplinary care of delirium in older patients admitted to a general medical service could reduce time to improvement in cognitive status. METHODS: Consecutive patients aged 65 or more who were newly admitted to 5 general medical units between Mar. 15, 1996, and Jan. 31, 1999, were screened with the Confusion Assessment Method within 24 hours after admission to detect prevalent delirium and rescreened within a week to detect incident cases. Patients with delirium were randomly allocated to receive the intervention or usual care. Subjects in the intervention group were seen by a geriatric specialist consultant and followed in hospital for up to 8 weeks by an intervention nurse who liaised with the consultant, attending physicians, family and the primary care nurses. Subjects in the usual care group received standard hospital services but could consult geriatric specialists as needed. A research assistant,

blinded as to treatment allocation, administered within 24 hours after enrolment the MiniMental Status Exam (MMSE), Delirium Index (measuring the severity of the delirium) and Barthel Index (measuring independence of personal care). Improvement was defined as an increase in the MMSE score of 2 or more points, with no decrease below baseline plus 2 points, or no decrease below a baseline MMSE score of 27. A short form of the Informant Questionnaire on Cognitive Decline in the Elderly was completed to identify patients with possible dementia. Subjects were assessed 3 times during the first week and weekly thereafter for up to 8 weeks in hospital or until discharge. Data on clinical severity of illness, length of stay and living arrangements after discharge were also collected. The primary outcome measure was time to improvement in MMSE score. RESULTS: Of the 1925 patients who met the inclusion criteria and were screened, 227 had prevalent or incident delirium and consented to participate (113 in intervention group and 114 in usual care group). There were no clinically significant differences between the intervention and usual care groups except for sex (female 58.4% v. 50.0%) and marital status (married 34.8% v. 41.2%). Overall, 48% of the patients in the intervention group and 45% of those in the usual care group met the predetermined criteria for improvement. The Cox proportional hazards ratio (HR) for a shorter time to improvement with the intervention versus usual care, adjusted for age, sex and marital status, was 1.10 (95% confidence interval [CI] 0.74-1.63). There were no significant differences within 8 weeks after enrolment between the 2 groups in time to and rate of improvement of the Delirium Index, the Barthel Index, length of stay, rate of discharge to the community, living arrangements after discharge or survival. Outcomes between the 2 groups did not differ statistically significantly for patients without dementia (HR 1.54, 95% CI 0.80-2.97), for those who had less co-morbidity (HR 1.36, 95% CI 0.75-2.46) or for those with prevalent delirium (HR 1.15, 95% CI 0.48-2.79). INTERPRETATION: Systematic detection and multidisciplinary care of delirium does not appear to be more beneficial than usual care for older patients admitted to medical services.AIM, IMAgedAged, 80 and overDelirium/nu [Nursing]Delirium/pc [Prevention & Control]FemaleGeriatric AssessmentHumansMalePatient Care PlanningPatient Care TeamProportional Hazards ModelsQuebecResearch Support, Non-U.S. Gov't

REF ID: 1346

Level VI: Opinion

Topic 4.1: Management-General

Crowther, M., Maroulis, A., ShaferWinter, N., & Hader, R. (2003). Evidence-based development of a hospital based heart failure centre... reprinted with permission of the honor society of nursing, sigma theta tau international from crowther M, maroulis A, shafer-winter, et al. evidence-based development of a hospital-based heart failure center. online J knowl synth nurs 2002;9:5C. *Evidence-Based Nursing, 6*(1), 4-6.

Journal Article Core Nursing JournalsNursing JournalsOnline/PrintUK & Ireland Journals.Advanced Nursing PracticeEvidence-Based PracticeAdvanced Practice NursesHeart Failure, Congestive/th [Therapy]Multidisciplinary Care TeamNurse-Managed CentersOutcomes (Health Care)Professional Practice, Evidence-BasedProgram Development

REF ID: 1298

Level VI: Opinion

Topic 3: Assessment

Dash, M. E., Foster, E. B., Smith, D. M., & Phillips, S. L. (2004). Urinary incontinence: The social health maintenance organization's approach. *Geriatric Nursing, 25*(2), 81-89.

Journal Article, Case Study, CEU, Exam Questions, Forms, Pictorial, Practice Guidelines, Tables/Charts

Urinary incontinence (UI) is a problem that affects more than 16 million Americans, most of them women. Although nearly half of the elderly in America have episodes of UI, it is not a normal consequence of aging. It remains a largely neglected problem despite its considerable prevalence, morbidity, and expense. This article reports on a successful proactive health risk screening process to treat this major problem.Core Nursing JournalsNursing JournalsPeer Reviewed JournalsUSA

Journals.Gerontologic CareAgedAmbulatory CareClinical Assessment ToolsEducation, Continuing (Credit)FemaleHealth Maintenance OrganizationsMultidisciplinary Care TeamNevadaPhysical ExaminationStress IncontinenceUrge Incontinence/dt [Drug Therapy]Urinary Incontinence/ci [Chemically Induced]Urinary Incontinence/di [Diagnosis]Urinary Incontinence/dt [Drug Therapy]Urinary Incontinence/et [Etiology]Urinary Incontinence/rf [Risk Factors]Urinary Incontinence/th [Therapy]Urinary Incontinence

REF ID: 1289

Level II: Individual experimental study

Topic 4.1: Management-General

Doughty, R. N., Wright, S. P., Pearl, A., Walsh, H. J., Muncaster, S., & Whalley, G. A. et al. (2002). Randomized, controlled trial of integrated heart failure management: The auckland heart failure management study.[see comment]. ***European Heart Journal, 23*****(2), 139-146.**

Clinical Trial. Journal Article. Randomized Controlled Trial

AIMS: To determine the effect of an integrated heart failure management programme, involving patient and family, primary and secondary care, on quality of life and death or hospital readmissions in patients with chronic heart failure. METHODS AND RESULTS: This trial was a cluster randomized, controlled trial of integrated primary/secondary care compared with usual care for patients with heart failure. The intervention involved clinical review at a hospital-based heart failure clinic early after discharge, individual and group education sessions, a personal diary to record medication and body weight, information booklets and regular clinical follow-up alternating between the general practitioner and heart failure clinic. Follow-up was for 12 months. One hundred and ninety-seven patients admitted to Auckland Hospital with an episode of heart failure were enrolled in the study. There was no significant difference between the intervention and control groups for the combined end-point of death or hospital readmission. The physical dimension of quality of life showed a greater improvement in the intervention group from baseline to 12 months compared with the control group (-11.1 vs -5.8 respectively, 2 P=0.015). The main effect of the intervention was attributable to the prevention of multiple admissions (56 intervention group vs 95 control group, 2 P=0.015) and associated reduction in bed days. CONCLUSIONS: This integrated management programme for patients with chronic heart failure improved quality of life and reduced total hospital admissions and total bed days. Copyright 2001 The European Society of Cardiology.AdultAgedAged, 80 and overFemaleFollow-Up StudiesHeart Failure, Congestive/th [Therapy]HumansMaleMiddle AgedPatient Care TeamPatient Readmission/sn [Statistics & Numerical Data]Quality of LifeResearch Support, Non-U.S. Gov't

REF ID: 1310

Level I: Systematic Reviews

Topic 3: Assessment

Douglass, C. (2001). The development and evolution of geriatric assessment teams over the past 25 years: A cross-cultural comparison of the US and the UK. ***Journal of Interprofessional Care, 15*****(3), 267-280.**

Journal Article, Research, Systematic Review, Tables/Charts

Findings from a literature synthesis and content analysis of the geriatric assessment team literature from the US and the UK over the past 25 years (1974-1999) are presented. Eighty-one geriatric assessment teams identified from the literature are analyzed (52 from the US and 29 from the UK). Geriatric assessment team characteristics are examined including team purpose, team setting, treatment link, team orientation, team composition, team size, and the client group targeted. The results show that teams in both the US and UK primarily have testing treatment effectiveness as their stated purpose, have strong treatment links, and are patient-oriented. Significant differences exist between the US and UK in terms of team setting, team composition, team size, and patients targeted by team. The US teams examined are more likely to operate in inpatient settings, include more disciplines and have more members on the team, and target specific subgroups of older people than those from the UK.Biomedical JournalsDouble Blind Peer ReviewedPeer Reviewed JournalsUK &

Ireland Journals.Evidence-Based PracticeGerontologic CareAgedCross Sectional StudiesDescriptive StatisticsMultidisciplinary Care TeamP-ValuePatient Assessment/td [Trends]United KingdomUnited States

REF ID: 1344

Level VI: Opinion

Topic 5: Evaluation/Follow-up

Graham, I. D., & Harrison, M. B. (2005). EBN users' guide. evaluation and adaptation of clinical practice guidelines. *Evidence-Based Nursing, 8*(3), 68-72.

Journal Article, Tables/Charts Core Nursing JournalsNursing JournalsOnline/PrintUK & Ireland Journals.Evidence-Based PracticeEvaluation/mt [Methods]Multidisciplinary Care TeamPractice Guidelines/st [Standards]Practice Guidelines/ev [Evaluation]Professional Practice, Evidence-Based

REF ID: 1290

Level II: Individual experimental study

Topic 4.1: Management-General

Griffiths, P., Harris, R., Richardson, G., Hallett, N., Heard, S., & Wilson-Barnett, J. (2001). Substitution of a nursing-led inpatient unit for acute services: Randomized controlled trial of outcomes and cost of nursing-led intermediate care. [see comment]. *Age & Ageing, 30*(6), 483-488.

Clinical Trial. Journal Article. Randomized Controlled Trial

OBJECTIVES: To evaluate the outcome and cost of transfer to a nursing-led inpatient unit for 'intermediate care'. The unit was designed to replace a period of care in acute hospital wards and promote recovery before discharge to the community. DESIGN: Randomized controlled trial comparing outcomes of care on a nursing-led inpatient unit with the system of consultant-managed care on a range of acute hospital wards. SETTING: hospital wards in an acute inner-London National Health Service trust. SUBJECTS: 175 patients assessed to be medically stable but requiring further inpatient care, referred to the unit from acute wards. INTERVENTION: 89 patients were randomly allocated to care on the unit (nursing-led care with no routine medical intervention) and 86 to usual hospital care. MAIN OUTCOME MEASURES: Length of hospital stay, discharge destination, functional dependence (Barthel index) and direct healthcare costs. RESULTS: Care in the unit had no significant impact on discharge destination or dependence. Length of inpatient stay was significantly increased for the treatment group (P=0.036; 95% confidence interval 1.1-20.7 days). The daily cost of care was lower on the unit, but the mean total cost was pound sterlings 1044 higher-although the difference from the control was not significant (P=0.150; 95% confidence interval - pound sterlings 382 to pound sterlings 2471). CONCLUSIONS: The nursing-led inpatient unit led to longer hospital stays. Since length of stay is the main driver of costs, this model of care-at least as implemented here-may be more costly. However, since the unit may substitute for both secondary and primary care, longer-term follow-up is needed to determine whether patients are better prepared for discharge under this model of care, resulting in reduced primary-care costs.AgedAged, 80 and overFemaleHealth Services for the Aged/ec [Economics]Health Services for the Aged/st [Standards]Hospital Costs/sn [Statistics & Numerical Data]HumansInpatientsMaleNurse PractitionersNurse's RoleOutcome Assessment (Health Care)/sn [Statistics & Numerical Data]Patient Care Team/ec [Economics]Patients' RoomsResearch Support, Non-U.S. Gov'tSensitivity and Specificity

REF ID: 1295

Level I: Systematic Reviews

Topic 4.1: Management-General

Haentjens, P., Lamraski, G., & Boonen, S. (2005). Costs and consequences of hip fracture occurrence in old age: An economic perspective. *Disability and Rehabilitation, 27*(18/19), 1129-1141.

