00:29:50 Conor Sullivan: Dear Colleagues,
Thank you for participating in the Geriatric Emergency Department Collaborative's webinar on September 14, "Dementia in the Geriatric Emergency Department"

Today's webinar is being recorded and a link the recording and the slides will be on the GEDC website event page later today. Link to the webinar recording and slides: https://gedcollaborative.com/event/webinar-the-dementia-friendly-ed/

Check out essential COVID Resources on the GEDC website https://gedcollaborative.com/resources/

Many thanks,
GEDC team

00:30:30 Michelle Moccia: Hello everyone. Welcome!
00:31:17 Conor Sullivan: Check out GEDCOLLABORATIVE.com
Please follow us on Twitter @theGEDC
and Don Melady @geri_EM

Check out Resources on the GEDC website https://gedcollaborative.com/resources/

00:31:53 Conor Sullivan: The GEDC is generously supported by the John A. Hartford Foundation and the Gary and Mary West Foundation. Thank you!
00:33:10 Conor Sullivan: Reminder: PLEASE USE THE CHAT ICON." For all your questions and comments to be seen, please be sure to have your chat set to "All panelists and attendees"
00:33:41 Jeremy Swartzberg: Oakland, CA. ED physician
00:33:42 kathleen jones: Kathleen Jones, MD, MBA
00:33:43 Marlena TANG Work: San Francisco, ED MD
00:33:44 Jen Raymond: Jen Raymond, DHMC Lebanon NH, Project Manager
00:33:46 820029: Social Worker at Advocate Aurora Health
00:33:47 Michael Jorolemon: Syracuse, NY - Senior Quality Officer for EM
00:33:50 Heidi Martin: UAB Highlands Emergency Department, Birmingham, Alabama Nurse Manager
00:33:52 Kathleen Wieliczko: Kathy Wieliczko, Geri ED Social Worker DHMC
00:33:53 Christian Nickel: Switzerland, ER physician
00:33:55 James van Oppen: Leicester, UK - ED Registrar
00:33:58 David Larson: Medical Director and Chief of Staff
00:33:58 Jennifer Wong: San Francisco, ED RN
00:33:58 MLFink: Atrium Medical Center-Middletown , Ohio. Program Mgr of Geriatric ED
00:34:02 Konstantin Vatrenko: Attending, Berkshire MC
00:34:03 Courtney Genge: Courtney Genge, Toronto Ontario. National Research Council of Canada.
00:34:03 Elizabeth Rogers: Bedford, MA Geropsychology Fellow

