Admission avoidance hospital at home with Comprehensive Geriatric Assessment	
ORGANIZATIONAL FEATURES	
Team members	Geriatrician, Nurse, Physiotherapist, Occupational therapist, 0.5wte Social worker, Speech therapist (online), for each 15 beds.
Responsibility	Attending geriatricians and specialized nurses.
Governance structure	Under the structure of Parc Sanitari Pere Virgili intermediate care hospital (Department of Ambulatory and Home-Care Geriatrics).
Patient referral route to CGA HAH	• Acute hospital, from the emergency room or acute wards. • Subacute care unit at the intermediate care hospital. • Primary care (family medicine or nursing).
Patient assessment when admitted to CGA HAH	All the referrals must include clinical and social information. **a)** Patients admitted from an acute hospital are assessed, before admission, by a reference professional, in some cases by a geriatric nurse performing a systematic short CGA. The nurse practitioner at the HAH collects information, contacts the referring staff by phone within 12 to 24 hours of referral, and discusses with a geriatrician and social worker who assesses them at home after admission. **b)** Patients admitted from home are assessed by a geriatrician, a specialized nurse, and a social worker within 24 to 48 hours.
Comprehensive geriatric assessment (CGA)	A specialized nurse completes the initial assessment, followed by a medical assessment (<24 hours after admission). Elements include: • Clinical history and examination; list of differential diagnoses. • Assessment of medical, functional, and cognitive needs in the home environment on the day of admission, which includes screening for delirium, geriatric syndromes, dementia and depression, assessment of frailty, skin, nutrition, vision, hearing. • Review of investigations and medication review. • Socio-economic status, risk assessment and home environment. • Multi-dimensional CGA-based individualized treatment plan. • Communication with patients (or representatives) and caregivers for shared goals, decision-making and advanced care planning.
Virtual ward or board rounds	In-person care is available from 8 am to 9pm. Home visits by all team members are planned depending on individual needs. Daily visits by at least one team member (Mon to Fri). Each patient's evolution, intervention plan and discharge planning are discussed in the weekly interdisciplinary board meeting.
Out-of-hours care	9 pm to 8 am is covered by the physican on call in hospital, providing telephone advice or activating the emergency services.
SPECIFIC ROLES of TEAM MEMBERS and PARTNERS	

Geriatrician and specialty training doctors	Clinical governance, clinical review, trainees supervision, communication with the primary care team, investigations orders, drug prescription and referrals to other specialties.
Specialized nurses	• Patients' assessment at home, including activities of daily living, delirium, physical or cognitive ability, and falls. • Provision of equipment and medication • Investigations requests, extraction of blood samples. • ECG, urinary catheterization, dressings to skin lesions… • IV fluids and drugs administration. • Link with community teams for follow-up care. • Pre-discharge visits in the hospital to build trust with patients.
Physiotherapists and occupational therapists	• Functional assessment to include gait, balance, managing stairs, chest physiotherapy, exercise program, and walking aids. • Assessment and training in the activities of daily living also outside the house; equipment provision and training.
Social workers	• Social and family assessment and detection of needs. • Guidance on procedures and social resources. • Coordination with external services (i.e., primary care social worker, social services) and referral to them if necessary. • Drafting of the social report upon discharge.
Pharmacists	• Medicine reconciliation, polypharmacy, and adherence checks.
Primary care physicians and teams	• Triage referrals for CGA HAH in case of step-up pathway • Cooperates during the process if particular issues arise • Receive discharge information through Shared Health Electronic platform of Catalonia and assume care continuity