Journal Article, Research, Systematic Review, Tables/Charts

Purpose : To summarize the reported short- and long-term costs associated with hip fracture

occurrence in old age, based on a systematic literature review of published studies. A further aim is to provide a clinician-oriented discussion of the different types of economic evaluations, with an emphasis on studies that examined potential determinants of the costs of care after hip fracture. Method : Literature review. Main results : Even after the initial hospitalization, hip fractures continue to generate significant costs throughout the one-year period after discharge, but particularly during the first three months. Cost estimates based on data obtained prospectively from hip-fracture patients and matched controls showed that the costs associated with the treatment of hip-fracture patients are about three times greater than those resulting from the treatment of age and residence-matched controls without a fracture. Two-fifths of these excess costs are incurred during the first three months following hospital discharge. Increasing age at the time of injury and living in an institution before the fracture are among the most important determinants of an increased cost of care after hospital discharge. Programs that focus on continuity of care, adopt a multidisciplinary approach, and accelerate rehabilitation have shown to be able to reduce the cost of care after hip fracture. Conclusions : This review emphasizes the importance of current and future interventions to decrease the incidence of hip fracture. While the current review cannot provide definite answers to the questions of cost containment, our review provides critically important evidence about the need to base health policy decisions on empirical observations. Comprehensive economic analyses of financial costs and health outcomes are needed to develop cost-effective strategies.Allied Health JournalsOnline/PrintPeer Reviewed JournalsUK & Ireland Journals.Evidence-Based PracticeGerontologic CareOccupational TherapyPhysical TherapyAcute Care/ec [Economics]Age FactorsAgedAged, 80 and OverCommunity LivingContinuity of Patient CareCost SavingsCosts and Cost AnalysisDescriptive StatisticsFemaleFunding SourceHealth Care CostsHip Fractures/ec [Economics]Hip Fractures/rh [Rehabilitation]Hip Fractures/su [Surgery]InstitutionalizationInsurance, Health, ReimbursementLong Term Care/ec [Economics]MaleMultidisciplinary Care TeamProductivityProfessional Practice, Evidence-BasedRehabilitation/mt [Methods]Rehabilitation, GeriatricTime Factors

REF ID: 1297

Level I: Systematic Reviews

Topic 4.1: Management-General

Hastings, S. N., & Heflin, M. T. (2005). A systematic review of interventions to improve outcomes for elders discharged from the emergency department. ***Academic Emergency Medicine, 12*****(10), 978-986.**

Journal Article, Research, Systematic Review, Tables/Charts

OBJECTIVES: To evaluate the evidence for interventions designed to improve outcomes for elders discharged from the emergency department (ED). METHODS: The study was a systematic review of English-language articles indexed in MEDLINE and CINAHL (1966-2005) with 1) key words "geriatric," "older adults," or "seniors," or 2) Medical Subject Heading (MeSH) terms "Geriatrics" or "Health Services for the Aged" AND key word "emergency," or 3) MeSH terms "Emergencies," "Emergency Service, Hospital," or "Emergency Treatment." Bibliographies of the retrieved articles were reviewed for additional references, and the authors consulted with content experts to identify relevant unpublished work. Patients of interest were community-dwelling elder patients discharged home from the ED. Data were abstracted from selected articles by the authors. Studies with interventions limited to patients with a single presentation or diagnosis (falls, delirium, etc.) or delivered only to patients who would have otherwise been hospitalized were not included. RESULTS: Of 669 citations, 27 studies (reported in 33 articles) met study criteria and were reviewed; six randomized controlled trials (RCTs), two nonrandomized clinical trials, and 19 observational studies or program descriptions. Three of four RCTs designed to measure functional outcomes showed a reduction in functional decline in the intervention group. The trials that resulted in functional benefits enrolled high-risk patients and included geriatric nursing assessment and home-based services as part of the intervention. Results of trials to decrease health service utilization rates following an ED visit were mixed. CONCLUSIONS: A significant number of programs to improve

outcomes for elders discharged from the ED exist, but few have been systematically examined. Development of interventions to improve the care of elder patients following ED visits requires further research into system and patient-centered factors that impact health care delivery in this situation.Biomedical JournalsOnline/PrintPeer Reviewed JournalsUSA Journals.Emergency CareEvidence-Based PracticeGerontologic CareActivities of Daily LivingAfter CareAgedAged, 80 and OverAustraliaCINAHL DatabaseCanadaClinical Assessment ToolsClinical TrialsConfidence IntervalsEmergency ServiceGeriatric Functional AssessmentGerontologic Nurse PractitionersHealth Resource UtilizationHome Nursing, ProfessionalMedlineMultidisciplinary Care TeamNonexperimental StudiesOdds RatioOutcomes (Health Care)OutpatientsP-ValuePatient DischargePatient SatisfactionQuality AssessmentQuality ImprovementRelative RiskScotlandShort Form-36 Health Survey (SF-36)Staff DevelopmentUnited States

REF ID: 1348

Level VI: Opinion

Topic 4.1: Management-General

Hickey, J. V. (2001). Patients in stroke units have better outcomes, but receive less personal nursing care. *Evidence-Based Nursing, 4*(4), 128.

Journal Article, Abstract, Commentary

CRITIQUE OF: Original Study: Pound P, Ebrahim S. Rhetoric and reality in stroke patient care. SOC SCI MED 2000 Nov; 51(10): 1437-46 [CINAHL Accession Number: 2001017401]; Entry Week: 20020816 Revised: 20040123

QUESTION: Which aspects of the process of care help to explain the improved outcomes of patients treated in stroke units? Design Case study of 3 care settings for stroke patients. Setting An elderly care unit (ECU), a general medical ward (GMW), and a stroke unit in teaching hospitals in the same city in the UK. Participants Nurses, physiotherapists (PTs), occupational therapists (OTs), and consulting physicians were observed caring for patients with stroke. Methods Using a qualitative non-participant observation method, the researcher recorded full descriptions of everything she saw and heard. Meetings and observation periods were conducted throughout the week, primarily during ward rounds, multidisciplinary team meetings, therapy sessions and assessments, and general activity on early and late shifts during a 2-3 month period in each setting. Observation included 40 hours at both the ECU and GMW, and 66 hours at the stroke unit. Data were content analysed by setting, then by event or activity, and then compared among the 3 settings. Main findings The philosophy of stroke rehabilitation is that nurses liaise with therapists about patients' treatment, then help patients to apply what they learn to daily ward activities. Relationships and functioning between nurses and patients, nurses and therapists, and among multidisciplinary teams were observed in terms of the extent to which this philosophy was applied in practice. Interactions between nurses and patients in the GMW were observed to be kind, but often "standardised and impersonal," and patients' independence was rarely encouraged. In the stroke unit, patients were sometimes observed to be ignored, and work was sometimes done "on" rather than "with" a patient. Nurses in the ECU often encouraged patients to do grooming activities independently, and were observed to be "gentle, warm, respectful, and attentive" in their interactions with patients. These nurses also showed a tendency toward "emotional labour"-the giving of oneself in a more personal, rather than standardised way. Observed communication between nurses and therapists in the ECU was "mutually respectful and full of interest for the patient." Nurses had worked in the ECU for a long time, so therapists had given them individualised training sessions. PTs communicated with nurses who they felt would use the information and follow a rehabilitation philosophy. In the GMW, therapists reported that rehabilitation was considered secondary to getting a patient medically stable. In the stroke unit, tension was observed between nurses and therapists, and further observation suggested a relationship in which therapists expected nurses to carry out orders rather than to work together. In the ECU, weekly multidisciplinary team meetings were led by a consultant and focused on practical issues related to patient discharge. Team members were not forthcoming with information during meetings,

and therapists did not feel meetings were useful for exchanging information about patients. In the stroke unit, multidisciplinary team meetings were also led by a consultant and focused on rehabilitation and patients' goals. PTs and OTs participated more in meetings than therapists on the ECU, and nurses contributed least and were least comfortable. On the GMW "little formalised communication between the professions" was observed. Different therapists did not work well together and no multidisciplinary team meetings were held. Conclusion Improved outcomes in patients treated for stroke may be attributed to the following benefits (found in an elderly care unit and stroke unit): less institutional units, several activities for patients, addressing carers' needs, good communication among therapists, and being headed by a consultant respected by the multidisciplinary team.Core Nursing JournalsNursing JournalsOnline/PrintUK & Ireland Journals.Evidence-Based PracticeCerebral Vascular Accident/nu [Nursing]Cerebral Vascular Accident/rh [Rehabilitation]InpatientsInterprofessional RelationsMultidisciplinary Care TeamMultimethod StudiesNonparticipant ObservationNurse-Patient RelationsNursing UnitsOccupational TherapyPhysical TherapyQualitative StudiesRehabilitation NursingUnited Kingdom

REF ID: 1355

Level I: Systematic Reviews

Topic 4.1: Management-General

Holland, R., Battersby, J., Harvey, I., Lenaghan, E., Smith, J., & Hay, L. (2005). Systematic review of multidisciplinary interventions in heart failure. ***Heart (British Cardiac Society), 91*****(7), 899-906.**

Journal Article; Meta-Analysis; Review; AIM; IM

OBJECTIVE: To determine the impact of multidisciplinary interventions on hospital admission and mortality in heart failure. DESIGN: Systematic review. Thirteen databases were searched and reference lists from included trials and related reviews were checked. Trial authors were contacted if further information was required. SETTING: Randomised controlled trials conducted in both hospital and community settings. PATIENTS: Trials were included if all, or a defined subgroup of patients, had a diagnosis of heart failure. INTERVENTIONS: Multidisciplinary interventions were defined as those in which heart failure management was the responsibility of a multidisciplinary team including medical input plus one or more of the following: specialist nurse, pharmacist, dietician, or social worker. Interventions were separated into four mutually exclusive groups: provision of home visits; home physiological monitoring or televideo link; telephone follow up but no home visits; and hospital or clinic interventions alone. Pharmaceutical and exercise based interventions were excluded. MAIN OUTCOME MEASURES: All cause hospital admission, all cause mortality, and heart failure hospital admission. RESULTS: 74 trials were identified, of which 30 contained relevant data for inclusion in meta-analyses. Multidisciplinary interventions reduced all cause admission (relative risk (RR) 0.87, 95% confidence interval (CI) 0.79 to 0.95, $p = 0.002$), although significant heterogeneity was found ($p = 0.002$). All cause mortality was also reduced (RR 0.79, 95% CI 0.69 to 0.92, $p = 0.002$) as was heart failure admission (RR 0.70, 95% CI 0.61 to 0.81, $p < 0.001$). These results varied little with sensitivity analyses. CONCLUSION: Multidisciplinary interventions for heart failure reduce both hospital admission and all cause mortality. The most effective interventions were delivered at least partly in the home.Cardiac Output, Low/mortality/therapyHome Care ServicesHospitalizationHumansPatient Care TeamRandomized Controlled Trials/standardsTreatment Outcome

REF ID: 1304

Level VI: Opinion

Topic 4.1: Management-General

Jackson, D., TurnerStokes, L., Khatoon, A., Stern, H., Knight, L., & O'Connell, A. (2002). Rehabilitation in practice. development of an integrated care pathway for the management of hemiplegic shoulder pain. ***Disability and Rehabilitation, 24*****(7), 390-398.**

Journal Article, Critical Path, Practice Guidelines, Research, Tables/Charts

abstract not availableAllied Health JournalsPeer Reviewed JournalsUK & Ireland Journals.Evidence-Based PracticeOccupational TherapyPain and Pain ManagementPhysical TherapyAdultAgedAnalgesiaCritical PathDescriptive StatisticsFemaleFunding SourceHemiplegia/th [Therapy]MaleMedical Practice, Evidence-BasedMiddle AgeMultidisciplinary Care TeamPain MeasurementPatient AssessmentPatient PositioningProspective StudiesQuality of Health Care/ev [Evaluation]Shoulder Pain/th [Therapy]Stroke Patients

REF ID: 1312

Level VI: Opinion

Topic 4.1: Management-General

Jano, S., & Harlin, S. A. (2000). Designing a carotid endarterectomy critical pathway for your organization. ***Military Medicine, 165*****(5), 385-389.**

Journal Article, Algorithm, Critical Path, Tables/Charts

BACKGROUND: Carotid endarterectomy (CEA) is one of the top-five surgical diagnosis-related groups at Keesler Medical Center. The geometric mean length of stay for CEA during fiscal year (FY) 1996 was 5.84 days (N = 41), compared with 1.79 for a benchmark facility. OBJECTIVE: Create a critical pathway to standardize care, maintain/improve patient outcomes, reduce lengths of stay, and decrease costs. METHODS: A multidisciplinary team was formed to evaluate four patient-flow options. The team decided to discharge patients directly from the intensive care unit to meet both patient and staff needs. RESULTS: The geometric mean length of stay decreased to 1.70 days (N = 54) in FY 1998, compared with 2.42 days (N = 40) in FY 1997. The cost savings ws $5,841 per case, compared with $1,684 before creation of the pathway. This represents an annual savings of more than $224,000 and a 30% reduction in length of stay. CONCLUSIONS: The CEA pathway has standardized the care received by this group of patients. By decreasing variation, processes have become routine and more efficient.Biomedical JournalsExpert Peer ReviewedPeer Reviewed JournalsUSA Journals.Academic Medical CentersAgedBenchmarkingCost ControlCost SavingsCritical PathEndarterectomy, Carotid/st [Standards]FemaleHealth Facility CostsLength of Stay/ec [Economics]Length of StayMaleMississippiMultidisciplinary Care TeamOutcome AssessmentProcess Assessment (Health Care)Program DevelopmentProgram EvaluationQuality AssuranceQuality Improvement

REF ID: 1328

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Johansen, B., Mainz, J., Sabroe, S., Manniche, C., & Leboeuf-Yde, C. (2004). Quality improvement in an outpatient department for subacute low back pain patients: Prospective surveillance by outcome and performance measures in a health technology assessment perspective. ***Spine, 29*****(8), 925-931.**

Journal Article

STUDY DESIGN.: Prospective cohort study. OBJECTIVES: To develop clinical indicators and standards in an outpatients' department for sub acute low back pain patients. SUMMARY OF BACKGROUND DATA: A systematic quantitative surveillance to assess quality of care was implemented using outcome and performance measures. These measures were developed within the framework of Health Technology Assessment, which comprises the areas of healthcare technology, patient, organization, and economy. METHODS: A multidisciplinary project group defined 1) clinical indicators in terms of outcome and performance measures and 2) the corresponding standards using the available evidence from literature. Observed outcomes were compared with the standards. Associations between process and outcome measures were investigated. RESULTS: A total of 300 patients were included consecutively. In relation to technology, the standards for the field of application were fulfilled (e.g., not too many patients were x-rayed). With respect to effectiveness, the observed rate of patients reaching a 50% cutoff point of improvement of pain and function did not fulfill the standards. In relation to patient aspects, the standards of, for example, proper understanding of patient education and satisfaction, were fulfilled. In relation to organization, nearly

one third of the patients were referred later to the department than the recommended 24 weeks. This refer variable showed an association to a reduced chance of scoring "better" or "much better" in "patients global assessment." The chance was reduced by 50% if patients were referred later than 12 weeks after onset of pain. In relation to economy, the cost of gaining a quality adjusted life-year by a course in the department was considerably lower than by comparison with total hip arthroplasty. CONCLUSIONS: Surveillance by clinical indicators in relation to the four areas of health technology assessment provides quantitative information that is meaningful for various stakeholders on important aspects of the quality of care (including consumers), provides a basis for quality improvement, and provides data for analysis of possible important relationships between structure, process, and outcome.Acute DiseaseAdolescentAdultAgedAged, 80 and overAmbulatory Care Facilities/ec [Economics]Ambulatory Care Facilities/st [Standards]Cohort StudiesDenmarkHumansLow Back Pain/di [Diagnosis]Low Back Pain/ec [Economics]Low Back Pain/th [Therapy]Middle AgedOutcome and Process Assessment (Health Care)/sn [Statistics & Numerical Data]Patient Care TeamProspective StudiesQuality Indicators, Health CareQuality-Adjusted Life YearsQuestionnairesTechnology Assessment, BiomedicalTotal Quality Management/sn [Statistics & Numerical Data]