00:34:05 Audrey-Anne Brousseau: Dre Marie-Laure Collinge and I (Audrey-Anne Brousseau) are Emergency Physicians from Sherbrooke (Quebec, Canada)
00:34:05 Hidetake Yamanaka: Ottawa, Canada - Nurse Practitioner Nurse led Outreach Team
00:34:05 Ula Hwang: Ula Hwang, Joining from Bronx VA GRECC, co-PI of GEDC
00:34:06 Valerie Scarfone: attending from Sudbury Ontario Canada Director of North East Specialized Geriatric Centre / Health Sciences North
00:34:06 Charlotte Bumstead: BSO Coordinator Enhanced Psychogeriatric Resource Consultant RN from Grey Bruce Health Services, Owen Sound
00:34:07 Megan Kemnitz: Durham, NC. ED physician at the Durham VA
00:34:07 Kathie Pulchinski: Kathie Pulchinski
00:34:08 Christine Binkley: Chapel Hill, NC - Geriatric EM Fellow
00:34:08 Adriane Lesser: Adriane Lesser, West Health Institute
00:34:11 David Larson: Waconia, Minnesota
00:34:11 Rosa McNamara: Ireland calling... emergency department St Vincent's hospital, Dublin
00:34:17 Linda Schnitker: Australia, RN, researcher.
00:34:18 Nadine Benoit: Hackensack University Medical Center, New Jersey . I am the Hospital Elder Life Program Elder Life Specialist.
00:34:19 Todd James: Todd James, UCSF, California, Geriatrics lead
00:34:20 aaron malsch: Aaron Malsch, RN. Geri ED System Manager
00:34:20 Pamela Martin: Bon Secours St. Mary's Hospital, Richmond VA- Senior Services ED NP and Program Director; GEDC faculty
00:34:20 Carl Berdahl: Cedars-Sinai Medical Center, Health Services Researcher working to improve quality of ED care for older adults
00:34:21 david mason: Syracuse NY ED medical director
00:34:21 Kevin Corcoran: Kevin Corcoran GED Syracuse VA
00:34:29 Jamie Davis: Galway, Ireland - EM Physician (Specialist Registrar)
00:34:29 Patti Pagel: Senior Services, Advocate Aurora Wisconsin
00:34:32 kathleen jones: Kathleen Jones, MD
00:34:32 Deborah Conley: Hi everyone, I am from Methodist Hospital Omaha NE (Service Executive Geriatrics))
00:34:34 Naomi Cheechoo: North Bay, Ontario, Canada. Emergency Department GEM RN
00:34:37 Martha Radovich: Marty Radovich Geriatric Clinical Specialist in Physical Therapy at Kaiser-SF
00:34:41 Christine Leskovar: Social Worker- Behavioural Support, Guelph Ontario
00:34:44 Kathie Pulchinski: Kathie Pulchinski from Ridgeview Medical Center in Waconia , MN, Nurse manager
00:34:55 Sangita Singh: Implementation Coach, Regional Geriatric Program of TORONTO
00:35:04 Nancy Wexler: Nancy Wexler, Program Officer, The John A. Hartford Foundation NY NY
00:35:05 Lauren Cameron Comasco: Lauren Cameron-Comasco, EM physician and GEM fellowship director, Beaumont Health, Royal Oak, MI
00:35:12 Michael Malone: Advocate Aurora Health WI and IL
00:35:29 kathleen jones: Palo Alto Veterans Administration, Ca
00:35:32 JANE CARMODY: The John A. Hartford Foundation, program officer. So pleased to attend this webinar on emergency care for people living with dementia. Thank you, GEDC team!
00:36:24 Virginia Painter: Geriatric Patient Navigator, Geriatric ED, Marrero, LA

00:36:34 Conor Sullivan: Today's webinar is being recorded and a link the recording and the slides will be on the GEDC website event page later today. Link to the webinar recording and slides: https://gedcollaborative.com/event/webinar-the-dementia-friendly-ed/

00:37:15 Avishka Gobin: ED registrar, Galway, Ireland
00:37:55 Conor Sullivan: Link to Mrs. Perdito:
https://geri-em.com/cognitive-impairment/mrs-perdito/

Please text in your observations:
- What could have been done better?
- How would things be different at your place?

00:38:08 Kevin Biese: Man the doctor in the video is no good!
00:39:29 Ula Hwang: Please remember to change your chat to "To: All panelists and attendees" so everyone can see your responses. =)
00:39:31 Michael Malone: The ED provider did not ask the patient why she came to the ED.
00:39:32 Jen Raymond: Might have been helpful to ask if there is someone came to the ED with her who could participate in the discussion.
00:39:33 Martha Radovich: Would have asked her why she was there? That would start assessment to see if she was oriented.
00:39:59 Don Melady: From Julia Rainbolt: Quick to diagnose-- asked only yes/no questions, no assessment of dementia or delirium, no family to give perspective
00:40:27 Michelle Moccia: Using open ended questions are best to check their understanding. Are we sure the patient heard what the physician was saying. Could they pick up their prescription. Could we fill it before the patient left the ED.
00:41:24 Margaret Wallhagen: San Francisco, Faculty, UCSF and VA Quality Scholars Program
00:41:27 Pamela Martin: MD standing over patient, sit down. Ask open ended questions, use teach back to verify understanding
00:42:09 Virginia Painter: Poor lighting and poor acoustics. No A&O questions. Did the patient understand the questions she was being asked?
00:42:30 Conor Sullivan: https://www.alz.org/professionals/health-systems-clinicians
https://www.alz.org/professionals/health-systems-clinicians/for-patients-caregivers

00:43:12 Rosa McNamara: use of urine dipstick for diagnosis of UTI not recommended in older people. history taken didn't meet diagnostic threshold for UTI. risk to patient eg antibiotic associated delrlium, not reaching true diagnosis...
00:45:07 Conor Sullivan: Morgan Daven

https://www.alz.org/professionals/health-systems-clinicians

https://www.alz.org/professionals/health-systems-clinicians/for-patients-caregivers

00:45:40 Margaret Wallhagen: Agree with many comments above - sit to gain some better connection and provide a sense that the practitioner was attending to her; assess

understanding; not use very clinical terminology like 'white cells', check hearing. So much could be different.

