AAH Geriatric Emergency Department Virtual Bootcamp

Advocate Good Samaritan

Aurora Memorial Hospital Burlington

Advocate Good Shepard

Aurora Lakeland Medical Center

Aurora St. Luke's Medical Center

June 15, 2020

GEDC | THE GERIATRIC EMERGENCY DEPARTMENT COLLABORATIVE

EDUCATE IMPLEMENT EVALUATE

AdvocateAuroraHealth®

Thank You
AAH Emergency Departments

Thank you for your dedication in preparing and caring for our patients and communities during this unprecedented pandemic!

Welcome

Mary Beth Kingston

PhD, RN, NEA-BC

Chief Nursing Officer

Thank you!

The implementation of the Geri ED program throughout AAH is generously supported by:

Judith Gardetto

AdvocateAuroraHealth

Goals for Today

- See each other (Please have your cameras on!)
- Engage & Discuss
- Learn (program, roles, and the other teams)
- Implementation happens after the bootcamp
- Welcome to the AAH Geri ED Family

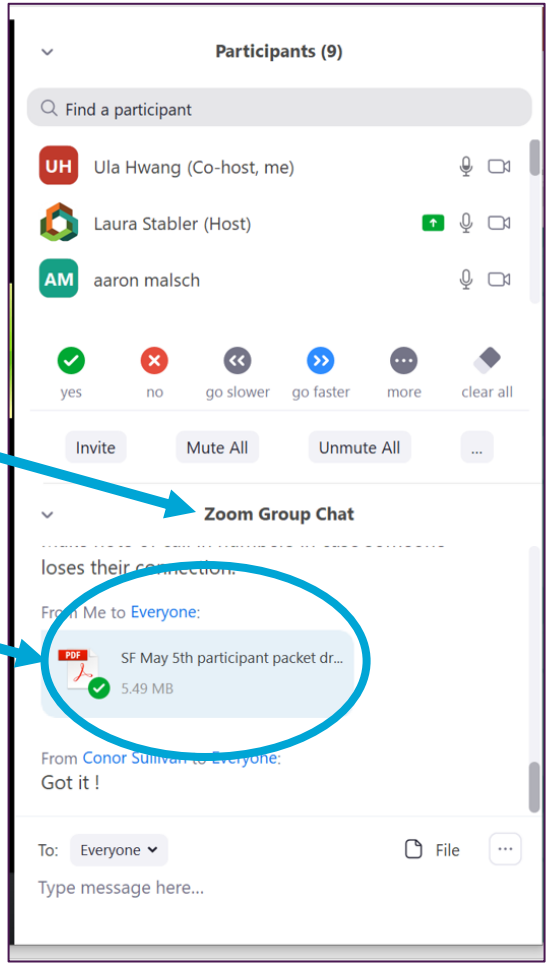
Tips for Participation

Open your zoom chat! (bottom toolbar)
We encourage dialogue in the Zoom Group Chat
Please write your comments, experiences at your hospital, feedback, questions.

Webinar packet
If you registered for this session, check your email for packet.
Also available for download via Zoom Chat as attachment.

Other materials may be uploaded in the chat during the session. Presenters will let you know if new materials are available.

Smile!
Turn on your cameras!



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Technical difficulties

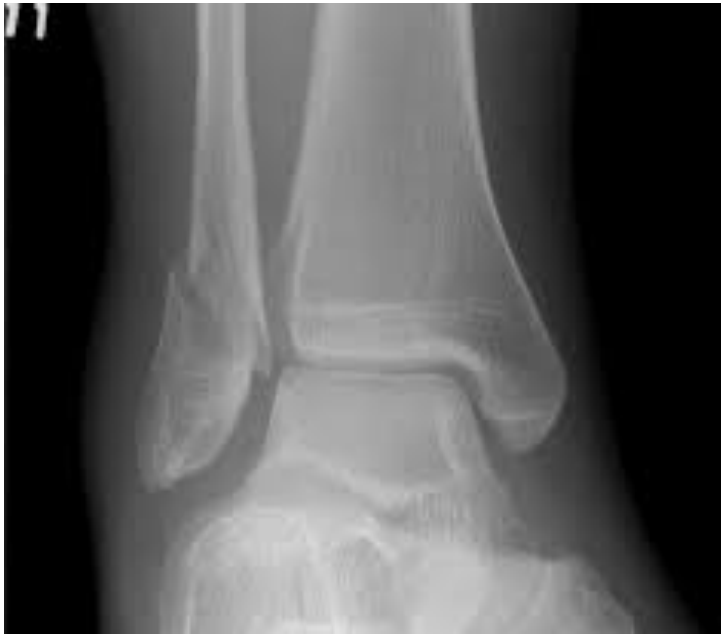
Please text:

Laura Stabler:	919-937-0411
Conor Sullivan:	910-200-1312
Chris Rubach:	262-945-2224
Lorraine Trecroce:	289-242-8936

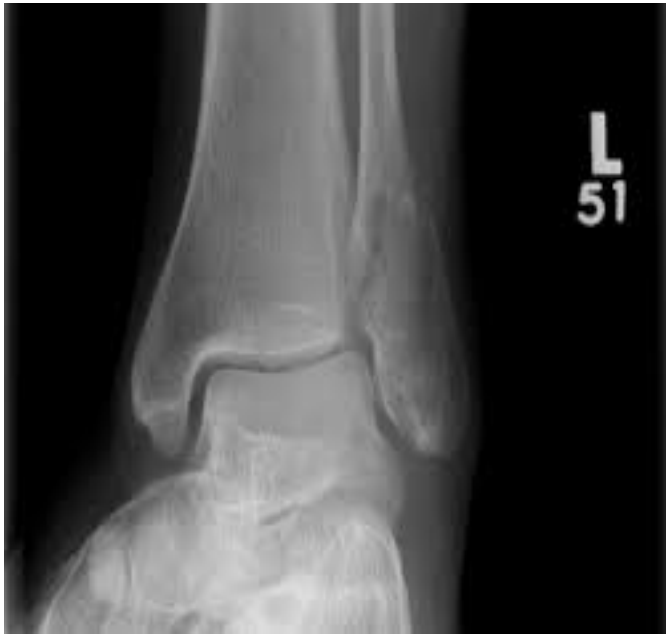
AdvocateAuroraHealth

A Tale of Two Ankle Fractures*

Mr. Jones



Mr. Smith



*Source: Dr. Adam Perry

A Tale of Two Ankle Fractures*

Mr. Jones

Mr. Smith

*Source: Dr. Adam Perry

Today's Agenda:

1300-1305: Welcome by MaryBeth Kingston, Chief Nursing Officer

1305-1315: Introductions & Agenda

1315-1335: Site Introductions

1335-1350: Creating Geriatric Appropriate EDs

1350-1430: Opportunities for Quality Improvement in the Geriatric ED

1430-1450: Fall Prevention and Mobility in the Emergency Department

1450-1500: Wrap up and next steps

Meet the Advocate Aurora Health Senior Services Team

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Michael Malone

MD

Dr. Michael Malone is the Medical Director of Aurora Senior Services and Aurora at Home. He is a Clinical Adjunct Professor of Medicine at the University of Wisconsin School of Medicine and Public Health. He also serves as the Director of the Geriatrics Fellowship Program at Aurora Health Care. Dr. Malone received his undergraduate and medical degrees from Texas Tech University in Lubbock, Texas; he completed his internal medicine residency and geriatric fellowship training at Mt. Sinai Medical Center in Milwaukee. His Aurora Health Care practice is to home bound older persons in inner city Milwaukee.

Patti Pagel
MSN RN GCNS-BC

Patti serves as the Director of Senior Services for Aurora Health Care. She received her associate nursing degree at Gateway Technical College in Kenosha, WI and completed her BSN and MSN at Alverno College in Milwaukee, WI. Patti is a board certified Registered Nurse and Geriatric Clinical Nurse Specialist. Through her career she's led the development of the Shared Governance model in the acute care setting and developed the Senior Resource Nurse program, Transition in Care program, eGeriatrician telehealth program and Community Paramedic program. She has implemented the NICHE nursing model in Aurora and Wheaton health care systems and partnered with local nursing homes to educate caregivers within the NICHE educational framework. Patti's nursing career has been devoted to improving the care of older adults throughout the health care continuum. She has taught multiple levels of health care providers in care of the older adult, dementia education, medication safety and developed the Aurora Health Care geriatric nursing certification course. She has worked in collaboration with her colleagues on projects that focused on patient safety for older adults using a community patient safety council committee framework.

Suzanne Ryer

MPT, GCS, CEEAA

Suzie is the Senior Project Coordinator in Senior Services at Advocate Aurora Health. She is physical therapist who is board certified in Geriatrics with over fifteen years of clinical experience in a variety of clinical settings. Her focus is on interdisciplinary geriatric care with emphasis on fall prevention and expanding and improving quality of Geriatric ED throughout the health system. Suzie has created interdisciplinary fall prevention and mobility programs for the health system to improve clinical outcomes and combat hospital-associated disability and readmission. Suzie is the co-chair of the Milwaukee County Falls Prevention Coalition and has created partnerships with a variety of community-based organizations. Suzie is active in national organizations including serving as current chair of the Balance and Falls Technology Task Force for APTA Geriatrics.

Aaron Malsch

RN, MSN, GCNS-BC

Aaron Malsch is the Senior Services Program Manager at Advocate Aurora Health (AAH) in Wisconsin & Illinois. He supports several geriatric models of care (NICHE, Geri ED, HELP, ACE Tracker, Geriatric Scholars). His focus is on nursing and interprofessional practice as it relates to the elder population throughout the AAH system of clinics, hospitals, emergency departments, home care services, and long term setting partners. In support of these models of care, Aaron has developed expertise in developing EHR workflow tools and reports to facilitate front line staff's efforts and demonstrate outcomes. He leads the Geriatric ED implementation and achieved ACEP Geri ED accreditation at all AAH EDs. Aaron contributes nationally to the improvement of care for older adults, highlighted by being Chair of the geriatric committee at the Emergency Nurses Association (ENA), co-planner of GEDC symposium at the ENA conference, and reviewer of Geriatric ED Accreditation program at ACEP.

Ann Gallo

Ann Gallo is the AAH Senior Services Program Coordinator. Since 2016, Ann has worked with Senior Services on the implementation of geriatric models of care to improve care for older adults across the AAH system. Ann leads the development and implementation of system Dementia Resource Training and system Geriatrics for Advanced Practice Education. Ann co-leads the Milwaukee County Falls Prevention Coalition and falls prevention protocol within AAH emergency department and primary care settings. Ann leads the Geriatrics Models of Care Collaborative and manages the national ACE Tracker contracts. Ann co-leads the quality improvement, implementation, accreditation, and maintenance of all AAH Geri EDs.

Stephanie Steger

Stephanie is the AAH Administrative Assistant Senior and supports Dr. Malone and Patti Pagel as well as the rest of the Senior Services team. She joined the team 3 years ago and her major responsibilities include organizing the annual ACE Conference, serving as managing editor of the Journal of Geriatric Emergency Medicine, data analytics, system reporting, and IT support.

Kenyata Johnson

Kenyata Johnson is an Administrative Assistant with Aurora Senior Services. She recently joined Senior Services this year and brings 10 years of experience providing direct patient care to older adults. Kenyata provides administrative support to various programs within Senior Services such as GAP, DRT, and Geri ED. She also assists with the collection of Geri ED Falls data and acts as the point of contact in the development of the Senior Services webpage.

Christopher Rubach

MBA, PMP

Christopher Rubach is the Senior Services Project Coordinator at Advocate Aurora Health (AAH). He uses his expertise in project management, data analytics, and tech support to organize and help manage Geri ED implementation at all AAH Emergency Departments.

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EDUCATE IMPLEMENT EVALUATE

Meet Our Faculty

Kevin Biese

MD, MAT, Co-PI

Dr. Kevin Biese serves as an Associate Professor of Emergency Medicine (EM) and Internal Medicine, Vice-Chair of Academic Affairs, and Co-Director of the Division of Geriatrics Emergency Medicine at the University of North Carolina (UNC) at Chapel Hill School of Medicine as well as a consultant with West Health. With the support of the John A. Hartford and West Health Foundations, and alongside Dr. Ula Hwang, he serves as Co- PI of the national Geriatric Emergency Department Collaborative. He is grateful to chair the first Board of Governors for the ACEP Geriatric Emergency Department Accreditation Program. His passion is for improved education and systems of care for older adults, and he has published multiple materials in both these areas.