REF ID: 1306

Level VI: Opinion

Topic 4.1: Management-General

Kaldy, J., & Tarnove, L. (2002). A clinical practice guideline approach to treating depression in long-term care. ***Journal of the American Medical Directors Association, 3*****(2), 103-110.**

Journal Article, Practice Guidelines, Review, Tables/Charts Biomedical JournalsPeer Reviewed JournalsUSA Journals.Gerontologic CareAgedAntidepressive AgentsClinical Assessment ToolsDepression/di [Diagnosis]Depression/dt [Drug Therapy]Depression/th [Therapy]Geriatric AssessmentGerontologic Care/st [Standards]InpatientsLong Term Care/st [Standards]Multidisciplinary Care TeamNursing Home Patients/pf [Psychosocial Factors]Patient Care PlansPsychotherapyQuality Assurance

REF ID: 1288

Level II: Individual experimental study

Topic 4.1: Management-General

Topic 2: Prevention

Kasper, E. K., Gerstenblith, G., Hefter, G., Van Anden, E., Brinker, J. A., & Thiemann, D. R. et al. (2002). A randomized trial of the efficacy of multidisciplinary care in heart failure outpatients at high risk of hospital readmission. ***Journal of the American College of Cardiology, 39*****(3), 471-480.**

Clinical Trial. Journal Article. Randomized Controlled Trial

OBJECTIVES: We sought to determine whether a multidisciplinary outpatient management program decreases chronic heart failure (CHF) hospital readmissions and mortality over a six-month period. BACKGROUND: Hospital admission for CHF is an important problem amenable to improved outpatient management. METHODS: Two hundred patients hospitalized with CHF at increased risk of hospital readmission were randomized to a multidisciplinary program or usual care. A study cardiologist and a CHF nurse evaluated each patient and made recommendations to the patient's primary physician before randomization. The intervention team consisted of a cardiologist, a CHF nurse, a telephone nurse coordinator and the patient's primary physician. Contact with the patient was on a prespecified schedule. The CHF nurse followed an algorithm to adjust medications. Patients in the nonintervention group were followed as usual. The primary outcome was the composite of the number of CHF hospital admissions and deaths over six months, compared by using a log transformation t test by intention-to-treat analysis. RESULTS: The median age of the study patients was 63.5 years, and 39.5% were women. There were 43 CHF hospital admissions and 7 deaths in the intervention group, as compared with 59 CHF hospital admissions and 13 deaths in the nonintervention group ($p = 0.09$). The quality-of-life score, percentage of patients on target

vasodilator therapy and percentage of patients compliant with diet recommendations were significantly better in the intervention group. Cost per patient, in 1998 U.S. dollars, was similar in both groups. CONCLUSIONS: This study demonstrates that a six-month, multidisciplinary approach to CHF management can improve important clinical outcomes at a similar cost in recently hospitalized high-risk patients with CHF.AdultAgedAged, 80 and overAmbulatory Care/st [Standards]Comparative StudyFemaleFollow-Up StudiesHealth Care CostsHeart Failure, Congestive/ec [Economics]Heart Failure, Congestive/mo [Mortality]Heart Failure, Congestive/th [Therapy]HumansMaleMaryland/ep [Epidemiology]Middle AgedPatient Care TeamPatient Readmission/ec [Economics]Patient ReadmissionPredictive Value of TestsProspective StudiesQuality of Life/px [Psychology]QuestionnairesResearch Support, Non-U.S. Gov'tRisk FactorsSurvival AnalysisTreatment Outcome

REF ID: 1324

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Kjaer, M. L., Mainz, J., Soernsen, L. T., Karlsmark, T., & Gottrup, F. (2005). Clinical quality indicators of venous leg ulcers: Development, feasibility, and reliability. *Ostomy Wound Management, 51*(5), 64-66.

Journal Article. Validation Studies

In the clinical setting, diagnosis and treatment of venous leg ulcers can vary considerably from patient to patient. The first step to reducing this variation is to document venous leg ulcer care through use of quantitative scientific documentation principles. This requires the development of valid and reliable evidence-based quality indicators of venous leg ulcer care. A Scandinavian multidisciplinary, cross-sectional panel of wound healing experts developed clinical quality indicators on the basis of scientific evidence from the literature and subsequent group nominal consensus of the panel; an independent medical doctor tested the feasibility and reliability of these clinical indicators, assessing the quality of medical technical care on 100 consecutive venous leg ulcer patients. Main outcome measures were healing, recurrence, pain, venous disease diagnosis, differential diagnosis and treatment, and inter- and intra-rater reliability. The indicators proved feasible and reliable to measure (inter-rater kappa = 0.79, $P < 0.01$ and intra-rater kappa = 0.89, $P < 0.1$). Within 3 months of initial examination, venous etiology was verified by duplex in 61 of the 98 participating patients (62%) and 31 (32%) were assessed for venous surgery. Distal arterial pressure was measured following initial examination in 33 of the patients (34%). All patients (100%) were prescribed compression therapy. Of the 98 patients, 11 (11%) had ulcers recur in 3 months and 72 (73%) healed in 12 months, which is in line with the literature. It is feasible to reliably measure the quality of medical technical venous leg ulcer care in the clinical setting using a few strategic clinically relevant indicators of quality.AgedBandagesBenchmarkingConsensus Development ConferencesDiagnosis, DifferentialEvidence-Based MedicineFeasibility StudiesFemaleGuideline Adherence/st [Standards]HumansMaleObserver VariationPatient Care Team/og [Organization & Administration]Pilot ProjectsPractice GuidelinesPrognosisQuality Indicators, Health Care/st [Standards]RecurrenceResearch Support, Non-U.S. Gov'tScandinaviaSkin Care/mt [Methods]Skin Care/st [Standards]Treatment OutcomeVaricose Ulcer/di [Diagnosis]Varicose Ulcer/et [Etiology]Varicose Ulcer/th [Therapy]Varicose Ulcer

REF ID: 1285

Level I: Systematic Reviews

Topic 4.1: Management-General

Langhorne, P., Taylor, G., Murray, G., Dennis, M., Anderson, C., & Bautz-Holter, E. et al. (2005). Early supported discharge services for stroke patients: A meta-analysis of individual patients' data.[see comment]. *Lancet, 365*(9458), 501-506.

Journal Article. Meta-Analysis

BACKGROUND: Stroke patients conventionally undergo a substantial part of their rehabilitation in hospital. Services have been developed that offer patients early discharge from hospital with

rehabilitation at home (early supported discharge [ESD]). We have assessed the effects and costs of such services. METHODS: We did a meta-analysis of data from individual patients who took part in randomised trials that recruited patients with stroke in hospital to receive either conventional care or any ESD service intervention that provided rehabilitation and support in a community setting with the aim of shortening the duration of hospital care. The primary outcome was death or dependency at the end of scheduled follow-up. FINDINGS: Outcome data were available for 11 trials (1597 patients). ESD services were mostly provided by specialist multidisciplinary teams to a selected group (median 41%) of stroke patients admitted to hospital. There was a reduced risk of death or dependency equivalent to six (95% CI one to ten) fewer adverse outcomes for every 100 patients receiving an ESD service (p=0.02). The hospital stay was 8 days shorter for patients assigned ESD services than for those assigned conventional care (p<0.0001). There were also significant improvements in scores on the extended activities of daily living scale and in the odds of living at home and reporting satisfaction with services. The greatest benefits were seen in the trials evaluating a coordinated multidisciplinary ESD team and in stroke patients with mild to moderate disability. INTERPRETATION: Appropriately resourced ESD services provided for a selected group of stroke patients can reduce long-term dependency and admission to institutional care as well as shortening hospital stays.Activities of Daily LivingAgedCerebrovascular Accident/rh [Rehabilitation]Home Care Services, Hospital-BasedHospital UnitsHumansLength of StayPatient Care TeamPatient DischargePatient SatisfactionResearch Support, Non-U.S. Gov't

REF ID: 1303

Level VI: Opinion

Topic 4.1: Management-General

LloydWilliams, M., & Payne, S. (2002). Can multidisciplinary guidelines improve the palliation of symptoms in the terminal phase of dementia? *International Journal of Palliative Nursing, 8*(8), 370, 372-5.

Journal Article, Practice Guidelines, Research, Tables/Charts

Dementia is a progressive terminal disease. More than 95% of patients will require 24-hour care either in long-stay hospital wards or in nursing homes at the end of life. There are many issues in the care of patients with dementia that parallel palliative cancer care, but relatively few patients with dementia currently access palliative care. Following an initial audit that found that many patients dying with dementia had symptoms that were not palliated, multidisciplinary guidelines were developed jointly by medical and nursing staff working in psychiatry for older people, together with pharmacy and palliative care staff. Following the implementation of guidelines, there was a significant decrease in the prescribing of antibiotics in the last 2 weeks of life and patients were much more likely to be prescribed analgesia, including opiates. This small study suggests that when developed collaboratively, multidisciplinary guidelines can have a positive impact on palliative care for non-oncology patients.Blind Peer ReviewedDouble Blind Peer ReviewedEditorial Board ReviewedExpert Peer ReviewedNursing JournalsOnline/PrintPeer Reviewed JournalsUK & Ireland Journals.Hospice/Palliative CareAgedAged, 80 and OverDementia/nu [Nursing]FemaleGerontologic NursingHospice and Palliative NursingMaleMultidisciplinary Care TeamPractice Guidelines/ut [Utilization]Quality of Health CareRetrospective DesignTerminal Care/st [Standards]

REF ID: 1284

Level I: Systematic Reviews

Topic 4.3: Management-Medication

Manley, H. J., Cannella, C. A., Bailie, G. R., & St Peter, W. L. (2005). Medication-related problems in ambulatory hemodialysis patients: A pooled analysis. *American Journal of Kidney Diseases, 46*(4), 669-680.

Journal Article. Meta-Analysis

BACKGROUND: Medication-related problems are common in hemodialysis (HD) patients. These patients often require 12 medications to treat 5 to 6 comorbid conditions. Medication-related problem research reports cannot be generalized to the entire HD population because data are obtained from

single centers and limited numbers of patients. We conducted a pooled analysis to gain additional insight into the frequency, type, and severity of medication-related problems and extrapolated the data to the entire US HD population. METHODS: Articles were identified through a MEDLINE search (1962 to March 2004). Seven studies were included in the analysis. Medication-related problems were categorized into the following 9 categories: indication without drug therapy, drug without indication, improper drug selection, subtherapeutic dosage, overdosage, adverse drug reaction, drug interaction, failure to receive drug, and inappropriate laboratory monitoring. A medication-related problem appearance rate was determined. RESULTS: We identified 1,593 medication-related problems in 395 patients (51.2% men; age, 52.4 +/- 8.2 years; 42.7% with diabetes). The most common medication-related problems found were inappropriate laboratory monitoring (23.5%) and indication without drug therapy (16.9%). Dosing errors accounted for 20.4% of medication-related problems (subtherapeutic dosage, 11.2%; overdosage, 9.2%). The medication-related problem appearance rate was 5.75e(-0.37x), where x equals number of months of follow-up (P = 0.02). CONCLUSION: HD patients experience ongoing medication-related problems. Reduction in medication-related problems in dialysis patients may improve quality of life and result in decreased morbidity and mortality. Pharmacists are uniquely trained to detect and manage medication-related problems. Pharmacists should be an integral member of the dialysis health care team.AdultAgedAlgorithmsAmbulatory CareCardiovascular Diseases/co [Complications]Cardiovascular Diseases/dt [Drug Therapy]Cohort StudiesComorbidityDrug InteractionsEndocrine System Diseases/co [Complications]Endocrine System Diseases/dt [Drug Therapy]FemaleGastrointestinal Diseases/co [Complications]Gastrointestinal Diseases/dt [Drug Therapy]HumansHyperlipidemia/co [Complications]Hyperlipidemia/dt [Drug Therapy]Infection/co [Complications]Infection/dt [Drug Therapy]Kidney Failure, Chronic/co [Complications]Kidney Failure, Chronic/dt [Drug Therapy]Kidney Failure, Chronic/th [Therapy]MaleMental Disorders/co [Complications]Mental Disorders/dt [Drug Therapy]Middle AgedOutpatientsPain/co [Complications]Pain/dt [Drug Therapy]Patient Care TeamPharmaceutical Preparations/ae [Adverse Effects]Pharmaceutical Preparations/cl [Classification]PharmacistsProspective StudiesRandomized Controlled TrialsRenal DialysisThrombosis/co [Complications]Thrombosis/dt [Drug Therapy]United States/ep [Epidemiology]

REF ID: 1305

Topic 4.1: Management-General

Level VI: Opinion

Markey, D. W., & Brown, R. J. (2002). An interdisciplinary approach to addressing patient activity and mobility in the medical-surgical patient. ***Journal of Nursing Care Quality, 16*****(4), 1-12.**

Journal Article, Practice Guidelines, Research, Tables/Charts

Patient functional activity and mobility are essential to recovery and minimization of the risks associated with immobility in hospitalized patients. In practice, there is inconsistency in attending to this aspect of patient care and limited information in the literature to guide clinicians caring for medical-surgical patients. An interdisciplinary quality improvement team of nurses, physical therapists, occupational therapists, and patient care assistants developed a programmatic approach to the assessment, planning, and implementation of patient activity criteria in this patient population. Increased awareness and application of the patient activity criteria have improved the consistency with which patient activity is addressed and reduced the incidence of immobility-associated complications. Copyright (C) 2002 by Aspen Publishers, Inc.Core Nursing JournalsNursing JournalsPeer Reviewed JournalsUSA Journals.Occupational TherapyPhysical TherapyQuality AssuranceAdultAgedFemaleFunctional AssessmentImmobility/co [Complications]Immobility/th [Therapy]MaleMedical-Surgical NursingMiddle AgeMultidisciplinary Care TeamNursing AssistantsOccupational TherapistsPhysical ActivityPhysical TherapistsProgram DevelopmentRecord ReviewRegistered Nurses