00:45:47 Conor Sullivan: Check out another great resource for EDs

Benjamin Rose Institute on Aging and Family Caregiver Alliance
https://bpc.caregiver.org/#home

This data-rich resource, with its easy to use program-compare feature, provides detailed information on more than 40 dementia caregiving programs developed in the U.S.

00:46:53 Don Melady: Great to have you here! Please keep up the insightful commentary.
00:47:57 Morgan Daven: Thank you for the opportunity to talk with you all today. Please feel free to contact me at mdaven@alz.org regarding resources available from the Alzheimer's Association in the US.
00:48:02 Don Melady: From Laura Clarke: No baseline information gathered. No assessment on 'what changed today' to bring her into ER... How was she brought in... ambulance, family or herself. No physical assessment done. No collateral gathered for social support system. Did not include allied health in assessment... eg. Mobility assessment. Geriatric Nurse Clinician assessment.
00:49:49 Don Melady: In the doctor's defence (and no, I don't practice like that), is there anything that can be done at the ED level to avoid this disastrous encounter?
00:50:38 Rosa McNamara: screening for cognitive impairment in triage/early in journey
00:51:15 Don Melady: What screening tools do you use at your place, Rosa?
00:51:15 Christian Nickel: collateral history
00:51:30 Rosa McNamara: we use 4AT
00:51:49 Don Melady: Who does it? Doc? RN?
00:52:21 Rosa McNamara: mix of gen nurse//
00:52:34 Rosa McNamara: sorry gen nurse/doc in triage
00:52:35 Linda Schnitker: 4AT used here in Australia too
00:52:56 Chris Carpenter: Star Trek is 1960's!
00:53:04 Rosa McNamara: frailty team OT/PT/sovial worker etc also screen
00:53:33 Chris Carpenter: Sometimes the needs of the one outweigh the needs of the many.
00:55:22 David Larson: Minicog
00:55:24 Jen Raymond: mini cog
00:55:24 Nadine Benoit: Mini-Cog assessment
00:55:26 Pamela Martin: mini-cog
00:55:29 Linda Schnitker: 4AT
00:55:39 Martha Radovich: Mini-cog
00:55:54 Michelle Moccia: OMCT
00:55:56 Kevin Biese: Hello all. In addition to emailing Morgan directly (mdaven@alz.org) you can also call your local AA chapter Helpline at 800.272.3900 - reach out to community partners for better options for our patients with cognitive impairment
00:55:56 Marlena TANG Work: For those of you using minicog in the ED,, how do you like it?
00:56:02 MLFink: Mini-Cog
00:56:05 Kevin Biese: We use MiniCog

