Clinical Tips from the Interdisciplinary Team in the Geriatric Emergency Department

Expert Panel Webinar

Monday, March 22, 2021

3:00–4:00 EST

Moderated by:

Don Melady, MD, MSc(Ed)
Emergency Physician
Mount Sinai Hospital, Toronto, Canada
GEDC Faculty

EXPERT PANEL

Kara McLoughlin, BSc (Hons) OT, MSc(OT)(c)
Clinical Specialist Occupational Therapist,
Beaumont Hospital,
Dublin, Ireland

Suzie Ryer, MPT, GCS, CEEAA
Geriatric Physical Therapist, Senior Project Coordinator
Advocate Aurora Health Senior Services,
Wisconsin, USA

Maya Genovesi, LCSW MPH
Social Work Manager
ED and Rapid Evaluation & Treatment Unit
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New York City, USA

Michelle Moccia, ANP-BC, GS-C
Program Director, Senior ED,
St. Mary Mercy Hospital
Michigan, USA

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Our Vision

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

Our Mission

We bring best practice into action.

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.

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https://geri-em.com/trauma-falls/consulting-the-team/

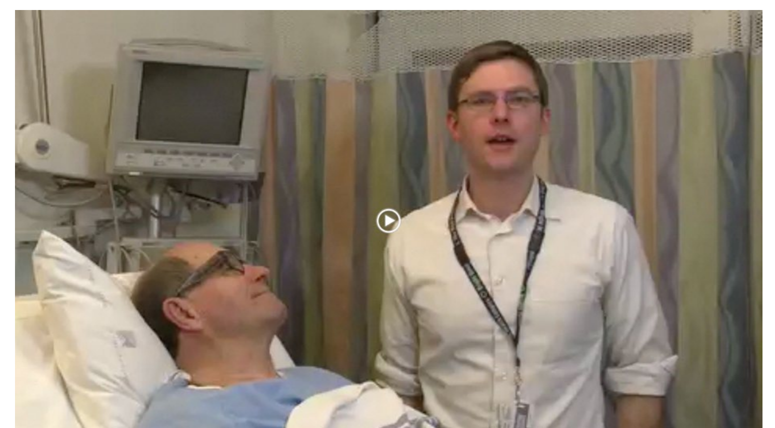
Consulting the Team

The Geriatric ED is a team sport.

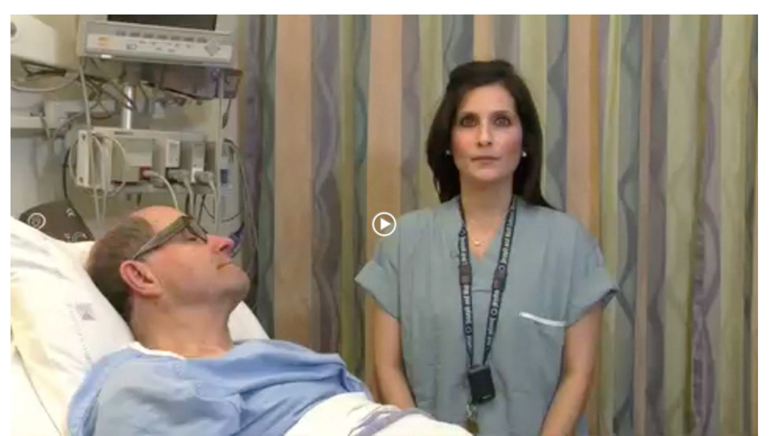
Mobilizing a team to more completely assess the older person across multiple domains helps avoid admissions and improves outcomes.

Geriatric Nurse Specialist

Occupational Therapist



Pharmacist



Physical Therapist

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Meet Your Expert Panel

Michelle Moccia
RN, DNP

Program Director,
Senior ED
St. Mary Mercy Hospital
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Suzie Ryer
MPT, GCS, CEEAA

Geriatric Clinical Specialist
Project Coordinator,
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Clinical Specialist
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Frail Intervention Therapy
Team
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Medicine
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QUICK POLL

If you are creating a Geriatric Emergency Department, and you could hire only one new person, which role would it be?

Geriatric nurse specialist

Geriatric physical therapist

Geriatric occupational therapist

Geriatric social worker

Michelle Moccia
RN, DNP
Program Director, Senior ED,
St. Mary Mercy Hospital, Michigan

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Mr. Vieilleux

Mr . Vieilleux is 84 and lives with his 82 yo wife, who may have some early dementia and is his main caregiver. He's in the ED after a fall while getting out of his walk-in shower. His wife says she thinks he slipped while sitting down on the shower-side chair. The doctor says he has an undisplaced longitudinal patellar fracture and has placed him in a straight-leg splint as the only treatment and has declared him "medically stable" and "good to go".

What can you contribute to crafting an appropriate durable discharge plan for this man/couple?

PMH

coronary artery disease; previous CABG with an admission four years ago for congestive heart failure (maybe because of a medication mix-up); Type 2 Diabetes; COPD (no admissions); poly myalgia rheumatica; osteoarthritis

MEDS

Amlodipine; metoprolol; atorvastatin; furosemide; ASA; metformin; sitagliptin; steroid inhaler; salbutamol inhaler; prednisone 2 mg; acetaminophen

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What would you like emergency doctors to add to their assessment of older ED patients?

Nursing: What do you wish all emergency physicians would do with older ED patients?

Apply the "D" and "E" of the primary survey (ABCDE) to help determine cognition and environmental status. The "environment" includes caregivers.

D = Delirium, Dementia, Depression & Drug management

E = Environment .

Recognize that undiagnosed dementia may lead to mismanagement of medications and inaccurate history.

Knowledge? Plan when med is missed? Pill count = prescribed regimen?

Med dosing in movement disorders and ER LOS – what is our responsibility?

Appreciate assessment of an older adult's current living Environment may improve the discharge plan and decrease return visits

Residential home, apartment, nursing facility, group home? Live alone? Safe to live alone? Caregiver able, willing and available? Capability meets their needs?

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Physical therapy: What do you wish all emergency physicians would do with older ED patients?

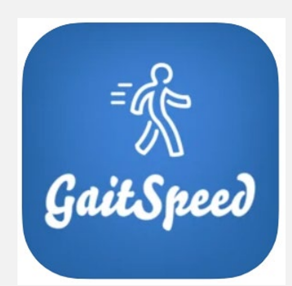
Ask about mobility not just today but a week and a month before. This includes assistive device used, assistance required, and distance.

When assessing gait and mobility, look beyond straight walking. Observe the patient stand, walk, turn, and sit.

Confirm that gait device used before ED visit is still appropriate upon discharge from ED. Consider an alternative that will meet needs.

twitter: **@RyerSuzanne**

Resources



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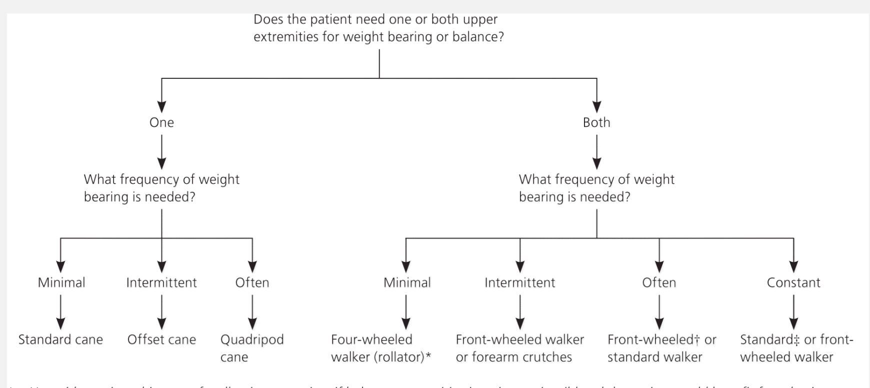

https://www.aafp.org/afp/2011/0815/p405.html

https://journals.lww.com/jgpt/Fulltext/2009/32020/White_Paper___Walking_Speed__the_Sixth_Vital_Sign_.2.aspx?casa_token=aYbrItFxlSIAAAAA:dMcA3MYSPbERI3Bgg1LeRxsrKnq_aKLcZ3PH3ZfxWaHXJGGtPK8CeWfgkUC7ZrFJmZVjEdK4jdaVXN0tKICa9JA

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Occupational therapy: What do you wish all emergency physicians would do with older ED patients?

Ask the high yield questions

- Who does your shopping?
- Do you go outside?
- Have you fallen in the last 6 months?
- Is there anything you can no longer do/struggle with at home?
- Are you continent? Do you get to the toilet on time during the day and during the night? Do you use continence wear?

Use a screening tool

Always consider delirium

It not always about the questions. Sometimes we need to take a step back and look at the whole picture

Age DOES NOT mean FRAIL
FRAIL does not mean a certain age

twitter: **@karamcloughlin**

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Resources

KARA McLOUGHLIN
twitter: **@karamcloughlin**

Royal College of Occupational Therapy (RCOT) Occupational therapy in the prevention and management of falls in adults;
https://www.rcot.co.uk/practice-resources/rcot-practice-guidelines/falls

Fit for frailty-British Geriatric Society;
https://www.bgs.org.uk/sites/default/files/content/resources/files/2018-05-23/fff_full.pdf

Acute Frailty Network
https://www.acutefrailtynetwork.org.uk/

Early Identification and Management of Delirium in the Emergency Department/ Acute Medical Assessment Unit Algorithm
https://dementiapathways.ie/care-pathways/acute-hospital-care/integrated-care-pathways-and-delirium-algorithms

End PJ Paralysis
https://endpjparalysis.org/

Fit to Sit
https://improvement.nhs.uk/resources/are-your-patients-fit-sit/

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Social Worker: What do you wish all emergency physicians would do with older ED patients?

Approach your patient with curiosity and eagerness.

Your best and most effective interventions are ones that demonstrate an eagerness to get to know the person in front of you.

Document clearly, and thoroughly, with phone numbers.

The Electronic Medical Record is a living document. Document well and thoroughly and always read the Social Work Notes. ***Phone numbers mean the world to us.***

"Safe enough" discharges preserve patient autonomy.

The most clinically appropriate plan is always the one that preserves the most of the patient's autonomy and promotes wellbeing. ***It is not just about making any referral, but the right one.***

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Q & A

Ask your questions

in the CHAT

We will try to get to everyone

https://www.bgs.org.uk/resources/resource-series/silver-book-ii

https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2776801

Invited Commentary | Emergency Medicine

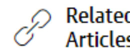
March 1, 2021

Geriatric Emergency Care Reduces Health Care Costs—What Are the Next Steps?

Maura Kennedy, MD, MPH[1,2]; Kei Ouchi, MD, MPH[2,3]; Kevin Biese, MD, MAT[4,5]

» Author Affiliations | Article Information

JAMA Netw Open. 2021;4(3):e210147. doi:10.1001/jamanetworkopen.2021.0147


Related Articles

Although older adults frequently receive care in emergency departments (EDs), conventional EDs may not adequately address the unique needs of geriatric patients, such as managing geriatric syndromes, addressing multimorbidity, and optimizing care transitions.[1] In direct response to the unique medical needs of older patients, the first self-identified geriatric ED (GED) in the United States was established more than a decade ago, after which there has been a rapid increase in the number of GEDs.[1] In 2018, the American College of Emergency Physicians launched a voluntary accreditation program, classifying GEDs as level 1 (gold), level 2 (silver), or level 3 (bronze) based on staffing, care processes, physical environment, and specialized equipment.[2] Despite rapid growth in the number of GEDs in the United States, there is limited research on the impact of GEDs and specialized geriatric emergency care models.

The most robust evidence supporting the GED model of care comes from the Geriatric Emergency Department Innovation in Care Through Workforce, Informatics, and Structural Enhancement (GEDI WISE) program. This multicenter care innovation program was supported by a Centers for Medicare & Medicaid Services (CMS) Health Care Innovations Award. It includes transitional care nurses (TCNs) and social workers (SWs) who staff the GEDI WISE level 1 GEDs and conduct geriatric assessments (including evaluations for delirium, fall risk, and functional decline), engage in

https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2776803

March 1, 2021

Association of a Geriatric Emergency Department Innovation Program With Cost Outcomes Among Medicare Beneficiaries

Ula Hwang, MD, MPH[1,2]; Scott M. Dresden, MD, MS[3]; Carmen Vargas-Torres, MA[4]; et al

» Author Affiliations | Article Information

JAMA Netw Open. 2021;4(3):e2037334. doi:10.1001/jamanetworkopen.2020.37334

Editorial Comment

Key Points

Question Is there an association between geriatric emergency department (ED) programs and total costs of care for Medicare?

Findings In this cross-sectional study of 24 839 Medicare fee-for-service beneficiaries at 2 EDs, there was a significant association with reduced total costs of care after being seen by either a transitional care nurse and/or social worker trained to deliver geriatric emergency care. Per beneficiary, these savings were as much as $2905 after 30 days and $3202 after 60 days of the index ED visit.

Meaning These findings suggest that geriatric emergency department care programs may be associated with savings value to hospitals and payers.

Abstract

Importance There has been a significant increase in the implementation and dissemination of geriatric emergency department (GED) programs. Understanding the costs associated with patient care would yield insight into the direct financial value for patients, hospitals, health systems, and payers.

Objective To evaluate the association of GED programs with Medicare costs per beneficiary.

OUR NEXT
EXPERT PANEL WEBINAR

The Geriatric ED: Making the case for its financial impact

Monday, May 17

Visit website to register

https://gedcollaborative.com/event/2021-05-17/

Delirium
IMPLEMENTATION TOOLKIT

https://gedcollaborative.com/toolkit/delirium/

Management of Delirium in Older Adults in the Emergency Department

An Implementation Toolkit

Share on

What's Inside

Delirium is a key ED symptom – like chest pain or abdominal pain. It is common among older ED patients and commonly missed in their assessment. This toolkit provides resources to help you make changes in your ED to provide better care for those presenting with delirium. It includes resources and tools and links to the evidence to support their implementation.

- Staffing ↓
- Policies & Procedures ↓
- Screening & Assessment ↓
- Process & Outcome Measures ↓
- Support for Patients & Caregivers ↓

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