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# Rural and Remote Geriatric ED Care

**Expert Panel Webinar**

Monday, August 14, 2023

3:00–4:00PM EST

Moderated by:



**Don Melady, MD, MSc(Ed)**

Emergency Physician

Mount Sinai Hospital, Toronto, Canada

GEDC Faculty

# What are some challenges or advantages of providing care to older patients in rural EDs?

175 Registrants from 10 Countries

## **What are some challenges OR advantages of providing care to older patients in rural EDs?**

**Access to transportation**

**Access to resources in the ED**

**Fewer community resources**

**Inadequate training and education for ED staff**

**High locum rates**

**Lack of reimbursement for enhanced care models for older adults**

**Easier access to resources in the community**

**There is no overcrowding, most of the patients are familiar with ED so their problems are known by ED staff.**

**People know each other**

**Quality care for older adults ensures best quality of life for rural communities**

[gedcollaborative.com](https://gedcollaborative.com)

## Mission & Vision

A world where all emergency departments provide the highest quality of care for older patients.

We transform and evaluate interdisciplinary best practice in geriatric emergency medicine, and then build and distribute practical, evidence-based clinical curriculum and quality improvement tools that support sustainable, quality care for older adults.

<https://gedcollaborative.com/membership/>

## Membership

GEDC Members work together to transform ED care of older adults; catalyze action at local and national levels to support these care transformations; and evaluate the impact of these new models of care for older people.

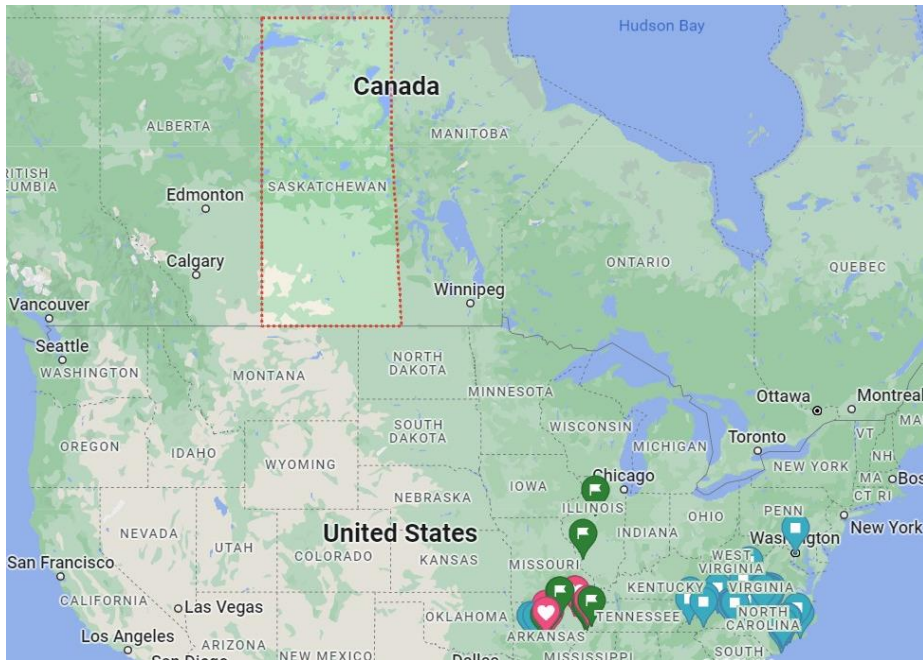
- **Make your plan to become a GED**
- **Access to GEDC Community**
- **Participate in consulting services**
- **Access to education tools**
- **Implementation tools and training**
- **Evaluation resources**



**Join  
the  
GEDC**

# Meet Your Expert Panel

What questions do you have for our panelists?



**Kristie R. Foster BSN, RN**

ED Nurse Manager/ Clinical Nurse Educator  
Alice Peck Day Memorial Hospital  
Dartmouth Health  
Lebanon, New Hampshire



**Kevin Wasko, MA, MD, CCFP(EM), CCPE**

Chief of Emergency Medicine and Program  
Medical Director, North York General Hospital  
Previous role: Physician Executive, Integrated  
Rural Health, Saskatchewan Health Authority



**Colleen McQuown, MD**

Director of SCOUTS (Supporting Community, Outpatient,  
Urgent Care & Telehealth Services)  
US Department of Veterans Affairs  
Cleveland, Ohio



**Brock Slabach, MPH, FACHE**

Vice-President, Chief Operations Officer  
National Rural Health Association  
Leawood, Kansas

