11:39:49 From Ula Hwang : Welcome participants to the San Francisco Geriatric ED Dementia Care Virtual Boot Camp!

11:51:58 From Ula Hwang : Welcome 9a Boot Camp participants! As you join, please complete the zoom poll that is appearing on your screen. There will be quick 2 questions for you to answer. Also please check your emails from the GEDC and today's session. There is a course packet in the email for you to download that you can reference during today's meeting.

12:01:07 From Ula Hwang : Welcome all! Encourage you to turn on your cameras during this boot camp!

12:14:22 From Nida Degesys : @Elizabeth thank you so much for sharing your experiences. Delirium is a terrifying experience and I am sorry you and your family has had to experience that.

12:15:22 From Nida Degesys : And exactly why we in the ED have to advocated for our patients, and there are exceptions for visitors if they have dementia.

12:15:23 From Michael Malone : Thank you Elizabeth. We will work together to improve care.

12:15:31 From Katherine Possin : Very compelling and all too common story Elizabeth. Thank you for sharing.

12:15:58 From Elizabeth Edgerly : Thank you all for the work you're doing!

12:16:01 From Allison Domicone - Hirsch & Associates : Thank you Elizabeth for sharing your story. It means a lot to have your encouragement for this project!

12:16:02 From Lorraine Trecroce : And consider using the comments section to share your thoughts! We'll be following up on questions and ideas shared here.

12:17:08 From Sheila : done

12:30:48 From Chris Carpenter : GEDC has published numerous studies describing the frequency, diagnosis, and management of the scenarios Kevin is providing in his case vignette. We'll be sure that you have access to those on the GEDC website!

12:31:21 From Chris Carpenter : https://gedcollaborative.com/

12:45:58 From Lorraine Trecroce : The original case handout from your course pack (in case you missed it)

12:46:33 From Ula Hwang : Thanks Sheila!

12:47:31 From Ula Hwang : There is no right or wrong answer with these cases.

12:48:46 From Ula Hwang : Things you would want to learn more about patient mobility - ambulate at home

12:49:32 From Ula Hwang : Options for care instead of hospitalization - observation unit for additional care, family supports and resources

12:49:59 From Ula Hwang : setting up home health assistance, medications, evaluation of functional status with ADLs and IADLs

12:50:29 From Ula Hwang : Diagnoses known. Now challenge of risk / benefit of admission. Are there tools to weigh this?

12:51:11 From Ula Hwang : Home care with family may be better than hospitalization

12:51:25 From Ula Hwang : CURB65 tool that weighs mortality risks with admission

12:52:24 From Ula Hwang : Nursing perspective - challenge that many of these patients typically get admitted because of lack of social supports at home.

12:54:09 From Ula Hwang : Disposition and placement and discharge planning from the ED is challenging. How to have safe discharge

12:55:25 From Ula Hwang : Importance of SW in care transitions and support for patient safe discharge

12:59:42 From pam : did she actually take the medication or were they dropped on floor at home?

13:01:51 From Chris Carpenter : Helpful article on building a dementia friendly ED - see Table 3 on page 28.

13:03:12 From Chris Carpenter : Everything you ever wanted to know about ED dementia screening instrument accuracy - including a test-treatment threshold explaining one scenario as to "why screen?"

13:06:13 From Nida Degesys : assessments and screenings are a general theme throughout these cases.

13:06:43 From Ula Hwang : Important point by Nida - screening and assessment and change from baseline is key!

13:07:21 From Chris Carpenter : First step to implementing new protocols is raising awareness then facilitating acceptance - see attached Knowledge Translation article. Dementia is no exception to this KT Pipeline.

13:07:21 From aaron malsch : Agreed, critical thinking is the foundation to this work

13:09:28 From pam : Baseline cognitive and functional history is key

13:11:00 From pam : We bridge the evening social worker with an afterhours referral to our CM so that it can be addressed the next morning

13:11:33 From pam : Coordination of care

13:12:37 From BOiyemhonlan : Opportunity for utilization of callback/follow-up program

13:14:30 From pam : Call back/ follow up programs would be great. Who would make the call? which patients would get a call?