REF ID: 1325

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Martinen, M., & Freundl, M. (2004). Managing congestive heart failure in long-term care: Development of an interdisciplinary protocol. ***Journal of Gerontological Nursing, 30*****(12), 5-12.**
Evaluation Studies. Journal Article

Congestive heart failure is common among assisted living and nursing home residents. Nationally recognized guidelines for diagnosis and management have been promulgated but are poorly used in clinical practice. This article describes the efforts of one facility to implement an interdisciplinary protocol to improve heart failure care. The protocol addressed identification of residents with heart failure, appropriate use of ACE inhibitors, weight monitoring, resident and family education, and preventive immunization. Following implementation of the guideline, quality indicators were monitored and process improvements addressed. Diagnostic information, use of ACE inhibitors, nursing assessment, and symptom management improved. While episodes of clinical deterioration occurred, most cases were able to be managed in the long-term care setting.AgedAngiotensin-Converting Enzyme Inhibitors/tu [Therapeutic Use]Clinical Protocols/st [Standards]Continuity of Patient Care/og [Organization & Administration]Geriatric Nursing/og [Organization & Administration]Heart Failure, Congestive/di [Diagnosis]Heart Failure, Congestive/nu [Nursing]Heart Failure, Congestive/pc [Prevention & Control]Hospitalization/sn [Statistics & Numerical Data]HumansLong-Term Care/og [Organization & Administration]Nurse's RoleNursing AssessmentNursing Evaluation ResearchOrganizational ObjectivesOutcome and Process Assessment (Health Care)Patient Care Planning/og [Organization & Administration]Patient Care Team/og [Organization & Administration]Patient EducationPractice GuidelinesProgram DevelopmentProgram EvaluationQuality Indicators, Health CareSkilled Nursing FacilitiesVaccinationWeight Gain

REF ID: 1292

Level II: Individual experimental study

Topic 2: Prevention

McDonald, K., Ledwidge, M., Cahill, J., Kelly, J., Quigley, P., & Maurer, B. et al. (2001). Elimination of early rehospitalization in a randomized, controlled trial of multidisciplinary care in a high-risk, elderly heart failure population: The potential contributions of specialist care, clinical stability and optimal angiotensin-converting enzyme inhibitor dose at discharge. ***European Journal of Heart Failure, 3*****(2), 209-215.**
Clinical Trial. Journal Article. Randomized Controlled Trial

BACKGROUND: Despite a growing body of data demonstrating the benefits of multidisciplinary care in heart failure, persistently high rates of readmission, especially within the first month of discharge, continue to be documented. AIMS: As part of an ongoing randomized study on the value of multidisciplinary care in a high risk (NYHA Class IV), elderly (mean age 69 years) heart failure population, we examined the effects of this intervention on previously high (20%) 1-month readmission rates. METHODS: Unlike previous studies of this approach, both multidisciplinary (MC) and routine care (RC) populations were cared for by the cardiology service, complied with adherence to clinical stability criteria prior to discharge (100% of patients) and received at least target dose angiotensin-converting enzyme (ACE) inhibition with perindopril prior to discharge (94% of indicated patients). We analysed death and unplanned readmission for heart failure at 1 month. RESULTS: This early report from the first 70 patients (67% male, 71% systolic dysfunction with a mean ejection fraction of 31.0+/-6.7%) enrolled in this study demonstrates elimination of 1-month hospital readmission in both RC and MC groups. This unexpected result represents a dramatic improvement both for this patient cohort (20% 30-day readmission rate prior to enrollment reduced to 0% following the index admission in both care groups) and in comparison with available data. CONCLUSIONS: Critical contributors to this improvement appear to be specialist cardiology care, adherence to clinical stability criteria prior to discharge and routine use of target or high-dose ACE inhibitor therapy prior to discharge. Widespread application of this approach may have a dramatic

improvement in morbidity of CHF while limiting the escalating costs of this condition.AgedAged, 80 and overAngiotensin-Converting Enzyme Inhibitors/ad [Administration & Dosage]Angiotensin-Converting Enzyme Inhibitors/ae [Adverse Effects]Dose-Response Relationship, DrugFemaleHeart Failure, Congestive/dt [Drug Therapy]Heart Failure, Congestive/mo [Mortality]HumansMaleMiddle AgedPatient Care TeamPatient DischargePatient ReadmissionPerindopril/ad [Administration & Dosage]Perindopril/ae [Adverse Effects]RecurrenceResearch Support, Non-U.S. Gov'tRisk FactorsSurvival Rate

REF ID: 1286

Level II: Individual experimental study

Topic 4.1: Management-General

McDonald, K., Ledwidge, M., Cahill, J., Quigley, P., Maurer, B., & Travers, B. et al. (2002). Heart failure management: Multidisciplinary care has intrinsic benefit above the optimization of medical care. ***Journal of Cardiac Failure, 8*****(3), 142-148.**

Clinical Trial. Journal Article. Randomized Controlled Trial

PURPOSE: This work addresses the unanswered question of whether multidisciplinary care (MDC) of heart failure (HF) can reduce readmissions when optimal medical care is applied in both intervention and control groups. METHODS: In a randomized, controlled study, 98 patients (mean age, 70.8 +/- 10.5 years) admitted to hospital with left ventricular failure (New York Heart Association Class IV) were assigned to routine care (RC, n = 47) or MDC (n = 51). All patients received the same components of inpatient, optimal medical care of HF: specialist-led inpatient care; titration to maximum tolerated dose of angiotensin-converting enzyme inhibitor before discharge; attainment of predetermined discharge criteria (weight stable, off all intravenous therapy, and no change in oral regimen for 2 days). Only those in the MDC group received inpatient and outpatient education and close telephone and clinic follow-up. The primary study endpoint was rehospitalization or death for a HF-related issue at 3 months. MAIN FINDINGS: At 3 months, four people had events in the MDC group (7.8% rate over 3 months) compared with 12 people (25.5% rate over 3 months) in the RC group (P = 0.04). CONCLUSION: These data demonstrate for the first time the intrinsic benefit of MDC in the setting of protocol-driven, optimal medical management of HF. Moreover, the event rate of 7.8% at 3 months, as the lowest reported rate for such a high-risk group, underlines the value of this approach to the management of heart failure.AgedAged, 80 and overFemaleFollow-Up StudiesHeart Failure, Congestive/th [Therapy]HumansMaleMiddle AgedPatient Care/mt [Methods]Patient Care TeamPatient DischargeQuality of LifeResearch Support, Non-U.S. Gov't

REF ID: 1302

Level VI: Opinion

Topic 2: Prevention

Topic 4.1: Management-General

McQueen, J. M. (2003). Fall management and prevention: A day hospital perspective. ***British Journal of Therapy & Rehabilitation, 10*****(3), 115-121.**

Journal Article, Practice Guidelines, Research, Tables/Charts

The aim of this pilot project was to establish and evaluate a multidisciplinary health promotion and education programme aimed at preventing falls in the elderly. The overall objective was to plan and provide a scheme based on therapy, rehabilitation and health education.Allied Health JournalsPeer Reviewed JournalsUK & Ireland Journals.Gerontologic CareOccupational TherapyPhysical TherapyAccidental Falls/pc [Prevention and Control]AgedAged, 80 and OverDay CareFemaleGeriatric AssessmentHealth PromotionMaleMultidisciplinary Care TeamPilot StudiesResearch InstrumentsRisk AssessmentScalesVideorecordingWestmead Home Safety Assessment (Clemson)Confidence-Rating ScaleElderly Mobility Scale (Smith).

REF ID: 1340

Level IV: Non-experimental study

Topic 4.2: Management-Behavior Therapy

Middaugh, S. J., & Pawlick, K. (2002; 2002). Biofeedback and behavioral treatment of persistent pain in the older adult: A review and a study. ***Applied Psychophysiology and Biofeedback, 27*****(3), 185-202.**

Persistent pain is a common health problem for older adults (aged 60 yrs and over) with a prevalence twice that in younger adults. Yet, older adults with chronic pain and headache are underrepresented in behaviorally oriented clinical programs that have proven effective for younger adults. A review of the literature indicates that older adults develop multiple pain-related problems that are similar to those of younger individuals. When offered the opportunity, older pain patients accept and benefit from multidisciplinary pain programs, cognitive-behavioral therapies and biofeedback training. A study comparing 58 older (26 males and 32 females, aged 55-82 yrs) and 59 younger (27 males and 32 females, aged 18-54 yrs) adults in a multidisciplinary pain program indicates that older pain patients readily acquire the physiological self-regulation skills taught in biofeedback-assisted relaxation training, and achieve comparable decreases in pain for the pain program as a whole. (PsycINFO Database Record (c) 2006 APA, all rights reserved)biofeedback, cognitive-behavioral treatment, persistent pain, older adults, younger adults, age differences, headache, multidisciplinary pain programs, relaxation trainingBiofeedbackChronic PainCognitive TherapyInterdisciplinary Treatment ApproachPain ManagementAge DifferencesHeadacheRelaxation Therapy

REF ID: 1341

Level VI: Opinion

Topic 6: Comprehensive

Mion L. Odegard PS. Resnick B. Segal-Galan F. Geriatrics Interdisciplinary Advisory Group,American Geriatrics Society. (2006). Interdisciplinary care for older adults with complex needs: American geriatrics society position statement. ***Journal of the American Geriatrics Society, 54*****(5), 849-852.**

Journal Article

abstract not available

REF ID: 1317

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Mitty, E. L. (2004). Assisted living: Aging in place and palliative care. ***Geriatric Nursing, 25*****(3), 149-56, 163.**

Journal Article, Pictorial, Tables/Charts

Principles of upstream palliative care can guide the planning, programs, and services associated with aging in place in assisted living residences (ALRs). Frail older adults who do not need a nursing home level of care are choosing to live-and die-in ALRs. This article describes the context of assisted living, resident characteristics, key indicators of palliative care, barriers to end-of-life care, and the role, responsibilities, and potential for professional nursing in assisted living. Stakeholder concerns about staff knowledge and skills in care of the elderly, medication management, the risks associated with residential care, and nursing delegation are discussed.Core Nursing JournalsNursing JournalsPeer Reviewed JournalsUSA Journals.Gerontologic CareHospice/Palliative CareAgedAged, 80 and OverAssisted LivingClinical IndicatorsFemaleFrail ElderlyFunding SourceGerontologic NursingGovernment RegulationsHealth Personnel, UnlicensedHealth Services AccessibilityHospice CareHousing for the ElderlyMaleMultidisciplinary Care TeamNurse Practice ActsNursing RolePalliative CarePatient AdmissionPatient DischargePersonnel Staffing and SchedulingPractical NursesRegistered NursesUnited States

REF ID: 1287

Level II: Individual experimental study

Topic 4.1: Management-General

Naglie, G., Tansey, C., Kirkland, J. L., Ogilvie-Harris, D. J., Detsky, A. S., & Etchells, E. et al. (2002). Interdisciplinary inpatient care for elderly people with hip fracture: A randomized controlled trial.[see comment]. ***CMAJ Canadian Medical Association Journal, 167*****(1), 25-32.**

Clinical Trial. Journal Article. Randomized Controlled Trial
BACKGROUND: Hip fractures in elderly people are associated with impaired function and ambulation and high rates of death and admission to institutions. Interventions designed to improve the outcomes of hip fracture (e.g., mobility and discharge to own home) that have incorporated interdisciplinary care have had mixed results. We compared the effectiveness of postoperative interdisciplinary care with that of usual care for elderly patients with hip fracture. METHODS: The study population consisted of 279 patients at least 70 years of age from the community and from nursing homes who underwent surgical repair of hip fracture at a university-affiliated acute care hospital. The subjects were randomly assigned to receive postoperative interdisciplinary care (n = 141) or usual care (n = 138) during their hospital stay. Interdisciplinary care included routine assessment and care by an internist-geriatrician, physiotherapist, occupational therapist, social worker and clinical nurse specialist, as well as twice-weekly interdisciplinary rounds to set goals for the patients and to monitor their progress. The primary outcome measure was the proportion of patients alive with no decline in ambulation or transfers in and out of a chair or bed and no change in place of residence at 6 months after surgery. RESULTS: At 6 months, 56 patients (39.7%) in the interdisciplinary care group and 47 (34.1%) in the usual care group were alive and had no decline from baseline in terms of ambulation, chair and bed transfers or place of residence (difference 5.6%, 95% confidence interval -5.6% to 17.0%). Multiple logistic regression analysis with adjustment for baseline factors showed no significant difference between treatment groups for the primary outcome measure at 3 months (p = 0.44) or at 6 months (p = 0.67). The initial length of stay in hospital was longer for patients receiving interdisciplinary care: 29.2 (standard deviation [SD] 22.6) v. 20.9 (SD 18.8) days (p < 0.001). However, the mean number of days spent in an institution (including hospital, inpatient rehabilitation and nursing home) over the 6-month follow-up period was similar in the 2 groups (p = 0.84). A subgroup analysis suggested a trend to benefit from interdisciplinary care in patients with mild to moderate cognitive impairment. INTERPRETATION: Postoperative inpatient interdisciplinary care did not result in significantly better 3- or 6-month outcomes in elderly patients with hip fracture.Activities of Daily LivingAgedAged, 80 and overFemaleHip Fractures/mo [Mortality]Hip Fractures/rh [Rehabilitation]Hip Fractures/su [Surgery]HumansLength of StayLogistic ModelsMaleMultivariate AnalysisOntario/ep [Epidemiology]Patient Care TeamPostoperative Care/mt [Methods]Research Support, Non-U.S. Gov't