GEDC

Chris Carpenter

MD, MSC, FACEP, FAAEM

Dr. Chris Carpenter is dual-board certified in Emergency Medicine and Internal Medicine and is Professor in Emergency Medicine at Washington University in St. Louis. His funded research interests include diagnostics, dementia, falls prevention, and implementation science. He is on the Society of Academic Emergency Medicine Board of Directors as well as the American College of Emergency Physicians Clinical Policy Committee. He is also Deputy Editor-in-Chief of Academic Emergency Medicine, Associate Editor of both Annals of Internal Medicine's ACP Journal Club and the Journal of the American Geriatrics Society. He co-led the collaboration to develop the American College of Emergency Physician/American Geriatrics Society Geriatric Emergency Department Guidelines As well as the international Standards for Reporting of Implementation Research (StaRI) reporting guidelines. He is also faculty for Emergency Medical Abstracts and Best Evidence in Emergency Medicine courses, as well as a contributor to Skeptics Guide to Emergency Medicine and Sketchy EBM.

GEDC

Teresita Hogan
MD

Dr. Teresita Hogan is an Associate Professor of Medicine and Director of Geriatric Emergency Medicine at University of Chicago Medicine. Her clinical research interest are Geriatric EM, Quality Improvement, Emergency Pain Management, Emergency Management of Falls in Older Adults, and Models of Care. . Dr Hogan is the ACEP representative to the AGS and serves on the executive committee Section for Enhancing Geriatreic Understanding and Epertise among Duregical and Medical Specialists. She is an expert in graduate medical education and led the expert consensus process to establish The Geriatric Competencies for Emergency Medicine Residents.

She has also worked on identifying the number and characteristics of geriatric emergency departments across the United States, and is a member of the GEDA Board of Governors.

Ula Hwang

MD, MPH, FACEP, Co-PI

Dr. Ula Hwang is Professor of Emergency Medicine and Geriatrics and Palliative Medicine at the Icahn
School of Medicine at Mount Sinai in New York and a core investigator at the GRECC (Geriatrics Research, Education and Clinical Center) at the James J. Peters Bronx VAMC. Her research focuses on improving the quality of care older adults receive in the ED setting that ranges from observational studies of analgesic safety and effectiveness in older patients to multi-centre implementation science studies of geriatric emergency care interventions.
Ula currently co-PIs the Geriatric Emergency Department Collaborative, and is the PI on the Geriatric Emergency care Applied Research (GEAR) network.

GEDC

Pamela Martin

FNP-BC, APRN GS-C

Pamela Martin is both nurse practitioner and program director at St Mary's Hospital Senior Services Emergency Department in Richmond, VA. St Mary's has the first Senior Services Emergency Department in the Commonwealth of Virginia. Pam received her undergraduate degree from Lynchburg College and her Masters of Nursing Science from the University of Virginia. She currently serves as President for the Central Virginia Gerontological Advanced Practice Nursing Association. She is a member of the American Geriatrics Society, the American Nurses Association, the Virginia Nurses Association, the American Association of Nurse Practitioners, and the Gerontological Advanced Practice Nursing Association.

Don Melady
MD

Dr. Don Melady is an emergency physician at Mount Sinai Hospital in Toronto, Canada and a founding member of the Geriatric Emergency Department Collaborative. He is the author of the website www.geri-EM.com – a CME accredited program for geriatric emergency medicine education – and the chair of the Geriatric EM committee of the International Federation of Emergency Medicine.

GEDC

Adam Perry
MD

Dr. Adam Perry is a community emergency physician and fellowship-trained geriatrician. Current positions include: faculty with The Geriatric Emergency Department Collaborative; reviewer with ACEP's Geriatric Emergency Department Accreditation program; educational consultant; and independently-contracted emergency physician with Commonwealth Health System in Northeastern Pennsylvania. He has worked emergency departments ranging from rural "critical access" to urban trauma centres; as well as in Post-Acute and Long-Term Care, and house call medicine.

Laura Stabler
Program Director

Laura Stabler is the Program Director of The Geriatric Emergency Department Collaborative. She received her MPH in Health Policy and Management from the University of North Carolina and her BS in Health Education from North Carolina State University. Before joining the Geriatric Emergency Department Collaborative, Laura was Director of OP Services for UNC Health Care Systems in Psychiatry for seven years and Radiation Oncology for 20 years.

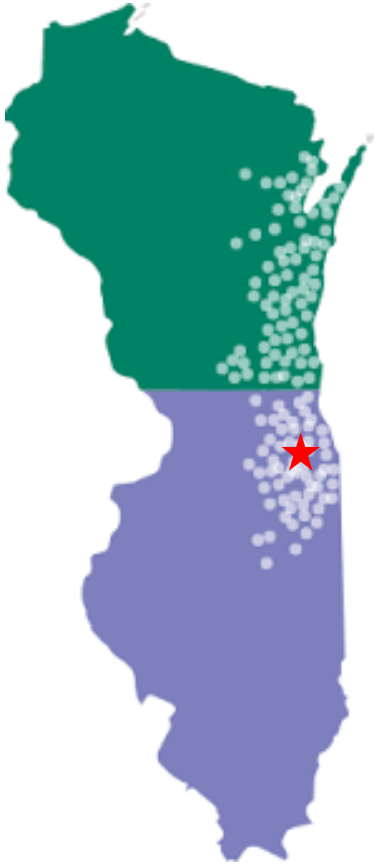
Conor Sullivan

Conor is a research associate and medical student working for the GEDC. He is very excited to be part of a collaborative effort endeavoring to find innovative and evidenced-based strategies to improve the delivery of healthcare to our nation's elder population. He looks forward to expanding his skill set and knowledge base as part of the GEDC team.

Who YOU Are

Each site has 4 minutes to describe their site.

All members please raise your hands so we can see who you are!



Advocate Good Samaritan

Presented by Steve Albery

June 15, 2020

Meet GSAM's Geri ED Team

Senior Leadership:	Jan Boonstra
ED Manager and/or ED Supervisor:	Steve Albery
ED Physician Champion:	Dr. Michael Logan
ED RN Champion:	Amy Wilson
ED RN Support:	Taelor Gibson, Samantha DiCianni
RN Educator/CNS:	Susan Surane
RN Case Manager/Social Worker:	Katie Harper
Quality:	Dr. William Rhoades or designee
Other:	Gina Kidder, CM Manager; Doug Reed, PT; Amy Tran, Pharm; Megan Corrigan, Dir. Pharm

GSAM's Geri ED (2019)

Annual volume (2019): 40,866

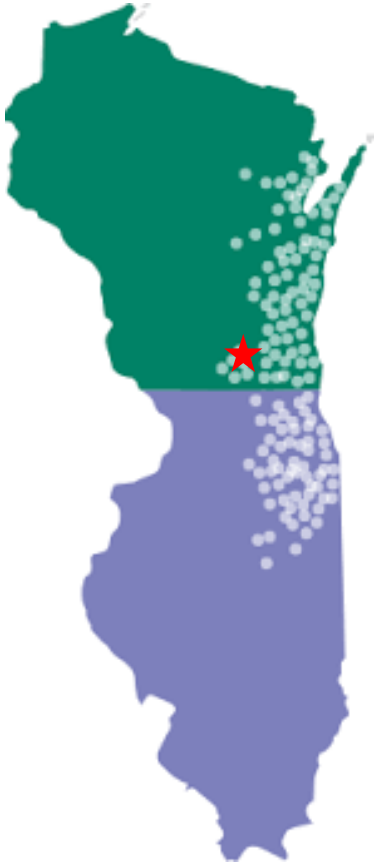
Older adult volume: Approximately 60% of annual visits

1. Unique aspect of GSAM and it's community:

- GSAM provides advanced service lines and high-level nursing care to our established community of aging residents and new incoming families, while maintaining a community hospital feel.

2. Why Geri ED at GSAM:

- GSAM ED team is committed to providing specialized services that meet the community health needs of our region. This is a great opportunity to elevate our care to our geriatric population.



Aurora Memorial Hospital Burlington

Presented by Cathy Duchow-Cross

June 15, 2020

Meet AMHB's Geri ED Team

Senior Leadership:	Nancy Korth & Quincy Lehmann
ED Manager and/or ED Supervisor:	Tricia Dretzka-Kaye
ED Physician Champion:	Monique Bushman MD and Kora Adams PA
ED RN Champion:	Cathy Duchow-Cross
RN Educator/CNS/Trauma/SATC:	Deloris (Ann) Marson, Jeri Smith
RN Case Manager/Social Worker:	Kate Brennan
Quality:	Brandon Ambrose
Other:	Brenda Wright, PT

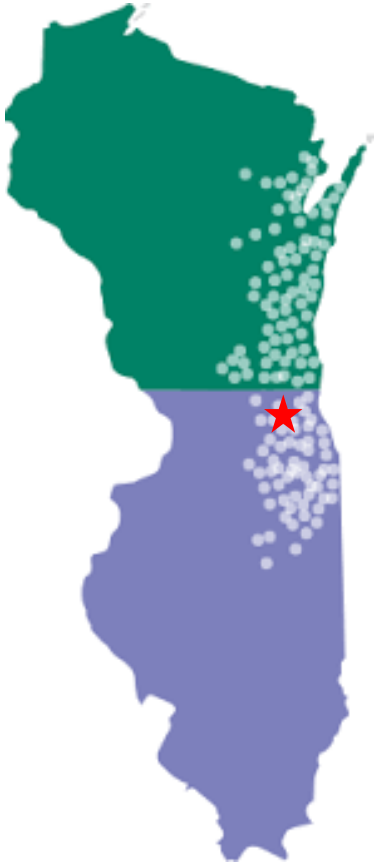
AMHB's Geri ED

Annual volume (2019): 14,925

Older adult volume: 5,207 (35%)

1. Unique aspect of AMHB and it's community:
    - Large older population with lack and limited resources
    - Numerous Adult family Homes (AFH), assisted living, nursing homes with limited resources

2. Why Geri ED at AMHB:
    - Desperate need resources (Elder abuse, referrals/eval before D/C), advocacy, and assistance to offer to patients and residents.



Advocate Good Shepherd

Presented by Dawn Moeller

June 15, 2020

Meet GSH's Geri ED Team

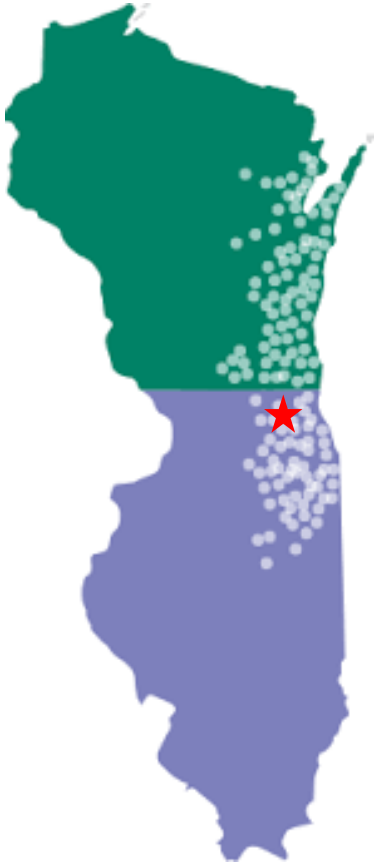
Senior Leadership:	Mary Roesch CNO / VP Nursing
	Jan Preston Director Critical Care and Emergency Department
	Mary Beth Brend Director Med-Surg and Care Management
ED Manager:	Dawn Moeller
ED Physician Champion:	Dr. Robert Romolo
ED RN Champion:	Rosalie Savella (Days), Stephanie Gore (Nights)
ED CNS:	Karla Christianson
RN CM/Social Worker:	Lisa Hall, CM; Shelley Coleman CM,
	James Messerschmidt, SW, and Maria Battaglia, CM Manager
Trauma Coordinator/EDAP CQI Liason:	Amy Crane
Other:	Germaine Timlin, PT/OT/ Speech; Tina Dyer, Pharmacy, Sue Grossinger Senior Services, Jeanne Ang and Keely Gallagher Community Health.