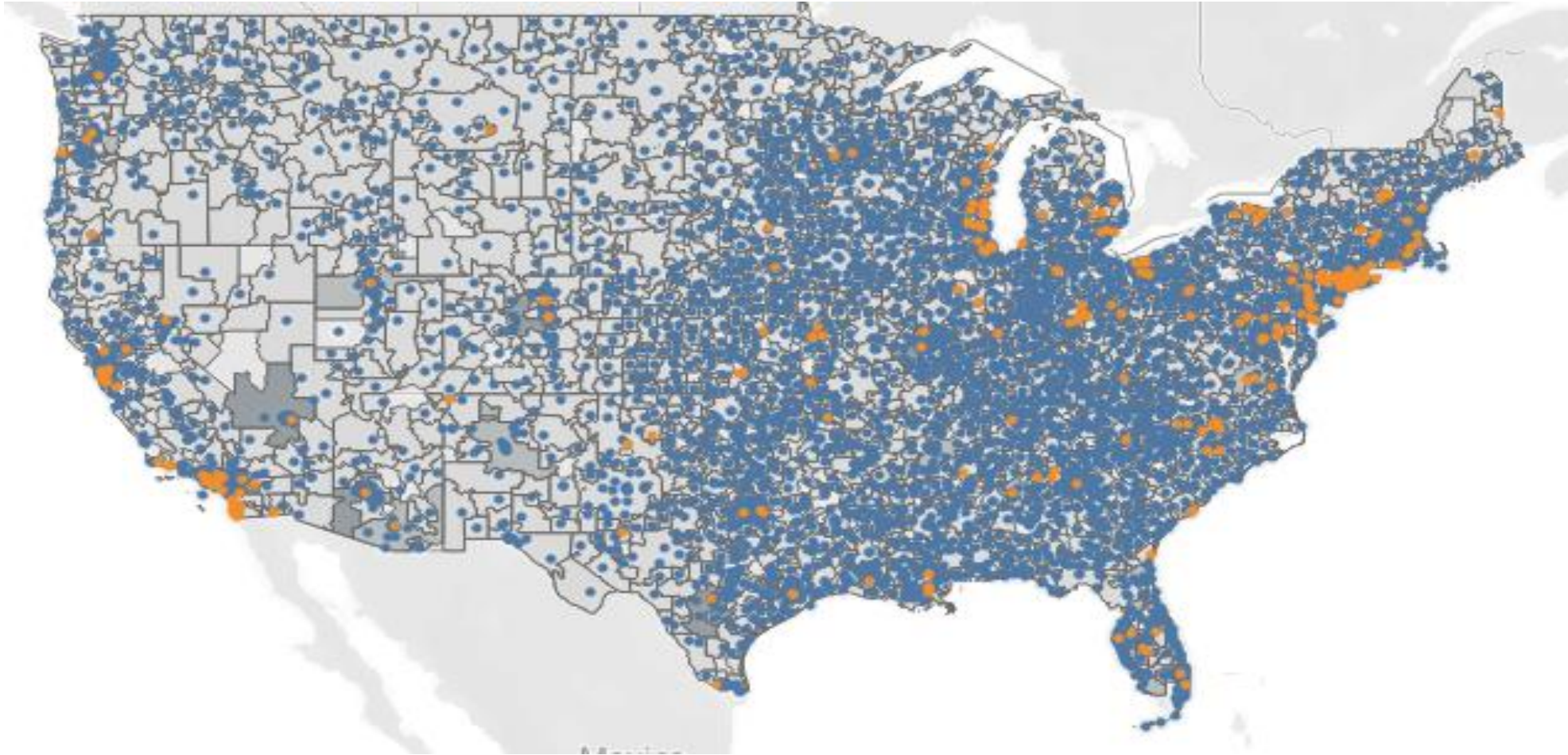
# GED Heat Map: Rural Market

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