REF ID: 1326

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Nichols, C. L., & Willis, L. A. (2004). The paired RAI/MDS specialist model. improving outcomes in veterans affairs nursing home care units.[erratum appears in J gerontol nurs. 2004 nov;30(11):45]. ***Journal of Gerontological Nursing, 30*****(10), 6-11.**
Evaluation Studies. Journal Article Activities of Daily LivingAgedGeriatric Assessment/mt [Methods]Geriatric Nursing/og [Organization & Administration]Homes for the Aged/og [Organization & Administration]HumansJoint Commission on Accreditation of Healthcare OrganizationsModels, NursingNurse's RoleNursing AssessmentNursing Evaluation ResearchNursing Homes/og [Organization & Administration]Patient Care Team/og [Organization & Administration]Pilot ProjectsQuality Indicators, Health CareTotal Quality Management/og [Organization & Administration]United StatesUnited States Department of Veterans Affairs

REF ID: 1299

Level I: Systematic Reviews

Topic 4.1: Management-General

Outpatient Service Trialists. (2004). Rehabilitation therapy services for stroke patients living at home: Systematic review of randomised trials. ***Lancet, 363*****(9406), 352-356.**
Journal Article, Research, Systematic Review, Tables/Charts Biomedical JournalsEditorial Board ReviewedExpert Peer ReviewedOnline/PrintPeer Reviewed JournalsUSA Journals.Evidence-Based PracticeAgedCerebral Vascular Accident/rh [Rehabilitation]Clinical Assessment ToolsClinical

TrialsConfidence IntervalsDescriptive StatisticsFunding SourceHome Occupational TherapyHome Physical TherapyHome RehabilitationMeta AnalysisMiddle AgeMultidisciplinary Care TeamOdds RatioOutpatients

REF ID: 1318

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Rees, A., Richards, A., & Shapiro, D. A. (2004). Utility of the HoNOS in measuring change in a community mental health care population. ***Journal of Mental Health, 13*****(3), 295-304.**

Journal Article, Research, Tables/Charts

Background: Given that, for many community health care teams, the HoNOS is the audit tool of choice, further work is needed to establish the viability of using this instrument to assess health change. Aims: To assess the usefulness of the HoNOS in measuring change in a population on the caseloads of community mental health teams. Method: Key workers or care co-ordinators of 195 selected patients on the caseloads of a national sample of 10 generic community mental health teams rated patients on the HoNOS four times over a period of 4 - 6 months. Patients had previously received a primary diagnosis of anxiety, depression, psychosis, personality disorder, or substance misuse on the Manchester Audit Tool. Results: In this population, the HoNOS marginally discriminated amongst diagnoses, and was associated with severity and complexity but not chronicity. Scores on the HoNOS changed differentially over time according to diagnosis and severity. Conclusion: A change of 3 to 4 points on the HoNOS is small, but statistically significant, and may be a useful basis for tracking the clinical improvement of neurotic patients, and the clinical stability of those with psychosis. Declaration of interest: This study was supported by a grant from the UK Department of Health's Policy Research Branch, Human Resources and Effectiveness Programme, to Michael West, Simon Garrod, and David Shapiro.Biomedical JournalsDouble Blind Peer ReviewedOnline/PrintPeer Reviewed JournalsUK & Ireland Journals.Psychiatry/PsychologyAdultAgedAnalysis of VarianceAnxiety/td [Trends]Audit/mt [Methods]Case MixChi Square TestClinical Assessment Tools/ev [Evaluation]Clinical Assessment Tools/ut [Utilization]Clinical IndicatorsDSMDepression/td [Trends]Descriptive StatisticsEvaluation ResearchFemaleHealth Status IndicatorsInstrument ValidationInterviewsMaleMental Disorders/di [Diagnosis]Mental Disorders/td [Trends]Mental Disorders, ChronicMental Health PersonnelMental Health ServicesMiddle AgeMultidisciplinary Care TeamMultivariate Analysis of VarianceOutcome Assessment/mt [Methods]P-ValuePearson's Correlation CoefficientProspective StudiesPsychological TestsPsychotic Disorders/td [Trends]Repeated MeasuresSeverity of Illness/cl [Classification]Health of the National Scales (HoNOS) (Wing et al)Team Climate Inventory (Anderson and West)Mental Illness Needs Index (Glover et al)Manchester Audit Tool (MAT)General Health Questionnaire (GHQ).

REF ID: 1347

Level VI: Opinion

Topic 4.1: Management-General

Topic 3: Assessment

Reid, U. V., & Ploeg, J. (2002). An outpatient geriatric evaluation and management programme was more effective than usual care in preventing functional decline in high risk older adults. ***Evidence-Based Nursing, 5*****(1), 19.**

Journal Article, Abstract, Commentary, Tables/Charts

Critique of Original Study: Boult C, Boult LB, Morishita L et al. A randomized clinical trial of outpatient geriatric evaluation and management. J AM GERIATR SOC 2001 Apr; 49: 351-9; Entry Week: 20021025 Revised: 20040123

QUESTIONS: Is an outpatient geriatric evaluation and management (GEM) programme more effective than usual care in preventing functional decline in high risk older adults? Do use and cost of healthcare services differ between groups? Design Randomised (allocation concealed}*, blinded

(outcome assessors), controlled trial with 18 months of follow up. Setting Ramsey County and adjacent zip codes, Minnesota, USA. Patients 568 patients (mean age 79 y, 56% men, 96% white) who were >/=70 years of age, community dwelling, fee for service Medicare beneficiaries, and at high risk for hospital admission and functional decline. Exclusion criteria included residence in a nursing home, illness requiring frequent physician visits, and communication barriers. Study participants (96%) or their proxies (4%) completed 97% of follow up interviews. Intervention 294 patients were allocated to the GEM team (geriatrician, gerontological nurse practitioner, and social worker) and received an initial home visit, monthly clinic visits, and regular telephone contacts. The GEM team provided assessment and primary care services for an average of 6 months. 274 patients allocated to usual care received health care from their physician. Main outcome measures Functional ability as measured b) the Sickness Impact Profile: Physical Functioning Dimension (SIP:PFD), bed disability days (BDDs), and restricted activity days (RADs); and use and cost of healthcare services (Medicare payments.). Main results Analysis was by intention to treat. Alter 18 months of follow up, the GEM group had lower SIP:PFD (15.7 v 18.9; mean difference 3.2, 95% CI 0.28 to 6.12, p /=3 points) than in the GEM group (table). After adjusting for functional and affective status at baseline, the GEM group was less likely to lose functional ability than the usual care group (adjusted odds ratio [OR] 0.67, CI 0.47 to 0.99). After adjusting for baseline use of services, the GEM group was less likely to use home care than the usual care group (adjusted OR 0.60, CI 0.37 to 0.98, at 12 months). Groups did not differ for nursing home use or total Medicarc costs (US$ 11354 v US$ 11786, p=0.93). Conclusion The geriatric evaluation and management programme was more effective than usual care for preventing functional decline and minimising home care use in high risk older adults, but did not differ for nursing home use or cost of healthcare services. *Information provided by author. **Value calculated from data in article.Core Nursing JournalsNursing JournalsOnline/PrintUK & Ireland Journals.Evidence-Based PracticeAgedClinical TrialsCommunity LivingFemaleFunctional StatusGeriatric AssessmentGeriatric Functional AssessmentGerontologic NursingHealth Services for the AgedMaleMinnesotaMultidisciplinary Care TeamOutpatientsPrimary Health Care

REF ID: 1309

Level VI: Opinion

Topic 4.1: Management-General

Richardson, J., Prentice, D., & Rivers, S. (2001). Clinical management extra: Skin care pathway. developing an interdisciplinary evidence-based skin care pathway for long-term care. ***Advances in Skin & Wound Care, 14*****(4 part 1), 197-205.**

Journal Article, CEU, Critical Path, Exam Questions, Glossary, Tables/Charts Double Blind Peer ReviewedEditorial Board ReviewedExpert Peer ReviewedNursing JournalsOnline/PrintPeer Reviewed JournalsUSA Journals.Evidence-Based PracticeWound CareAgedAged, 80 and OverCritical PathEducation, Continuing (Credit)FemaleLong Term CareMaleMultidisciplinary Care TeamPressure Ulcer/th [Therapy]Professional Practice, Evidence-BasedProgram EvaluationProgram ImplementationProgram PlanningRehabilitationSkin Care

REF ID: 1314

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Rockwood, K. (2005). Frailty and its definition: A worthy challenge. ***Journal of the American Geriatrics Society, 53*****(6), 1069-1070.**

Journal Article, Editorial

abstract not availableBiomedical JournalsPeer Reviewed JournalsUSA Journals.Gerontologic CareAgedClinical IndicatorsComorbidityFrail ElderlyGeriatricsMultidisciplinary Care TeamObesity/ep [Epidemiology]Research

REF ID: 1321

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Rowe, J. (2002). Care awaiting placement unit: The first 12 months. ***Geriaction, 20*****(4), 9-14.**
Journal Article, Tables/Charts
The Care Awaiting Placement Unit (CAP Unit) is a SCGH administered 22 bed facility which opened for business on the 30th July 2001. The primary aims of the establishment of the CAP Unit were to: * free up, or make more readily available, acute in patient beds at SCGH; and * provide interim and appropriate care for patients who no longer require acute nursing/medical care, and who are awaiting placement in either a Nursing Home or Hostel. The CAPUnit Team comprises Advanced Gerontological RNs, Resident Care Assistants, CNM, Senior Medical Officer and other medical support, Social Worker, Therapy Assistants, Occupational Therapist, Physiotherapist, Speech Pathologist, Podiatrist and Dietician. The Unit functions in a similar manner to Nursing Home/Hostel environments. The focus of general nursing care and therapy activities is to provide opportunities for residents to achieve and maintain/improve holistic well-being, including independent self-care and communication. Support of families/significant others is viewed as an integral component of appropriate Aged Care. Residential Classification Scale (RCS) assessment of residents admitted to the CAPUnit has demonstrated that over 86% were at Category 1-4 dependency. A transfer document, designed to translate 'acute care' information into 'RCS' language, has been well received as a useful contribution to interim care planning on admission to the Residential Facility. The future of CAP Units as one of a range of alternative methods of appropriate care services for aged people requires further investigation.Australia & New Zealand JournalsBiomedical JournalsBlind Peer ReviewedEditorial Board ReviewedExpert Peer ReviewedPeer Reviewed Journals.Gerontologic CareAgedAged, 80 and OverClinical IndicatorsDischarge PlanningHospital UnitsInpatientsMultidisciplinary Care TeamPatient AdmissionPatient ClassificationProgram EvaluationSubacute CareWaiting Lists

REF ID: 1334

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Ryan, A., Carter, J., Lucas, J., & Berger, J. (2002). You need not make the journey alone: Overcoming impediments to providing palliative care in a public urban teaching hospital. ***American Journal of Hospice & Palliative Care, 19*****(3), 171-180.**
Evaluation Studies. Journal Article
The majority of dying patients continue to receive care in acute, tertiary settings. This has generated the development of hospital-based palliative care (HBPC). The Symptom Management and Palliative Care Program (SMPCP) at LAC+USC Medical Center provides HBPC. The SMPCP operates as an interdisciplinary consultative service, assessing inpatients, and documenting recommendations for primary physicians. Over a 28-month period the SMPCP provided clinical recommendations, education, and research for patients, family members, and hospital staff Demographic, clinical, psychosocial, financial, and outcome information was collected on 265 patients. The SMPCP documented the attainment of defined quality end-points, including pain control within 24 hours, a Do Not Resuscitate (DNR) discussion with patient and family within 72 hours, and control of nausea and vomiting within 24 hours. Team members also documented impediments to implementing recommendations and the success of interventions to overcome impediments. Results indicated that the SMPCP achieved a high rate of quality end-point attainment when impediments were not present. The most significant impediments resulted from behaviors by primary physicians. The SMPCP's ability to overcome barrier behaviors improved the rate of end-point attainment, confirming the importance of palliative care at the end of life.Academic Medical Centers/og [Organization & Administration]AdultAgedAged, 80 and overFemaleHealth Services Accessibility/og [Organization & Administration]Health Services ResearchHospice Care/og [Organization & Administration]Hospitals, Public/og [Organization & Administration]Hospitals, Urban/og [Organization & Administration]HumansLos AngelesMaleMiddle AgedNeeds Assessment/og [Organization & Administration]Palliative Care/og [Organization & Administration]Patient Care Team/og [Organization & Administration]Program EvaluationQuality Indicators, Health

CareReferral and Consultation/og [Organization & Administration]Total Quality Management/og [Organization & Administration]

REF ID: 1300

Level VI: Opinion

Topic 2: Prevention

Santos, D., Gillies, J., Vartiainen, E., Dunbar, J., & Nettleton, B. (2004). Implementing the evidence: A disease management system for secondary prevention of coronary heart disease in the scottish borders. ***Quality in Primary Care, 12*****(1), 65-72.**