Good Shepherd's Geri ED

Annual volume (2019): 35,959

Older adult volume: 12,600 (35%)

1. Unique aspect of GSH and it's community
    - Suburban – located approximately 40 miles west of Chicago
    - MAGNET
    - 3x ENA Lantern Award Winner, BEACON Award Winner
    - Bariatric, EDAP, Stroke, Oncology, and A-Fib Certified
2. Why Geri ED at GSH:
    - Provide improved older adult services
    - Improves team member competency and awareness for this special population



Aurora Lakeland Medical Center

Presented by Anthony Quintanilla

June 15, 2020

Meet ALMC's Geri ED Team

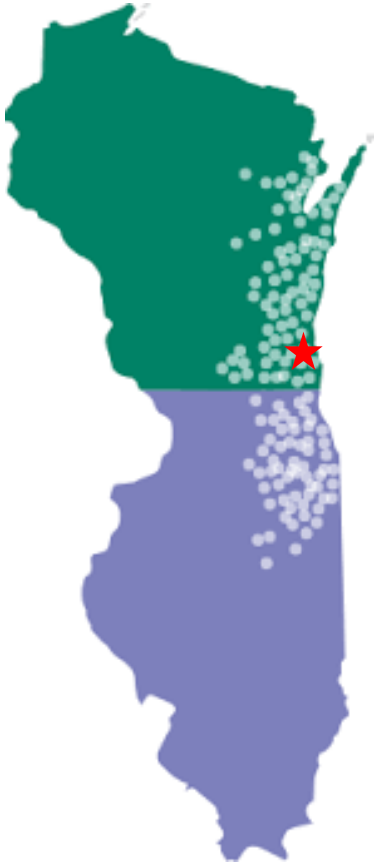
Senior Leadership:	Nancy Korth
ED Manager and/or ED Supervisor:	Anthony Quintanilla
ED Physician Champion:	Dr. Monique Bushman
ED RN Champion:	Karin Ross
RN Educator/CNS:	Tina Schwichow / Becky Weeks
RN Case Manager/Social Worker:	Kate Brennan
Quality:	Brandon Ambrose
Other:	Jessica Ottow, PT

ALMC's Geri ED

Annual volume (2019): 15,367

Older adult volume: 4,641 (30%)

1. Unique aspect of ALMC and it's community
    - ALMC is located in the center of Walworth County. One third of our volume is older adults.
2. Why Geri ED at ALMC:
    - We have a growing population of older patients who will need emergency care. We look to develop a standardization of guidelines that can improve the care and outcomes of our geriatric population.



Aurora St. Luke's Medical Center

Presented by Julie Mackenzie

June 15, 2020

Meet ASLMC's Geri ED Team

Senior Leadership:	Lynn Sisler
ED Manager and/or ED Supervisor:	Kristin Anagnostopoulos
ED Physician Champion:	Dr. Keith Rader
ED RN Champion:	Kaitilin Paterson
RN Educator/CNS:	Julie Mackenzie
RN Case Manager/Social Worker:	Sandra Ryan
Quality:	Mari St Clair
Other:	Deb Wasilik, CM Manager

ASLMC's Geri ED

Annual volume (2019): 79,109

Older adult volume: 24,137 (31%)

1. Unique aspect of ALMC and it's community
   - 623 bed quaternary access referral hospital located in urban Milwaukee, Wisconsin with multiple specialty service lines including cancer care, orthopedics, rehabilitation services.
   - 5 consecutive Magnet Designations. Strong Shared Governance Nursing Model.
   - Chest Pain Accredited Center with robust cardiac surgery program and pioneer in cardiac transplant with over 800 cardiac transplants performed at this center. Medicare approved abdominal transplant program.
   - Certified Joint Commission Primary Stroke Center.
2. Why Geri ED at ALMC:
   - Implementation of the Geri ED at Aurora St Luke's Medical Center will help to provide foundational knowledge for nurses to better care for this vulnerable patient population to improve outcomes.

Creating Geriatric Appropriate EDs

Kevin Biese, MD MAT

Associate Professor Emergency Medicine and Geriatrics, University of North Carolina School of Medicine; ACEP Geriatric ED Accreditation Chair

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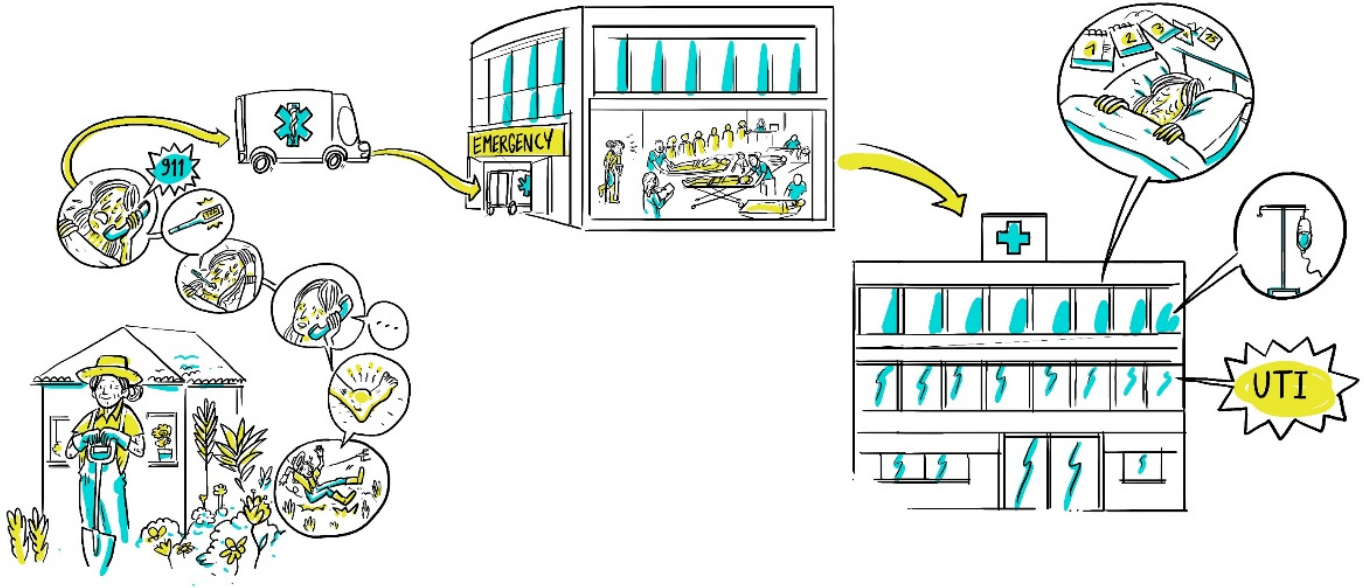

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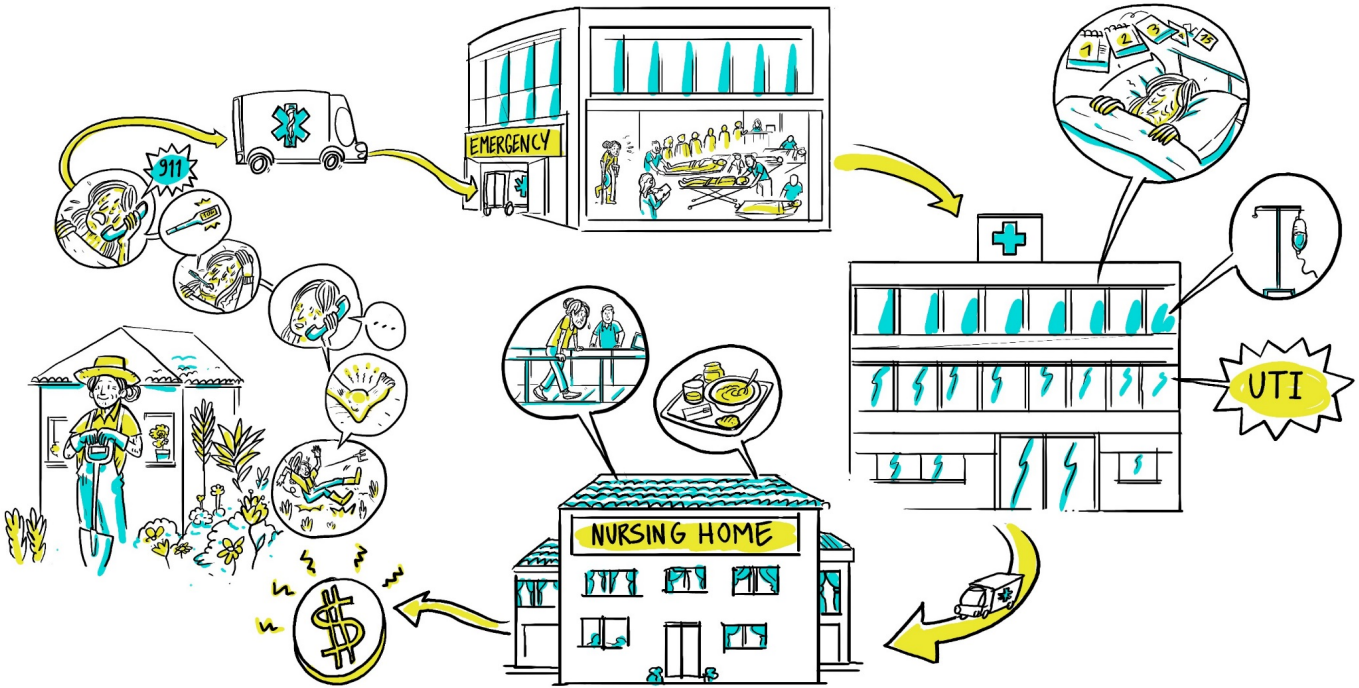

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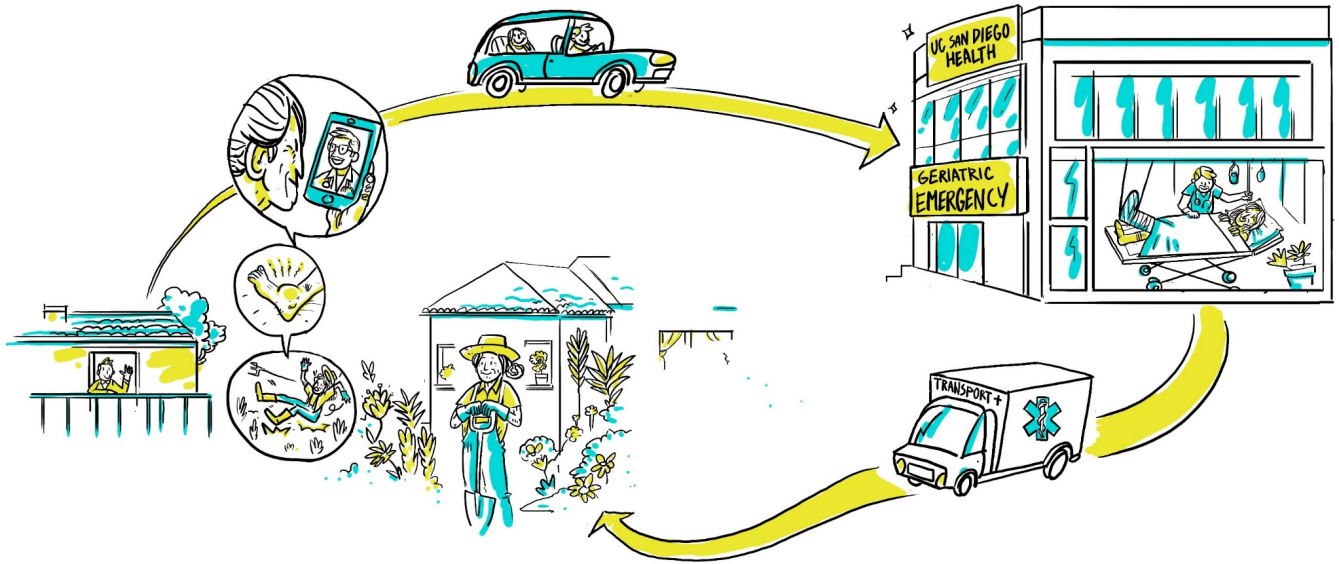

