Evaluating a model of service integration for older people with complex health needs.

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Abstract

Background: Older people with multiple chronic conditions and complex health care needs require a comprehensive, accessible and well-coordinated system of services along the continuum of care. To address this growing problem, a consortium of acute and community based health care organisations implemented a 'Patients First' model of service integration for the target population. The project evaluation utilised a combination of quantitative and qualitative methods in an action research framework.

Findings: The recruited clients were aged over 65 yr and frequent presenters to the local hospital emergency departments (> 4 yr^{-1}). The evaluation process contributed to the identification and implementation of tools for the assessment of client needs and health. The evaluation identified the following key aspects of the model:

- The appropriateness of the target group whose Emergency Department presentations were on the increase prior to their recruitment but have declined since their recruitment.

- The pivotal role of Care Facilitators, who are responsible for assessing the client, identifying their needs, communicating with other health care providers and facilitating the client's access to the health services they require.
- Recruitment difficulties, as members of the targeted population were often reticent to provide informed consent and accept services.
- Challenges to the acquisition of valid and reliable data upon which to assess the efficacy of the model.

Background

Older people (>65 years) with multiple health problems (Complex Needs) are a group who require particular assistance with their health care and accessing the services they require (DHS, 2003; Wolff, Starfield, & Anderson, 2002). Within the Western suburbs of Melbourne, the experiences of the health care staff suggested that members of this 'Older Complex Needs' group used the Emergency Departments of their local Hospitals as their primary means of accessing the health care system. Consequently staff at the hospitals experienced numerous presentations to the Emergency Departments that were deemed to be inappropriate or preventable. Examples of these include patients waiting too long before responding to changes in their symptoms, resulting in the need for an emergency admission, or attending ED when anxious about their symptoms despite there being little change in their condition. In such cases, appropriate use of community health services and better self-management, facilitated by an improved understanding of their condition, would be likely to improve patient health and reduce the use of acute sector services.

One of the factors likely to contribute to the prevalence of this situation within the Western suburbs of Melbourne is the demographic of the region, which is characterised by mild socio-economic disadvantage (DHS, 2002). Consequently many of the aforementioned clients are of low income and view the hospital as a free or low cost service. Furthermore, this phenomenon of over-using the hospital emergency departments is likely to have been accentuated by the decreasing number of General Practitioners who bulk bill. This results in low-income clients, who do not wish to pay for services being disinclined to visit their GP even if they will be reimbursed eventually. Additionally the region is the most culturally diverse area in Victoria (DHS, 2002). Over one third of the region's population were not born in Australia, or speak a language other than English at home. Consequently they are likely to experience difficulties in understanding the health care system, the options available to them, and how to access these services. Inevitably therefore, the local acute hospital is seen as the primary location for seeking health advice and intervention (Tod, Read, Lacey, & Abbott, 2001).

Moreover, this situation is exacerbated further by a limited number of options for ongoing support and 'client-centred' case management services (Roberts, 2002). Significant waiting lists exist for clients requiring care coordination and multiple services and are even more extensive for patients requiring significant levels of case management or have high level, complex care needs. Limited ability of the existing 'system-centred' (Ibid.) case management services to address the needs of older people is well evident in the Western suburbs of Melbourne.

It was therefore proposed that with appropriate assistance, the health care needs of this Older Complex Needs group could be; more clearly identified, health care plans produced according to evidence based practice, access to appropriate services facilitated, client health & quality of life improved, and use of hospital emergency and inpatient services reduced. To address the issues surrounding this Older Complex Needs group and other groups of patients with chronic diseases, a *'Patients First'* model of care was developed (Smith, Amsing et al., 2003). The overall goal of the *Patients First* strategy was to create a patient-centred, sustainable service system that allowed a consortium of acute and community health providers to deliver effective health outcomes to these patients.

In 2003 the Western HARP Consortium implemented two projects using this '*Patients First'* model: (i) The Chronic Disease Management Project (CDMP), which targeted patients with specific chronic conditions such as Chronic Obstructive Pulmonary Disease, Chronic Heart Failure, Angina and Paediatric Asthma, and (ii) The Complex Needs Project, which targeted people aged 65 years and over, who frequently presented themselves to the Emergency Departments and inpatients services at Western Health with multiple geriatric conditions, such as decreased mobility, incontinence, cognitive decline and depression. Within this paper we describe the evaluation of the *Patients First* model during the early stages of its implementation with a group of Older Complex Needs patients, and how the evaluation process contributed to the development of the project.