Journal Article, Practice Guidelines, Research, Tables/Charts

Scotland has one of the highest rates of coronary heart disease (CHD) in the world. The Hearts in the Borders project was set up in the Scottish Borders with the aim of providing the highest possible standards of care and improving the health of patients with CHD. The project is multidisciplinary and multi-organisational with an innovative implementation strategy involving guideline development and implementation, audit, staff training, and the development and use of a resource pack. The project started in 1998 and three audit cycles (in late 1999, 2000 and 2002) have been conducted to date. All practices in the Borders now have a CHD register. The project targeted patients under the age of 75 years with a history of myocardial infarction, coronary artery bypass grafting and/or angioplasty. Major improvements occurred in cholesterol control with the number of patients with cholesterol below 5 mmol/l improving from 29% to 62%. Aspirin prescribing is high with trends towards better control of blood pressure. Improvements in lifestyle advice given were also found. A positive outcome of the project was a reduction in hospital admissions from 32% in the 1999 audit to 20% in 2002. The project has benefited the Borders by introducing new ways of working across professional and organisational divides, and provided a foundation for the development of a management clinical network for CHD. The model developed has also allowed more rapid planning of a local project to implement the hypertension guidelines. The project has been awarded three national awards for its innovative approach to CHD.Editorial Board ReviewedExpert Peer ReviewedHealth Services Administration JournalsNursing JournalsOnline/PrintPeer Reviewed JournalsUK & Ireland Journals.Evidence-Based PracticeQuality AssuranceAdultAgedAuditBlood PressureCardiovascular Risk FactorsCholesterol/bl [Blood]Coronary Disease/dt [Drug Therapy]Coronary Disease/rf [Risk Factors]Coronary Disease/pc [Prevention and Control]CounselingDisease ManagementFamily PracticeFemaleFunding SourceLife StyleMaleMiddle AgeMultidisciplinary Care TeamPatient EducationPractice GuidelinesPrimary Health CareRural AreasScotlandSurveysTeaching MaterialsTreatment Outcomes

REF ID: 1349

Level VI: Opinion

Topic 4.1: Management-General

Schulz, M. (2001). Intensive geriatric rehabilitation reduced hospital stay and time to independent living in hip fracture patients with mild to moderate dementia... commentary on huusko TM, karppi P, avikainen V, et al. randomised, clinically controlled trial of intensive geriatric rehabilitation in patients with hip fracture: Subgroup analysis of patients with dementia. BMJ 2000 nov 4;321:1107-11. ***Evidence-Based Nursing, 4*****(2), 54.**

Journal Article, Abstract, Commentary, Tables/Charts

Commentary on Huusko TM, Karppi P, Avikainen V, et al. Randomised, clinically controlled trial of intensive geriatric rehabilitation in patients with hip fracture: subgroup analysis of patients with dementia. BMJ 2000 Nov 4;321:1107-11

QUESTION: In hip fracture patients with dementia, is intensive geriatric rehabilitation (IGR) effective and does its effectiveness vary with degree of dementia? Design Preplanned subgroup analysis of a randomised (unclear allocation concealment), unblinded, controlled trial with 1 year of follow up. Setting Jyvaskyla Central Hospital, Finland. Patients 260 independently living patients >/= 65 years of age (mean age 80 y, 72% women) who were admitted to hospital with a hip fracture.

Exclusion criteria were inability to walk unaided before the fracture, pathological fractures, multiple fractures, serious early complications, receiving calcitonin treatment, or terminal illness. 238 patients (92%) completed the study. Intervention After surgery for hip fracture, 130 patients were allocated to IGR, which consisted of providing advice, training, drug treatment, physiotherapy, occupational therapy, speech therapy; listening to patients' concerns; and help with use of appliances, equipment, and daily living aids all provided within the geriatric ward of the Central Hospital. 130 patients were allocated to the control group, which involved discharge to a local hospital. Main outcome measures Length of hospital stay, independent living, and mortality 3 months and 1 year after surgery. Main results In patients with normal scores on the Mini Mental State Examination (MMSE) and in those with scores indicating severe dementia, no difference existed between the intervention and control groups for length of hospital stay. For patients with mild and moderate dementia, however, hospital stay was shorter for those in the intervention group (table 1). More patients with mild and moderate dementia in the intervention group were living independently at 3 months (table 2); this difference was no longer statistically significant at 1 year. No difference existed between the groups for mortality. Conclusion In hip fracture patients with mild to moderate dementia, intensive geriatric rehabilitation led to fewer days in hospital and more patients were able to return to independent living. [Original article accession number: 2001043495 (clinical trial, research, tables/charts)]Core Nursing JournalsNursing JournalsOnline/PrintUK & Ireland Journals.Evidence-Based PracticeActivities of Daily LivingAgedAged, 80 and OverClinical Assessment ToolsClinical TrialsConfidence IntervalsDementiaEarly AmbulationFemaleFinlandGeriatric Functional AssessmentHip Fractures/rh [Rehabilitation]Hip Fractures/su [Surgery]Length of StayMaleMultidisciplinary Care TeamQuestionnairesRehabilitation, GeriatricTreatment Outcomes

REF ID: 1320

QM: Quality Measures

Topic 5: Evaluation/Follow-up

ScisneyMatlock, M., Makos, G., Saunders, T., Jackson, F., & Steigerwalt, S. (2004). Comparison of quality-of-hypertension-care indicators for groups treated by physician versus groups treated by physician-nurse team. ***Journal of the American Academy of Nurse Practitioners, 16*****(1), 17-23.**

Journal Article, Research, Tables/Charts

PURPOSE: To determine whether the type of health care provider (i.e., physician versus physician-nurse team) affected the quality of hypertension care given to two groups of randomly selected adult women. DATA SOURCES: Three indicators measured the quality of hypertension care: blood pressure control level, knowledge of hypertension, and discussion about blood pressure medications with the health care provider(s). Blood pressure readings were taken with a 24-hr ambulatory blood pressure monitor, and demographic data from survey results taken at orientation and researcher-collected data on posttreatment knowledge of hypertension and cognitive representations of hypertension were gathered. Chi-square and t tests were used to analyze the data. CONCLUSIONS: The group whose care was managed by a physician-nurse team demonstrated lower means for 24-hr systolic blood pressure and diastolic blood pressure (systolic: M = 132, SD = 14.9; diastolic: M = 75, SD = 11.3) than the group whose care was managed only by one or more physicians (systolic: M = 136, SD = 13.4; diastolic: M = 79, SD = 11.24). Also, the group whose care was managed by a physician-nurse team revealed significantly higher scores for discussion of blood pressure medication than the group whose care was managed only by one or more physicians. There were no group differences for knowledge of hypertension. IMPLICATIONS FOR PRACTICE: Nurses qualified to assist with meeting the needs of hypertension clients in primary care settings can positively affect clients' knowledge about blood pressure medication and--perhaps as a result of this knowledge--how well the clients control their blood pressure.Nursing JournalsPeer Reviewed JournalsUSA Journals.Advanced Nursing PracticeAdultAgedBlacksBlood Pressure Monitoring, AmbulatoryChi Square TestClinical IndicatorsComparative StudiesDescriptive ResearchDescriptive StatisticsFemaleFunding SourceHealth Knowledge/ev [Evaluation]Hypertension/th

[Therapy]Medical CareMiddle AgeMultidisciplinary Care TeamNurse PractitionersPhysiciansPower AnalysisPractice GuidelinesQuality of Health CareRandom SampleResearch InstrumentsT-TestsTwo-Tailed TestWhitesCheck Your High Blood Pressure Prevention IQ (NHLBI).

REF ID: 1327

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Silver, M. P., Geis, M. S., & Bateman, K. A. (2004). Improving health care systems performance: A human factors approach. ***American Journal of Medical Quality, 19*****(3), 93-102.**

Journal Article

Under contract from the Centers for Medicare & Medicaid Services (CMS), Medicare Quality Improvement Organizations (QIOs) promote improvement in health care system performance. With the QIO contract cycle that began in the fall of 1999, CMS adopted a broad national improvement agenda emphasizing 24 quality measures from 6 clinical topic areas. The Utah QIO developed a human factors and organizational safety management-based intervention strategy for the inpatient clinical topic areas, borrowing approaches and principles previously applied in hospital-based medication systems safety improvement efforts. Evaluation used measures and methods established by CMS to assess the adequacy of QIO performance nationwide. Comparison of statewide inpatient quality indicator performance rates in 1998 and 2000 showed absolute improvement on 15 of the 16 measures used. The average reduction in the failure rate for these clinical topic areas in Utah was 27.3%; this was the highest rate of improvement for any state in the nation. Utah's overall ranking on the combined inpatient clinical topic areas went from 16th at baseline to first at follow-up. The evaluation demonstrates exceptional levels of performance improvement in Utah hospitals when compared with national trends. It is, however, neither possible to uniquely isolate the effects of the QIO intervention from larger trends operating statewide, nor can the contributions of the various facets of the QIO intervention be disaggregated. The application of human factors and organizational safety management principles represents a promising strategy for accelerating the pace of improvement in health care.AgedCardiovascular Diseases/th [Therapy]Hospital Administration/mt [Methods]HumansMedicareOutcome and Process Assessment (Health Care)/mt [Methods]Outcome and Process Assessment (Health Care)/og [Organization & Administration]Patient Care Management/mt [Methods]Patient Care Management/og [Organization & Administration]Patient Care Team/og [Organization & Administration]Patient Care Team/st [Standards]Pneumonia/th [Therapy]Quality Assurance, Health Care/mt [Methods]Quality Assurance, Health Care/og [Organization & Administration]Quality Indicators, Health Care/og [Organization & Administration]Research Support, U.S. Gov't, Non-P.H.SUtah

REF ID: 1316

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Silver, M. P., Geis, & Bateman, K. A. (2004). Improving health care systems performance: A human factors approach. ***American Journal of Medical Quality, 19*****(3), 93-102.**

Journal Article, Research, Tables/Charts

Under contract from the Centers for Medicare & Medicaid Services (CMS), Medicare Quality Improvement Organizations (QIOs) promote improvement in health care system performance. With the QIO contract cycle that began in the fall of 1999, CMS adopted a broad national improvement agenda emphasizing 24 quality measures from 6 clinical topic areas. The Utah QIO developed a human factors and organizational safety management-based intervention strategy for the inpatient clinical topic areas, borrowing approaches and principles previously applied in hospital-based medication systems safety improvement efforts. Evaluation used measures and methods established by CMS to assess the adequacy of QIO performance nationwide. Comparison of statewide inpatient quality indicator performance rates in 1998 and 2000 showed absolute improvement on 15 of the 16 measures used. The average reduction in the failure rate for these clinical topic areas in Utah was 27.3%; this was the highest rate of improvement for any state in the nation. Utah's overall ranking on

the combined inpatient clinical topic areas went from 16th at baseline to first at follow-up. The evaluation demonstrates exceptional levels of performance improvement in Utah hospitals when compared with national trends. It is, however, neither possible to uniquely isolate the effects of the QIO intervention from larger trends operating statewide, nor can the contributions of the various facets of the QIO intervention be disaggregated. The application of human factors and organizational safety management principles represents a promising strategy for accelerating the pace of improvement in health care.Blind Peer ReviewedEditorial Board ReviewedHealth Services Administration JournalsPeer Reviewed JournalsUSA Journals.Quality AssuranceAgedCardiovascular Diseases/th [Therapy]Clinical IndicatorsDescriptive StatisticsFunding SourceHealth Facility AdministrationMedicareMultidisciplinary Care Team/st [Standards]Outcome AssessmentPneumonia/th [Therapy]Process Assessment (Health Care)Quality Assurance/am [Administration]Quality Assurance/mt [Methods]Utah

REF ID: 1345

Level VI: Opinion

Topic 4.1: Management-General

Slimmer, L. (2003). A collaborative care management programme in a primary care setting was effective for older adults with late life depression. *Evidence-Based Nursing, 6*(3), 91.

Journal Article, Abstract, Commentary, Tables/Charts

QUESTION: Is a collaborative care management programme offered in a primary care setting effective for older adults with late life depression? Design Randomised (allocation concealed), blinded (outcome assessors) controlled trial with 1 year of follow up. Setting 18 primary care clinics from 8 healthcare organisations in 5 states in the US. Patients 1801 patients >/= 60 years of age (mean age 71 y 65% women) who met the Diagnostic and Statistical Manual of Mental Disorders, 4th edition criteria for major depression or dysthymia or both and who were planning to use general medical care from a participating clinic. Exclusion criteria were drinking problems, bipolar disorder or psychosis, severe cognitive impairment, or acute risk of suicide. Follow up was 98%. Intervention 906 patients were allocated to the Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) management programme, which comprised /= 50% reduction in the baseline Symptom Checklist (SCL)-20 score (20 depression items from the SCL-90); complete remission of depressive symptoms, defined as a SCL-20 score < 0.5; self reported use of antidepressants or psychotherapy; health related functional impairment; and quality of life. Main results 17% of participants had major depression, 30% had dysthymic disorder, and 53% had major depression and dysthymic disorder. Analysis was by intention to treat. The intervention group had higher rates of treatment response, complete remission of depressive symptoms, and any use of antidepressant medications or psychotherapy (table) than the usual care group. Also, the intervention group had less health related functional impairment (p < 0.001) and greater quality of life (p < 0.00l) than those in the usual care group. Conclusion In older adults with late life depression, a collaborative care management programme offered in a primary care setting increased treatment response, remission of depressive symptoms, use of antidepressants or psychotherapy, and quality of life, and reduced functional impairment.Core Nursing JournalsNursing JournalsOnline/PrintUK & Ireland Journals.Case ManagementEvidence-Based PracticeGerontologic CareAgedAntidepressive Agents/tu [Therapeutic use]Clinical TrialsDepression/th [Therapy]Health Services AccessibilityMultidisciplinary Care TeamPrimary Health CarePsychological TestsPsychotherapyQuality of LifeUnited StatesSymptom Checklist (SCL) (Derogatis).

REF ID: 1342

Level VI: Opinion

Topic 4.1: Management-General

Stewart, S. (2006). Review: Multidisciplinary interventions reduce hospital admission and all cause mortality in heart failure. *Evidence-Based Nursing, 9*(1), 23.