August 14th, 2023

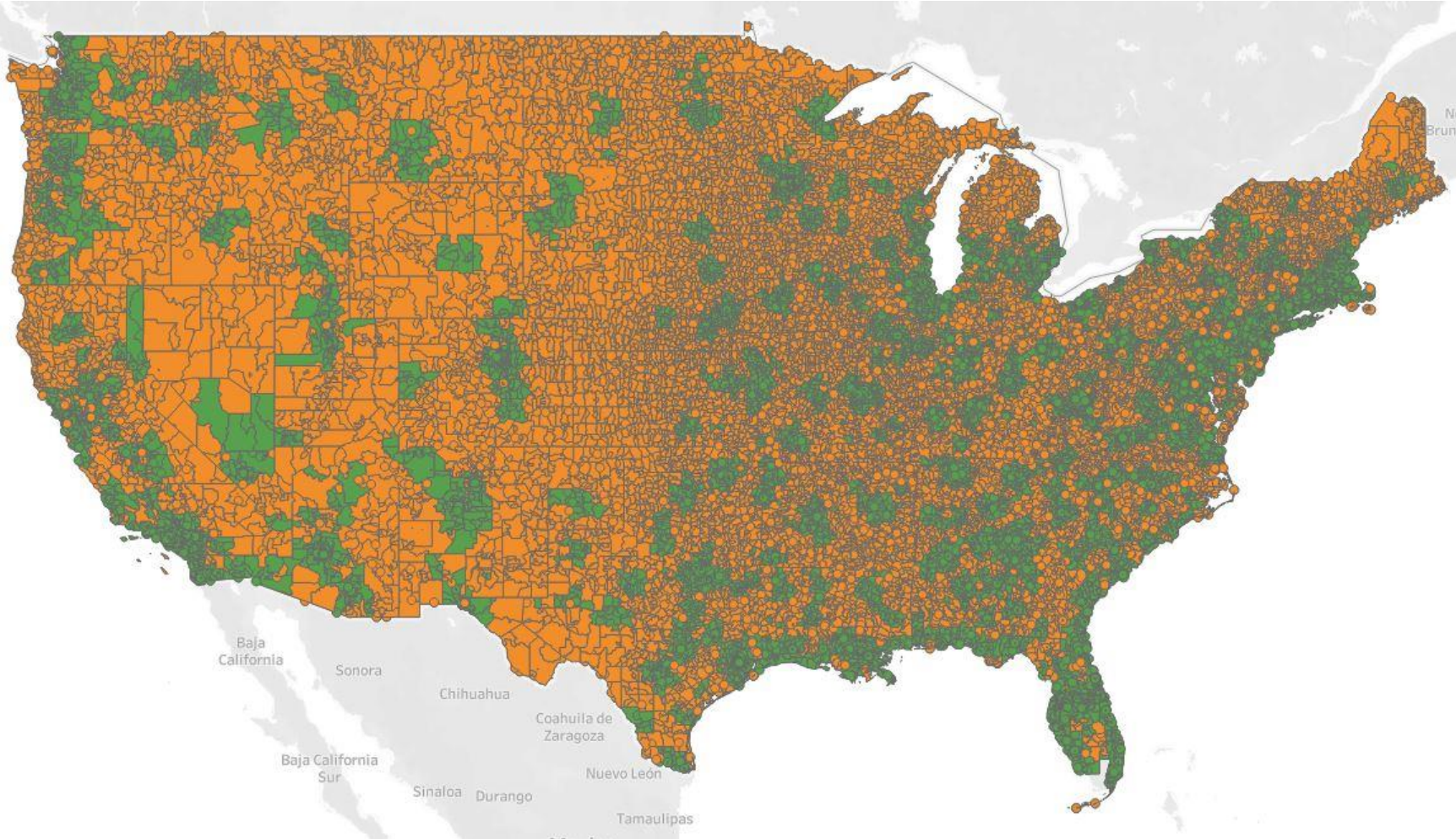
# US Emergency Departments by GED Status