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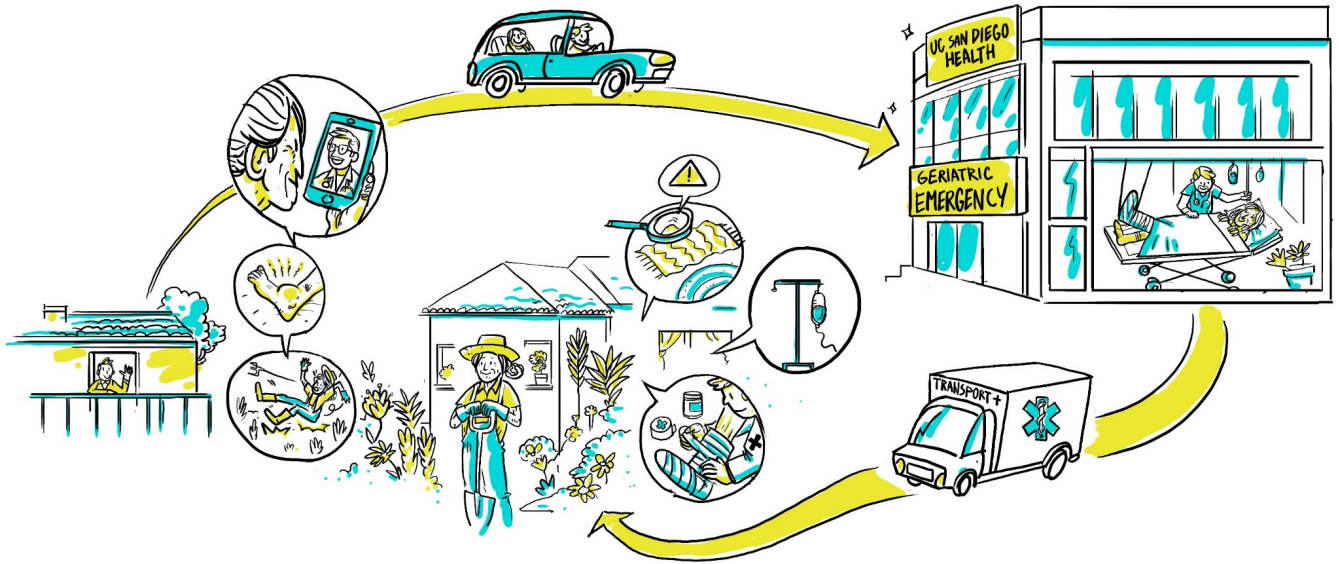

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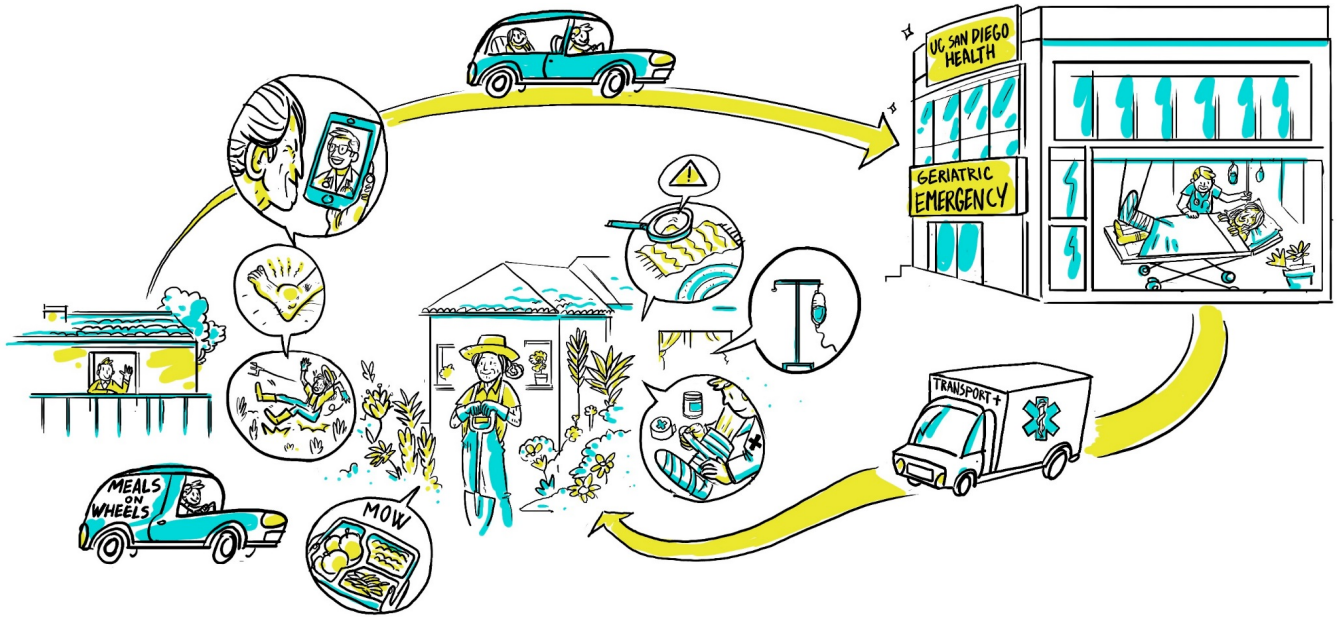

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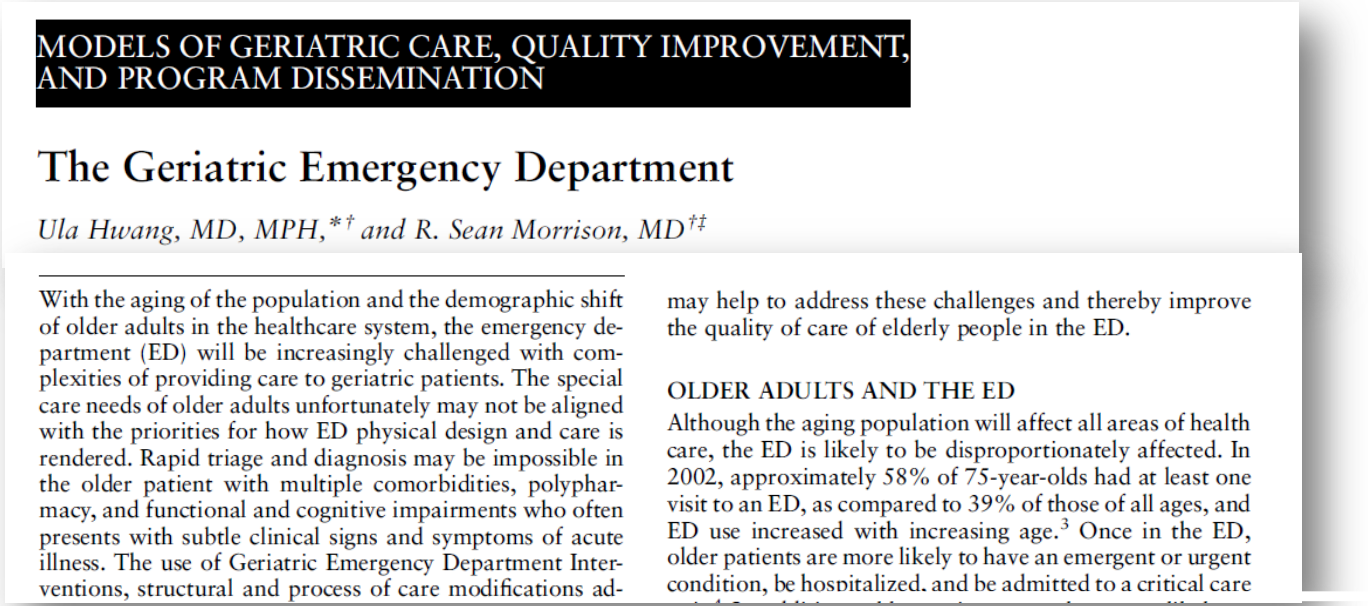

MODELS OF GERIATRIC CARE, QUALITY IMPROVEMENT, AND PROGRAM DISSEMINATION

The Geriatric Emergency Department

Ula Hwang, MD, MPH,[*†] and R. Sean Morrison, MD*[†‡]

With the aging of the population and the demographic shift of older adults in the healthcare system, the emergency department (ED) will be increasingly challenged with complexities of providing care to geriatric patients. The special care needs of older adults unfortunately may not be aligned with the priorities for how ED physical design and care is rendered. Rapid triage and diagnosis may be impossible in the older patient with multiple comorbidities, polypharmacy, and functional and cognitive impairments who often presents with subtle clinical signs and symptoms of acute illness. The use of Geriatric Emergency Department Interventions, structural and process of care modifications ad-

may help to address these challenges and thereby improve the quality of care of elderly people in the ED.

OLDER ADULTS AND THE ED

Although the aging population will affect all areas of health care, the ED is likely to be disproportionately affected. In 2002, approximately 58% of 75-year-olds had at least one visit to an ED, as compared to 39% of those of all ages, and ED use increased with increasing age.[3] Once in the ED, older patients are more likely to have an emergent or urgent condition, be hospitalized, and be admitted to a critical care

- Paradigm shift of ED physical design and care (Pediatric, Psych EDs)
- Geriatric ED Interventions (GEDIs) – (effective inpatient models (HELP)
- No “Geriatric EDs” or “Senior EDs” at time of press (2007)

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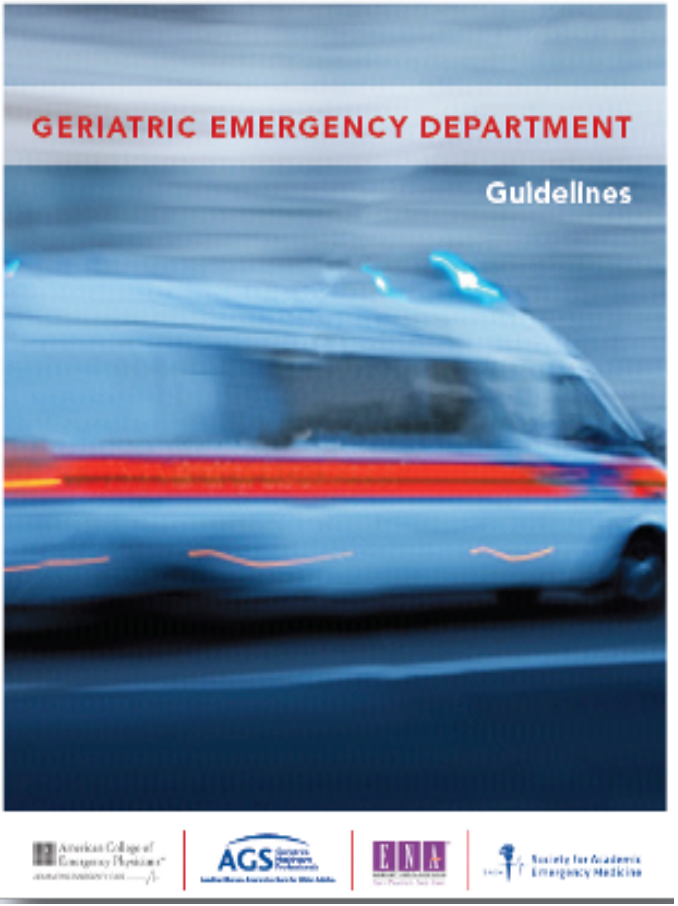

The Geriatric ED Guidelines

KEY CONTENT

- ✓ Structure
- ✓ Process of care
  - ✓ Care coordination
  - ✓ Medication reconciliation
  - ✓ Screening
- ✓ Education
  - ✓ GENE
  - ✓ POGOe
- ✓ Community Connection

Elder mistreatment is recommended education & QI intervention

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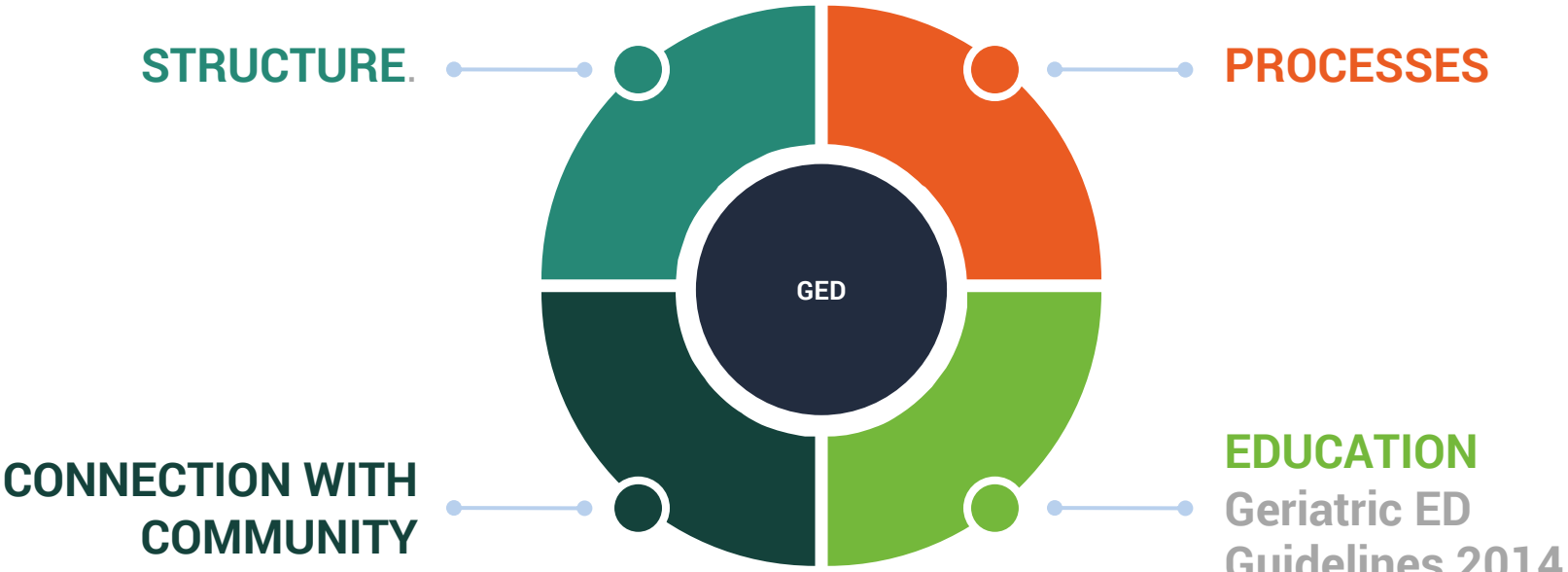
Four Critical Components of a Geriatric-Appropriate ED