00:56:14 Virginia Painter: AD8
00:56:28 Don Melady: We tried ten years ago to implement the Mini-Cog. Initially it had a lot of uptake but gradually tapered off. I don't know if we are now missing a lot of CI. Or perhaps there has just been a heightened awareness among our staff about "hidden dementia".
00:56:31 Hidetake Yamanaka: Ottawa 3DY scale
00:56:37 Deborah Conley: Mini cog for selected patients
00:56:56 Kevin Biese: I like it - we only do clock draw if the patient get 1 or 2 out of 3 words right. So most patients down get clock draw and it fits into work flow well
00:56:58 Luna Ragsdale: we use mini cog
00:56:58 Don Melady: Please switch your chat to All panelists and attendees
00:57:17 Aine Mitchell: I want to say 4AT, but to "screen" we should be doing it on all our patients (over 70 as per hospital protocol). Instead we seem to complete the 4AT when it's obviously abnormal (>4), so I believe we "use gestalt" and as such, probably catch Delirium commonly, but miss Dementia. Trying to improve!
00:57:28 Hidetake Yamanaka: 3DY is for cog impairment and done at triage
00:57:39 Don Melady: From Ritesh Parkeh: We don't, we can barely get our ER to screen for delirium.
00:57:43 Michelle Moccia: We found we had to stop using it because patients with visual and physical impairment had difficulty drawing the clock, seeing the clock to draw in the numbers and hands of the clock. Also the nurse had to find a clipboard and pen with a paper and had to position the patient to hold the clipboard. We changed to the OMCT which is a 6 item screener.
00:58:01 Don Melady: From Ritesh Parekh: We don't, we can barely get our ER to screen for delirium.
00:58:18 Don Melady: Who else has implemented AD8?
00:58:33 Ula Hwang: Thank you for your responses about dementia screening. Tally's as follows:
00:58:39 Ula Hwang: Mini-cog:10
00:58:42 Ula Hwang: 4AT:3
00:58:51 Ula Hwang: AD*:2
00:58:57 Ula Hwang: AD8:2
00:59:07 Ula Hwang: Ottawa 3DY:2
00:59:12 Ula Hwang: OMCT:1
00:59:14 Don Melady: Chris makes a super important point: this process is not about "diagnosing dementia" It is about identifying if this person MIGHT have some difficulty to engage in the processes of the ED or be at risk in transitions of care.
01:00:09 Ula Hwang: Early emerging themes from chats and presentations:

1. Open Good communication with persons with dementia includes use of open-ended questions to ascertain history and understanding by patient.
2. Assessment of BASELINE patient cognitive status, "poor historian" as a flag, gathering history from collateral sources.
3. Performance of cognitive assessment early in ED evaluation can be done by many / any of the clinicians in the ED.
4. Communication and coordination of information from primary care, pre-hospital

history about risks and flags of dementia. AND if patient discharged, coordinating this with outpatient clinicians for follow-up.

5. Dementia screening important! Do DELIRIUM screening first.

01:01:42 Barbara Siepierski: knowing the date and the day might be problematic even for younger people in this time of COVID and disruption of schedules. Also retirees don't necessarily keep track of date as they do not follow strict schedules.

01:01:53 Conor Sullivan: Here is the list of what tools level 1 and 2 GEDs are currently using to screen for dementia. GEDA Dementia Screening Tools Used: There were 12 Level 1 and 2 EDs that listed a dementia protocol Mini Cog – 3 Short Portable Mental Status exam – 3

Blessed – 2
Ottawa 3Dy – 2
MOCA – 1
AD8- 1

01:02:09 Ula Hwang: [OMCT (orientation memory concentration test) and Short Blessed Test are similar]

01:02:09 Don Melady: For those sites that ARE using screening tools, I'm interested to know whose JOB it is to do it? Do you have a particular person who is responsible for this?

01:02:55 Luna Ragsdale: The person who performs the ISAR in our ED will also perform the mini cog

01:03:00 Rosa McNamara: usually triage team. in one ED I worked in reception staff were trained to do screening

01:04:36 Michelle Moccia: The ED RN taking care for the patient 65 and older. Delirium is screened first.

01:04:45 Pamela Martin: The one that will be completed more often by whomever is determined to completed it. Engage stakeholders to determine what is already in use in your system, consult with staff who will be completing it and how it will fit into their workflow

01:05:10 Don Melady: From Vicki Spurway: would be interested in the upload of screening

01:05:51 Don Melady: From Masa Patricevic: triage nurse does frailty assessment, treating doctor assess for dementia (4 AT)

01:06:21 Virginia Painter: Triage RN completes screening

01:07:00 Don Melady: Virginia — do you get push back from Triage that "this is too much to do at Triage"? What tool do you use?

01:08:30 Virginia Painter: Yes. We use the AD8. If triage RN is not able to complete screening then RN who cares for patient is to complete the screening.

01:08:48 Chris Carpenter: The challenge over the last 20 years has been to raise awareness and facilitate acceptance that unrecognized dementia is problematic for the ED. The next challenge will be to demonstrate that recognizing dementia (via screening) improves some measurable outcome in a patient-centric way - whether that improvement is the direct consequence of screening alone or some action linked to recognizing dementia.