The *Patients First* model of care

A consortium of community health organizations and Western Health (acute sector hospitals) was formed to implement the '*Patients First'* model of care. The project team included a project manager, six multi-skilled Care Facilitators with professional expertise in nursing, psychology, gerontology, case management, community development and social work, and a specialist geriatrician. Brokerage funds were available for purchasing other health and aged care services, as required. The Hospital Admission Risk Programme (HARP) in Victoria funded the implementation of the model for this group. The four key components of the model were:

1. *A 'Gateway System'*. Suitable patients who frequently presented to the hospital were identified from hospital records, and upon presentation at the hospital, were invited to participate in the new model of care. They were then screened to ensure they meet the inclusion criteria and if agreeing to participate, provided written informed consent.
2. *Clinical streams*. Patients were managed in streams most appropriate to their clinical needs, using evidence-based guidelines and personalised, outcome-based treatment plans.
3. *Care coordination and facilitation*. Each potential client, identified from the Gateway System, was allocated a Care Facilitator who had a maximum caseload of 30 patients. The Care Facilitator performed a comprehensive assessment in the patient's home, which included:
    - Active Client Record XL Sheet (Internal CNP data collection tool)
    - Inter-RAI Comprehensive Assessment for Community Care (Heaney, Lydall-Smith, O'Connor, & Tenni, 2003; interRAI-UK, 2002; Morris, Fries et al., 2003)

    - Comprehensive Quality of Life (Com-QoL) subjective scale (Cummins, 1993, 2000; Cummins, McCabe, Romeo, & Gullone, 1994)
    - SF-12 Health Survey (Andrews, 2002; Jenkinson, Chandola, Coulter, & Bruster, 2001; Sanderson & Andrews, 2002; Taylor, Wilson, Grande, & Ben-Tovim, 2000; Ware, Kosinski, Turner-Bowler, & Gandek, 2002)
    - Carer Strain Index (Sullivan, 2002, 2003; Thornton & Travis, 2003)

   The results of the assessment were used to identify issues for the patient, unmet health care needs, barriers to management of their health by community services and factors putting them at risk of further functional decline. The assessment results were taken to a case conference attended by the Geriatrician who reviewed the medical record to attain a clear picture of the patient's history and resultant interventions. Information from these two sources was then combined and used as the basis for designing an individual care plan for each patient.

4. *A suite of services*. The Care Facilitators then facilitated the patient's access to the suite of health services they required. They contacted the health services and made appointments for the client, ensuring that the service would be provided in a location accessible to the patient. Examples of services arranged included specialist medical clinics (continence, cognition, and medical outpatients), allied health therapies and carer support services.

Evaluation of the *Patients First* model when implemented in the Older Complex Needs project

The evaluation of the project utilised an action research framework with a combination of quantitative and qualitative methods. A summary of selected objectives, indicators and sources of data are presented in table 1. The evaluation is ongoing with 6 monthly reports being made to the project steering committee (composed of representatives of the partnership organizations in the consortium). A selection of the project aims and objectives are reported in this paper, and the data reported here refers to the initial six months of participant recruitment. To gain a better understanding of the care facilitation process, the Care Facilitators recorded details of their activities and participated in focus groups and interviews, which were used to identify the core components of their professional practice. The reported durations of the care facilitation tasks were then subjected to principal component analysis.

Evaluation challenges and responses

1. For much of their data the evaluators were reliant upon many different health care workers to provide complete, valid, reliable, accurate and meaningful data. This being undertaken in a context in which health staff experience work pressures and data recording may not be a high priority. This resulted in the evaluators receiving incomplete data, overly brief descriptions or categorisations that did not fully explain the scenario, delays in completing data collection and non-responses to requests for data. To address this the evaluators had to take a pro-active approach in asking staff for missing data, cross referencing data from different sources to check its validity (Hospital computer records and Care Facilitator data sheets on each participant) and to develop a positive working relationship with the project's management and staff. One aspect of this was conveying to staff that the evaluation process was

an integral part of the project that would provide useful information concerning the efficacy of the model and potential refinements to its workings. It was therefore a positive element rather than an additional burden. Likewise clarification was required concerning the comprehensive assessments, which may have been perceived primarily as evaluation tools, whereas in reality, they had been recommended and/or approved by the clinical specialists for the purposes of providing vital information about the patient, which could also be utilized in the evaluation.