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Developing Solutions

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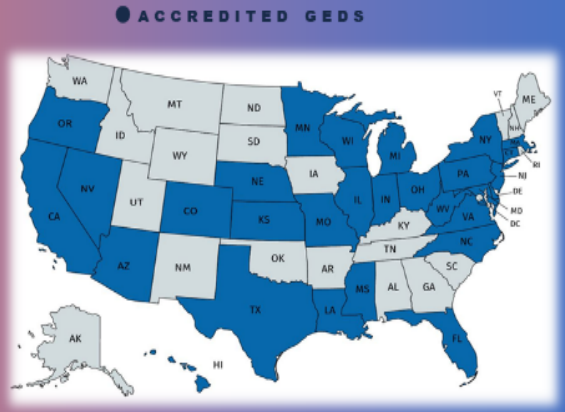
Geriatric ED Sites are Expanding

MAY 2018
FIRST 8 accredited
Geriatric EDs

JUNE 2020
152 ACCREDITED GEDS

>90%
of accredited Geriatric EDs launched
WITHOUT EXTERNAL FUNDING



GREATER
PATIENT SATISFACTION

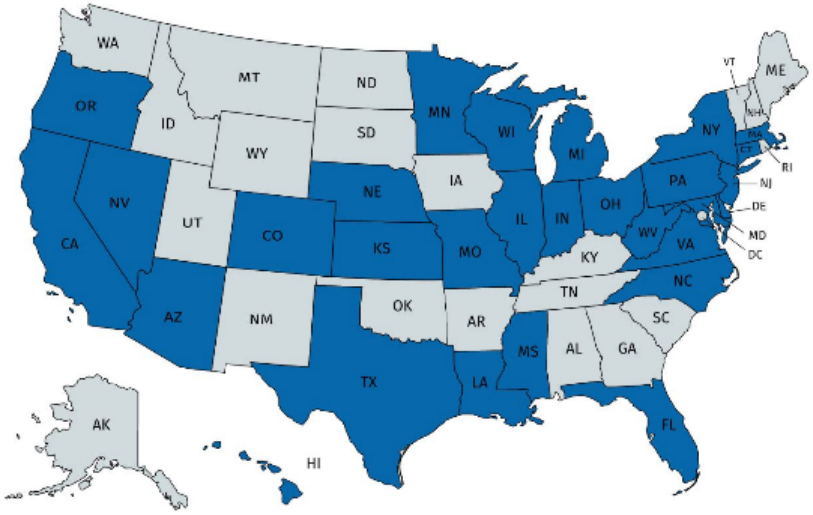
LOWER COSTS
LEVERAGING INTERDISCIPLINARY TEAM

16.5%
REDUCED RISK OF HOSPITAL ADMISSIONS

LOWER RISK
OF 30-DAY FALL-RELATED ED REVISITS

westhealth 1

ACCREDITED GERIATRIC EDS



152 Accredited EDs
- 30 states
- Brazil
- Spain

Level 1	**10**
Level 2	**12**
Level 3	**130**
	152

GEDC

Partnership

GEDC Partners 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.

GEDC is comprised of Emergency Departments dedicated to accomplishing these goals together, and sharing best practices in order to accelerate the evolutions in care models needed to improve emergency care for older adults. Read our Vision Mission and Values to understand more about who we are.

About GEDC →

gedcollaborative.com/partnership

laura_stabler@med.unc.edu

conor_sullivan@med.unc.edu

GEDC

GEDC is Generously Supported by

The John A. Hartford Foundation
Dedicated to Improving the Care of Older Adults

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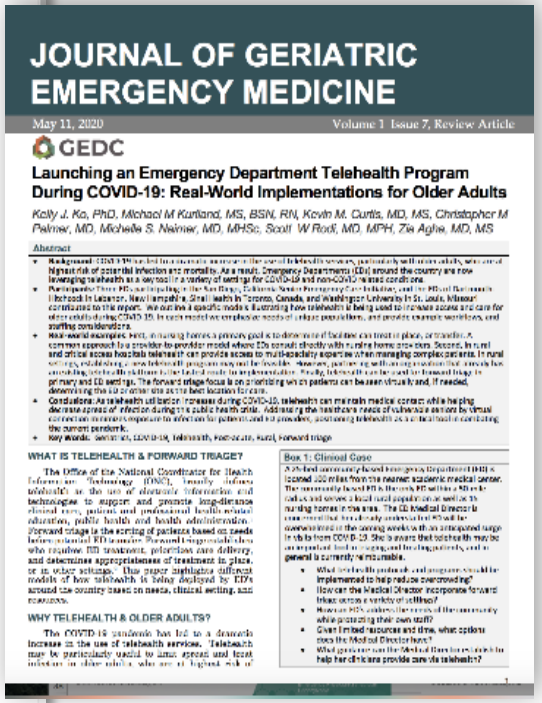
institute

GEDC

Teresita Hogan, MD

Michael Malone, MD



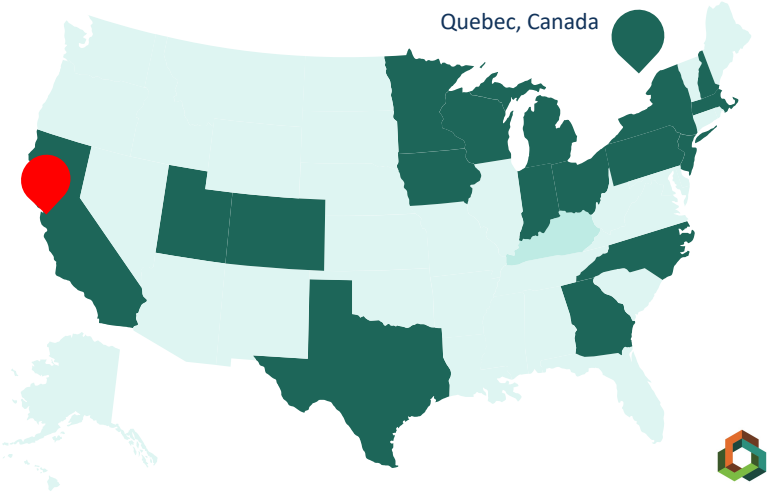
GEDC

GEDC Member Sites

Aurora Sinai Medical Center (Milwaukee, WI)
Aurora Sheboygan Memorial MC (Sheboygan, WI)
Aurora West Allis Medical Center (West Allis, WI)
Aurora St. Luke's South Shore (Cudahy, WI)
Aurora Medical Center Oshkosh (Oshkosh, WI)
Aurora Medical Center Grafton (Grafton, WI)
Aurora Medical Center Summit (Summit, WI)
Aurora Medical Center Washington (Hartford, WI)
Aurora Medical Center Baycare (Green Bay, WI)
Aurora Medical Center Kenosha (Kenosha, WI)
Emory University / Grady Memorial Hospital (Atlanta, GA)
Magee Women's Hospital of UPMC (Pittsburgh, PA)
Mount Sinai Medical Center (NYC, NY)
Northwestern University (Chicago, IL)
St. Joseph Mercy (Paterson, NJ)
University of California, San Diego (San Diego, CA)
University of Chicago (Chicago, IL)
UNC Hospitals Hillsborough Campus (Hillsborough, NC)
St. Mary Mercy Hospital (Livonia, MI)
Cleveland Veterans (Cleveland, OH)
Tufts Medical Center (Boston, MA)
Dartmouth-Hitchcock (Lebanon, NH)
Ohio State University (Columbus, OH)
Mayo Clinic Rochester (Rochester, MN)
Mayo Clinic Eau Claire (Eau Claire, WI)
Université de Sherbrooke (Quebec, Canada)
University of Iowa (Iowa City, IA)
University of Utah (Salt Lake City, UT)
Anne Arundel Medical Center (Annapolis, MD)
University of Colorado (Boulder, CO)
University of Wisconsin (Madison, WI)
Hackensack Meridian (Hackensack, NJ)
Missouri Baptist Medical Center (St. Louis, MO)
Northwell LIJ Forest Hills (Forest Hills, NY)
Duke Regional (Durham, NC)

GEDC Members Coming Soon

- KP (San Francisco, CA)
- UCSF (San Francisco, CA)
- ZSFG (San Francisco, CA)



GEDC

Opportunities for Quality Improvement in the Geriatric ED

Don Melady, MD MSc(Ed)
Adam Perry, MD

GEDC

Small Group Case Discussions

AT THE END OF THIS ACIVTITY, YOU WILL BE ABLE TO:

01 Increase your awareness of the Geri-ED Guidelines and Accreditation criteria

02 Consider challenges in your own ED

03 Discover opportunities for improvement based on the Geri-ED Guidelines

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When You Come Back

CASE DEBRIEFS

Assign someone in your group to describe:

- One barrier to quality care for your patient at your ED now
- One opportunity for improvement that you could implement in your ED now
- 3 minutes per group

Five Older ED patients

CASE 1: **Mrs. Cado**	78-year-old woman with a broken wrist “ready for discharge”	Don Melady & Suzie Ryer
CASE 2: **Mr. Kikway**	82-year-old man with pneumonia “admit or not admit”	Pam Martin & Kevin Biese
CASE 3: **Mrs. Schwach**	80-year-old woman, not feeling right “Mom seems a little off”	Chris Carpenter & Aaron Malsch
CASE 4: **Mrs. Ivanhoe**	87-year-old with fatigue and cough “seventh admission in 6 months”	Adam Perry & Mike Malone
CASE 5: **Mrs. Piedra**	74-year-old woman, third visit in three days “failure to cope”	Tess Hogan & Ula Hwang

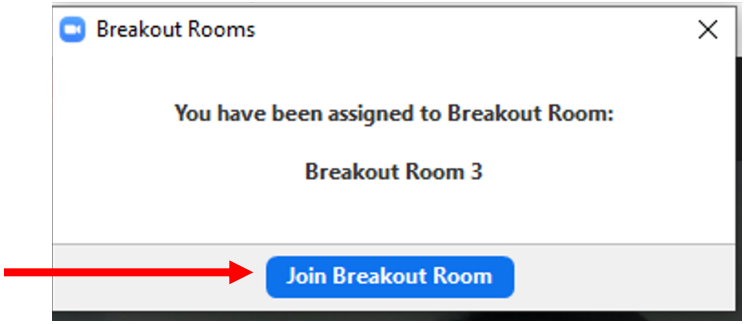
Joining Breakout Rooms

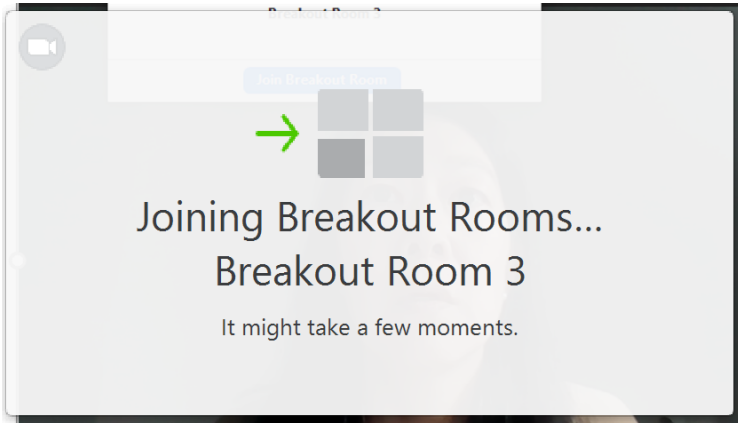
QUICK OVERVIEW

You have already been assigned to your breakout room.