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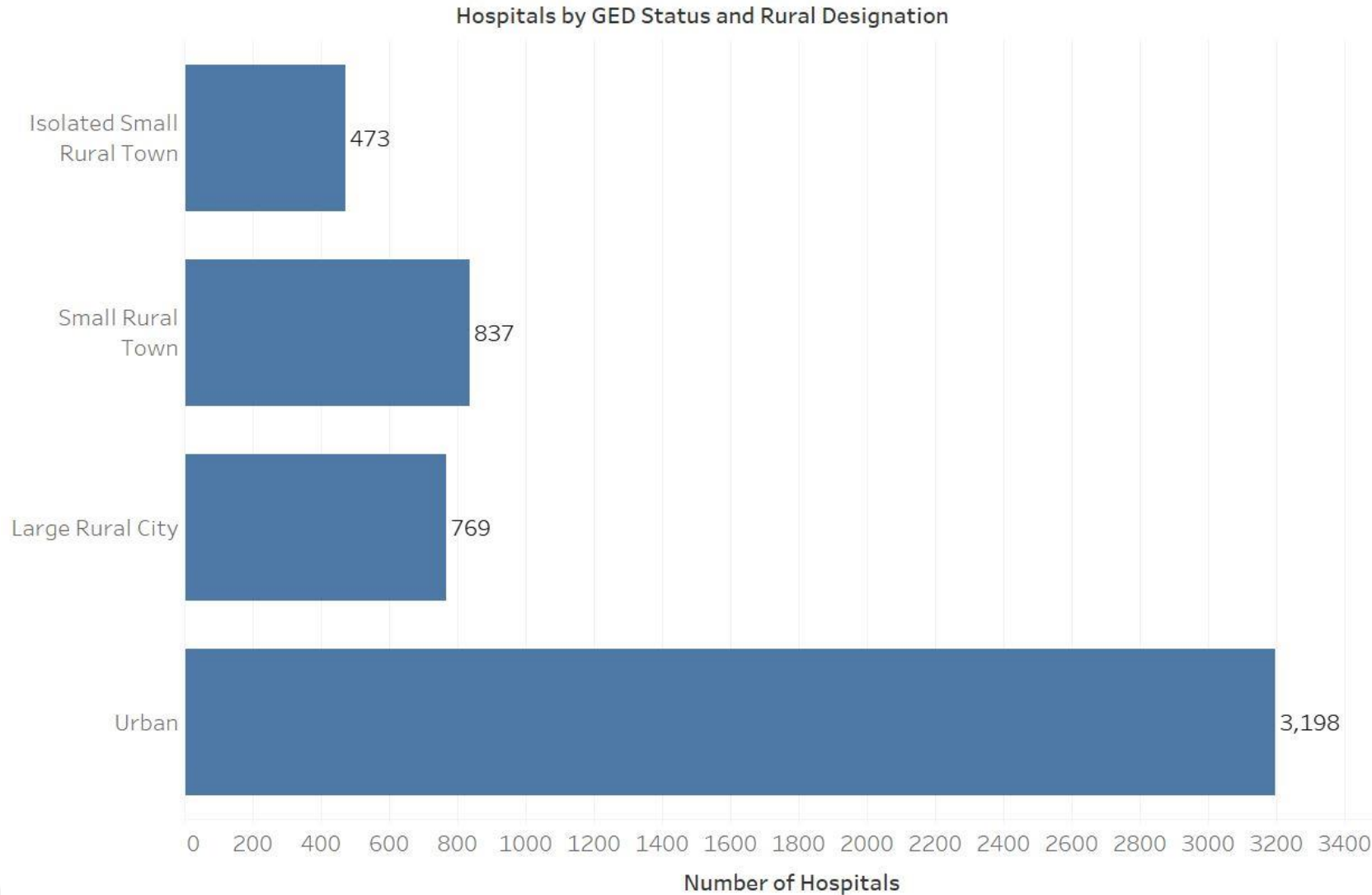
# Visualization: Geographic Rurality