2. The initial approach to the reporting of Care Facilitators' activities was developed by the project management team. This approach focused on a distinction between direct and indirect involvement of the participant. All actions that involved personal interaction between Care Facilitators and participants were reported in the 'direct' category' whereas all other actions that did not personally involve the participant, such as liaison with services and making referrals, were reported in the 'indirect' category'. One of the prominent care facilitation tasks that emerged in the 'direct category' was 'encouraging the participant to accept services' which reflected the reticence of the target population. However, the initial analysis of the direct and indirect care facilitation tasks and subsequent presentation of findings to Care Facilitators revealed the need for a fundamental review of the very concept of 'client centeredness'. Care Facilitators were concerned that the initial data collection tools tacitly implied that 'direct' interventions were superior to indirect interventions. Care Facilitators vigorously and convincingly argued that their 'indirect' interventions on behalf of the participant, which often

involved high level negotiation and advocacy skills, were effectively contributing to the implementation of the *'Patients First'* model of care. Developing collaborative partnerships with service providers and involving General Practitioners were identified as essential components of the 'client-centered' approach. In response, the evaluators organized a series of focus groups with the project management team and Care Facilitators to explore the care facilitation practice. The process continued until full consensus of the Care Facilitation team was achieved. Fifteen distinct care facilitation tasks were distinguished that in the opinion of Care Facilitators truly reflected the complexity of their practice. Subsequently, Care Facilitators commenced reporting their time spend on the activities and tasks.

When analyzing the activities of the Care Facilitators the evaluators experienced the scenarios described in the existing literature with regard to the importance of implicit practitioner knowledge (Bussing & Herbig, 2003; Herbig & Bussing, 2003) and the complexities inherent in the measurement of professional expertise among health care and case management workers (Mateo, Matzke, & Newton, 1998; van-der-Heijden, 2000). However the direct involvement of the Care Facilitators in the assessment of their role, through focus groups and individual face-to-face interviews, enhanced the sense of ownership of the outcomes and resulted in an improved data collection and reporting practice.

3. Completion of the comprehensive assessment is lengthy and needed to be undertaken over several sessions. Due to the limited capacity of this group to

participate in such a task for prolonged periods, assessments initially took many weeks to complete. This made regular reassessments problematic. This was doubly problematic since the health status of people within this group can change rapidly and therefore regular reassessment is desirable from a health care service provision. Therefore a balance between regular monitoring and over-assessing the participants was required.

4. This is a sick group with complex health care needs. Many of the participants have conditions that result in a progressive deterioration of their health. Consequently using a longitudinal approach to compare their health and Quality of Life is problematic. Likewise cross sectional data using either a comparator group from another region, the records of a group of matched individuals previous years or those who declined to consent is also problematic as the groups may not be matched for medical conditions, health issues, socio-cultural factors, health system availability and environmental factors. Consequently several approaches were required and the indications from each compiled to produce a coherent overview from which inferences could be made using logical reasoning.

5. Some clients declined or refused services, and consequently there were often gaps between the services to which they had been referred and what they actually received. Identifying these gaps required cross-referencing different data sources from different partner organizations, with each using different data recording systems.

6. Whilst the Emergency Department records the primary reason for admission on the discharge file, other confounding factors may not be recorded in the computerised database. It was interesting to note that of the 22 principal diagnoses, Pain syndrome was the most common (13.5%). This may suggest that it was the principal factor affecting the functioning of this group, yet Bodily Pain was not the most significant factor affecting their health and social functioning, according to SF12. Indeed of the 8 constructs it was their second best score. This may be due to the ED department system splitting the different diseases categories, whereas the SF12 clumps their effects. Consequently caution needs to be exercised when interpreting the data, particularly when two different collection tools are used and the evaluation process is not the primary reason for data recording.