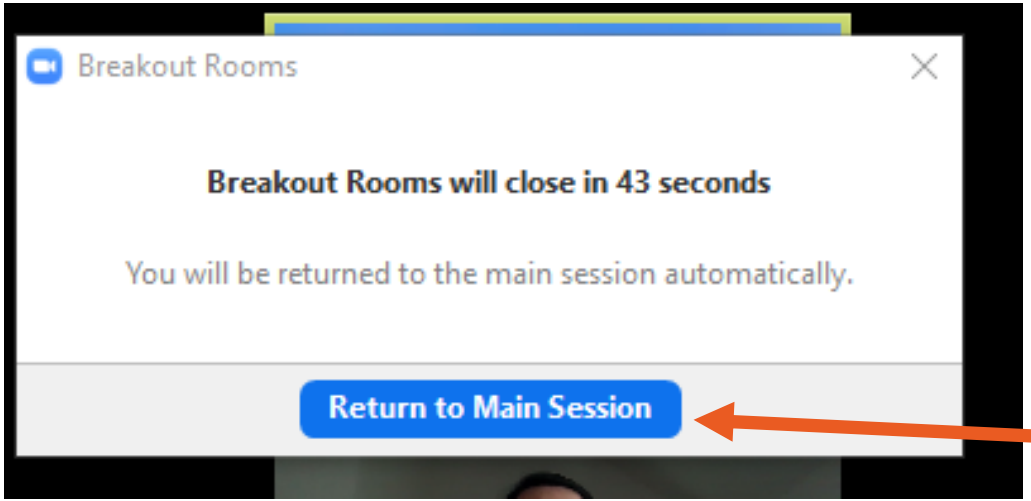
In the bottom toolbar in Zoom, you may click the button to join your breakout room.
Please be patient.

It can take a little while for all the connections to come through.





Leaving Breakout Rooms



When your case discussion time is over (20 minutes), you will receive a 2-minute countdown warning. After 2 minutes you will be automatically returned to the Main Session.

To leave the breakout room, click “Return to Main Session” (instead of Exiting the zoom meeting)

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Five Older ED patients

CASE 1: **Mrs. Cado**	78-year-old woman with a broken wrist “ready for discharge”	Don Melady & Suzie Ryer
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Debrief

BARRIER TO QUALITY OF CARE

- Time – busy ER/no bandwidth to dig in (review meds, etc)
- Getting a full picture of the social history
- No complete workup, foley catheter placement
- Focus on metrics – boarding, time in ED
- Staffing restrictions (off shifts), not adjusted for complex needs older adults
- Focused assessment
- Unclear if individual understands dc instructions

OPPORTUNITY FOR IMPROVEMENT

- Case manager in ED/ coordination of care by single person
- Goals of care discussion – using an interdisciplinary team
- Collaborate with family and other physicians, support system, resources on off shift
- Standard screen for delirium
- Care management early in process/screening for high risk pts
- Integration with community resources
- Partnering with pt for return to home
- Standard cognitive screening

Some Learning Resources

- https://gedcollaborative.com
- https://geri-em.com
- https://geriatric-ed.com
- http://geriatricfastfacts.com
- Melady, Perry, and Macias. An Approach to the Older Patient in the Emergency Department, Clinics in Geriatric Medicine, Volume 34, Issue 3, August 2018, 299-311
- Melady, and Perry. Ten Best Practices for the Older Patient in the Emergency Department, Clinics in Geriatric Medicine, Volume 34, Issue 3, August 2018, 313-326.

THANK YOU

Adam Perry

and all

the GEDC Faculty

Fall Prevention and Mobility in the Emergency Department

Teresita M Hogan MD, FACEP
Director of Geriatric Emergency Medicine
University of Chicago

THE UNIVERSITY OF CHICAGO MEDICINE

Suzie Ryer MPT, GCS, CEEAA
Advocate Aurora Health

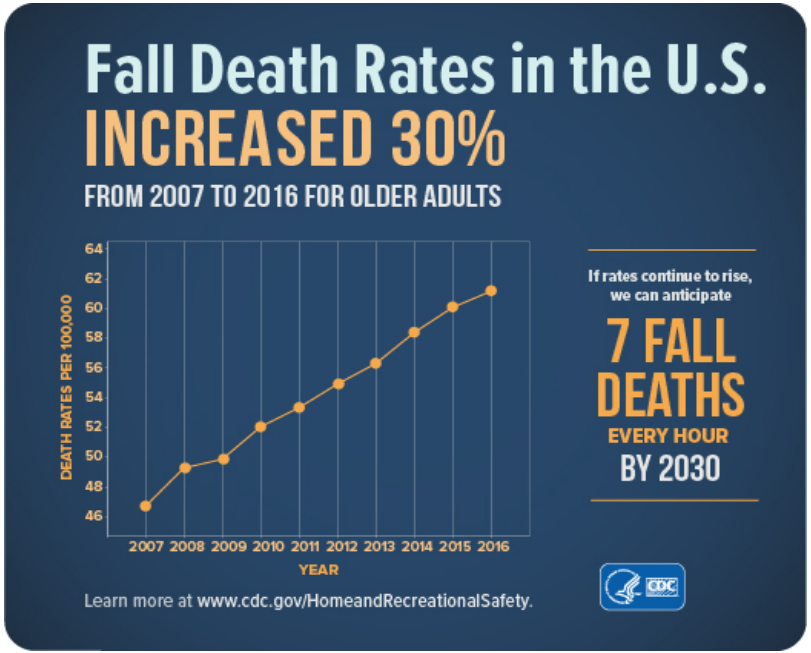
AdvocateAuroraHealth

GEDC

Falls are a Public Health Crisis

CURRENT STATE

- One in four Americans aged 65+ falls each year.
- Falls are the leading cause of older adult injury and death.
- In 2015, the total cost of fall injuries was $50 billion. Medicare and Medicaid shouldered 75% of these costs.



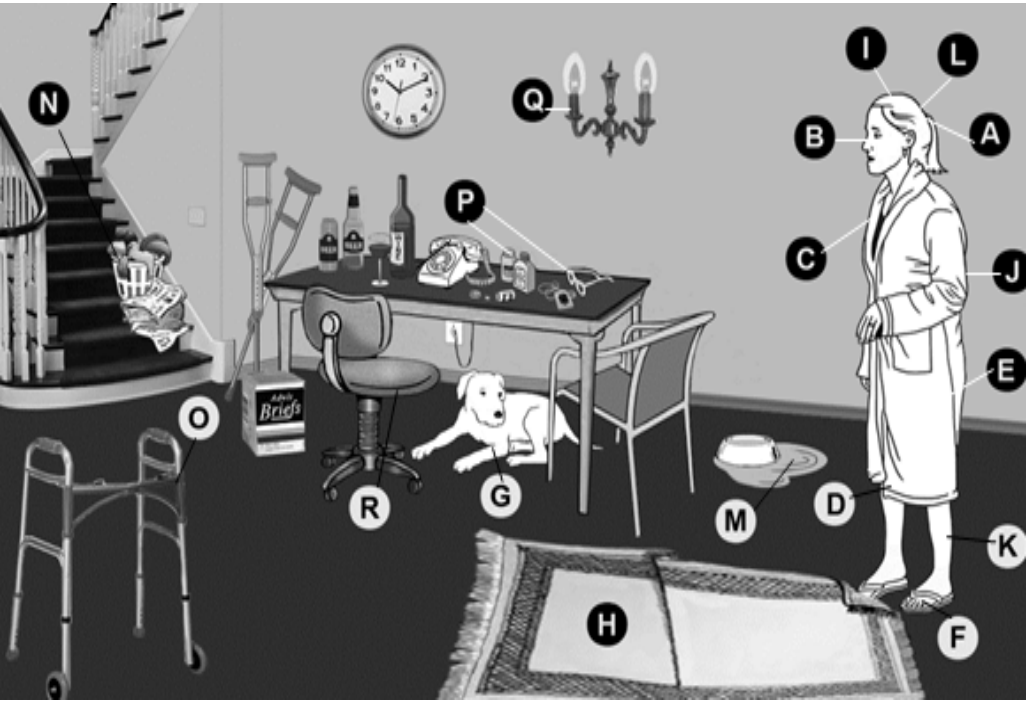
Falls and the Emergency Department

CURRENT STATE

- Every 11 seconds, an older adult is treated in the emergency room for a fall.
- Falls result in more than 2.8 million injuries treated in emergency departments annually, including over 800,000 hospitalizations and more than 27,000 deaths.
- About 1/3 of those seen in the ED for a fall require hospitalization and 2/3 are evaluated and discharged.

Center for Disease Control, 2018

Emergency Department Challenges



- Multiple factors lead to falls
- Hard to prioritize needs or contributing factors during short assessment period
- Challenges to meeting the complex psychosocial needs of the older adults in this setting (24/7).

Traditional ED's Take Poor Care of Fallen Elders

- High utilization
- High cost
- Poor outcomes
- No metrics to guide performance
- No guidelines!?!

"Botched attempt is correct. But can anyone suggest a more family-friendly way of describing what happened?"

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Evolution in GED Care

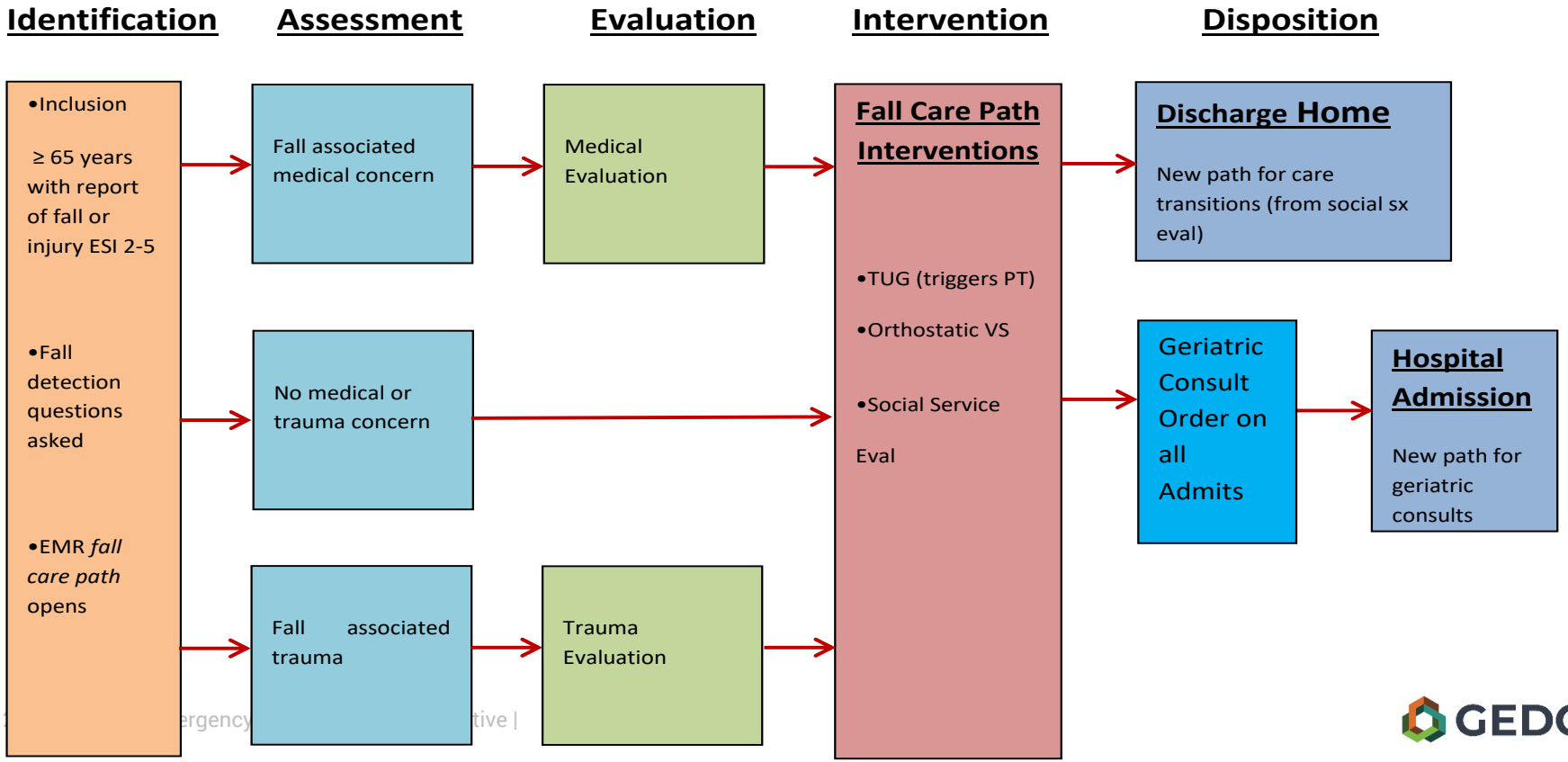
- **Paradigm shift**

  Reactive → **Proactive**

- Current best practice:
  - Evaluate pre-fall cause and post-fall trauma
  - We often fail to achieve this “best practice” state
- New best practice: *in addition* add
  - Gait assessment,
  - Ensure safer discharge,
  - Preserve and even improve mobility