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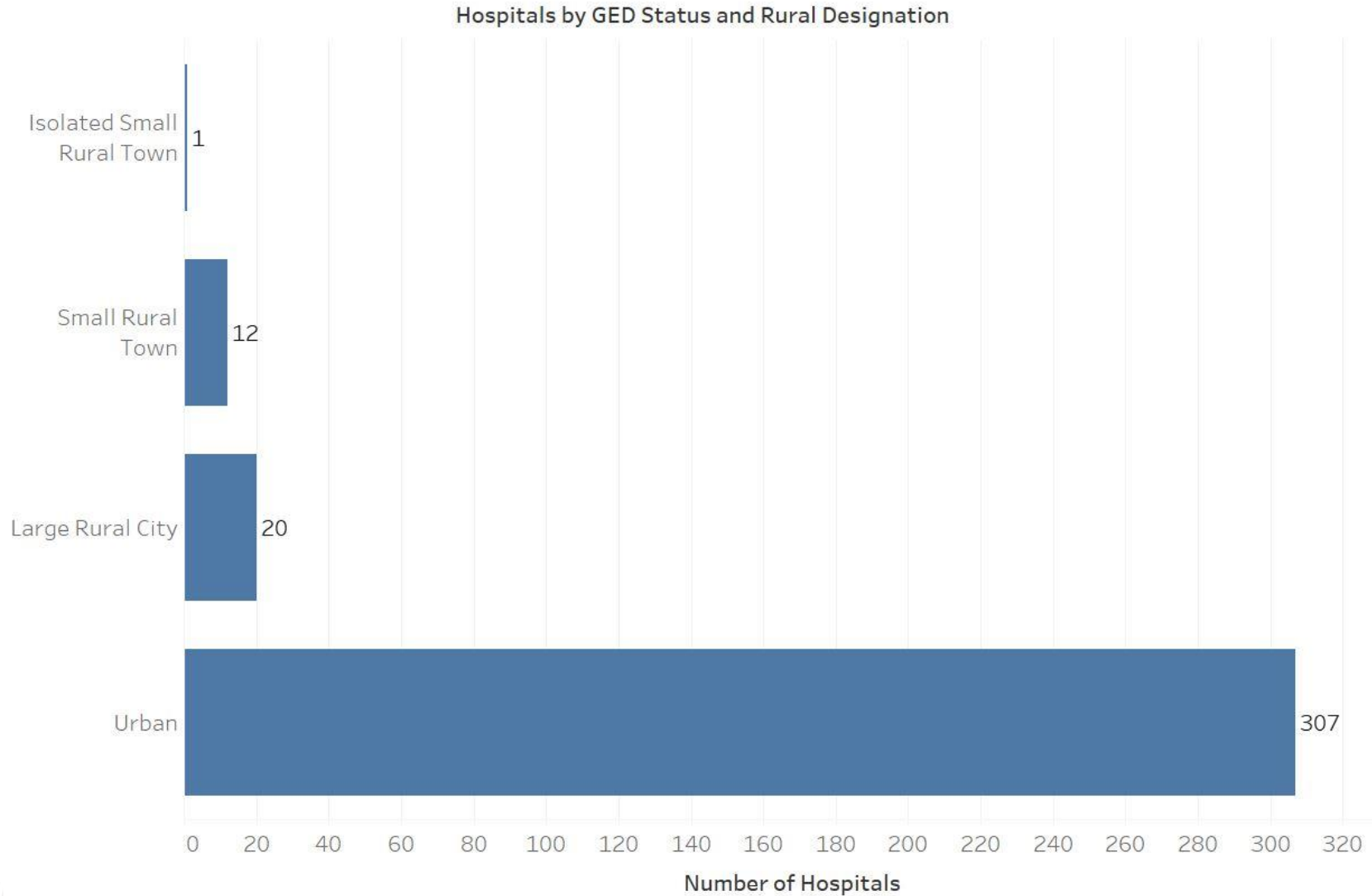




# ED's by Rural Designation



# GED's by Rural Designation



# Overview

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- **% of older adults living in Rural vs. Urban per RUCA**
  - 13.35 million older adults live in rural areas (about 17%)
- **# of GEDA that are Critical Access Hospitals**
  - 15 GED's are CAH
- **# of rural sites that are GEDA**
  - 33 GED's are in Rural areas



Don Melady



# Geriatric Care in a Rural ED with Kevin Wasko



# Take away points: Brock Slabach

1. Long-term strategies to improve recruitment and retention: “grow your own” (longer timeline); address pain points in day-to-day operations (like providing more options for older person care.)
2. Access an out outside consultant (like GEDC) to assess your resources and needs.
3. Smaller centers have many advantages in providing older person care: a more cohesive community; care providers who know the community better and are more connected to it; easier to establish connections with nursing homes to prevent ED transfers.
4. Use the 4M model as a way of organizing care.

# Take away points: Kevin Wasko

1. Changes don't need to be complex or extensive: Basic and practical changes can have an impact.
2. Universal Screening of seniors presenting to the ED is a proactive way to identify those living at risk.
3. System Integration at the local level improves care for seniors.

# Take away points: Kristie Foster

1. Explore community resources available in your community, there are likely opportunities for collaboration that already exist.
2. Care of patients should not end at the ambulance door. Follow-up care is a needed resource to bridge care gaps, improve patient satisfaction and decrease readmission rates.
3. Take the time to listen to what your patients want and explore what matters most to them to guide treatment plans and resource planning.



# Take away points: Colleen McQuown

1. When the emergency department providers can assure patients unmet home and healthcare needs are identified and addressed in a timely manner, they are more likely to choose discharge over admission.
2. The follow up home visits gives an additional opportunity to address the cause of the ED visit.
3. Single home visit can help the whole healthcare team implement a patient centered plan.