Journal Article, Abstract, Commentary, Tables/Charts

critique of Original Study [see REF ID 1355]: Holland R, Battersby J, Harvey I, Lenaghan E, Smith

J, Hay L. Systematic review of multidisciplinary interventions in heart failure. HEART 2005 Jul; 91(7): 899-906 (research) [CINAHL Accession Number: 2009113460]; Entry Week: 20060512 Revised: 20060602

Do multidisciplinary interventions (MDIs) (in which patient mangement is the responsibily of a multidisciplinary team that includes medical input plus >/=1 of a specialist nurse, pharmacist, health educator, dietitian, or social worker) reduce hospital admission and all cause mortality in patients with heart failure) (HF) METHODS Data sources: Medline, EMBASE/Excerpta Medica, CINAHL, AMED, Cochrane Controlled Trials Register, Cochrane Effective Practice and Organization of Care Study Registry, Biomed, TRIP Database, Meta-Register of Current Controlled Trials, Research Findings Electronic Register, NHS Research Register, Cochrane Database of Systematic Reviews, and Database of Abstracts of Reviews of Effects (from inception to June 2004); and reference lists of relevant studies and reviews. Study selection and assessment randomised controlled trials (RCTs) in any language that compared MDIs, such as nurse led programmes, medication review, medication adherence interventions, patient education, or enhanced monitoring in any setting, with usual care for management of patients with HF. Trials that focused on pharmaceutical, exercise, or physician behaviour interventions were excluded. Individual study quality was assessed based on 8 criteria. Outcomes: all cause hospital admission, all cause mortality, and hospital admission for HF. MAIN RESULTS 30 trials (n=8158, mean age 56-86 y, 27-99% men) met the selection criteria. 22 of 30 studies met >/=5 of 8 quality criteria. Meta-analyses were done using a random effects model and showed that MDIs reduced all cause hospital admissions (table), all cause mortality (table), and HF admissions (relative risk reduction [RRR) 30%, 95% CI 19 to 39). Subgroup analysis by intervention type showed that home visits reduced all cause admissions (table) and HF admissions (RRR 38%, CI 26 to 49); home physiological monitoring or televideo contact reduced all cause mortality (table) and HF admissions (RRR 30%, CI 15 to 43). Hospital, clinic, or general practice based interventions had no significant effect on any outcome (table). CONCLUSION Multidisciplinary interventions reduce hospital admission and all cause mortality in patients with heart failure.Core Nursing JournalsNursing JournalsOnline/PrintUK & Ireland Journals.Evidence-Based PracticeAgedAged, 80 and OverClinical TrialsFemaleHeart Failure, Congestive/mo [Mortality]Heart Failure, Congestive/th [Therapy]Home Health CareHospitalizationMaleMeta AnalysisMiddle AgeMultidisciplinary Care TeamSystematic Review

REF ID: 1332

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Stier, L., Dlugacz, Y. D., O'Connor, L. J., Eichorn, A. M., White, M., & Fitzpatrick, J. (2004). Reinforcing organization wide pressure ulcer reduction on high-risk geriatric inpatient units. ***Outcomes Management, 8*****(1), 28-32.**

Journal Article

Skin care and pressure ulcer prevention programs abound, although their content varies and their outcomes are often difficult to quantify. This article describes 2 complementary programs, their quality improvement processes, and a variety of ways of measuring their success. The first program was broad in scope, emphasizing system-wide changes in administration and coordination of resources, while the second focused on nursing education on high-risk units. These 2 approaches could be adapted for use in any health care setting.AgedBenchmarking/og [Organization & Administration]Education, Nursing, Continuing/og [Organization & Administration]Evidence-Based MedicineGeriatric Nursing/ed [Education]Geriatric Nursing/st [Standards]Hospital UnitsHospitals, VoluntaryHumansIncidenceInservice Training/og [Organization & Administration]New York/ep [Epidemiology]Nursing Staff, Hospital/ed [Education]Nursing Staff, Hospital/st [Standards]Outcome and Process Assessment (Health Care)Patient Care Team/st [Standards]Practice GuidelinesPressure Ulcer/ep [Epidemiology]Pressure Ulcer/pc [Prevention & Control]Quality Indicators, Health

CareRisk FactorsSkin Care/st [Standards]Total Quality Management/og [Organization & Administration]

REF ID: 1351

Level VI: Opinion

Topic 2: PreventionTopic 4.1: Management-General

Strang, V. R. (2000). The addition of a home visit by a cardiac nurse to usual multidisciplinary care reduced deaths and readmissions in patients with chronic congestive heart failure... commentary on stewart S, marley JE, horowitz JD. effects of a multidisciplinary, home-based intervention on unplanned readmissions and survival among patients with chronic congestive heart failure: A randomised controlled study. LANCET 1999 sep 25;354(9184):1077-83. *Evidence-Based Nursing, 3*(2), 56.

Journal Article, Abstract, Commentary

commentary on Stewart S, Marley JE, Horowitz JD. Effects of a multidisciplinary, home-based intervention on unplanned readmissions and survival among patients with chronic congestive heart failure: a randomised controlled study. LANCET 1999 Sep 25;354(9184):1077-83

QUESTION: In patients with chronic congestive heart failure (CHF) who are discharged home after acute admission, does the addition of a home visit by a cardiac nurse to usual multidisciplinary care reduce out of hospital deaths and unplanned readmissions? Design: Randomised (concealed), blinded (outcome assessor), controlled trial with 6 months of follow up. Setting: A tertiary referral hospital in Adelaide, South Australia, Australia. Patients: 200 patients >/= 55 years of age (mean age 76 y, 62% men) echo were to be discharged home, had CHF, and had >/=1 previous admission for acute CHF. Exclusion criteria were reversible ischaemia precipitating heart failure, valvular heart disease amenable to surgery, intended heart transplantation, terminal illness, or residence outside of the catchment area. Follow up was complete. Intervention: 100 patients were allocated to usual discharge care (appointment with primary care physician and/or cardiology outpatient clinic within 2 weeks of discharge and contact with a cardiac rehabilitation nurse, dietician, social worker, pharmacist, and community nurse, as needed). 100 patients were allocated to usual care plus a home based intervention, which included a structured home visit by a cardiac nurse 7-14 days after discharge. During this visit, the nurse did a physical examination and assessed patient adherence to treatment understanding of disease, fluid and sodium intake, physical activity, and psychosocial and community based support. A report of the nurse's findings was sent to the primary care physician and cardiologist. If required, patients were referred for urgent medical treatment. On the basis of the nurse's assessment, patients received remedial counselling and strategies to address areas that needed attention. Home visits were repeated if patients had >/= 2 unplanned admissions within 6 months. Patients were contacted by telephone at 3 and 6 months. Main outcome measure: The primary endpoint was combined frequency of unplanned readmissions plus (all cause) out of hospital deaths. Main results: 88 of 100 patients assigned to the home based intervention received a home visit; median duration was 2 hours. At 6 months, the home based intervention group had fewer primary events (unplanned readmissions plus out of hospital deaths) (77 v 129. p=0.02), fewer unplanned readmissions (68 v 118. p=0.03), and fewer associated days in hospital (460 v 1174 d, p=0.01) than did the usual care group. The groups did not differ for out of hospital deaths (9 v 11, {p=0.64},*). Conclusion: In patients with congestive heart failure who were discharged home, the addition of a home visit by a cardiac nurse to usual multidisciplinary care reduced the combined endpoint of out of hospital deaths and unplanned readmissions. *p-value calculated front data in article. [Original article accession number: 2000003615 (clinical trial, research, tables/charts)]Core Nursing JournalsNursing JournalsUK & Ireland Journals.AustraliaClinical TrialsComorbidityCox Proportional Hazards ModelHealth Care CostsHeart Failure, Congestive/mo [Mortality]Heart Failure, Congestive/th [Therapy]Home Health CareHome VisitsKaplan-Meier EstimatorMann-Whitney U TestMultidisciplinary Care TeamQuality of LifeQuestionnairesReadmissionResearch InstrumentsSurvival Analysis

REF ID: 1301

Level VI: Opinion

Topic 4.1: Management-General

Suman, S., & Lockington, T. J. (2003). Generic care pathway for acute geriatric care and rehabilitation as a tool for care management, discharge planning and continuous clinical audit. ***Journal of Integrated Care Pathways, 7*(2), 75-79.**

Journal Article, Critical Path

Acute medicine for older people is characterised by major diversity in the impairments, disabilities and social contexts encountered. A novel structured generic care pathway is presented to accommodate this diversity, facilitate case management and multidisciplinary teamwork, whilst building an auditable and researchable description of a complex system of care and of the process of discharge planning.Health Services Administration JournalsPeer Reviewed JournalsUK & Ireland Journals.Case ManagementGerontologic CareAcute Disease/th [Therapy]AgedAuditCritical PathDischarge PlanningMultidisciplinary Care TeamNational Health Programs/am [Administration]Rehabilitation, GeriatricUnited Kingdom

REF ID: 1330

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Topic 2: Prevention

Theodos, P. (2004). Fall prevention in frail elderly nursing home residents: A challenge to case management: Part II. ***Lippincott's Case Management, 9*(1), 32-44.**

Evaluation Studies. Journal Article

Parts I and II of this article examine the impact of a falls prevention program on the fall incidents among the residents in a nursing home. It was hypothesized that a diagnostic, therapeutic, and preventive approach should be used for nursing home residents identified as being at high risk for falls in order to reduce the number of fall incidents and to improve quality of life for this vulnerable population. The program effectively targeted both intrinsic and extrinsic factors to reduce risks facing the residents. The effectiveness of the program was evaluated by examining changes in the rate of falls after the program was implemented. The results identified that a multifaceted program, one that utilized multiple personalized interventions, was effective in reducing the falls rate of frail (those with complex medical and psychosocial problems) nursing home residents, and that muscle-strengthening interventions may be beneficial for this vulnerable population. Program outcomes verified that case managers can impact quality of life for frail elderly nursing home residents by promoting their independence and safety, and postponing problems resulting from inactivity. Part I (LCM, Nov-Dec 2001) discussed the background and process of a falls program and factors contributing to the occurrence of falls. This month we examine the interdisciplinary team approach to assessment, method, and implementing strategies for an effective fall prevention program. Tools used for prevention, monitoring, and investigation of falls are also detailed.Accident PreventionAccidental Falls/pc [Prevention & Control]Accidental Falls/sn [Statistics & Numerical Data]Activities of Daily LivingAgedAged, 80 and overArchitectural AccessibilityCase Management/og [Organization & Administration]DocumentationExercise TherapyFemaleFrail Elderly/px [Psychology]Frail Elderly/sn [Statistics & Numerical Data]Frail ElderlyGeriatric AssessmentGeriatric Nursing/mt [Methods]Homes for the AgedHumansMaleNursing Evaluation ResearchNursing HomesOutcome and Process Assessment (Health Care)Patient Care Team/og [Organization & Administration]Program EvaluationQuality Indicators, Health CareQuality of LifeRisk ManagementTotal Quality Management/og [Organization & Administration]

REF ID: 1315

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Travis, S. S., Moore, S., Larsen, P. D., & Turner, M. (2005). Clinical indicators of treatment futility and imminent terminal decline as discussed by multidisciplinary teams in long-term

care. ***American Journal of Hospice & Palliative Medicine, 22*****(3), 204-210.**
Journal Article, Research, Tables/Charts
Focus group methodology was used to describe how members of multidisciplinary teams in long-term care facilities recognize when residents are approaching end-stage disease, document evidence that associated treatment futility has occurred, and convey this information to the residents, each other, and family members. In addition to the typical clinical indicators of treatment futility found in the literature (e.g., recurrent infections, weight loss, falls, functional decline), team members described a set of physical and affective changes that were apparent to them as their residents approached trajectories of imminent terminal decline. While more difficult to quantify and measure, these other indicators have a significant impact on the ways that team members assess and interpret a person's survival potential. Using these indicators of both treatment failure and imminent decline requires knowledge of a resident's history, clinical condition, course of care, and individual idiosyncrasies. Together, the indicators offer important cues that are needed for the identification of persons who might benefit from earlier transitions to palliative care.Core Nursing JournalsDouble Blind Peer ReviewedEditorial Board ReviewedExpert Peer ReviewedNursing JournalsPeer Reviewed JournalsUSA Journals.Hospice/Palliative CareAgedAudiorecordingClinical IndicatorsDecision Making, ClinicalFocus GroupsLong Term CareMultidisciplinary Care TeamNursing HomesSoutheastern United StatesTerminal Care