Results

Cohort Characteristics

In accordance with the HARP-CNP recruitment criteria all participants were aged 65 years and over, had presented to the Emergency Department at Western Health at least four times in the previous 12 months and, presented with two or more of the preliminary risk factors. The following preliminary risk factors were identified among the project's participants:

1. Self care problems (87.8%),
2. Using services in the past (68.9%),
3. Living alone (28.4%),
4. Having a caregiver's responsibility for others (12.2%),
5. Not being able to nominate a regular General Practitioner (2%),
6. Being at risk of homelessness (4%),

In recognition of the central role of the informal carers, the CNP Care Facilitators identified the seventh risk factor, which was consequently added to the original list:

7. Having an informal/family caregiver under stress (33.8%)

The initial CNP participant profiles indicate that *'having an informal/family caregiver under stress' was* almost three times more prevalent than *'having a caregiver's responsibility for others'*. These findings illustrate the unique ability of the community-based Care Facilitators to identify additional risk factors and to explore non-clinical reasons for frequent ED attendances of older people. For this reason the CNP management now contemplate to relax the recruitment criteria and allow recruiting older people at their fourth ED presentation in the past 12 months without any screening for the preliminary risk factors. The rationale is to allow an in depth exploration of factors that contribute to frequent use of the acute care services.

Data obtained using the InterRAI showed the recruited participants to have an average (median) number of 5 diagnosed conditions per person (Mean=5.18, SD=2.11), which ranged from 1 to 12 conditions. They were taking an average (median) of 7 medications per person (Mean= 6.75, SD=5.16), which ranged from zero to 24. From among the eight constructs of SF-12, the lowest mean standardised scores, indicating the poorest health were identified with regard to ‘vitality’ and ‘physical functioning’. The highest mean standardised scores were identified with regard to ‘role emotional’, ‘bodily pain’ and ‘mental health’. Thirty-eight participants (51.4%) reported English as their first language. Other participants reported speaking 13 different community languages. Seventeen participants (23%) required an interpreter. Twenty-two principal diagnostic categories were identified at the discharge from the Emergency Department, the most prevalent being: Pain Syndrome, Cardiac Failure, Infection, Pneumonia, Diabetes, Fracture(s), COPD, Renal failure, Parkinson’s, Gastritis, Depression and Asthma.

Impact of the model

Evaluation of Objective – Reduction in use of Emergency Department and Inpatient services.

Within the period of 12 months prior to recruitment the recruited participants had an average (median) of 4 presentations per participant (Mean= 5.35, SD 1.93) with a maximum of 12. Since commencement of the project the recruited participants had made a total of eighteen presentations to ED. Care Facilitators assessed 15 of these presentations as ‘appropriate’ and 3 as ‘preventable’. The low number of inappropriate or preventable presentations suggests improved self-management and effective use of alternative health care providers.

To further evaluate the efficacy of the model of care upon Emergency Department presentations the participants presentations for the 12 months prior to their recruitment were analysed and compared with their presentations post recruitment. To account for participants being recruited onto the programme for differing lengths time the data were scaled to activities per patient per month. For the year prior to recruitment the 74 participants made 396 presentations, which corresponded to 0.45 per patients per month. Post recruitment the ED presentation rate was 0.13 per patient per month. This difference was statistically significant (Wilcoxon test $Z = -6.48$, $p<0.001$) and for a cohort of 74 participants suggests a saving of 284 Emergency Department presentations a year. As indicated above, some of this reduction may be due to the selection of recent frequent presenters and possible regression to the mean, but when considered along with other data, it suggests that a major contributor is the model of care contributing to improved health status, improved self-management and access to alternative and appropriate health care services.

Evaluation of Objectives - Client Health status and Quality of Life

Difficulties were encountered in attaining longitudinal data that could be used to determine changes in health status and quality of life. These were outlined in the above section on evaluation challenges. However longitudinal monitoring will occur as the project progresses.