# ACEP Journal of Rural EM



Resources

Meetings

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## Resources

### Journal of Rural Emergency Medicine

#### Issue One (PDFs)

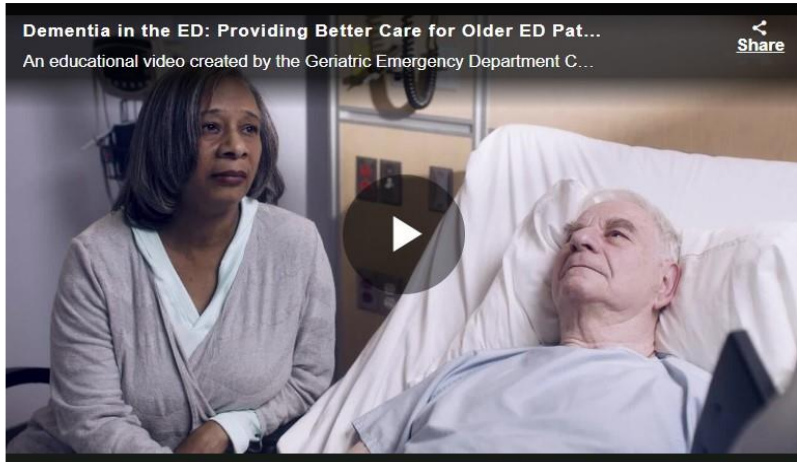
- ≡ Celebrating the Birth of a Journal
- ≡ Rural Emergency Medicine and the American College of Emergency Physicians: The Time is Ripe for Enhancing Two-Way Communication
- ≡ Malpractice as a Perceived Barrier to Specialist Referral for Physicians Practicing in Rural Emergency Departments
- ≡ Stigma of Rural Emergency Medicine
- ≡ Dementia and the Rural Emergency Department
- ≡ Evidence Based Medicine and the Rural Emergency Physician
- ≡ The Rural Emergency Physician Workforce
- ≡ Relative Survivability of Cardiopulmonary Arrest in Rural Emergency Departments Utilizing Telemedicine

<https://www.acep.org/rural/resources>

# Learn More: AARP Videos

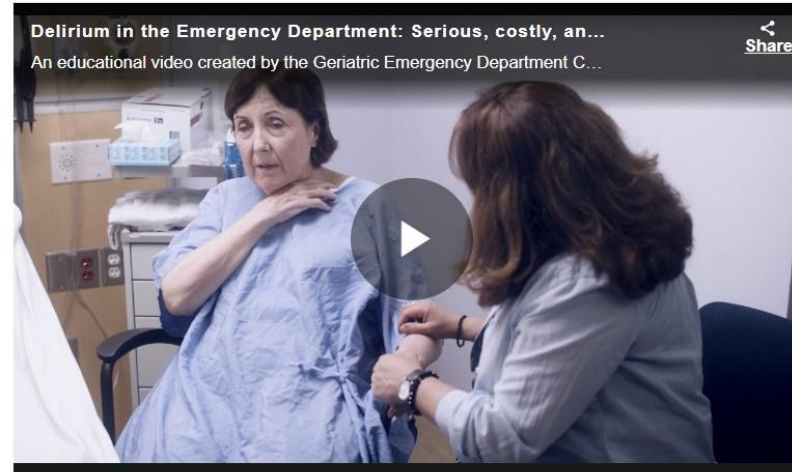
## Dementia in the ED: Providing Better Care for Older ED Patients

A diagnosis of dementia affects every step of the ED process from assessment, treatment, to discharge planning. And what if a diagnosis isn't on the medical record? Watch the video to gain some tips and insights.



## Delirium in the ED: Serious, Costly, and Potentially Deadly

Delirium is a frightening experience for patients and caregivers and has serious medical consequences including increased risk of readmission and death. Watch the video to see why it's easy to miss delirium in the ED, and how we can take simple steps to identify delirium, and even prevent it from developing during an ED visit.



<https://gedcollaborative.com/article/brain-health-in-the-ed-videos/>



## Q & A

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Ask your questions  
in the chat!

We will try to get to everyone

# Resources

- ACEP Journal of Rural EM <https://www.acep.org/rural/resources>
- AARP Videos: <https://gedcollaborative.com/article/brain-health-in-the-ed-videos/>

## Kevin

- Geriatric Care in a Rural ED Kevin Wasko Video: [https://www.youtube.com/watch?v=Z\\_dRly2iO3Q](https://www.youtube.com/watch?v=Z_dRly2iO3Q)
- InterRAI ED Screener: <https://interrai.org/wp-content/uploads/2020/07/interrai-ed-a4.pdf>

## Kristie

Kinder Fall Scale: <https://pubmed.ncbi.nlm.nih.gov/27160606/>

## Colleen

- SCOUTS pilot paper: <https://doi.org/10.1111/1475-6773.14058>
- ICTs as a geriatric EM workforce: <https://doi.org/10.17294/2694-4715.1014>

## Brock

- IHI Age-Friendly Health Systems: <https://www.ihl.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/default.aspx>