13:14:49 From kevinbiese : Observation units really important. Lauren Southerland at Ohio State has created a series of geriatric OBS protocols to help take care of patients late a night in a better space that are not quite ready to go home yet. She also published a paper this past year in Annals of EM on the models of Geriatirc EDs

13:15:38 From kevinbiese : One final comment on the cases - I never heard anything about the patient wishes, shared decision making, goals of care etc. How can we weigh risk and benefits without starting with the patient goals of care?

13:16:58 From pam : Great observation Kevin and I think this mirrors real life in the ED

13:21:51 From pam : SF teams you have a valuable resource in the Alzheimer's Association and they are engaged as evidenced by Elizabeth's presence on this call.

13:22:40 From i310826 : Thank you, Aaron, for sharing care transition mode. What is the frequency of the TUG test performed in ED ? Ty

13:23:11 From Ula Hwang : Great question! TUG is the timed up and go an assessment for falls risk

13:23:36 From Ula Hwang : I can try to answer from our experience here at Sinai - We try to do this on our older adults that are identified at risk.

13:23:43 From Ula Hwang : The challenge is space

13:23:52 From i310826 : Thank you

13:23:58 From Ula Hwang : You need space to walk the patient in the ED about 10 meters from a sitting position

13:24:07 From Chris Carpenter : Information on older adult shared decision making

13:24:18 From Ula Hwang : Ours nurses and techs are trained to do this

13:24:33 From Ula Hwang : but don't always have and space to do it

13:25:07 From Chris Carpenter : Lauren Southerland's Annals EM manuscript on different models of Geriatric ED care mentioned by Kevin, including her Ohio State Observation Unit model.

13:25:08 From i310826 : Any criteria when PT is ordered after TUG completed? Ty

13:26:36 From Jeremy Swartzberg : It seems like ISAR is the most popular tool to identify patients to get GED services. Is there movement to use other tools instead? Why or why not?

13:27:49 From pam : We are fortunate to have PT based in our ED and they will screen patients and see patients with high risk for falls and rarely use the TUG. We are encouraging our nurses especially after hours to do a 10meter walk instead of the TUG

13:27:55 From Elizabeth Edgerly : SF is such a highly diverse city - having tools and resources that are culturally appropriate is an added challenge. Also, 30% of persons with dementia in SF live alone.

13:28:35 From pam : Jeremy, my hospital uses TRST instead of ISAR.

13:28:49 From Chris Carpenter : Agree that cultural appropriateness of dementia screening tools is essential. In St. Louis, we found that MOCA identified ~90% of African Americans as cognitively impaired.

13:28:50 From kevinbiese : ISAR is most popular in GED land - no real great reason but easy to use and I hypothesize that it actually functions as an educational tool for the staff - you start asking ISAR questions and you understand your patients better, even if the screener cut off is not significantly precise to really determine who is at risk of bad outcome after ED discharge

13:29:02 From Ula Hwang : ISAR actually has poor predictive ability, but has now become most commonly used by many EDs. As a self report of 6 questions, it seems to have gained most traction by GEDC sites probably for ease of use. Other popular tool is TRST

13:29:08 From Ula Hwang : Triage Risk Screening Tool

13:29:58 From Nida Degesys : does trst have better predictive ability?

13:30:31 From kevinbiese : Worth noting that PT in the ED is reimbursable; many EDs screen any patient not obviously ambulatory with TUG and then positive screens get PT in ED consult (or sometimes next day)

13:31:04 From aaron malsch : For the TUG, CDC states >12 sec, but we use >14 as our trigger to consult PT to do a full assessment in the ED.

13:31:20 From aaron malsch : Our PT bills as Out patient services

13:31:40 From i310826 : Thank you

13:31:47 From Chris Carpenter : Regarding TRST vs. ISAR, both have positive likelihood ratio ~1.0 and negative likelihood ratio ~1.0 for any outcome at any timeframe. A good LR+ is >10 and a good LR- is < 0.10 (to identify high- and low-risk subsets respectively).