Evaluation of Objective - System functioning

- Model components
  1. Gateway - Care Facilitators screened the total of 460 persons between 1 February and 31 July 2004. From these, 74 patients were recruited and the

Care Facilitators were awaiting receipt of consent from a further 34 eligible clients. Of the others, 148 were identified as ineligible for participation in HARP-CNP, of these, 71 persons (48%) were in residential care and 69 persons were adequately managed by other agencies or programmes, which meant that they were not suitable for recruitment. A further 114 either declined consent (27.2%), did not respond (52.6%) or died (14.9%). Based on the total number of eligible participants (n = 199), there was a 30.1% non-response rate and a 15.6% decline rate. The high number of potential participants who did not respond to letters inviting them to participate in the project was identified as a concern. These were primarily individuals who had been discharged from ED before a Care Facilitator could meet with them. Given the concern that many of these individuals may have been able to benefit from the programme, the project team applied for permission and received approval from the ethics committee to contact the applicants by telephone, to explain the project and invite their participation.

2. Principal component analysis of Care Facilitators' activity

Fifteen care facilitation tasks and activities were identified via focus groups with the CNP Care Facilitators. The reported duration data on behalf of 52 participants were available and suitable for factoring (Kaiser-Meyer-Olkin measure of sampling adequacy = 0.631). Five groups of care facilitation tasks were extracted with eigenvalues greater than unity. These five components accounted for 70.1% of the variance explained in the reported durations of care facilitation activities. Using the quartimax rotation method the five components were identified and five-factor model was adapted. This model illustrates care facilitation practice in the initial stage of the project (Table 2).

Liaison with service providers and the provision of direct client support emerged as a single most important component of the client-centred care facilitation practice (accounting for 30.1% of the variance explained). Assessment, referrals and client education loaded as Factor 2. The third factor was primarily composed of case conferencing and reporting activities. Interestingly, participant recruitment and GP involvement, which were identified by the project management team as two areas that required special attention, loaded together on one factor. The last, fifth factor contained a direct intervention task of arranging and accompanying the participant to attend appointments.

3. Access to a suite of services. Prior to their recruitment, participants (N=52) were receiving 62 services that were arranged before their last hospital admission or ED presentation and, 17 services arranged as part of the Western Health discharge plan. By 30 June 2004, the CNP Care Facilitators had initiated/arranged 115 services in 31 categories. This suggested that prior to their recruitment the participants may not have been accessing all of the services they required and therefore the model was having a positive impact upon their health and quality of life.

References

Andrews, G. (2002). A brief integer scorer for the SF-12: Validity of the brief scorer in Australian community and clinic settings. *Australian and New Zealand Journal of Public Health, 26*(6), 508-514.

Bussing, A., & Herbig, B. (2003). Tacit knowledge and experience in working. *Psychology Science, 45*(Supplement III), 142-164.

Cummins, R. A. (1993). *Comprehensive Quality of Life Scale for Adults. Fourth Edition (ComQol-A4) Manual*. Burwood 3125, Australia: School of Psychology, Deakin University.

Cummins, R. A. (2000). Objective and Subjective Quality of Life: an interactive model. *Social Indicators Research, 52*(1), 55-72.

Cummins, R. A., McCabe, M. P., Romeo, Y., & Gullone, E. (1994). The Comprehensive Quality of Life Scale (ComQol): instrument development and psychometric evaluation on college staff and students. *Educational and Psychological Measurement, 54*(2), 372-382.

DHS. (2002). *Western Metropolitan Region Health and Social Wellbeing Profile* (2nd ed.). Melbourne: Department of Human Services.

DHS. (2003). *Hospital admission risk program (HARP): Integrated care for clients with complex needs working party report*. Melbourne: Hospital Demand Management, Metropolitan Health and Aged Care Services Division, Victorian Government Department of Human Services.

Heaney, C., Lydall-Smith, S., O'Connor, C., & Tenni, C. (2003). *The utility of the resident assessment instrument for home care (RAI-HC)*. Bundoora, Australia: Victorian Coordinated Healthcare Trial.

Herbig, B., & Bussing, A. (2003). Comparison of the role of explicit and implicit knowledge in working. *Psychology Science, 45*(Supplement III), 165-188.

interRAI-UK. (2002). *Outcome Measurement with Minimum Data Set Assessments*. Canterbury: interRAI UK, Centre for Health Service Studies, George Allen Wing, University of Kent.

Jenkinson, C., Chandola, T., Coulter, A., & Bruster, S. (2001). An assessment of the construct validity of the SF-12 summary scores across ethnic groups. *Journal of Public Health Medicine, 23*(3), 187-194.