01:09:03 Morgan Daven: Yes, at the Alzheimer's Association we encourage EDs to make a plan for working the cognitive test into the workflow, including whose role it is to administer, just as Pamela described.

01:09:04 Aine Mitchell: Emergency Doctor directly caring for the patient should ensure 4at complete and take account of it in care. It can often be helpfully completed at triage or post-triage by an Emergency Nurse.
01:09:27 Chris Carpenter: For example, we have little research evidence demonstrating that identifying dementia reduces incident delirium or preventable ED returns.
01:09:28 Conor Sullivan: Dr. Linda Schnitker

Process and Structural Quality Indicators
https://pubmed.ncbi.nlm.nih.gov/25754937/

https://pubmed.ncbi.nlm.nih.gov/25754936/

01:09:30 Rosa McNamara: key is that triage team know that an outcome will happen if the spend the time screening. for us patients are steers to dementia friendly area, have a falls assessment expedited and and 1-2-1 special assigned as needed if exit seeking behaviours. activities to keep patients busy available. all activated by identification at triage.
01:10:38 JANE CARMODY: Adding site for the Age-Friendly Health Systems and the 4Ms, helpful to emergency care within an AFHS location.
01:10:43 JANE CARMODY: http://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/default.aspx
01:11:12 Pamela Martin: Rosa what is 1-2-1 special assignment?
01:12:19 Kevin Biese: @Ritesh, I have worked with several rural, smaller EDs that have made getting GED Accreddtted a marketing strategy for their survival, they then got their administration to hire a GEM nurse that does these screens on all patients over age 65, their ED volume and subsequent hospital admissions (total number even if percentage admits down) increased, a financial win for the hospital that got the ED the resources they needed, happy to connect you with these EDs
01:12:51 Chris Carpenter: Link to editorial accompanying Linda's quality indicator research: https://onlinelibrary.wiley.com/doi/full/10.1111/acem.12619
01:12:54 Don Melady: Linda — I notice you mentioned "formal OR informal" cognitive screening should be used. What do you think of appropriate "informal" screening?
01:13:34 Marlena TANG Work: Pain assessment in dementia super important in ED setting....thank you for highlighting this!!!
01:13:54 Conor Sullivan: Dr. Linda Schnitker

Process and Structural Quality Indicators
https://pubmed.ncbi.nlm.nih.gov/25754937/

https://pubmed.ncbi.nlm.nih.gov/25754936/

PAINAID
http://dementiapathways.ie/_filecache/04a/ddd/98-painad.pdf

Appropriate communication

https://www.dementia.org.au/sites/default/files/helpsheets/Helpsheet-CaringForSomeone01-Communication_english.pdf

Education Resource: ED Dementia Care Training
https://www.dementia.org.au/sites/default/files/NATIONAL/documents/ED-Dementia-Care-Training.pdf

01:14:16 Chris Carpenter: Apologies to attendees but cannot upload PDF for some reason. These links provide open access to PDFs. This is the dementia screening instrument systematic review of which I spoke https://onlinelibrary.wiley.com/doi/full/10.1111/acem.13573
01:15:09 Don Melady: Great resources in the links!
01:16:12 Marlena TANG Work: ED Geriatric RN specailists: does scheduled toileting while in the ED help at all? Like assisting to toilet Q2 when not sleeping? Curious
01:17:44 Chris Carpenter: If folks prefer podcasts/blogs to journal articles, here is an episode of GEMCast discussing the integration of dementia screening into an age-friendly ED's operations and design: https://gempodcast.com/2016/06/29/5-ways-to-geriatricize-your-ed/
01:18:09 Ula Hwang: great questions Marlena. I'll try to ask the panelists if they don't respond.
01:19:01 Chris Carpenter: Does toileting help with what outcomes? Dementia-associated incident ED delirium?
01:19:27 Chris Carpenter: I've not seen any studies demonstrating a benefit of scheduled toileting for this outcome.
01:19:58 Kevin Biese: At my ED we create name tags with big pictures of ourselves so that our patients can "see us" with all our PPE on
01:20:42 Don Melady: Also probably "responsive behaviours" — sometimes what we interpret as "aggression" or "agitation" is just needing to void or stool. Given that complex older patients are often around the ED for many hours, some addition to those basics of life may prevent problems. Michelle just mentioned "hourly rounding" in the ED! How often does that ever happen?
01:21:30 Marlena TANG Work: Yes! Michelle tell us more about hourly rounding!!!
01:22:06 Chris Carpenter: Dementia-friendly care is also possible in rural emergency departments - see https://emergencymedicine.wustl.edu/wp-content/uploads/2018/10/DementiaRuralEMJREMIssue1.pdf
01:23:11 Kevin Biese: Care Givers are not Visitors: https://blog.aarp.org/thinking-policy/theyre-not-visitors-covid-19-visitor-restrictions-highlight-need-for-change
01:23:14 Don Melady: I'm going to announce that we are extending to 4:05 to allow a few questions. Okay?
01:23:28 Kevin Biese: @Don good with me
01:23:28 Chris Carpenter: Okey dokey
01:23:56 Ula Hwang: Questions I will ask are how to get your ED to do cognitive screening.
01:24:23 Laura Clarke: Michelle and Pamela.... you are singing to the choir... !!! Yes Yes Yes!!!!
01:24:38 Morgan Daven: Yes, that works for me
01:25:04 Linda Schnitker: sure :)

01:25:17 Don Melady: What success have people had in getting new members of the choir? How do you convince front-line RNs and MDs that these things work?

01:25:23 Adam Perry: On voiding, many nursing home, with limited resources, consider it such an important antecedent to distressed behaviors that the purchase bladder scanners. Use the bladder scanner early and often👍

01:25:28 Ula Hwang: Think of what advice you would give to particpants of low hanging fruit to get busy ED to integrate assessment for dementia. (e.g., champions, linking screening to a change in patient ED care pathway, etc.)

01:26:24 Kevin Biese: @Don - to get the team on board - have a forum to share weekly/ monthly stories about why the extra work matters. And Michelle example of kits to make people feel like they have cognitive impairment raises awareness

01:26:30 Ula Hwang: Additional emerging themes from chats and presentations:
6. Cognitive impairment itself is a FLAG for patients at greater risk of poor outcomes.
7. Future – demonstrating that ED recognition (screening) of dementia impacts patient care and improves their outcomes. (improved patient outcomes and even for ED staff to know their screening matters and changes the ED care pathway for patients.
8. Remember to assess for:
- DELIRIUM,
- PAIN,
- asking for GOALS of care for patients
- functional status (what is BASELINE)(may need info from caregiver)
9. CAREGIVER as COLLATERAL info

01:26:34 Chris Carpenter: Response to Don's question of obtaining buy-in from frontline nurses and physicians - see this open access manuscript https://escholarship.org/uc/item/90m9w87w

01:27:55 Rosa McNamara: some great practical advice!

01:28:06 Kevin Biese: @Pam, @ Michelle - awesome!!! Thank you!!!

01:28:09 Michelle Moccia: How do you improve sensitivity to care for a patient with dementia?

01:28:18 Laura Clarke: I try to convince staff that this will be as much a benefit to THEM and to the patient... By being proactive and PATIENT, you can prevent delirium and escalation in behaviors. I also work along WITH them and get them to mirror my approach... ask for assistance with assessment rather than directing bedside nurse to 'do' the assessment on their own.

01:28:36 Chris Carpenter: How many of these resources (Alzheimer's Association, Area Agency on Aging, etc.) exist in Europe?

01:28:43 Chris Carpenter: And Australia?

01:30:23 Conor Sullivan:
• geri-EM.com website for education for doctors and nurses on cognitive impairment in the ED – and five other modules
https://geri-em.com/

• Our colleagues at Advocate Aurora Health in Wisconsin Illinois host an excellent conference annually – On November 6, this year it's live cast and FREE! Information for

registration is on the GEDC website:

Advocate Aurora National Acute Care of the Elderly conference
https://gedcollaborative.com/event/ace-2020/

• Benjamin Rose Institute on Aging and Family Caregiver Alliance
https://bpc.caregiver.org/#home

This data-rich resource, with its easy to use program-compare feature, provides detailed information on more than 40 dementia caregiving programs developed in the U.S.

01:31:06 Rosa McNamara: similar from my experience in UK/Ireland. worth checking if age-friendly groups exist in local area.

01:31:20 Adam Perry: Great point about the emerging outpatient Value Based Primary Care entities such as JenCare and Caremore. These organizations are rapidly disseminating and can offer significantly augmented outpatient services, such as home visits, close followup, respite, and hospice. They can be a valuable resource to designing safe transitions.

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Thank you! GEDC Team
Follow us: @the GEDC
Join the GEDC: laura_stabler@med.unc.edu

URL for the Geriatric Emergency Department's website (https://gedcollaborative.com/)

Thank you so much! Stay tuned for the GEDC's next webinar "Monday October 19, 2020 on implementing a geriatric volunteer program in your ED.

The GEDC is generously supported by the John A. Hartford Foundation and the Gary and Mary West Foundation. Thank you!

01:31:47 Michelle Moccia: Thank you again for attending the session. We learn a lot from each other

01:32:03 Osamuyimen Obamwonyi:Excellent presentations and highly informative.

01:33:29 JANE CARMODY: Great webinar! thank you. Always important info. Michelle, always learn from you.

01:33:42 Barbara Siepierski: I apologize if this was already answered as I was called away. Are there research studies that prove the cost/ benefit of these interventions?

01:33:52 Conor Sullivan: On the GEDC event page, we have added a link to the webinar recording, chat resources and slides: https://gedcollaborative.com/event/webinar-the-dementia-friendly-ed/

01:34:15 Chris Carpenter: No studies yet demonstrate benefit of these ED dementia interventions, yet alone cost-benefit.
01:35:13 Don Melady: From Jennifer Clay": Train some ED nurses to be a GENIE (Geriatric Emergency Nurse Initiative Expert) i am a GENIE and screen seniors and educate ED staff at meetings about delirium dementia etc
01:35:26 Aine Mitchell: Can't wait the GEDC's next webinar "Monday October 19, 2020 on implementing a geriatric volunteer program in your ED.
01:35:34 Don Melady: We have GENIEs at UC San Diego
01:35:41 Chris Carpenter: GENIE's are an excellent resource if able to convince healthcare system to make that investment.
01:35:53 Heidi Martin: We have Genie's at UAB HIghlands… we are awaiting our certification...
01:36:35 Conor Sullivan: Dear Colleagues,
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01:36:36 Aine Mitchell: Can I ask if the Geriatric Volunteer Programme is Covid-proofed?
01:36:47 Rosa McNamara: great webinar- thanks for organising!
01:37:06 Morgan Daven: Thank you all!
01:37:08 Heidi Martin: Thank you!
01:37:13 aaron malsch: Thank you!
01:37:17 Martha Radovich: Thanks for this incredible presentation!
01:37:17 Marlena TANG Work: Thank you!
01:37:20 Christian Nickel: Thank you
01:37:44 Virginia Painter: Thank you!
01:38:33 Ula Hwang: Yes, Chat will also be posted.

01:38:36 Pamela Martin: Yes chat will be available
01:38:48 Don Melady: Yes
01:41:46 Conor Sullivan: Dr. Linda Schnitker

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https://www.alz.org/professionals/health-systems-clinicians

https://www.alz.org/professionals/health-systems-clinicians/for-patients-caregivers

Dr. Chris Carpenter

Dementia-friendly care is also possible in rural emergency departments - see https://emergencymedicine.wustl.edu/wp-content/uploads/2018/10/DementiaRuralEMJREMIssue1.pdf

GEMCast discussing the integration of dementia screening into an age-friendly ED's operations and design: https://gempodcast.com/2016/06/29/5-ways-to-geriatricize-your-ed/

01:41:50 Conor Sullivan: This is the dementia screening instrument systematic review of which I spoke https://onlinelibrary.wiley.com/doi/full/10.1111/acem.13573

obtaining buy-in from frontline nurses and physicians - see this open access manuscript https://escholarship.org/uc/item/90m9w87w

Dr. Kevin Biese

Care Givers are not Visitors: https://blog.aarp.org/thinking-policy/theyre-not-visitors-covid-19-visitor-restrictions-highlight-need-for-change