13:32:45 From Nida Degesys : Are you finding that most geri patients struggle to do the TUG? We are moving towards using other fall risk assessment tools of STRATIFY and STEADI

13:33:09 From Chris Carpenter : Here is citation for ISAR, TRST, and multiple other predictors of geriatric ED patient "vulnerability" https://onlinelibrary.wiley.com/doi/full/10.1111/acem.12569

13:33:26 From aaron malsch : TRST vs ISAR—as Chris said are relatively poor instruments. We found the 'true' value of this screening is the practice change in RNs and MDs addressing the unique challenges of older adults—getting past the 'treat m' & street m'

13:34:05 From Marlena : video is great

13:34:07 From kevinbiese : As per Chris comment - the ISAR and TRST don't really differentiate who is at risk by a certain score, but I think utilizing them teaches us all how to approach our patients, for example Aurora hospitals with up to 33% relative decrease ED revisit within 30 days after implementing ISAR< home health, and mobility screening - the screens themselves are not discriminatory but the ED cultural evolution seems impactful

13:35:04 From Ula Hwang : video VERY effective teaching tool

13:35:17 From Ula Hwang : Geriatricscareonline.org

13:36:49 From Chris Carpenter : Some elaborations on why ISAR and TRST have less predictive ability than desired and next steps https://emj.bmj.com/content/33/1/2.long and http://www.njmonline.nl/getpdf.php?id=1760 We've got another editorial with updated thoughts that will be online early at the Journal of the American Geriatrics Society within a week.

13:36:55 From Ula Hwang : Delirium screening - who will do this screening? how to incorporate into ED care workflow

13:37:48 From kevinbiese : In our ED we do RAS at triage and then if abnormal, BCAM by bedside nurse

13:38:36 From Nida Degesys : we are thinking of using AWOL+nuDESC and then bCAM as appropriate

13:39:24 From Nida Degesys : @vanja perhaps you could speak to those

13:39:26 From pam : Delirium Triage Screen - RASS and spell LUNCH backwards if positive then BCAM and deciding who will complete the BCAM and where and what happens with the information

13:39:27 From Jeremy Swartzberg : We built the DTS->bCAM into a dot phrase that physicians can use (optionally) as part of their neuro exam dot phrase template.

13:40:27 From Ula Hwang : UCSF hospital wide nudesc screening already implemented.

13:41:11 From Chris Carpenter : As far as I know, my team is working on diagnostic meta-analysis of ED delirium screening instruments NUDESC has not been validated in ED settings. Correct?

13:41:38 From Chris Carpenter : Lack of ED validation means we're not sure how accurate or inaccurate NUDESC is relative to bCAM.

13:41:41 From Jennifer Wong : What does everyone do for non-English speaking patients? What do you ask in lieu of spelling LUNCH backwards?

13:41:44 From Vanja Douglas : I think you are correct Chris - NuDESC not validated in ED to my knowledge.

13:41:49 From Michael Malone : nuDESC was chosen by the ED at Emory /Grady hospital

13:42:00 From Vanja Douglas : However, it has been validated in PACU setting.

13:42:34 From Oriana Edsall : there is no delirium screening currently at UCSF ED for nurses

13:43:17 From Marlena : good question about non English speaking pt!

13:44:32 From Vanja Douglas : Spelling a 5 letter word backward works for Romance languages, German, English, Russian. Arabic and East Asian language speakers better to use serial 7s or digit span (forward or backward).

13:45:27 From Vanja Douglas : Since we assess delirium risk using AWOL on all admitted patients (which includes WORLD backwards), we have a translation algorithm reflecting above that we can share.

13:45:29 From Nida Degesys : AWOL (dual dementia/delirium screening) is in 6 languages

13:50:06 From Chris Carpenter : In addition to accuracy, these are highlighted because they are simple and feasible for ED use.

13:50:38 From Chris Carpenter : Lots of problems with the ED-based studies for all of these dementia instruments - all highlighted in the meta-analysis.

13:52:12 From Ula Hwang : Dementia vs. delirium. Will need to do both.