# APD Fall Prevention Program

## Kinder Fall scale (ages 18 years +)

**Fall Risk** ↑ ↓

Time taken: 3/2/2021 1230 Responsible Show Row Info  Show Last Filed Value  Show Details  Show All Choices

Fall Risk - Kinder 1 ↑

**Present to ED due to fall?**  
1=Yes 0=No 📄

**AGE GREATER THAN 70?** Examples include disorientation, impaired judgement, poor safety awareness, or inability to follow instructions  
1=Yes 0=No 📄

**Altered Mental Status?** Examples of when a patient is considered to have impaired mobility; Ambulates or transfers with assistive devices or assistance; unable to ambulate or transfer  
1=Yes 0=No 📄

**Impaired Mobility** Factors that could pose a fall risk, e.g. bowel or bladder incontinence, diarrhea, urinary frequency, incontinence, sensory deficits, orthostatic hypotension, dizziness, vertigo, medications such as narcotics or sedatives  
1=Yes 0=No 📄

Nursing Judgement Score > 1 is considered a fall risk and safety interventions should be implemented 📄

**Intervention Score - Kinder 1**  
[Progress bar]

**Safety Management** ↑

**Safety Promotion/Fall Prevention**

activity supervised  assistive device/personal items within reach  clutter free environment maintained  elopement precautions initiated  fall prevention program maintained  lighting adjusted 📄

mobility aid in reach  nonskid shoes/slippers when out of bed  room organization consistent  safety round/check completed  toileting scheduled  other (see comments)

**Enhanced Safety Measures** 📄

bed alarm set  bed alarm refused  chair alarm set  family to remain at bedside  mattress on floor  monitored by video  protective helmet on  room near unit station  safety attendant at bedside 📄

security transponder on  other (see comments)

**Medication Review/Management**

medications reviewed  dosing adjusted  high-risk medications identified  infusion held  infusion initiated  infusion titrated  pharmacy consulted  provider consulted  other (see comments) 📄

Restore Close Cancel ↑ Previous ↓ Next

## Kinder score and associated interventions

Patients 18 years and older that present to the ED will be screened for fall risk using the Kinder Fall Risk Scale. If the Kinder screen is positive (score >1), staff will place a fall risk bracelet and yellow non-slip socks on the patient. Other fall risk interventions will populate below the kinder scale in a check box fashion. Interventions that are appropriate should be checked off and implemented.

The bedside nurse ensures that all related screening takes place and informs the provider of positive results.

The provider further evaluates the patient's condition to determine a clinically appropriate follow-up plan which may include the following:

- PT/OT consult in the ED
- Referral to outpatient PT/OT



Except in extreme circumstances, alternatives to physical and chemical restraints should be implemented prior to the use of physical restraints. These can include the following:

### Treatment Modifications

- Removal of drains and catheters as soon as possible
- Keeping drains and catheters out of sight of patient
- Addressing/relieving patient's discomfort/pain
- Frequent toileting
- Maintenance and promotion of adequate nutrition and hydration
- Promoting/encouraging mobilization

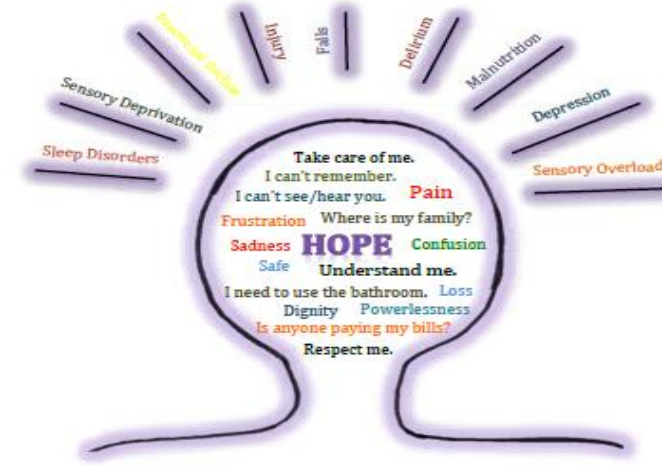
### Environment Modifications

- Adjusting lighting to create a calm environment
- Reducing environment noise
- Providing vision and hearing aids as indicated.
- Placing the call bell within easy reach
- Placing bed alarm if fall risk
- Encouraging family/loved ones to be at bedside
- Minimizing interruptions
- Providing calm music if desired
- Providing a trained sitter for direct supervision if needed

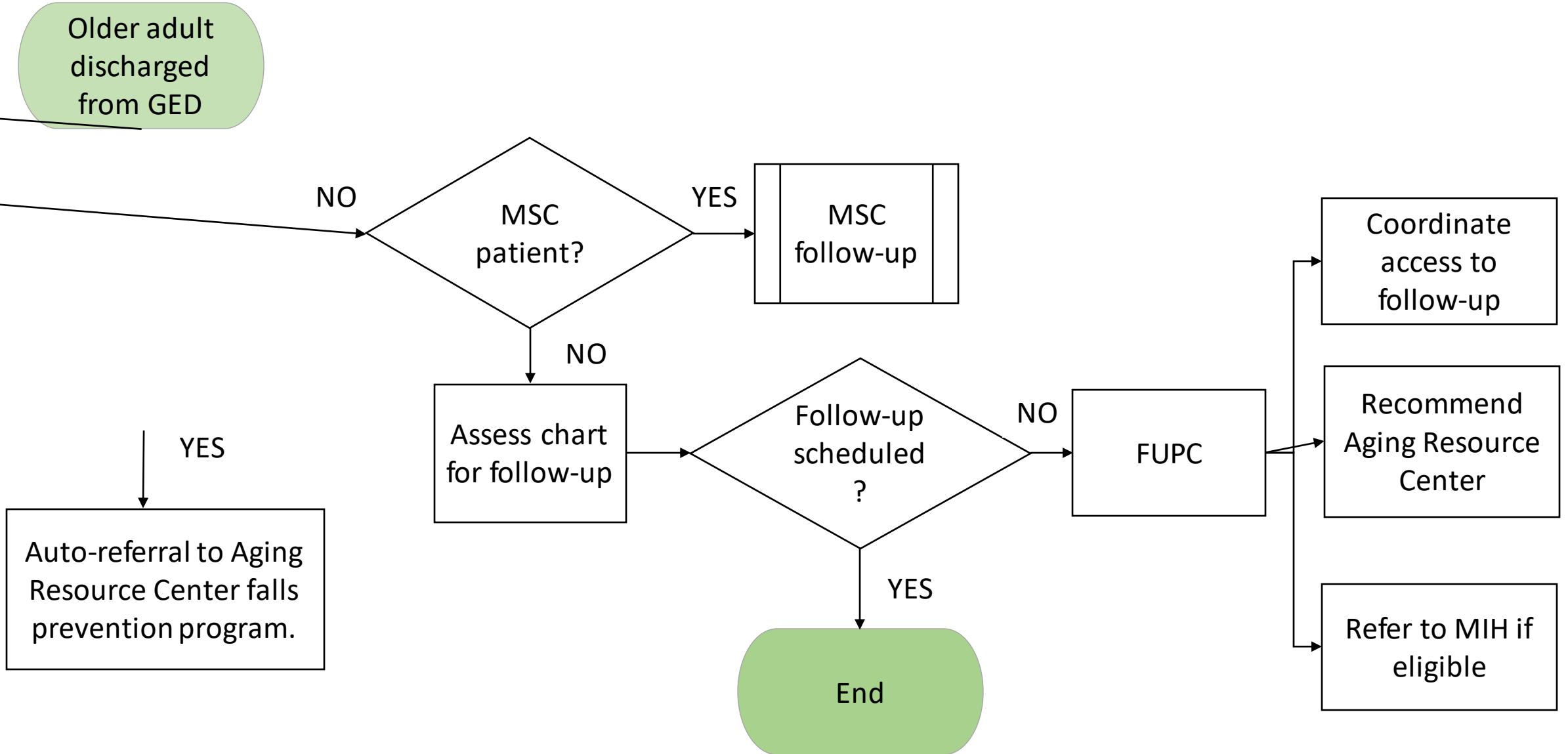
### Diversion

- Inviting/encouraging family presence
- Providing a volunteer visit for games, conversation
- Providing music, TV or radio
- Providing cards, magazines, puzzles
- Take care kit

## TAKE Care Kit Therapeutic Activity Kit



# Post ED Visit planning and resources







OUR NEXT GEDC  
EXPERT PANEL WEBINAR

## Community Paramedicine and Geriatric EDs

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**November 6, 2023**  
**3-4pm EST**



Register now:

<https://gedcollaborative.com/event/community-paramedicine-and-geriatric-eds/>





# GEDDC

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We bring best practice into action.

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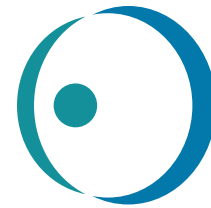
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GEDDC membership application



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