REF ID: 1294

Level I: Systematic Reviews

Topic 4.1: Management-General

TurnerStokes, L., Disler, P. B., Nair, A., & Wade, D. T. (2006). Multi-disciplinary rehabilitation for acquired brain injury in adults of working age. ***The Cochrane Library,*** **(1)**
Journal Article, Research, Systematic Review
A substantive amendment to this systematic review was last made on 23 May 2005. Cochrane reviews are regularly checked and updated if necessary. Background: Evidence from systematic reviews demonstrates that multi-disciplinary rehabilitation is effective in the stroke population, where older adults predominate. However, the evidence base for the effectiveness of rehabilitation following acquired brain injury (ABI) in younger adults is not yet established, perhaps because there are different methodological challenges. Objectives: To assess the effects of multi-disciplinary rehabilitation following ABI in adults, 16 to 65 years. To explore approaches that are effective in different settings and the outcomes that are affected. Search strategy: We used a wide range of sources including: Cochrane Central Register of Controlled Trials (CENTRAL), MEDLINE (1966-2004), EMBASE (1988-2004), CINAHL (1983-2004), PsycLIT (1967-2004), AMED, the National Research Register 2004 and ISI Science Citation Index (1981-2004). Selection criteria: Randomised controlled trials (RCTs) comparing multi-disciplinary rehabilitation with either routinely available local services or lower levels of intervention; or trials comparing intervention in different settings or at different levels of intensity. Quasi-randomised and quasi-experimental designs were also included, providing they met pre-defined methodological criteria. Data collection and analysis: Two authors selected trials and rated their methodological quality independently. A third reviewer arbitrated when disagreements could not be resolved by discussion. We performed a 'best evidence' synthesis by attributing levels of evidence, based on methodological quality. We sub-divided trials in terms of severity of ABI and the setting and type of rehabilitation offered. Main results: We identified ten trials of good methodological quality and four of lower quality. Within the subgroup of predominantly mild brain injury, 'strong evidence' suggested that most patients make a good recovery with provision of appropriate information, without additional specific intervention. For moderate to severe injury, there is 'strong evidence' of benefit from formal intervention. For patients with moderate to severe ABI already in rehabilitation, there is strong evidence that more intensive programmes are associated with earlier functional gains, and 'moderate evidence' that continued outpatient therapy can help to sustain gains made in early post-acute rehabilitation. There is 'limited evidence' that specialist in-patient rehabilitation and specialist multi-disciplinary community

rehabilitation may provide additional functional gains, but the studies serve to highlight the particular practical and ethical restraints on randomisation of severely affected individuals for whom there are no realistic alternatives to specialist intervention. Authors' conclusions: Problems following ABI vary; different services are required to suit the needs of patients with different problems. Patients presenting acutely to hospital with moderate to severe brain injury should be routinely followed up to assess their need for rehabilitation. Intensive intervention appears to lead to earlier gains. The balance between intensity and cost-effectiveness has yet to be determined. Patients discharged from in-patient rehabilitation should have access to out-patient or community-based services appropriate to their needs. Those with milder brain injury benefit from follow-up, and appropriate information and advice. Not all questions in rehabilitation can be addressed by traditional research methodologies. There are important questions still to be answered and future research should employ the most appropriate methodology. [CINAHL Note: The Cochrane Collaboration systematic reviews contain interactive software that allows various calculations in the MetaView.]OnlineUK & Ireland Journals.Evidence-Based PracticeAdolescenceAdultAgedBrain Injuries/rh [Rehabilitation]Clinical TrialsFunctional StatusMiddle AgeMultidisciplinary Care TeamOutcomes (Health Care)Severity of Injury

REF ID: 1333

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Vega-Stromberg, T., Holmes, S. B., Gorski, L. A., & Johnson, B. P. (2002). Road to excellence in pain management: Research, outcomes and direction (ROAD). ***Journal of Nursing Care Quality, 17*****(1), 15-26.**

Journal Article

Effective pain management is a critical patient care goal mandated by numerous health care organizations. There remains great opportunity to improve pain management across all sites of care. This article describes an interdisciplinary model for process improvement within an integrated health care system. An outcome-based approach to pain management resulted in the development of four key clinical indicators that are measured across sites, including acute care, long-term, ambulatory, and home care. Early outcome data are presented. Strategies for improving pain management focus on visibility, staff accountability, patient rights, and education.AgedHealth Services ResearchHumansMaleModels, OrganizationalMulti-Institutional Systems/st [Standards]Pain/th [Therapy]Pain MeasurementPatient Care Team/st [Standards]Patient RightsQuality Assurance, Health CareQuality Indicators, Health CareTreatment OutcomeWisconsin

REF ID: 1307

Level VI: Opinion

Topic 4.1: Management-General

Wagner, E. H., Davis, C., Schaefer, J., Von Korff, M., & Austin, B. (2002). A survey of leading chronic disease management programs: Are they consistent with the literature?... reprinted from managed care quarterly, vol. 7, no. 3, pp. 56-66, (C) 1999 aspen publishers, inc. ***Journal of Nursing Care Quality, 16*****(2), 67-80.**

Journal Article, Practice Guidelines, Research, Tables/Charts

Caring for patients with chronic illness in an era of cost constraints and performance monitoring has led to a sharp growth in "disease management" efforts by health systems utilizing internal innovators or outside firms. This paper describes surveys and site visits of the chronic disease management activities of 72 programs nominated by experts in the field of chronic illness care as being particularly innovative and effective. The survey and analysis were guided by a Model for Effective Chronic Illness Care derived from a process of literature synthesis and expert review. The model proved to be useful in describing the characteristics consistently shared by successful programs, and the surveys indicated common barriers to further expansion of innovative pilot programs. The survey indicated that most of the nominated programs were limited in their effectiveness and reach by their reliance on traditional patient education, rather than modern self-management support, poor linkages

to primary care, and reliance on referrals rather than population-based approaches. Copyright (C) 2002 by Aspen Publishers, Inc.Core Nursing JournalsNursing JournalsPeer Reviewed JournalsUSA Journals.Evidence-Based PracticeQuality AssuranceAdultAgedChronic DiseaseData AnalysisDecision Support Systems, ClinicalDisease ManagementExpert SystemsFunding SourceInterviewsModels, TheoreticalMultidisciplinary Care TeamPatient EducationPractice GuidelinesProfessional Practice, Evidence-BasedProgram EvaluationQuestionnairesSelf CareStaff DevelopmentSurveysTelephoneWork Redesign

REF ID: 1337

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Walker, E., & Dewar, B. J. (2001). How do we facilitate carers' involvement in decision making? *Journal of Advanced Nursing, 34*(3), 329-337.

Journal Article

BACKGROUND: Government health care policy urges service providers to involve service users in the decision-making process. Research studies have recommended changes to current health care practice to facilitate this involvement. However, carers' organizations continue to highlight a gap between policy and practice in relation to involvement. AIM: The aim of the study reported on in this paper was to investigate involvement in a specific health care context with a view to identifying both opportunities for change and practical, realistic ways of bringing about that change. This was a qualitative case study using a case study design. The field site selected was a respite and assessment (23 bedded) ward within the Psychiatric Unit of a hospital specializing in the care of older people. Informal carers (n=20) and members of the multidisciplinary team (n=29) were interviewed about their views and experiences. The interviews were audiorecorded and transcribed. Family meetings, multidisciplinary team meetings and ward routines were the focus of non-participant observation. Field notes from these observations, together with the interview data were analysed using constant comparative method. RESULTS AND CONCLUSIONS. The reported experiences of carers in this study highlighted four markers of satisfactory involvement: feeling that information is shared; feeling included in decision making; feeling that there is someone you can contact when you need to; and feeling that the service is responsive to your needs. The majority of carers felt dissatisfied with the level of involvement. The situation we found echoed that found in other studies, i.e. the majority of informal carers (henceforth 'carers') interviewed were dissatisfied with the level of their involvement. However, our investigation, in which the views of health care professionals as well as those of carers were sought, provided invaluable insight into why this might be the case. Two main sources of difficulty were found: hospital systems and processes, and the relationship between nursing staff and carers. The argument made is that practitioners themselves must notice and challenge these barriers if carer involvement is to be facilitated.AgedAttitude of Health PersonnelAttitude to HealthCaregivers/ed [Education]Caregivers/px [Psychology]Decision Making, OrganizationalDementia/th [Therapy]Family/px [Psychology]Focus GroupsGeriatric PsychiatryHospitals, SpecialHumansNursing Methodology ResearchOrganizational Case StudiesOutcome and Process Assessment (Health Care)Patient Care Planning/og [Organization & Administration]Patient Care Team/og [Organization & Administration]Personnel, Hospital/ed [Education]Personnel, Hospital/px [Psychology]Professional-Family RelationsQuality Indicators, Health CareQuestionnairesResearch Support, Non-U.S. Gov'tSystems Analysis

REF ID: 1319

Level V: Case report QM: Quality Measures

Topic 5: Evaluation/Follow-up

Warchol, K. (2004). An interdisciplinary dementia program model for long-term care. *Topics in Geriatric Rehabilitation, 20*(1), 59-71.

Journal Article, Case Study, Review, Tables/Charts

An emerging area for geriatric rehabilitation specialists is in dementia care in long-term care facilities. With a high percentage of residents affected by Alzheimer's disease and related disorders,

the skills of physical, occupational, and speech therapists can be used to assess cognition and function and to implement programs that allow cognitively impaired residents to maximize their remaining capabilities and avoid excess (unnecessary) disabllity, and thus improve their quality of life. Residents with mild dementia can learn new skills. This article presents an interdisciplinary model based on a theoretical foundation, using the theory of retrogenesis, developed by Dr Barry Reisberg, and the Allen cognitive disabilities theory, developed by Claudia Allen, OTR/L. Examples of components of the "Forget-Me-Not" dementia program developed by the author are given.Allied Health JournalsPeer Reviewed JournalsUSA Journals.Gerontologic CareOccupational TherapyPhysical TherapyActivities of Daily LivingAgedAged, 80 and OverAlzheimer's DiseaseClinical Assessment ToolsClinical IndicatorsCognition/ev [Evaluation]Dementia/rh [Rehabilitation]FamilyFemaleGeriatric Functional AssessmentInpatientsInsurance, Health, ReimbursementLong Term CareMedicareModels, TheoreticalMultidisciplinary Care TeamNursing Home PatientsNursing HomesOmnibus Budget Reconciliation ActRehabilitation, CognitiveRehabilitation, Geriatric

REF ID: 1283

Level I: Systematic Reviews

Topic 4.1: Management-General

Whellan, D. J., Hasselblad, V., Peterson, E., O'Connor, C. M., & Schulman, K. A. (2005). Metaanalysis and review of heart failure disease management randomized controlled clinical trials. *American Heart Journal, 149*(4), 722-729.

Journal Article. Meta-Analysis. Review

BACKGROUND: The medical community has turned to disease management (DM) to bridge the gap between proven therapies and clinical practice for patients with heart failure (HF). The aim of this study was to assess the effectiveness of DM programs in reducing hospitalization and mortality in patients with HF on the basis of the results of existing trials. METHODS: We compared the published results from 19 randomized controlled clinical trials evaluating HF DM programs. A random effects model was used to combine the hazards ratio for all-cause hospitalization across the studies evaluating specific types of HF DM programs. RESULTS: We identified 19 relevant studies, with 5752 enrolled patients, which assessed the benefits of HF DM programs. The overall effect was a significant decrease in all-cause hospitalization for patients with HF. There was significant heterogeneity in the results ($P < .0001$). CONCLUSIONS: The results of this analysis indicate that HF DM is an intervention that could significantly decrease hospitalization for patients with HF. However, due to differences in the types of strategies and the variety of health care settings in which they were evaluated, further studies of HF DM programs with multiple participating centers are required. [References: 42]AgedAustraliaCardiovascular Agents/tu [Therapeutic Use]Case Management/ec [Economics]Case Management/og [Organization & Administration]Case Management/sn [Statistics & Numerical Data]Clinical ProtocolsDrug Utilization/sn [Statistics & Numerical Data]EuropeFemaleFollow-Up StudiesHeart Failure, Congestive/ec [Economics]Heart Failure, Congestive/nu [Nursing]Heart Failure, Congestive/th [Therapy]Home Care ServicesHospitalization/sn [Statistics & Numerical Data]HumansMaleMedicareMiddle AgedModels, TheoreticalNorth AmericaOutpatient Clinics, HospitalPatient Care PlanningPatient Care TeamProportional Hazards ModelsQuality of LifeRandomized Controlled Trials/sn [Statistics & Numerical Data]Research Support, Non-U.S. Gov'tResearch Support, U.S. Gov't, Non-P.H.SRisk

REF ID: 1329

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Woodring, S., Polomano, R. C., Haagen, B. F., Haack, M. M., Nunn, R. R., & Miller, G. L. et al. (2004). Development and testing of patient satisfaction measure for inpatient psychiatry care. *Journal of Nursing Care Quality, 19*(2), 137-148.

Journal Article. Validation Studies

Patient satisfaction is one of the most important indicators for service excellence. Investigations have

been done with population-specific patient satisfaction tools for psychiatric patients; however, there are few published measures for evaluating inpatient care. We developed and tested a 15-item instrument to evaluate the interdisciplinary care model and therapeutic interventions. Results demonstrated reliability and validity of the tool.AdolescentAdultAgedAnalysis of VarianceFemaleHealth Care SurveysHumansInpatients/px [Psychology]MaleMental Disorders/px [Psychology]Mental Disorders/th [Therapy]Middle AgedModels, OrganizationalPatient Care Team/og [Organization & Administration]Patient SatisfactionPennsylvaniaPsychiatric Department, Hospital/st [Standards]PsychometricsQuality Indicators, Health CareQuality of Health Care/st [Standards]Questionnaires/st [Standards]

REF ID: 1308

Level V: Case report

Level VI: Opinion

Topic 2: Prevention

Zevola, D. R., Raffa, M., & Brown, K. (2002). Using clinical pathways in patients undergoing cardiac valve surgery. ***Critical Care Nurse, 22*****(1), 31-2, 34-9, 44-8 assm.**

Journal Article, Case Study, Critical Path, Protocol, Review, Tables/Charts

Clinical pathways--a standard of practice for the care of a certain population of patients--have been used to improve patients' care and use of resources, resulting in cost containment. In this article, the authors describe a clinical pathway for cardiac surgery patients, review protocols used together with this pathway, and present 2 case studies.Blind Peer ReviewedCore Nursing JournalsDouble Blind Peer ReviewedEditorial Board ReviewedExpert Peer ReviewedNursing JournalsOnline/PrintPeer Reviewed JournalsUSA Journals.Critical CarePerioperative CareAgedBowel and Bladder ManagementCoronary Artery BypassCritical Care NursingCritical PathDocumentationExtubationHeart Valves/su [Surgery]Length of StayMaleMiddle AgeMitral Valve/su [Surgery]Multidisciplinary Care TeamNursing AssessmentNursing ProtocolsPhysical ActivityPostoperative CarePostoperative Complications/pc [Prevention and Control]Pressure Ulcer/pc [Prevention and Control]Risk AssessmentTreatment OutcomesVentilation, MechanicalWalking