GEDC

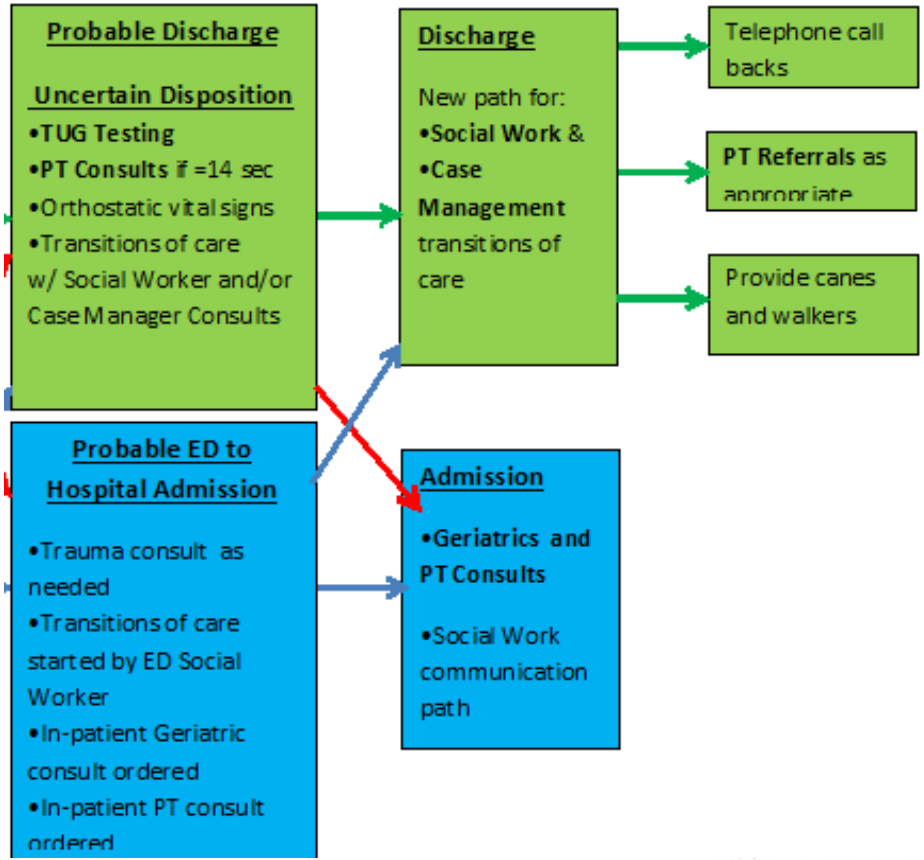
Transforming Emergency Care of Older Adults Who Fall



GEDC

Did You See the Paradigm Shift?

- Intervention and Disposition are New
- Bring expertise of GED team to the bedside!
  - Physical therapists
  - Social workers
- Disposition Decisions
  - Enhanced Admission Care
  - Advanced Transitions of care



Wide Range of Falls Interventions

- Interventions vary from single falls initiatives to parts of full GEDs
- From prevention of falls in the ED to promotion of safer mobility
- Resources vary from presence of on site ED interdisciplinary teams to use of protocols only with no added ED staffing
- The Ohio State University, Hospital Costs and Reimbursement Model for a Geriatric Emergency Department
- https://onlinelibrary.wiley.com/doi/pdf/10.1111/acem.13998
- ED size varies from small community to major university site
- Make the initiative fit your abilities and resources
- The key is to WANT to IMPROVE and ENABLE STAFF

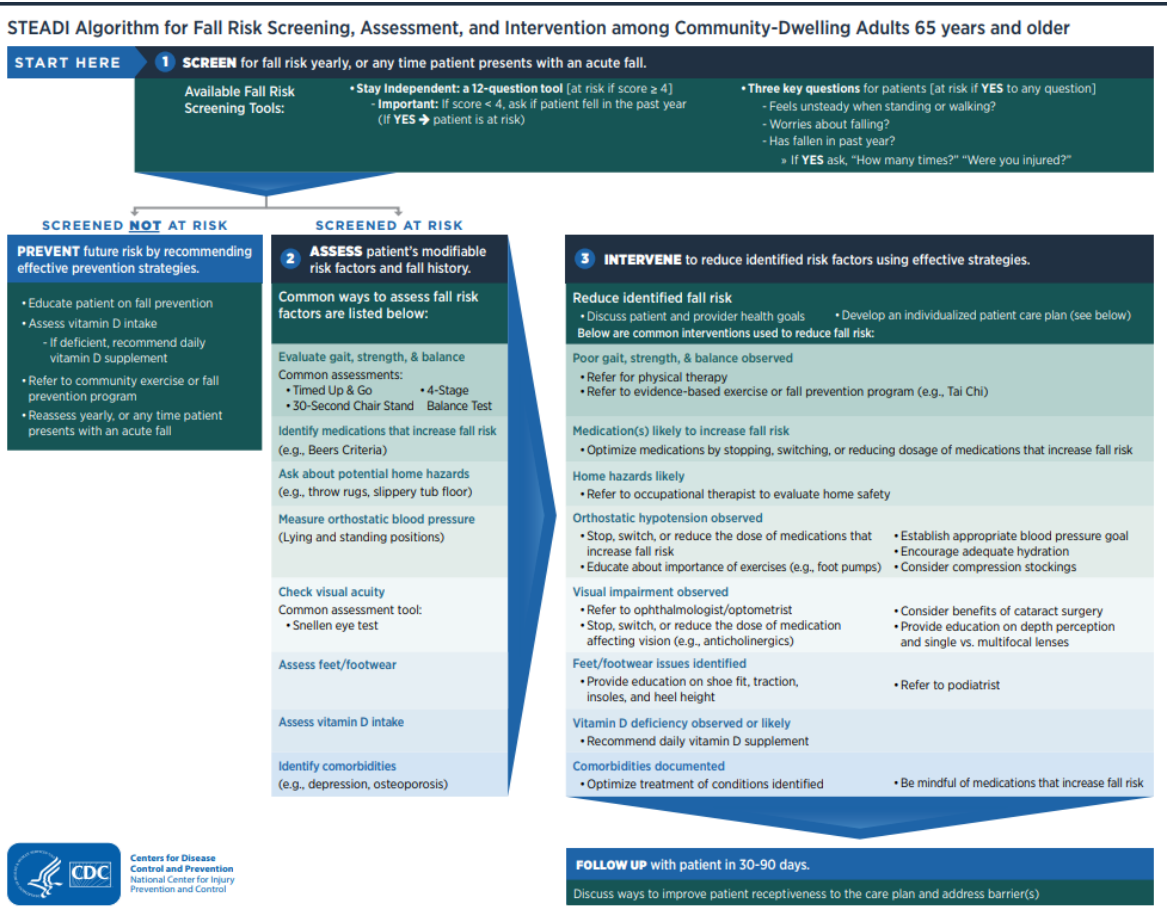
Falls Protocol

- Geri ED accreditation journey identified the need to provide appropriate screening/assessment and interventions for fall.

- An interdisciplinary team: ED Physician, ED Mgr/Supv., RNs, PT, Primary Care MD, Trauma RN and Case Mgmt was formed to develop a falls protocol within the ED setting.

- CDC STEADI served as the guide to develop the falls protocol.

CDC STEADI


STEADI Algorithm for Fall Risk Screening, Assessment, and Intervention among Community-Dwelling Adults 65 years and older
START HERE
1 SCREEN for fall risk yearly, or any time patient presents with an acute fall.
Available Fall Risk Screening Tools:
• Stay Independent: a 12-question tool [at risk if score ≥ 4]
- Important: If score < 4, ask if patient fell in the past year (If YES → patient is at risk)
• Three key questions for patients [at risk if YES to any question]
- Feels unsteady when standing or walking?
- Worries about falling?
- Has fallen in past year?
» If YES ask, "How many times?" "Were you injured?"
SCREENED NOT AT RISK
PREVENT future risk by recommending effective prevention strategies.
• Educate patient on fall prevention
• Assess vitamin D intake
- If deficient, recommend daily vitamin D supplement
• Refer to community exercise or fall prevention program
• Reassess yearly, or any time patient presents with an acute fall
SCREENED AT RISK
2 ASSESS patient's modifiable risk factors and fall history.
Common ways to assess fall risk factors are listed below:
Evaluate gait, strength, & balance
Common assessments:
• Timed Up & Go
• 4-Stage Balance Test
• 30-Second Chair Stand
Identify medications that increase fall risk
(e.g., Beers Criteria)
Ask about potential home hazards
(e.g., throw rugs, slippery tub floor)
Measure orthostatic blood pressure
(Lying and standing positions)
Check visual acuity
Common assessment tool:
• Snellen eye test
Assess feet/footwear
Assess vitamin D intake
Identify comorbidities
(e.g., depression, osteoporosis)
3 INTERVENE to reduce identified risk factors using effective strategies.
Reduce identified fall risk
• Discuss patient and provider health goals
• Develop an individualized patient care plan (see below)
Below are common interventions used to reduce fall risk:
Poor gait, strength, & balance observed
• Refer for physical therapy
• Refer to evidence-based exercise or fall prevention program (e.g., Tai Chi)
Medication(s) likely to increase fall risk
• Optimize medications by stopping, switching, or reducing dosage of medications that increase fall risk
Home hazards likely
• Refer to occupational therapist to evaluate home safety
Orthostatic hypotension observed
• Stop, switch, or reduce the dose of medications that increase fall risk
• Educate about importance of exercises (e.g., foot pumps)
• Establish appropriate blood pressure goal
• Encourage adequate hydration
• Consider compression stockings
Visual impairment observed
• Refer to ophthalmologist/optometrist
• Stop, switch, or reduce the dose of medication affecting vision (e.g., anticholinergics)
• Consider benefits of cataract surgery
• Provide education on depth perception and single vs. multifocal lenses
Feet/footwear issues identified
• Provide education on shoe fit, traction, insoles, and heel height
• Refer to podiatrist
Vitamin D deficiency observed or likely
• Recommend daily vitamin D supplement
Comorbidities documented
• Optimize treatment of conditions identified
• Be mindful of medications that increase fall risk
FOLLOW UP with patient in 30-90 days.
Discuss ways to improve patient receptiveness to the care plan and address barrier(s)
CDC
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

Advocate Aurora Health Protocol

Falls Protocol to Assess and Manage Older Adults in and beyond the Emergency Department:

Identification:

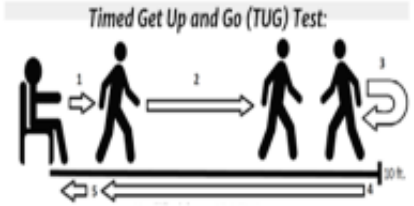
Patients aged >=65 years in the Emergency Department.
Is this ED visit the result of a fall?

Screening

1). If injury, then initiate trauma team (per protocol of each site).

2). If no injury, RN completes Memorial Falls Scale

If No Fall **or** Low Risk on Memorial Falls Scale, then, initiate Mobility Procedure while in ED.



Assessment:

ED nursing staff-
As soon as patient deemed stable for weight bearing:
a) Complete set of Orthostatic VS.
b) Timed Up and Go test.

Results of both communicated to provider.

Do you want a physical therapy consult? Yes/no.

1) **Daytime-**
Notify HUC to arch page PT per template.
2) **Off hours-**
Leave a voice mail for PT at extension xxxx whether admitted or if Outpatient.

TUG >14 seconds

TUG <14 seconds

Intervention:

Admitted patients: initiate protocol to prevent falls in the ED. Automatic PT consult on admission.

Not sure:
1) Referral to PT (**within 30 minutes) while in ED.
2) 2) PT input to provider.

Discharged patients:
1) PT assessment **while in ED.**
2) Referral to outpatient physical therapy **while in ED.**
3) Order assist device **in ED.**
4) Provide a home safety checklist handout.
5) Med reconciliation by Pharmacy Tech .
6) Pharmacist to send Epic telephone message to primary care provider.

Mobility Procedure while in ED.