Mateo, M. A., Matzke, K., & Newton, C. (1998). Designing measurements to access case management outcomes. *Nursing Case Management, 3*(1), 2-6.

Morris, J. N., Fries, B. E., Bernabei, R., Steel, K., Ikegami, N., & Carpenter, I. (2003). *interRAI-HOME CARE (interRAI-HC) item by item assessment manual: Primer on Use of the HC Assessment Form and the Client Assessment Protocols (CAPs)*. Washington, DC: interRAI Corporation.

Roberts, D. Y. (2002). Reconceptualizing case management in theory and practice: a frontline perspective. *Health Services Management Research, 15*(3), 147-164.

Sanderson, K., & Andrews, G. (2002). The SF-12 in the Australian population: Cross-validation of item selection. *Australian and New Zealand Journal of Public Health, 26*(4), 343-346.

Smith, L. C., Amsing, N., Pilbrow, D. S., Bird, S. R., Sinnott, H. M., Teichtahl, H., et al. (2003). Providing better care for patients with chronic disease. *Australian Journal of Primary Care, 9*(2&3), 119-126.

Sullivan, M. T. (2002). Caregiver strain index (CSI). *Journal of Gerontological Nursing, 28*(8), 4-5.

Sullivan, M. T. (2003). Caregiver Strain Index (CSI). *Healthcare Nurse, 21*(3), 197-198.

Taylor, A. W., Wilson, D. H., Grande, E. D., & Ben-Tovim, D. (2000). Mental health status of the South Australian population. *Australian and New Zealand Journal of Public Health, 24*(1), 29-34.

Thornton, M., & Travis, S. S. (2003). Analysis of the reliability of the modified caregiver strain index. *The Journals of Gerontology, 58B*(2), S127-S132.

Tod, A. M., Read, C., Lacey, A., & Abbott, J. (2001). Barriers to uptake of services for coronary heart disease: qualitative study. *British Medical Journal, 323*(7306), 214-217.

van-der-Heijden, B. I. J. M. (2000). The development and psychometric evaluation of a multidimensional measurement instrument of professional expertise. *High Ability Studies, 11*(1), 9-39.

Ware, J. E., Kosinski, M., Turner-Bowler, D. M., & Gandek, B. (2002). *How to score Version 2 of the SF-12 Health Survey*. Lincoln, Rhode Island: QualityMetric Incorporated & Health Assessment Lab.

Wolff, J. L., Starfield, B., & Anderson, G. (2002). Prevalence, expenditures, and complications of multiple chronic conditions in the elderly. *Archives of Internal Medicine, 162*(20), 2269-2276.

Table 1. Summary of project aims and indicators

Primary Aims	**Components**	**Secondary Objective**	**Data source**	**Indicators**
To develop and implement a model of care that delivered effective health outcomes for the targeted patients	Effective Gateway	Effective Patient identification and recruitment	Care Facilitator records	• Number of recruited patients. • Proportion of screened and eligible patients who are recruited.
	Care Facilitation and Co-ordination	Clients comprehensively assessed and services matched to identified needs	Care Facilitator records	• Rate of assessment and after recruitment • Completed assessments with the results informing Care Plans
	Access to suite of services	Patients accessing services required as determined from their care plan.	Care Facilitator records	• Proportion of clients receiving new services
Improve patient Health			Records of Assessment. (Assessments repeated 3 – 6 months)	• Changes in Assessment scores over time
Improve patient Quality of Life			Records of Assessment. (Assessments repeated 3 – 6 months)	• Changes in Assessment scores over time
Reduce ED presentations			Hospital records and care Facilitator spread sheets	• Changes in the rate of ED presentations • Reductions in preventable and/or inappropriate presentations
Reduce use of inpatient services			Hospital records and care Facilitator spread sheets	• Changes in use of inpatients services

Table 2: Five Factor Model*of Fifteen** CNP Care Facilitation Tasks.

*Factor loadings and eigenvalues available from the authors.. **Re-Assessment did not load on any factor.

Liaison & Support	Assessment & Referrals	Reporting & Equipment	Recruitment & GP Involvement	Appointments
Liaison Acute Support Liaison Family Liaison Community Monitoring	Referrals Education Assessment	Case Conference Reporting Equipment	Recruitment Liaison GP	Appointments