13:52:39 From Ula Hwang : screening first for delirium, if negative then dementia screening

13:53:36 From Nida Degesys : Eds should not be diagnosing dementia. We can screen for risk for dementia and cognitive impairment, but not diagnose it

13:53:55 From Chris Carpenter : Agree completely - we cannot and should not diagnose dementia.

13:54:44 From pam : Agree with above statements. Not diagnosing but having appropriately follow up

13:55:07 From Katherine Possin : Yes I agree with Nida and Kevin, although there is no pharmaceutical treatment to slow dementia, there is so much that can be done to improve care for other conditions and link to supportive care services (including the Alz Assoc resources) that can improve quality of life and reduce caregiver burden, and in some RCTs reduce ED visits (eg, Care Ecosystem)

13:55:10 From Vanja Douglas : Interesting that AWOL is essentially same as Ottawa 3DY (world backwards, series of orientation questions) - identifies patients at high risk for developing delirium after admission.

13:55:17 From Chris Carpenter : However, I don't think our inability to definitely diagnose dementia is a reasonable argument to not screen for cognitive impairment.

13:55:57 From Nida Degesys : we def should screen!

13:56:38 From Chris Carpenter : I spend an hour every week at our Wash U Alzheimer's Dementia Research Center and even after months of testing (LP, PET scans, hours of neuro-cognitive testing), they even argue about whether dementia is present or absent.

13:56:50 From Katherine Possin : Even a documented diagnosis of cognitive changes or memory impairment can help guide care (if not dementia)

13:57:00 From Chris Carpenter : Agreed Katherine!

13:57:25 From Vanja Douglas : Awesome boot camp - thank you so much for your insights. Sad we couldn't do this in person but this was fantastic.

13:57:32 From Chris Carpenter : Communicating ED screening results and next steps to patients/families is another issue. We don't want to scare patients!

13:58:09 From Chris Carpenter : I enjoyed "meeting" all of you and look forward to seeing you in San Francisco someday soon! Stay healthy everyone!

13:58:12 From Edgar Pierluissi : I agree. This was very insightful and fun.

13:58:13 From Katherine Possin : Thinking about economics, Medicare advantage plans now provide an added risk adjustment payment when dementia diagnosis is coded, esp. with complications. So when you are confident, there may be an economic benefit for the health system in diagnosing. Perhaps Dr. Bott is thinking about this.

13:58:13 From Lorraine Trecroce : Thank you for participating, everyone! We have a three-question survey for you to fill out so we can tailor future content and improve our future virtual boot camps. Please share your feedback here: https://us4.list-manage.com/survey?u=528454b8e9eab7ae41bd3b06e&id=153e1729a2

13:58:42 From Oriana Edsall : Thank you, hope to see this take off in our ED.

13:59:54 From Elizabeth Edgerly : GEDC is such an exciting project. Thank you all for your work on this!

14:00:05 From Nida Degesys : @ula which two dementia screenings did you recommend as the two to use? The packet has all of them

14:00:27 From Chris Carpenter : O3DY to rule out and AMT4 to rule in for dementia

14:00:31 From Susie Whipps RN : Looking forward to implementing more tools in our Kaiser SF ED. Very helpful, thank you!

14:00:44 From Allison Domicone - Hirsch & Associates : Thank you all for your time and participation!

14:00:48 From Nida Degesys : Cab you make the feedback link live, can't copy from chat

14:01:13 From Lorraine Trecroce : https://us4.list-manage.com/survey?u=528454b8e9eab7ae41bd3b06e&id=153e1729a2

14:01:16 From i310826 : Thank you from Kaiser SF Physical Therapists.

14:01:24 From Lorraine Trecroce : https://us4.list-manage.com/survey?u=528454b8e9eab7ae41bd3b06e&id=153e1729a2

14:01:55 From Nicholas Stark : Thank you!

14:02:04 From Katherine Possin : Great meeting!

14:02:10 From pam : We are gathering a list of EDs that have physical therapists embedded and happy to connect you with them if you have specific questions