Disposition:

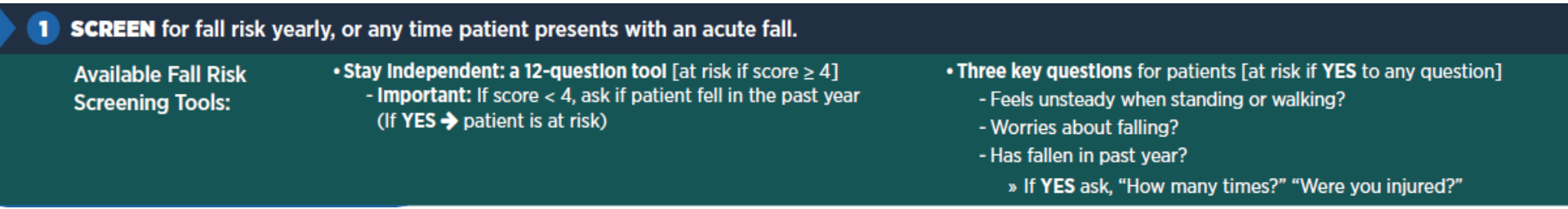
Order early PT assessment in the hospital

1) **ED provider to send Epic "Staff Message" to primary care** for follow up
2) **Referral to outpatient physical therapy** (order can come from the initial ED physician and the subsequent plan of care from the PCP) or
3) **Referral to home care physical therapy** / OT/ home safety evaluation.
4) **Primary care follow up for:**
a. Medication review/management
b. Assess osteoporosis risk and Vitamin D supplements
c. assess vision impairment
d. manage foot/ foot ware problems
e. complete home care order
f. review home safety checklist

Version 10.0
January 29, 2019
Advocate Aurora Health

CDC STEADI – SCREEN

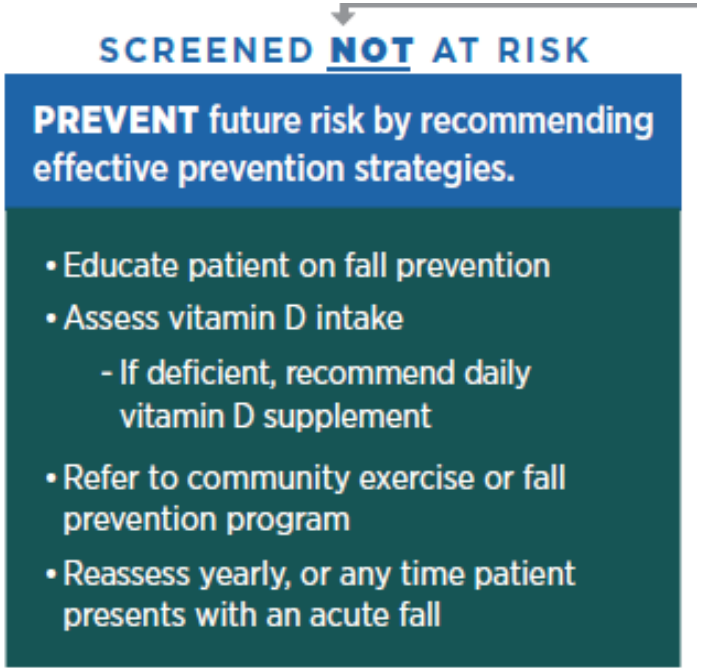
- Patients presenting with fall diagnosis or chief complaint automatically screen positive



Advocate Aurora Health Protocol

- 65 with other chief complaint ask key questions
  - Do you feel unsteady when standing or walking
  - Do you worry about falling?
  - Have you fallen in the last year?

CDC STEADI Prevention

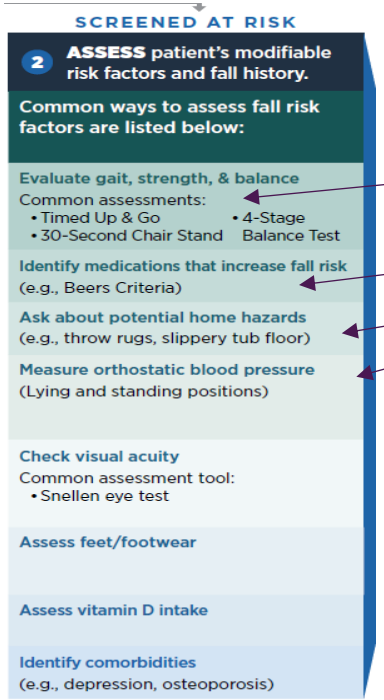


Advocate Aurora Health Protocol

- Initiate early mobility while in ED to maintain function
- Fall prevention/home safety checklist at discharge
- Recommendations for community-based fall prevention programs

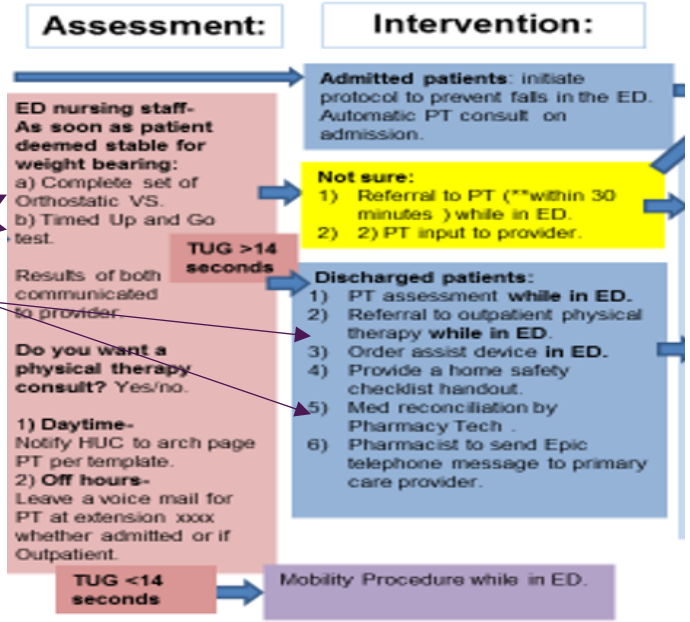
AdvocateAuroraHealth

CDC STEADI Prevention



Multifactorial fall assessment

Advocate Aurora Health Protocol

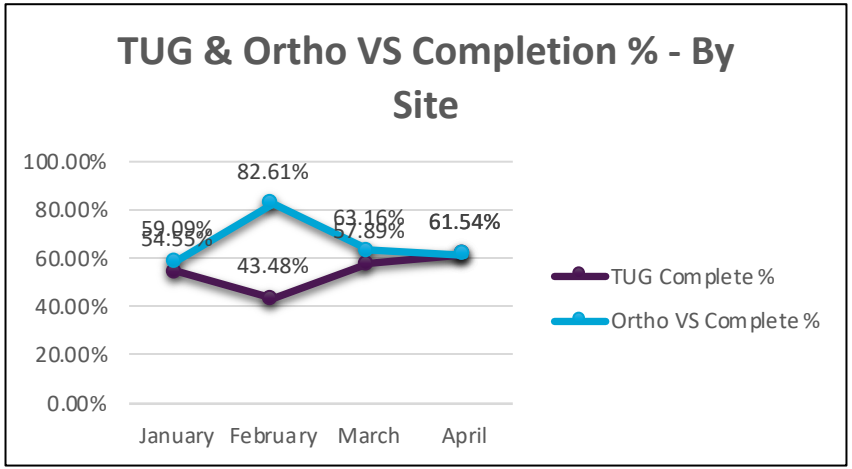


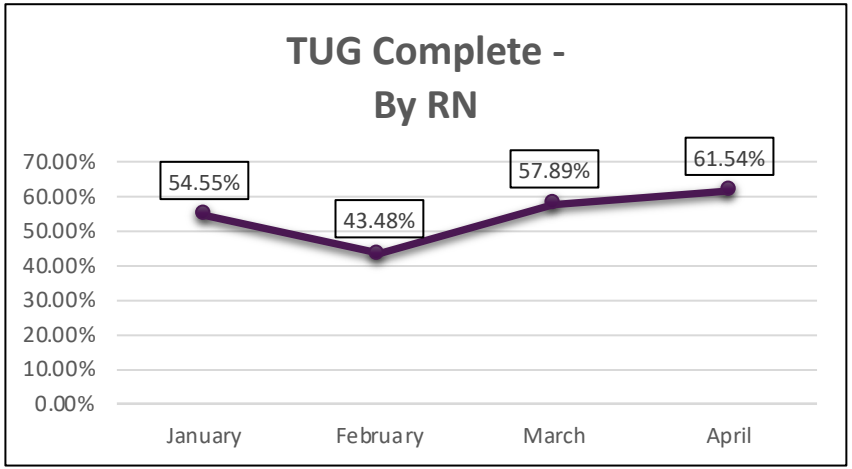
AdvocateAuroraHealth

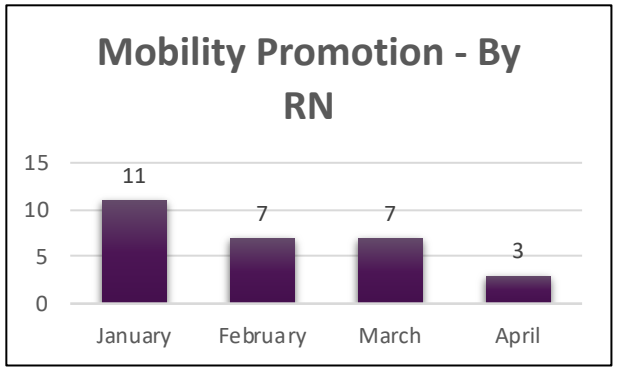
Key Points for Implementation

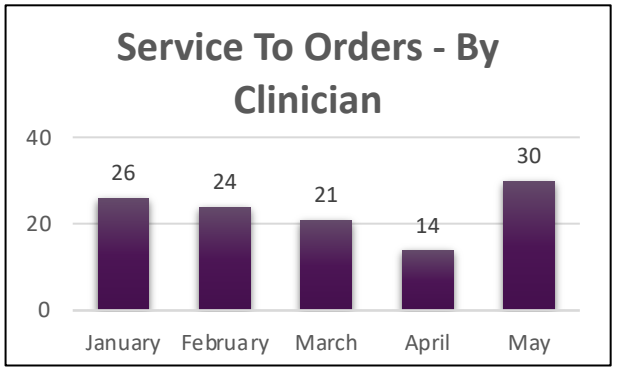
- Work as an interdisciplinary team throughout all steps of implementation
- Engage Physical Therapy (PT) in the ED in a way that works for your hospital setting (housed in ED or available as needed)
- Collaborate with community partners- Health Depts., EMS, Home Care, Assisted Living, Community-based fall prevention programs
- Engage Pharmacy for Medication Reconciliation while in the ED
- Incorporate supporting resources into discharge instructions - Home Safety Check List, CDC STEADI resources, community resources
- Link patients to primary care for additional follow-up

Outcomes and Dashboard









Next Steps

- Disseminate the AAH Falls and Mobility protocol to existing sites.
- Enhance and customize protocol to meet the unique needs of diverse sites.
- Enhance and further integrate interdisciplinary teams into protocol.
- Create an EPIC order set specific to falls.
- Research and study protocol design and utilization across sites
- GEAR/Data Warehouse for additional insights
- Further develop Falls metric dashboard.

Questions?

Thank you for your dedication to vulnerable older adults

Closing & Next Steps

GEDC Faculty feedback

Questions

Monthly site implementation meetings

Booster Session Fall 2020

Post Bootcamp Eval and Resources

Appendix:

Reference

Geriatric ED Key Components

- RN ISAR screening of all patients age >= 65
- RN Coordinates with MD
  - MD assessment with interdisciplinary team
    - Referrals, service-to orders, PT eval, PharmD med rec
- Case manager Coordinate post- ED services.
  - Helps to link patient to primary care.
  - Link to community resources
- Project champions review outcomes
  - Continuous Improvement with admin support
  - Develop new clinical protocols (falls, palliative care)
- Automated EHR reports

ED Demographics

	Geri ED Sites 2019	Total visits in ED (all ages)	Total pts >65 in ED	%
Current	Sheboygan	23,327	5,772	25%
	West Allis	40,583	10,685	26%
	South Shore	22,584	6,063	27%
	Oshkosh	23,573	5,200	22%
	Sinai	62,431	5,581	9%
	Grafton	19,445	8,106	42%
	BayCare	37,082	7,473	20%
	Hartford	8,564	2,978	35%
	Summit	22,854	5,460	24%
	Kenosha	32,402	8,337	26%
Future	St. Luke's	79,109	24,137	31%
	Burlington	14,925	5,207	35%
	Lakeland	15,367	4,641	30%
	Manitowoc	14,120	3,693	26%
	Grand Total	**416,366**	**103,333**	**25%**

Post Covid-19 2020 Timeline: