Welcome to:

HANYS Geriatric ED Bootcamp

Monday, March 27, 2023
1:00 PM – 4:00 PM EST

GEDC EDUCATE IMPLEMENT EVALUATE

HANYS Always There for Healthcare

ACEP Geriatric Emergency Department Accreditation

artment Collaborative |

Bootcamp Facilitators

Kevin Biese
MD, MAT (Co-PI)
University of
North Carolina

Pamela Martin
MS, RN, FNP GCNS-BC
Yale University

Aaron Malsch
RN, MSN, CGNS-BC
Advocate Aurora Health

Laura Stabler
MPH
Program Director GEDC

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

Tess Hogan
MD, FACEP
University of Chicago

Kira Gossack-Keenan
Geriatric Emergency
Medicine Fellow
University of Toronto

Conor Sullivan
BS
Program Manager GEDC

Heather Wojtarowicz
BS, BA
Program Specialist GEDC

Accreditation Statement

In support of improving patient care, this activity is planned and implemented by Mayo Clinic College of Medicine and Science and The Geriatric Emergency Department Collaborative (GEDC). Mayo Clinic College of Medicine and Science is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) to provide continuing education for the healthcare team.

JOINT ACCREDITATION™
INTERPROFESSIONAL CONTINUING EDUCATION

Credit Statement(s)

AMA

The Mayo Clinic College of Medicine and Science designates this live activity for a maximum of 2.5 *AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

CPD

ANCC

The Mayo Clinic College of Medicine and Science designates this live activity for a maximum of 2.5 ANCC contact hours. Nurses should claim only the credit commensurate with the extent of their participation in the activity.

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Learning Objectives

By the end of this activity, you should be able to:

- Identify focused quality improvement projects that can be implemented over the next six months to improve care for older patients in your ED
- Identify problems and opportunities in ED regarding care of their older patients
- Describe the Level 3 components of a geriatric ED based on the GED Guidelines
- Demonstrate familiarity with the GEDC Geri ED implementation resources available to HANYS ED Sites

GEDC

Topic	Presenter(s)
1:00-1:20 (20 mins)	Welcome & Introductions	GEDC / HANYS
1:20-1:40 (20 mins)	Why GEDs & Accreditation Criteria	Kevin Biese
1:40-2:15 (35 mins)	Case Studies – Breakout Rooms	Don Melady (Moderator & Presenter) Tess Hogan, Pam Martin, Aaron Malsch, Kevin Biese, Kira Gossack-Keenan (Presenters)
2:15-2:25 (10 mins)	Break	
2:25- 3:25 (60 mins)	GED Implementation & GEDC QI Resources	ISAR Screening – Aaron Malsch Delirium – Pam Martin Falls & Mobility – Aaron Malsch Tips & Resources – Kevin Biese
3:25–3:35 (10 mins)	Closing Remarks	HANYS
3:35-4:00 (25 mins)	Questions, Next Steps & Wrap Up	GEDC

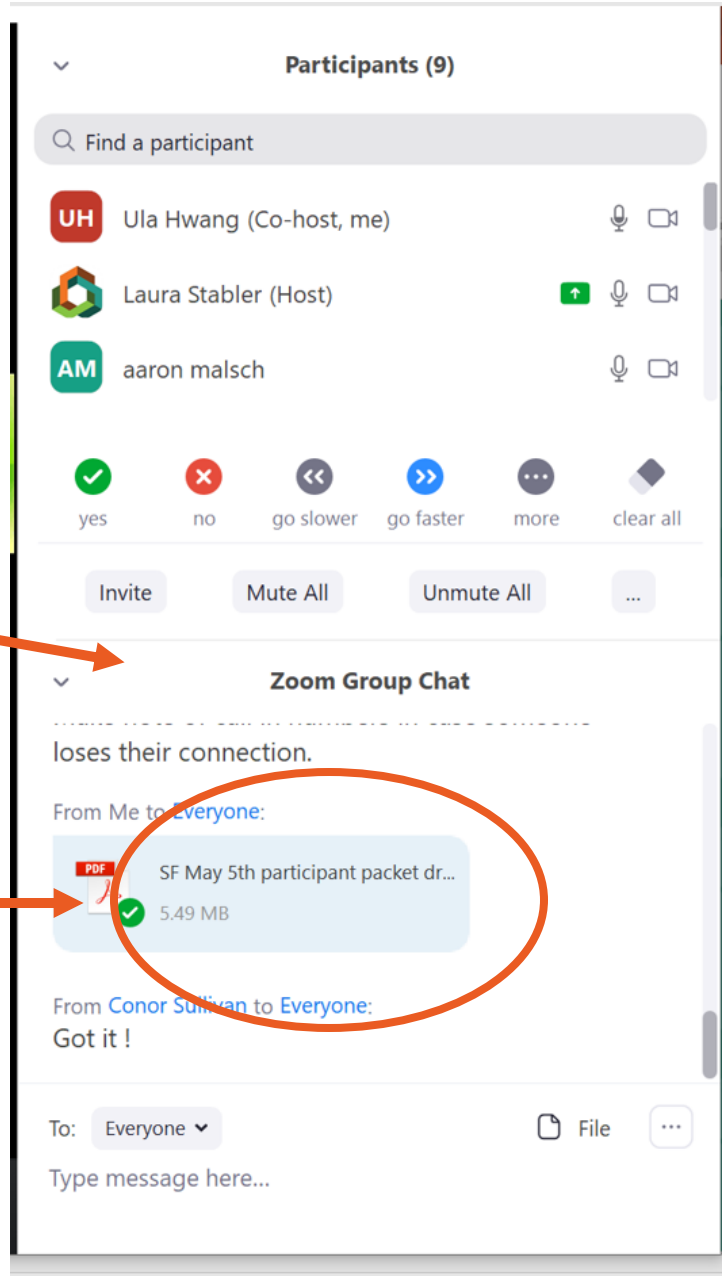
Tips for Participation

GET THE MOST OUT OF YOUR BOOTCAMP

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

Smile! Turn on your cameras! ☺

Technical difficulties:
Please text Conor Sullivan: 910-200-1312
or Heather Wojtarowicz: 501-504-4406



What if I have Questions!?

Use the Zoom Chat feature! The chat will be monitored and we will try to answer questions there.

Consolidate your questions and email

CONTACT INFO

Stay tuned for follow up sessions focused on the implementation of the toolkits we are briefly introducing today

GEDC

GEDC THE GERIATRIC EMERGENCY DEPARTMENT COLLABORATIVE

EDUCATE IMPLEMENT EVALUATE

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/application/

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

HANYS Geriatric ED Accreditation

Dora Fisher, MPH, CPHQ
Director, Post-Acute and Continuing Care

HANYS®
Always There for Healthcare

Welcome

New York City New York

- Montefiore Medical Center – Moses Campus (Bronx, NY)
- Montefiore Medical Center – Wakefield Campus (Bronx, NY)
- Montefiore Medical Center – Weiler Campus (Bronx, NY)
- Montefiore Medical Center – Westchester Square (Bronx, NY)
- Mount Sinai – Beth Israel (New York, NY)
- Mount Sinai – Brooklyn (Brooklyn, NY)
- Mount Sinai – Morning Side (New York, NY)
- Mount Sinai – Queens (Queens, NY)
- Mount Sinai – The Mount Sinai Hospital (New York, NY)
- Mount Sinai – West (New York, NY)
- NYC Health + Hospitals – Queens (Queens, NY)
- NYU Langone – Brooklyn Hospital
- NYU Langone – Cobble Hill
- NYU Langone – Tisch Hospital (New York, NY)
- Wyckoff Heights Medical Center (Brooklyn, NY)

Central New York

- Bassett Health System – A.O. Fox Hospital
- Bassett Health System – A.O. Fox Hospital (Tri Town Campus)
- Bassett Health System – Cobleskill Regional Hospital
- Bassett Health System – Little Falls Hospital
- Bassett Health System – O'Connor Hospital

North Country New York

- UVM Health – Central Vermont Medical Center (Berlin, VT)
- UVM Health – Champlain Valley Physicians Hospital (Plattsburgh, NY)
- UVM Health – Elizabethtown Community Hospital (Elizabethtown, NY)
- UVM Health – Main Campus (Burlington, VT)
- UVM Health – Porter Medical Center (Middlebury, VT)

Hudson Valley New York

- Columbia Memorial Hospital (Hudson, NY)
- Montefiore Mount Vernon (Mount Vernon, NY)
- Montefiore New Rochelle (New Rochelle, NY)
- Montefiore Nyack (Nyack, NY)
- Montefiore St. Luke's Cornwall (Newburgh, NY)
- Montefiore White Plains Hospital (White Plains, NY)

Long Island New York

- Catholic Health Mercy Hospital (Long Island) (Rockville Centre, NY)
- Catholic Health St. Catherine of Siena Hospital (Smithtown, NY)
- Catholic Health St. Charles Hospital (Port Jefferson, NY)
- Mount Sinai – South Nassau (Oceanside, NY)
- NYU Langone – Long Island Hospital

Western New York

- Catholic Health/Mercy Hospital (Buffalo, NY)
- Erie County Medical Center (Buffalo, NY)

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Bronze - Level 3

Pursuing Level 3

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- Montefiore Medical Center – Moses Campus (Bronx, NY)
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Silver - Level 2

Pursuing Level 2

- Mount Sinai – Beth Israel (New York, NY)
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- Mount Sinai – Morning Side (New York, NY)
- Mount Sinai – Queens (Queens, NY)
- Mount Sinai – West (New York, NY)
- Montefiore White Plains Hospital (White Plains, NY)
- NYU Langone – Brooklyn (Brooklyn, NY)
- NYU Langone – Tisch (New York, NY)
- NYU Langone – Long Island (Mineola, NY)
- Catholic Health Mercy Hospital (Long Island) (Rockville Centre, NY)
- Catholic Health St. Catherine of Siena Hospital (Smithtown, NY)
- Catholic Health St. Charles Hospital (Port Jefferson, NY)
- Mount Sinai – South Nassau (Oceanside, NY

Gold - Level 1

Pursuing Level 1

- Mount Sinai – The Mount Sinai Hospital (New York, NY)

Geriatric EDs: The Why?

Kevin Biese
MD, MAT

Geriatric Emergency Department Collaborative Implementation PI

Chair, Geriatric Emergency Department Accreditation

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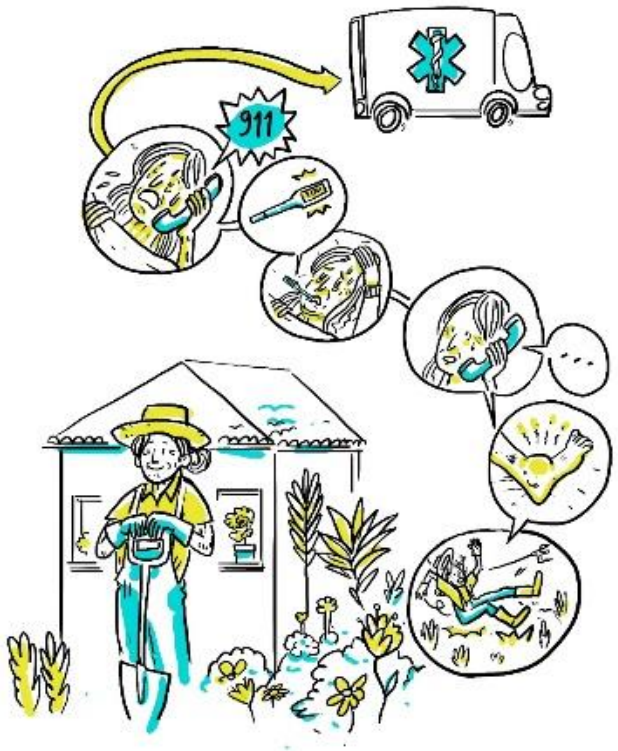
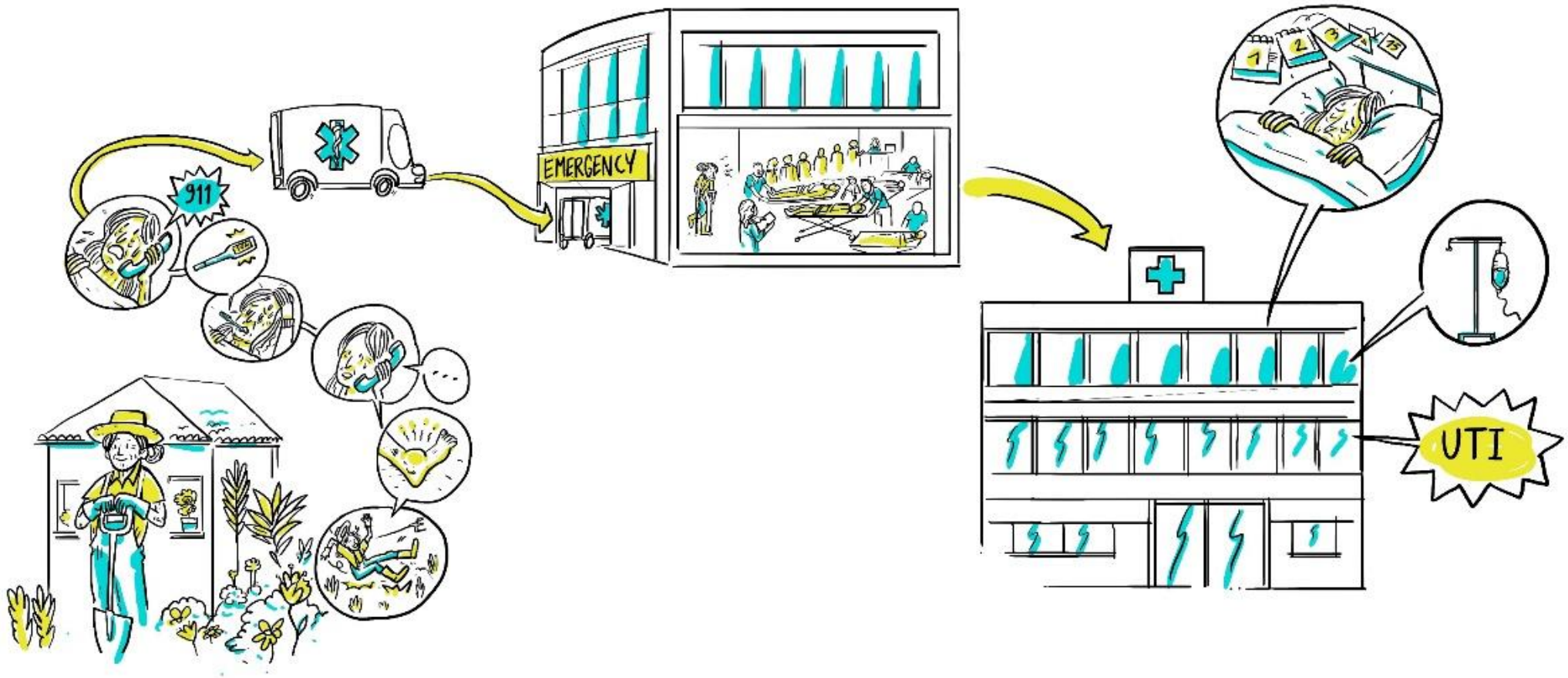

911


911
EMERGENCY



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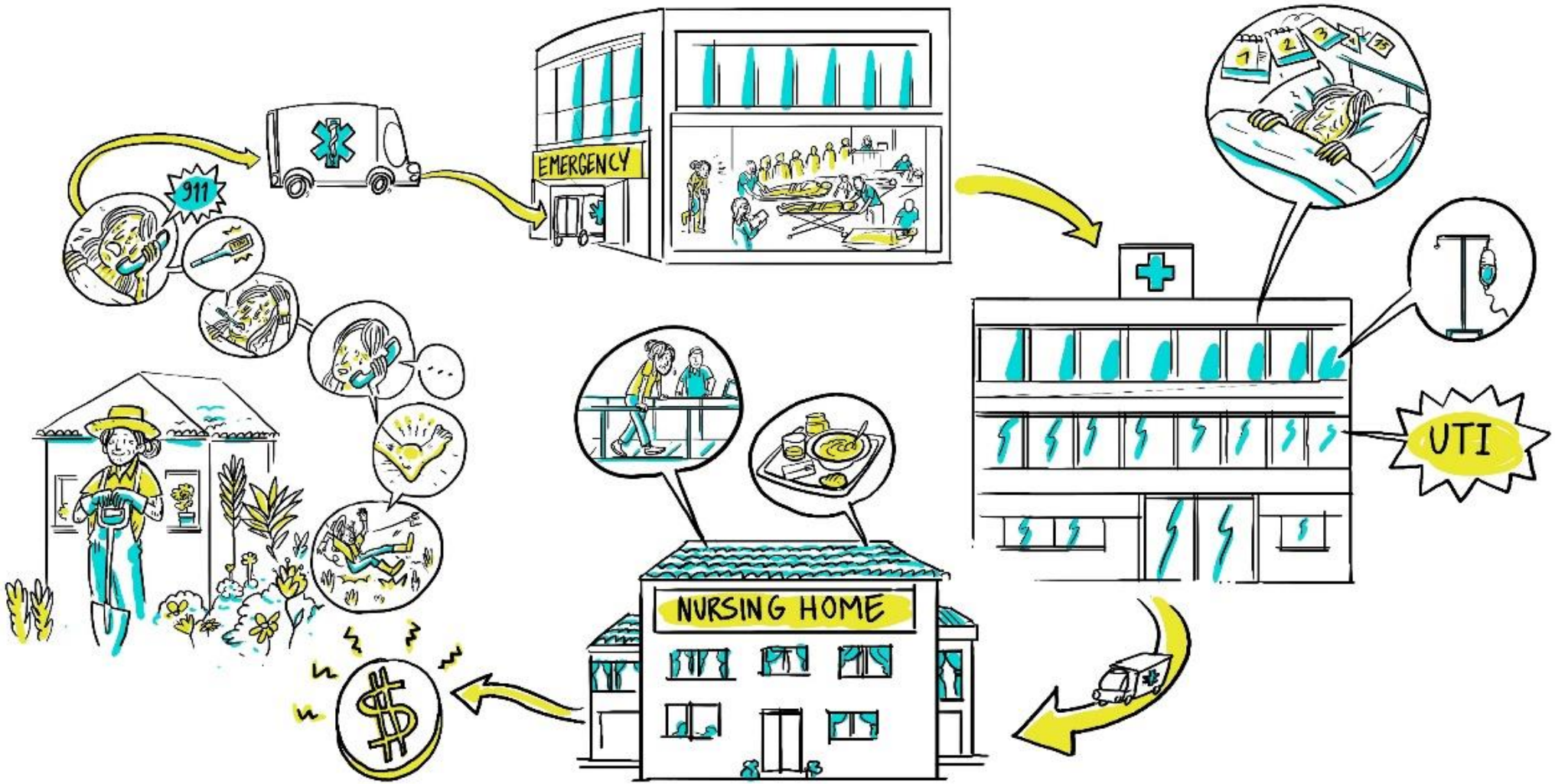

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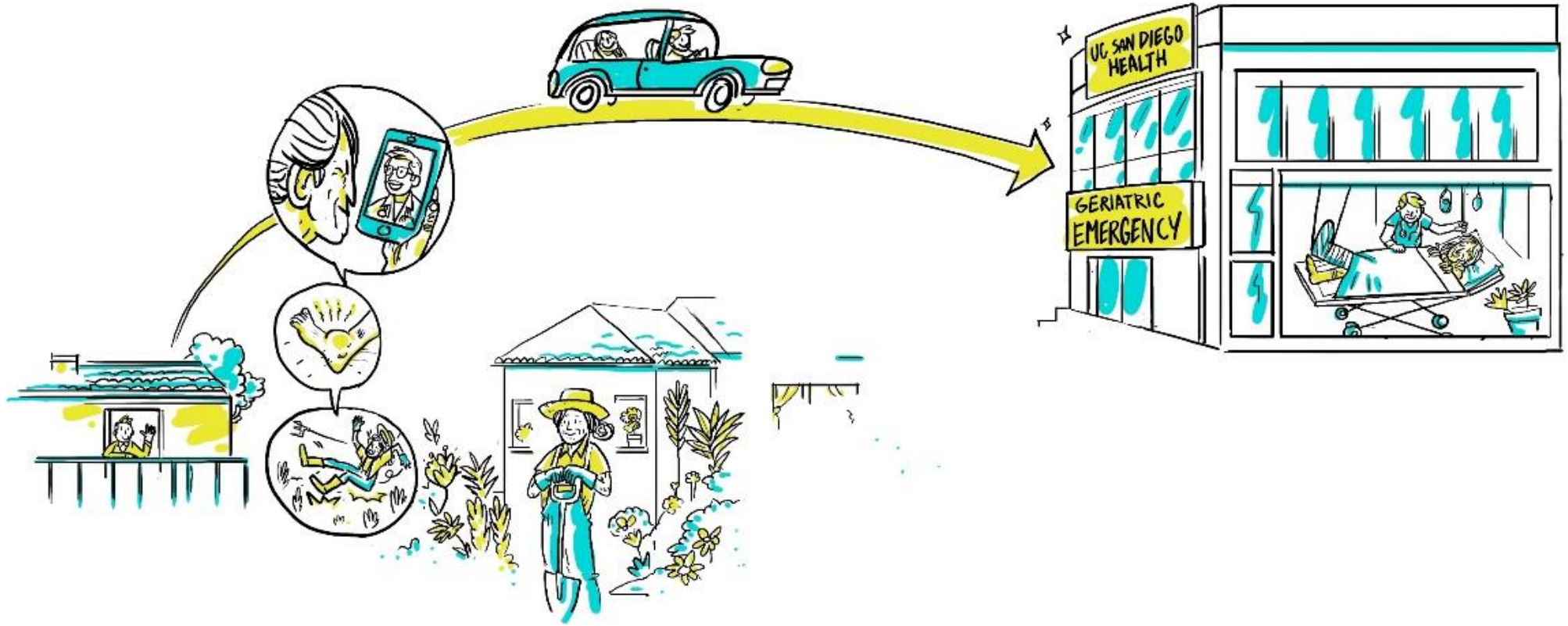

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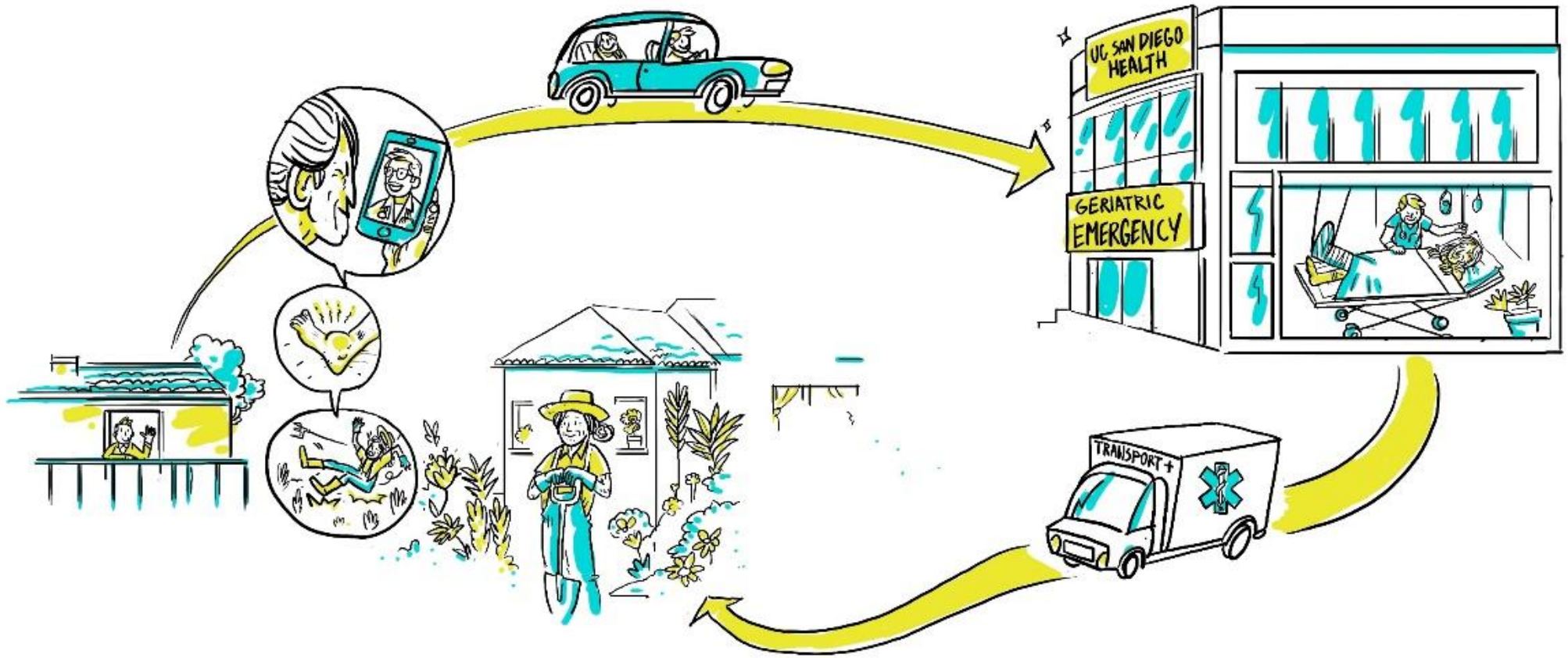

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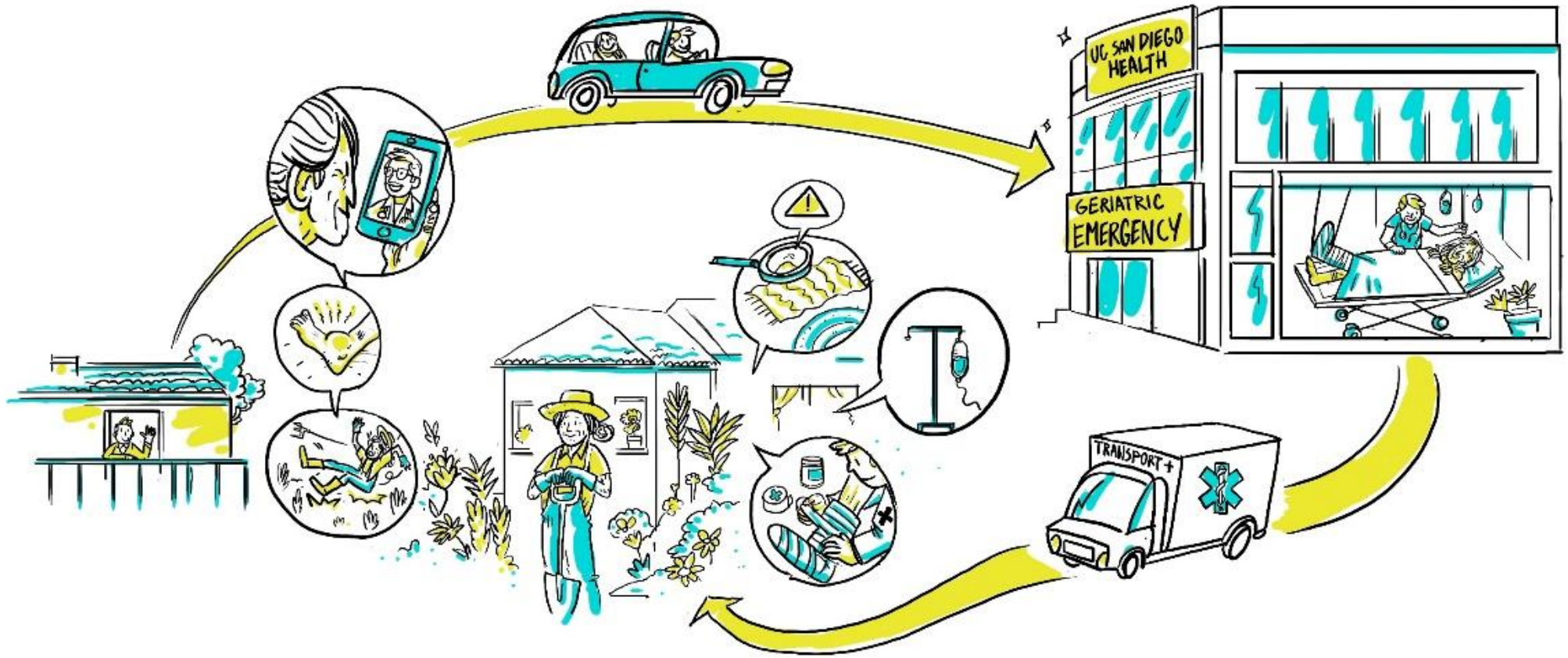

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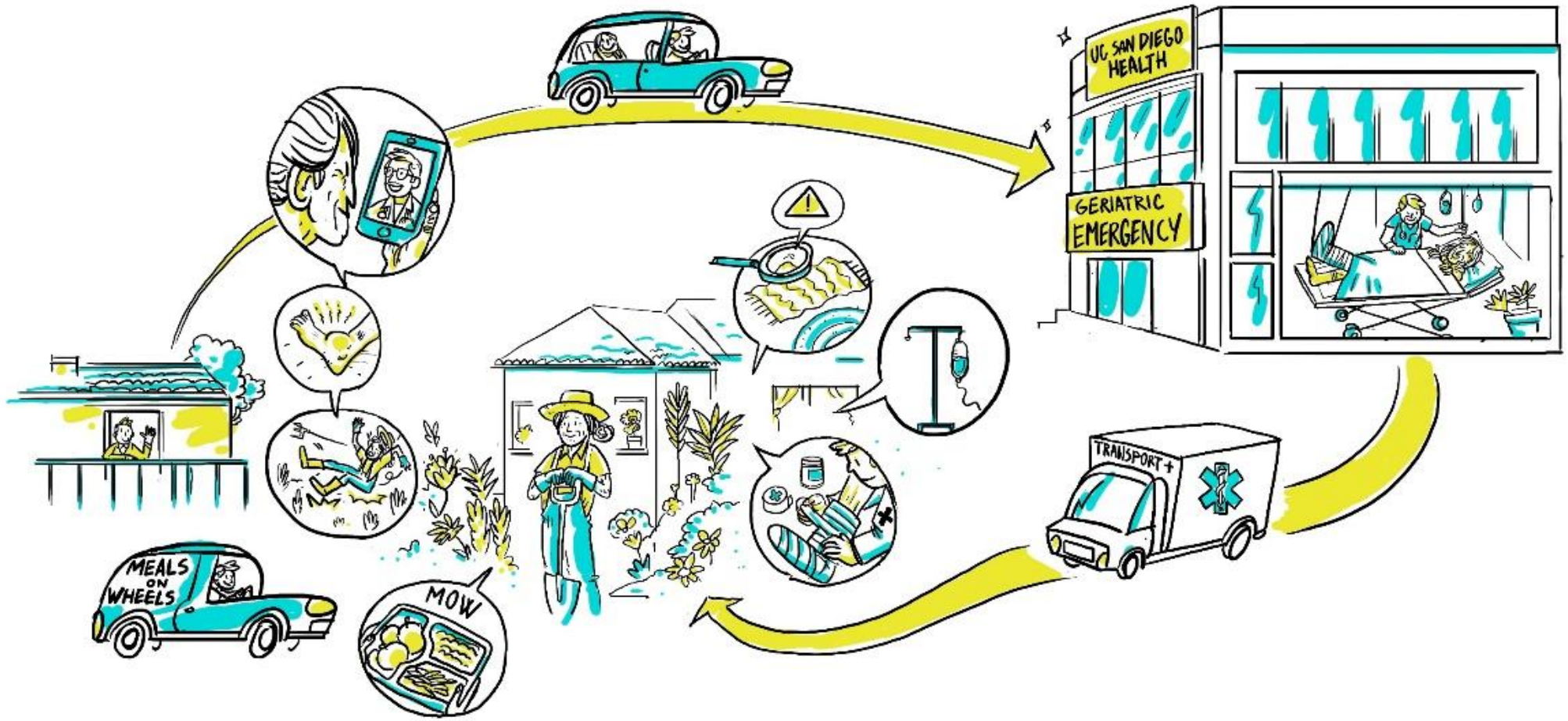

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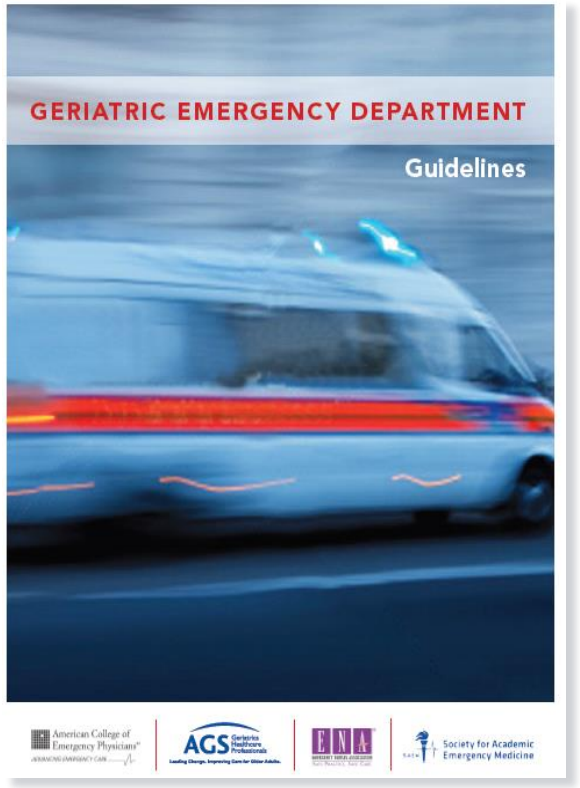
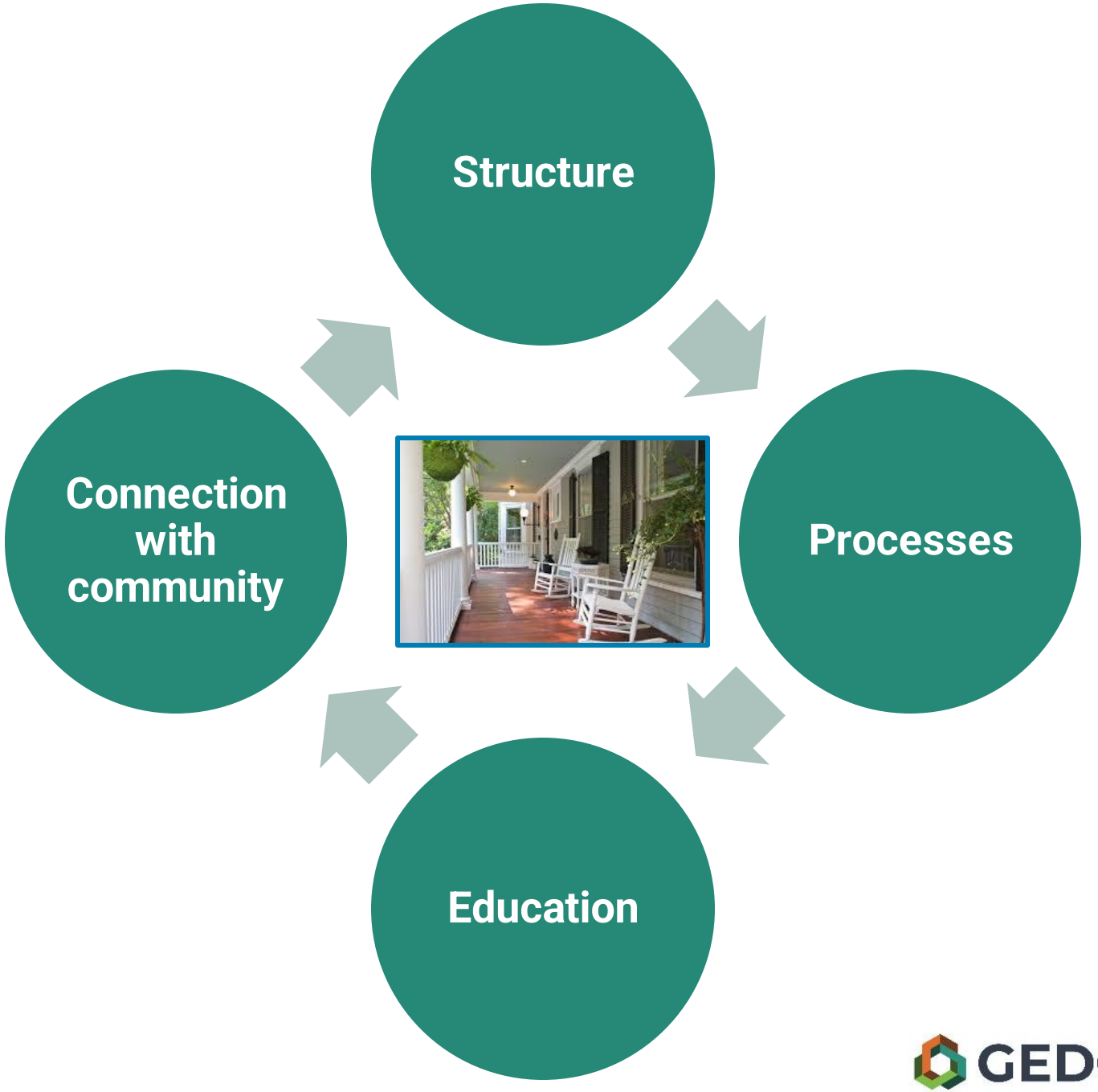
Geriatric ED Guidelines

Four Critical Components of a Geriatric-Appropriate ED



Geriatric ED Guidelines 2014



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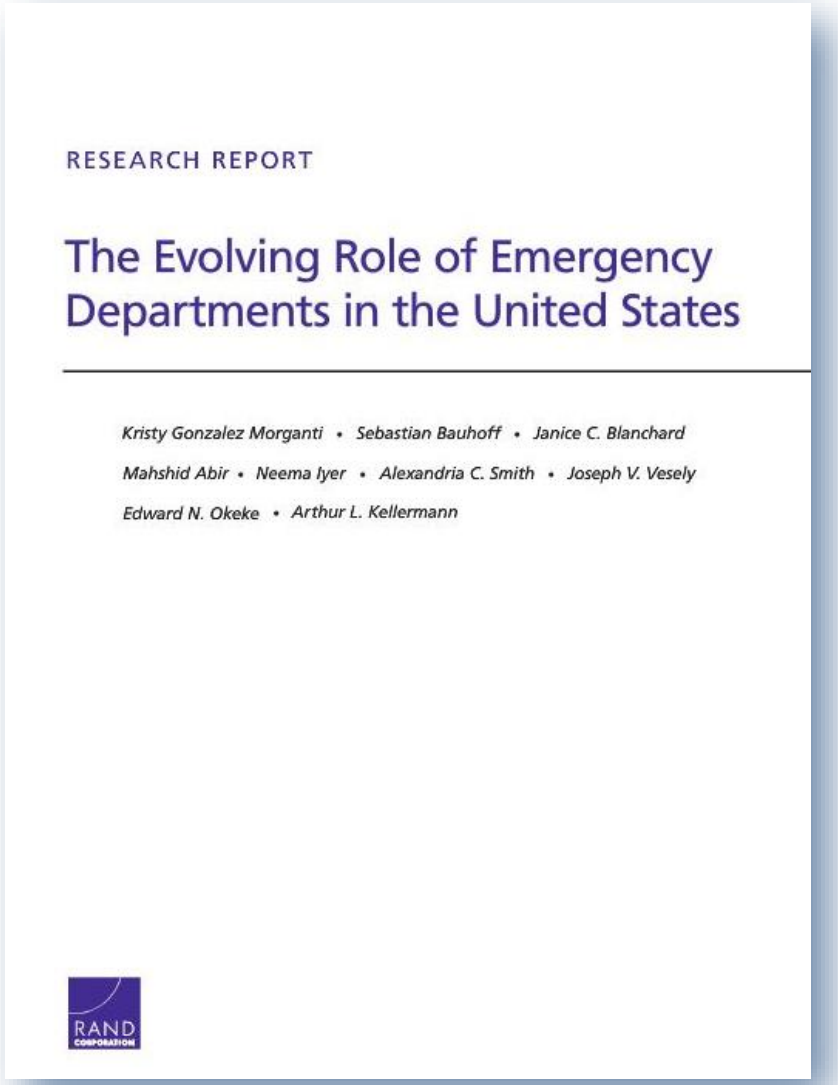
Critical Role of ED in Cost and Care Trajectory

- 60% of older adults **admitted** to hospital come **through** the ED
- The ED itself is not the huge cost center of US Health Care, however …
- ED makes decisions with tremendous cost implications (admit vs. discharge)
    - *Average admission >$22,000*
- ED makes decisions with tremendous care implications
- Can the ED identify and intervene upon underlying social needs and integrate medical care to improve the care and cost trajectory?



A new library of literature supports Geriatric EDs as a solution

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Greater than 90% of Accredited GEDs launched without external funding

INITIAL OUTCOMES AT A GLANCE

GREATER

Patient Satisfaction

LOWER COSTS

Leveraging interdisciplinary team

16.5%

Reduced risk of hospital readmission

LOWER RISK

Of 30-day fall-related ED revisits

westhealth

What can a Geriatric Emergency Department do for my hospital?

DECREASE READMISSIONS

Recent update from SE US site:
13 Estimated Readmissions Prevented over first 3 months

DECREASE ED REVISITS IN HIGH-RISK POPS.

Midwest GED site: 9% decrease in ED revisits
JAGS article: PT in the ED associated with reduced 30- and 60-day revisits ($p<0.001$).

INCREASE MARKET SHARE

Actual case: Urban safety net hospital seeking more Medicare patients.
Actual case: Hospital in competitive area w/ many “snowbirds” seeks differentiation

BETTER CENSUS MANAGEMENT

CFO of academic system in NE: “I am tired of seeing the air-ambulance fly over us because we are on diversion. This can help us put our beds to better use.”

INCREASE STAFF SATISFACTION

Result seen at multiple health systems across all levels of accreditation

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Level 3

Good Geriatric ED Care

- At least one MD and one RN with evidence of geriatric focus (champions)
- Evidence of geriatric focused care initiative
- Mobility aids
- Food & drink 24/7

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
ACCREDITED
GERIATRIC EMERGENCY DEPARTMENT

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Level 3 Accreditation

1

Champion Education

- Role of the Delirium Champion
- Screening Tools & Workflows
- Caregiver Handouts

2

Mobility and Nutrition

3

Protocol

- Existing policy vs. GED protocol
- Additional overlay with existing
- Evaluation: Clear describe who, what, frequency of metrics
- Process Measures & Patient Outcomes

4

General Tips for Success Pre-Peri-Post Application

- Multiple Sites & 1 Goal
- Economies of Scale: Protocol development, metrics, Job descriptions, charter
- Interprofessional: Empower all disciplines, define roles & expectations
- Journey, not a destination…continuous improvement…Not going to be perfect at the start
- Align with Existing Resources: Shared Governance

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Key Application Criteria: Physician & RN Champion

Job Description

- Describe Role & Responsibilities
  - Document for each discipline
- How they support Program, ED, Site, & Staff
  - Q? meetings, review metrics, provide feedback, report to ED & Hospital
- Different than HR documents, CVs, etc
- Minimum is RN & MD Champ
  - Multiple is helpful to provide feedback on different perspectives and shifts

Education

- Must be Geriatric Specific!
- **Physician:** 4 CME
  - https://geri-em.com
  - https://gedcollaborative.com/clinical-curriculum/
- **Nurse:** No minimum
  - ENA GENE courses 1-3
  - Beginner-Expert
  - https://enau.ena.org/Public/Catalog/Main.aspx?Criteria=19

Key Application Criteria: Protocol

Existing Policy vs. GED Protocol

- Build upon what is existing
  - IE: Don't wait for new EHR tool
  - IE: Its ok to use paper…for a while
- Clearly Defines WHAT is different for Older Adults
  - IE: Urinary Cath Policy as a start, but what is the new screening, assessment, interventions, metrics, staff education, etc

Transition Beyond the ED

- Process for improving transitions
  - IE: Falls protocol- Referrals to out-patient PT and/or PCP for fallen pts

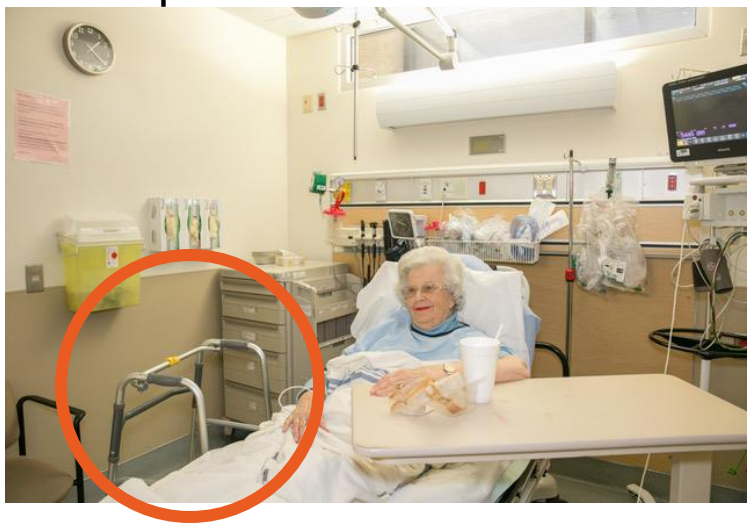
Evaluation

- Clearly describe who, what, when, & frequency of reviewing the metrics
  - Bake in Metrics into process
  - Process Measures VS Patient Outcomes
- IE: RN complete ISAR on all older adults, >3 scores are referred to CM & MD for discharge. The Geri ED champs presents data monthly, team reviews & make changes to decrease rate of 72hr & 30day ED revisits.
  - RN ISAR % (Process)
  - % + pts with post ED services (Process)
  - 30day ED revisit (Patient Outcomes)

Key Application Criteria: Mobility & Nutrition

Access to Mobility Devices

- Patient use in the ED (*not DME)
- Hospital approved devices
- Describe: who uses them, where are they located, how to access them, How is staff educated
- Take a picture!

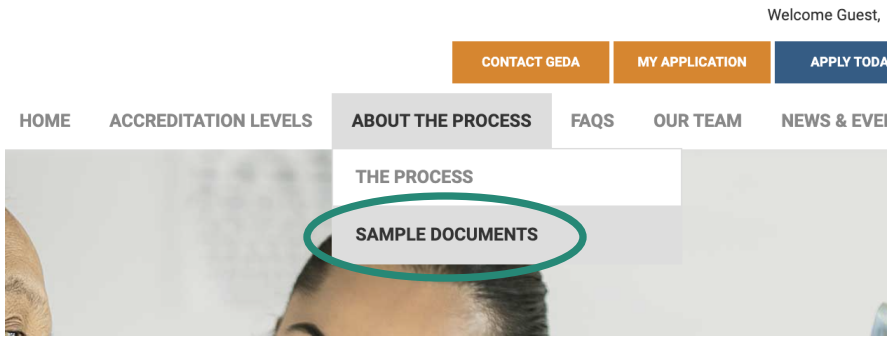


Access to Nutrition

- 24/7 Access
- Range of choices, not just apple sauce
- Describe: Regular tray service AND how you provide nutrition afterhours
- Take a picture!

https://gedcollaborative.com/jgem/vol2-is1-sup3-clinical-aspects-of-providing-a-meal-of-an-older-patient-in-the-ed/

Sample Documents



ACEP Geriatric Emergency Department Accreditation

Welcome Guest, Log In

CONTACT GEDA | MY APPLICATION | APPLY TODAY

HOME | ACCREDITATION LEVELS | ABOUT THE PROCESS | FAQS | OUR TEAM | NEWS & EVENTS

Sample Documents

To facilitate the application process, we recommend that you gather the appropriate documentation before beginning the application. Below is a checklist of some of the documents needed to complete the application. Sample documents for these items have been provided below. Documents must be uploaded in PDF format.

	Level 3	Level 2	Level 1
Staffing	⬇	⬇	⬇
Education	⬇	⬇	⬇
Policies / Protocols Guidelines & Procedures	⬇	⬇	⬇
Quality Improvement		⬇	⬇
Outcome Measures		⬇	⬇
Equipment & Supplies		⬇	⬇
Physical Environment	⬇	⬇	⬇

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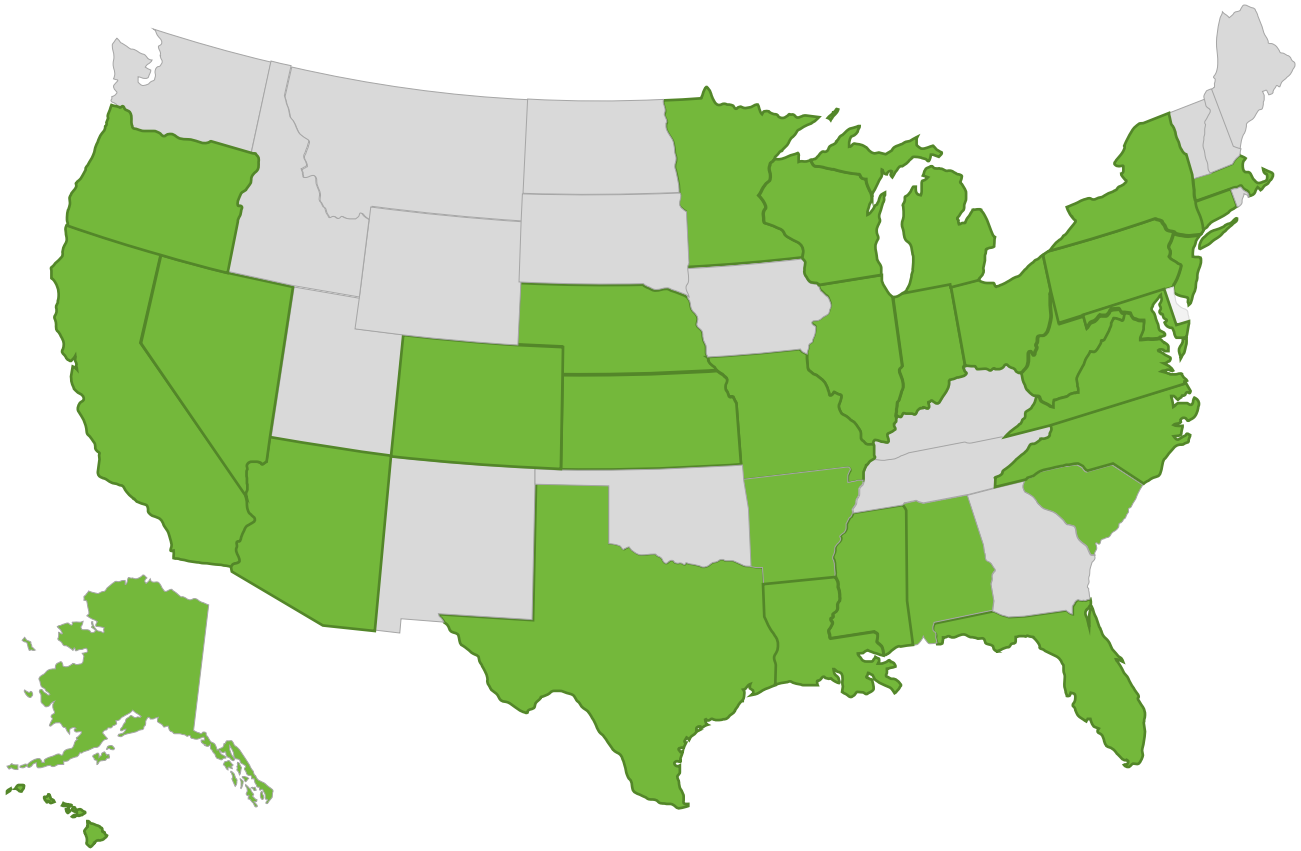
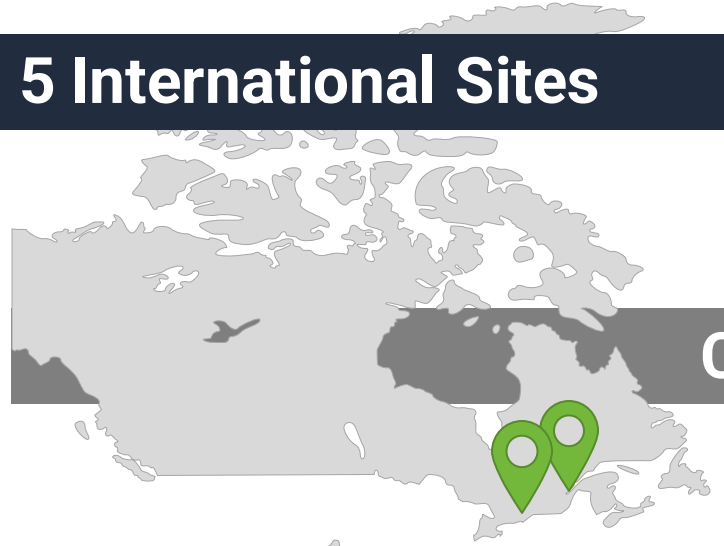
412 Accredited Sites

Nationally: 412 across 45 states



5 International Sites



Canada

Level 2
Level 3

Brazil

Level 3

Spain

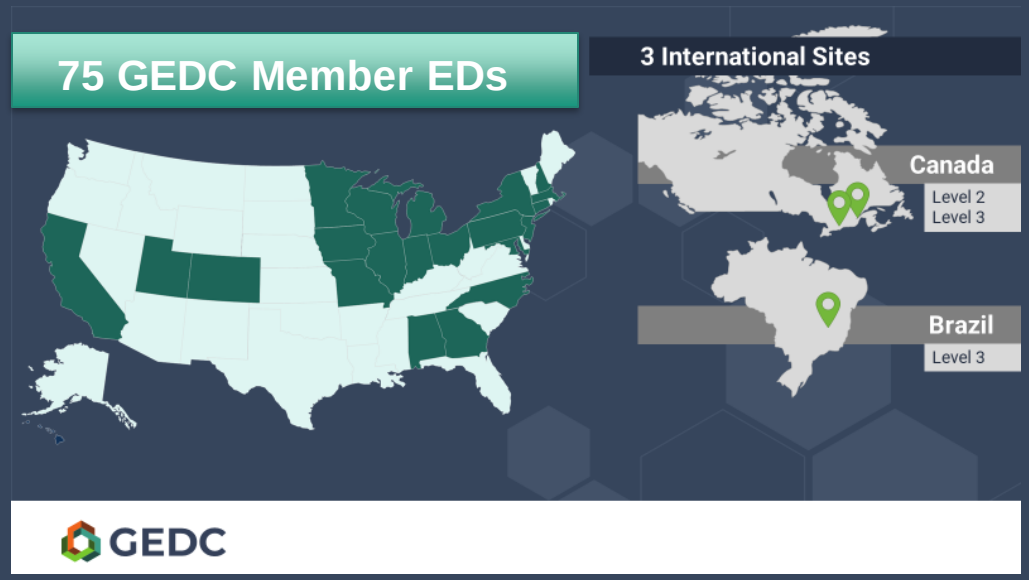
Level 3

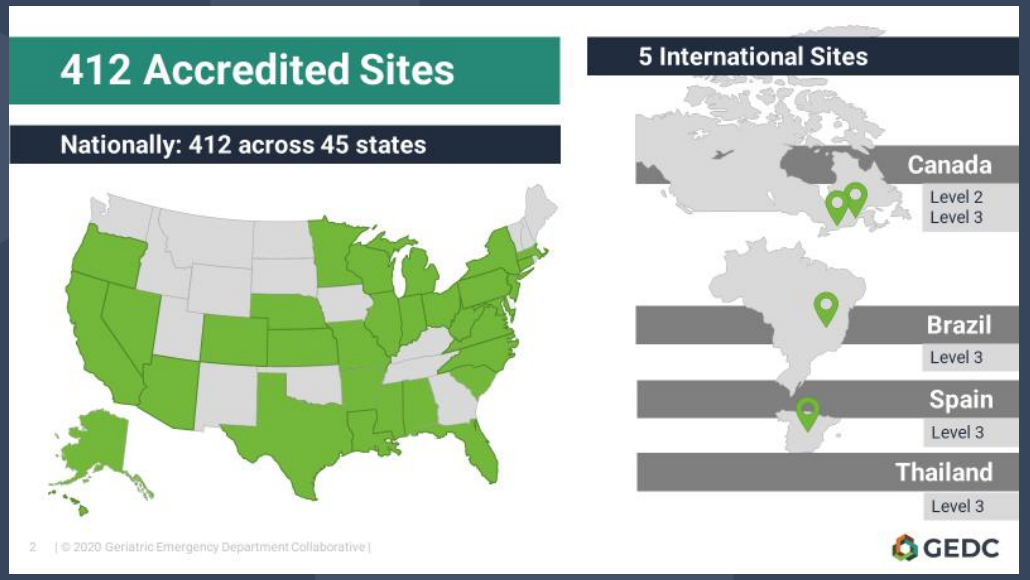
Thailand

Level 3

GEDC

Synergy:
Geriatric EDs Are Expanding Along With GEDC Membership





Greater Patient Satisfaction

Lower Costs

16.5% Reduced risk of readmission

LOWER RISK Of 30-day fall-related ED revisits

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Case Studies

Mrs. Cado
78-year-old woman with a broken wrist "ready for discharge"

With your GEDC Expert
Kevin Biese

Mrs. Schwach
80-year-old woman, not feeling right "Mom seems a little off"

With your GEDC Expert
Aaron Malsch

Mrs. Perdito
79-year-old woman, unclear reasons for visit; "must be a UTI"

With your GEDC Expert
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Mrs. Cado
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Mrs. Perdito
79-year-old woman, unclear reasons for visit; "must be a UTI"

With your GEDC Expert
Kira Gossack-Keenan

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Case Studies

- What challenges would you have when managing this patient in your ED?
- What components of Accreditation (e.g., any of the care processes) would improve care for this patient?

Mrs. Cado

Challenges

Care processes

GEDC

Mrs. Schwach

Challenges?

Care processes?

Mrs. Perdito

Challenges?

Care processes?

Break

10 minutes

Implementing Care Processes to Prepare For All Levels of Accreditation

ISAR Screening and Falls and Mobility

Aaron Malsch

Delirium Screening w/ Follow-up

Pam Martin

Implementation Tips & QI Resources

Kevin Biese

GEDC

Geriatric Emergency Department Processes

ISAR Screening Tool:
Identification of Senior At Risk (ISAR)

AdvocateAuroraHealth®

Objectives: ISAR

- Why does this matter?
- What tools are available?
- Where can this happen in workflow?
- Who does it?
- What to do with the info you come up with, i.e. what happens next?
- What metrics can identify success?

Purpose of Geriatric ED

- Identify unique challenges encountered by older adults in the ED setting
  - Screening, Assessment, Intervention in ED

RN performing ISAR & Communicates risk to MD and RN CM

- Coordinate post-ED care transitions and follow up care for vulnerable older adults
  - Promote Post-ED Service-to Orders

MD orders post-ED services & RN CM executes orders

- Promote best outcomes for patients including avoiding unnecessary admissions and reduce revisits
  - Reduce ED revisit & Hospital Admissions

Patients are more successful in their homes & Cost Reduction to AAH

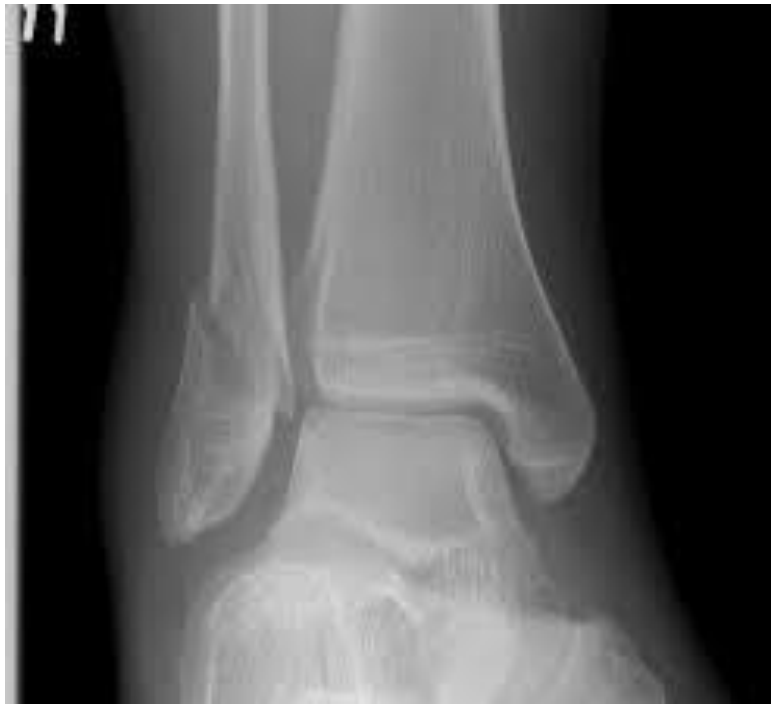
Screening: Why does this matter?

- Emergency nurses are uniquely positioned to assess for risk and special needs of the older adult patient
- Screening tools are the start to formulating individualized treatment plans and developing patient centered disposition planning
- There are numerous screening tools:
  - Identification of Seniors At Risk
  - InterRAI ED
  - PRISMA-7

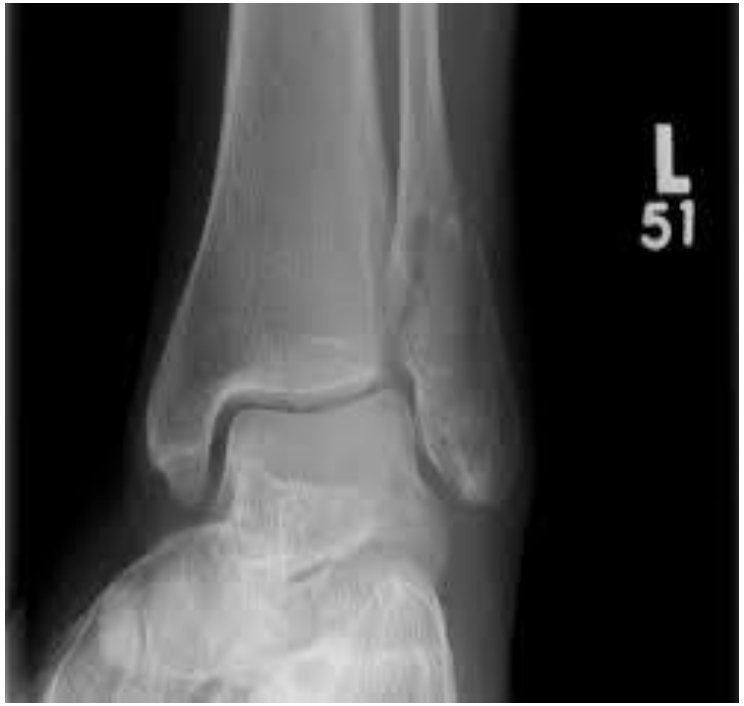
Screening: Why does this matter?

A Tale of Two Ankle Fractures*

- Mr. Jones



- Mr. Smith



*Source: Dr. Adam Perry

Mr. Jones

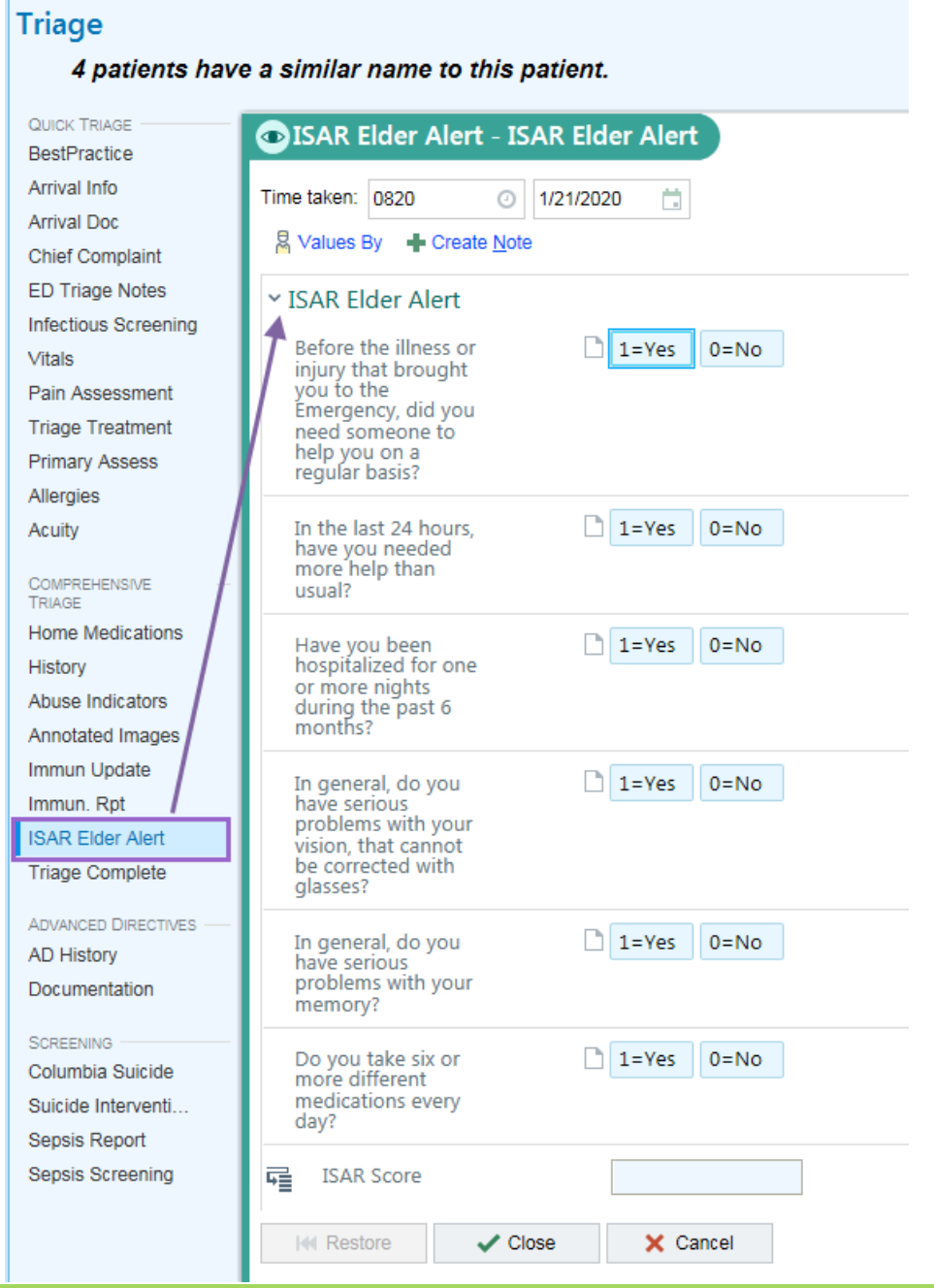
Mr. Smith

ISAR: Why does this matter?

- Identification of Seniors At Risk (ISAR), most well studied risk tool
  - 6 Question Tool
- Designed & Validated for patients 65 years and older in the ED
- Predicts admission, LTC disposition, even death.
- ≥2 score is at Risk (Sensitivity from 72% to 94%)
- Easy to ask, easy to answer, and administered in less than 2 minutes.

ISAR: Where can this Happen and Who Does it?

- **Utility in the ED**:
  - RNs in Triage or the Assigned RN
  - ≥65 years olds
  - ≥2 or more could trigger a consultation with a GEM nurse
    - 0-1 No Risk
    - 6 is the highest Risk



ISAR: What is done with the Info?

- Communication & Critical Thinking is essential for an effective Geri ED
  - What are the key information or ‘clues’ to understanding the broader clinical and SDOH situation
  - Communication can happen differently: EHR, verbally, face-to-face, telephonically, secure chat, etc
  - Critical thinking and consolidating numerous pieces of information from interviewing, screening, and assessing provides actionable information for the team to develop plans of care.

ISAR: What is done with the Info?

Example of a Delirium Case:

- "Dr. Jones, I am concerned that Mrs. Smith may have delirium. She scored an ISAR score of 2. I talked with the daughter and she wasn't confused prior to the onset of her fever 2 days ago. The Daughter states that she goes in and out of being confused. I performed the CAM assessment and she is positive because of 1) Acute onset 2) Fluctuating course and 3) she can't maintain attention."

ISAR: Communication & Critical Thinking

Examples of Effective RN Comments for CM & Program Tracking:

"Pt has visiting nurse for wound care at home. Pt is comfortable with cares at home."

"Patient is caretaker for spouse and needs help with respite care resources."

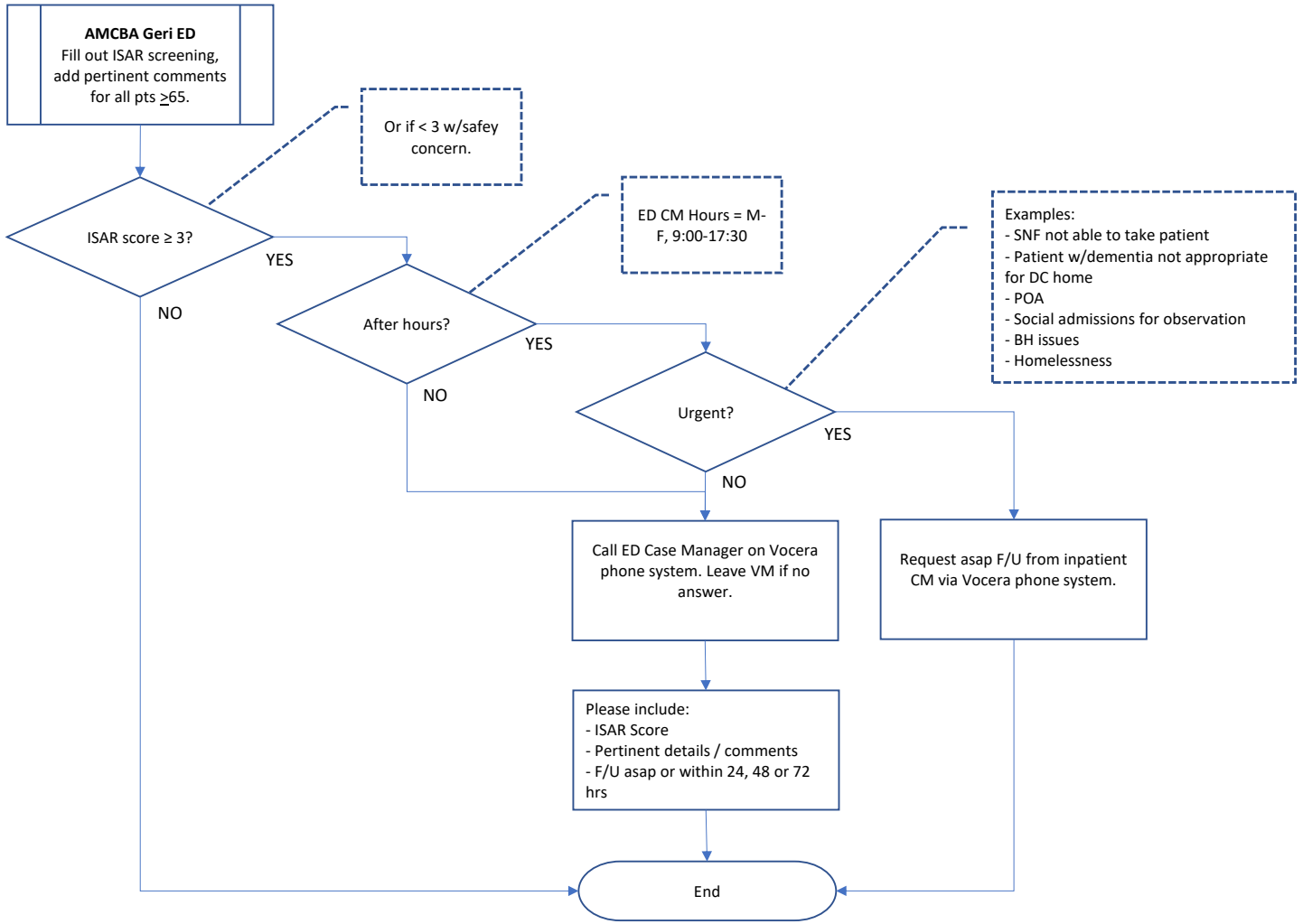
"Family has been staying and helping out, including frequently spending the night there."

Assigned Nurse	ISAR, %	ISAR, totals	Comments, %	Comments, totals
[redacted]	74.2%	66	14.3%	1
	88.7%	157	41.2%	7
	66.7%	16	50.0%	1
	90.2%	239	72.0%	18
	92.3%	48	80.0%	4
	89.4%	59	85.7%	6
	81.6%	40	42.9%	3
	92.0%	161	64.0%	16
	73.1%	19	0.0%	0
	93.2%	136	61.5%	8
	84.0%	79	35.7%	5
Total	**87.2%**	**4364**	**44.0%**	**250**

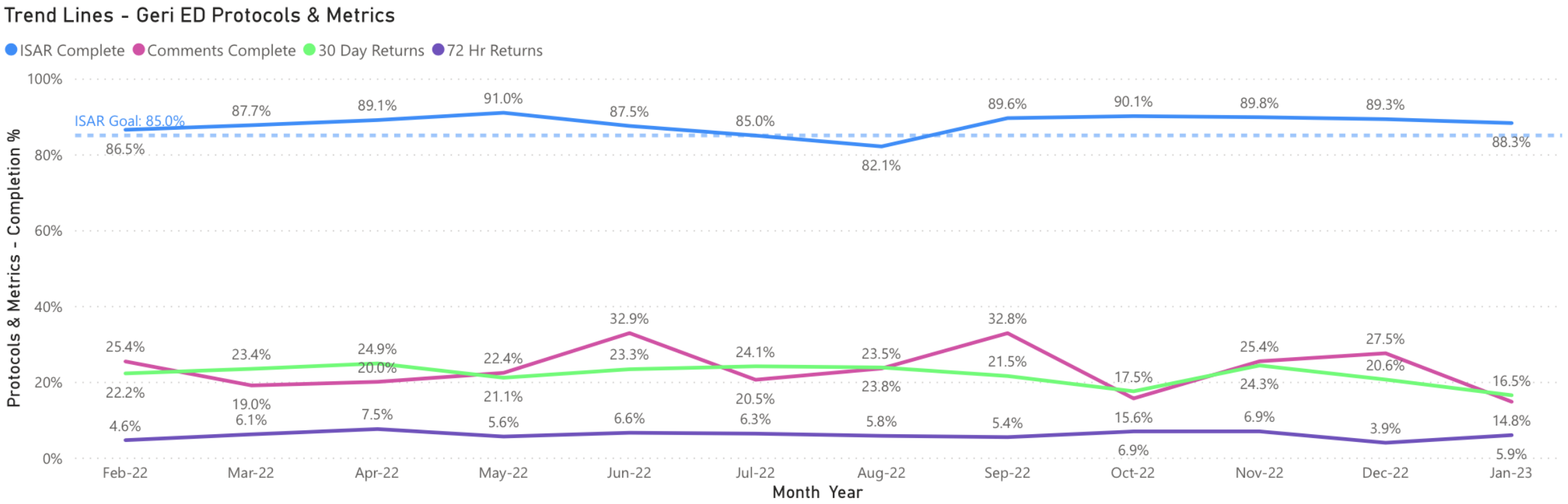
ISAR: What metrics can identify success?

- Set specific goals for ISAR Screening
  - Who, when, where
  - Train all staff
- Clearly define the rationale for doing the ISAR
  - This is not just another 'task'
- Measure key process measures AND patient outcomes
- Provide Feedback & Ask for Feedback
  - Celebrate high performers
  - Identify challenges & barriers

ISAR: RN-CM Workflow Example



ISAR : Metrics & Dashboard Example



RN Metrics | Falls Metrics | Demographics & Outcomes | Volumes by Time

Feedback

Site B Falls Outcomes

Site B fall patient outcomes 2020 Vs 2022

STO: Service-to Orders (PCP, Homecare, Palliative, PT Cx, OP PT)

High Risk Population (>65 years old, discharged, Chief Complaint of Fall

Comparison: 2020 Vs 2022 STO Rate and 30day ED revisit

The completion of the ISAR by RN, talk with MD and CM about needs, and post ED service orders keeps Patients safe at home.
Thank you, RNs, for doing the ISAR!!!

Summary: Significant Practice Change (180% rate increase in STO) & 50% reduction in 30day return

2020 Fallen Pts (Jan-Dec)

n= 186

4.3% received STO

n=8

27.4% 30 Day revisit

n=51 returns

In 2020, only 4.3% of patients received a post ED order

In 2022, 12% of patients received a post ED order
180% INCREASE!

50% Reduction in ED revisits!!
27.4% vs 13%

2022 Fallen Pts (Jan-June)

n= 100

12% received STO

n=12

13% 30 Day revisits

n=13 returns

Feedback

Site A Outcomes:

Site A patient outcomes Pre-Post New CM (April vs July 2022)

STO: Service-to Orders (PCP, Homecare, Palliative, PT Cx, OP PT)

Population: >65 years old, discharged to community

Comparison: Pre-Post .6 CM FTE (Amanda), STO Rate, and 30day ED revisit

Summary: Significant Practice Change in rate increase in STO & reduction in 30day return

21% Reduction in ED revisits!!

Pre CM FTE (April 2022)

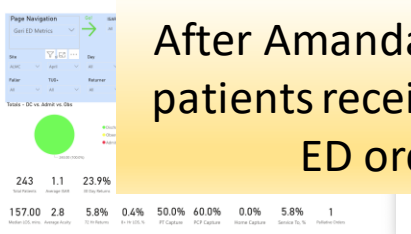
n= 243

5.8% received STO

n=14

23.9% 30 Day revisit

Prior to Amanda, only 5.8% of patients received a post ED order



After Amanda, 18.4% of patients received a post ED order

Post CM FTE (July 2022)

n= 304

18.4% received STO

n=56

18.8% 30 Day revisit

The completion of the ISAR by RN and letting Amada know who needs what allows her to focus on patient needs post ED. Thank you, RNs, for doing the ISAR!!!

Reference:

- McCusker, J., Bellavance, F., Cardin, S., Trepanier, S., Verdon, J., & Ardman, O. (1999). Detection of older people at increased risk of adverse health outcomes after an emergency visit: the ISAR screening tool. Journal of the American Geriatrics Society, 47(10), 1229-1237.
- Carpenter CR, Griffey RT, Stark S, et al. Physician and Nurse Acceptance of Geriatric Technicians to Screen for Geriatric Syndromes in the Emergency Department. West J Emerg Med. 2011;12: 489-495.
- McCusker J, Bellavance F, Cardin S, Belzile E. Validity of an activities of daily living questionnaire among older patients in the emergency department. Journal of clinical epidemiology. 1999 Nov;52(11):1023-30. PubMed PMID: 10526995.
- Thiem U, Heppner HJ, Singler K. Instruments to identify elderly patients in the emergency department in need of geriatric care. Zeitschrift fur Gerontologie und Geriatrie. 2015 Jan;48(1):4-9. PubMed PMID: 25592177.
- Hebert R, Bravo G, Korner-Bitensky N, Voyer L. Predictive validity of a postal questionnaire for screening community-dwelling elderly individuals at risk of functional decline. Age and ageing. 1996 Mar;25(2):159-67. PubMed PMID: 8670547.
- Salvi F, Morichi V, Lorenzetti B, Rossi L, Spazzafumo L, Luzi R, et al. Risk stratification of older patients in the emergency department: comparison between the Identification of Seniors at Risk and Triage Risk Screening Tool. Rejuvenation research. 2012 Jun;15(3):288-94. PubMed PMID: 22730956

A Standardized Delirium Screening Guideline *(DTS, CAM, 4AT, other) with appropriate follow-up*

Pamela Martin, MS, RN, FNP, GCNS-BS
Yale University

The WHY

THE PRICE OF DELIRIUM

Delirium is the 2nd most costly hospital condition[1]

Delirium is associated with 2 million emergency department visits per year[2,3]

2
Days increased length of stay with delirium in the ED[3]

37%
Mortality in patients with ED delirium vs. 14% in patients without[4]

2x
Risk of nursing home or post-acute placement[5]

$8 BILLION
Medicare yearly hospital expenditures related to delirium[6]

$150 BILLION
Estimated yearly post-acute care costs due to delirium[6]

Sources: 1. Verma AA, et al. J Gen Intern Med 2018: https://www.ncbi.nlm.nih.gov/pubmed/30054888. 2. National Center for Health Statistics, CDC 2013: https://www.cdc.gov/nchs/data/databriefs/db130.htm 3. Kennedy M, et al. JAGS 2014: https://www.ncbi.nlm.nih.gov/pubmed/24512171. 4. Han JH, et al. Ann Emerg Med 2010: https://www.ncbi.nlm.nih.gov/pubmed/20363527. 5. Witlox J, et al. JAMA 2010: https://www.ncbi.nlm.nih.gov/pubmed/20664045. 6. Rubin FH, et al. JAGS 2011: https://www.ncbi.nlm.nih.gov/pubmed/21314654.

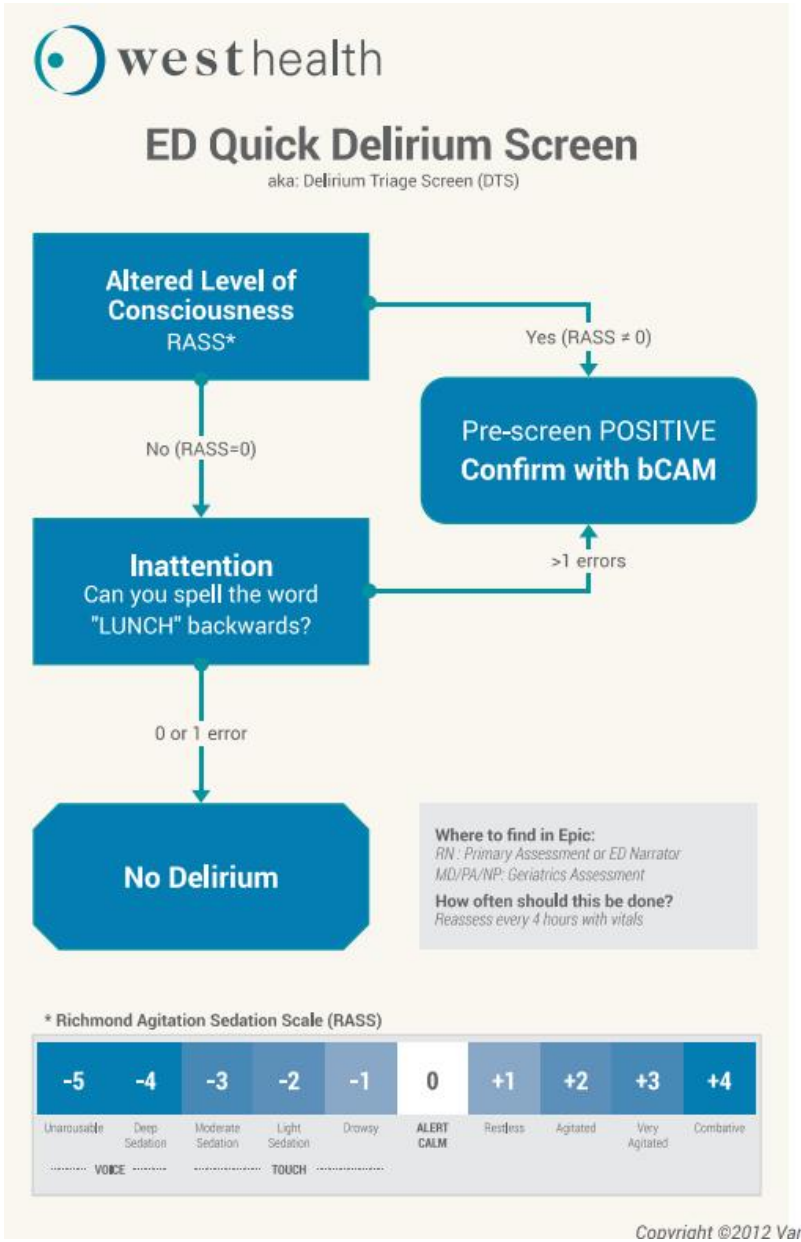
Screening Tools

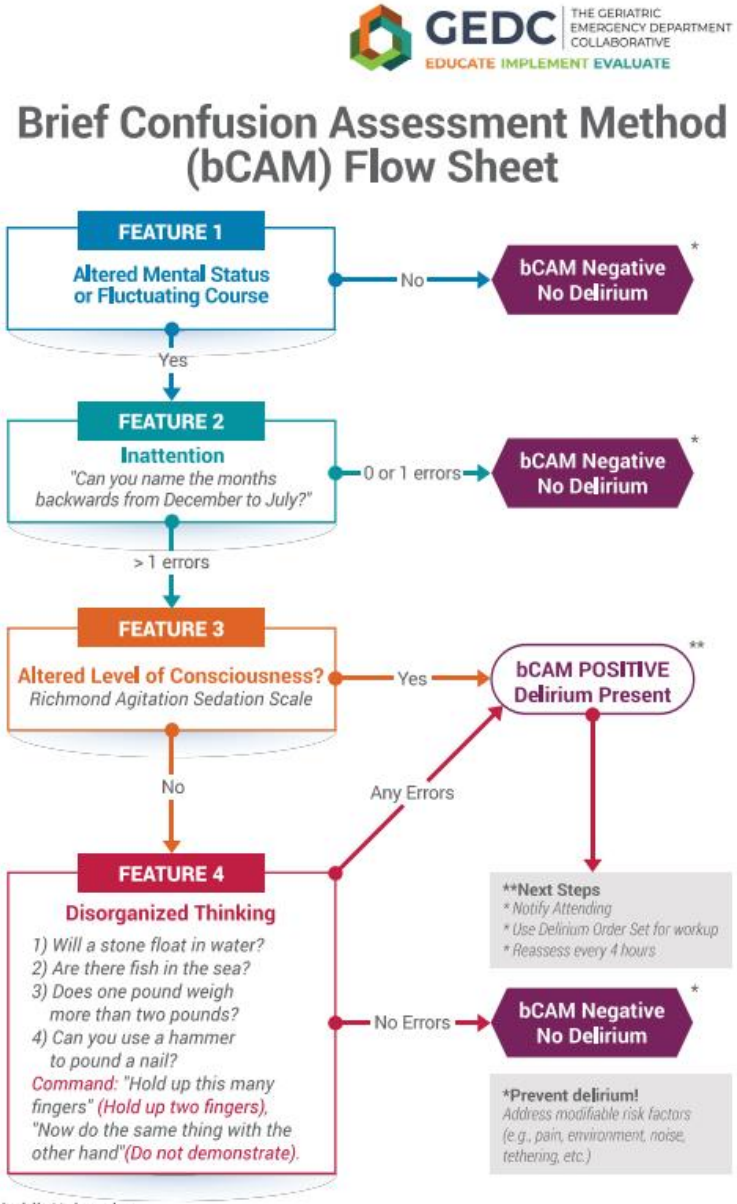
Section V. Assessment and Evaluation

Resource V-A: Delirium Instrument Summary

Delirium Instrument (Year)	Validated in ED	No. items	Time to complete	Rater Qualifications	Sensitivity (95% CI)	Specificity (95% CI)	Special Tested Populations
3D Confusion Assessment Method (3D-CAM)[1]	No	22	3 mins	Trained lay raters or clinicians	0.95 (0.84-0.99) compared to diagnosis by clinical psychologists and practice nurses	0.94 (0.90-0.97) compared to diagnosis by clinical psychologists and practice nurses	Patients with superimposed dementia
4AT[2]	Yes	4	<2 mins	Lay or clinical raters without specialized training	0.93 (0.83-0.98) compared to DSM-IV-TR diagnosis by geriatrician	0.91 (0.88-0.94) compared to DSM-IV-TR diagnosis by geriatrician	Patients with superimposed dementia
Brief Confusion Assessment Method (bCAM)[3]	Yes	7	<2 mins	Trained lay raters or clinicians	0.84 (0.72-0.92) compared to DSM-IV diagnosis by psychiatrist	0.96 (0.93-0.97) compared to DSM-IV diagnosis by psychiatrist	--
Confusion Assessment Method (CAM)[4-6]	Yes	4	2-3 mins (Mini-Cog) 6-8 mins (Abbreviated MMSE)	Trained lay raters or clinicians	0.94 (0.91-0.97) compared to diagnosis from geriatric psychiatrist	0.89 (0.85-0.94) compared to diagnosis from geriatric psychiatrist	Patients with superimposed dementia
Confusion Assessment Method for the Intensive Care Unit (CAM-ICU)[7]	Yes	8	2-3 mins	Trained lay raters or clinicians	1.00 compared to DSM-IV-TR diagnosis	0.98 compared to DSM-IV-TR diagnosis	Mechanically ventilated patients
Delirium Triage Screen* (DTS) with bCAM[3]	Yes	2	<2 mins	Trained lay raters or clinicians	0.82 (0.69-0.90) rated by physician; compared to DSM-IV diagnosis by psychiatrist	0.96 (0.93-0.97) rated by physician; compared to DSM-IV diagnosis by psychiatrist	--
Modified Confusion Assessment Method for the Emergency Department (mCAM-ED)[8]	Yes	12	3-6 mins	Trained clinicians	0.90 (0.70-0.97) compared to DSM-IV-TR diagnosis by geriatrician	0.98 (0.95-0.99) compared to DSM-IV-TR diagnosis by geriatrician	Patients with superimposed dementia
Nursing Delirium Screening Scale (Nu-DESC)[9]	No	5	1-2 mins	Trained lay raters or clinicians	0.86 (0.65-0.95) compared to Confusion Assessment Method	0.87 (0.73-0.94) compared to Confusion Assessment Method	--
Ultrabrief Two-Item Bedside Test for Delirium with 3D-CAM (UB-2)[10]	No	2	<40 seconds	Trained lay raters or clinicians	0.93 (0.81-0.99) compared to DSM-IV diagnosis by geriatrician†	0.64 (0.56-0.70) compared to DSM-IV diagnosis by geriatrician	To be used followed by 3D-CAM for positive screens

DELIRIUM SCREENING - DTS + BCAM





Appropriate Follow-up

What are you doing with the information?

- Provider notification
    - Non-pharmacological measures to prevent and treat delirium
        - Redirection, reassurance, distraction
        - Address physical needs (nutrition, hydration, bathroom)
        - Normalize sleep wake cycles
        - Mobilize early, remove tethers
    - Geri Comfort Cart/ Delirium Prevention Cart/ Dementia Cart
- Admission vs Discharge
- Outpatient follow-up

Yale New Haven Health System Process

- Geri – ED strategic team meetings
- Care signature pathways

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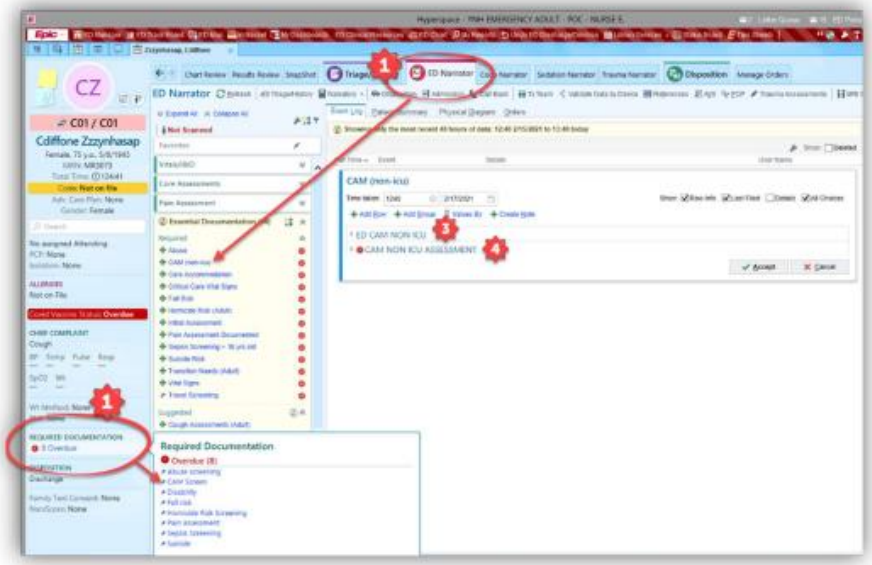
Epic, Emergency Department - Confusion Assessment Method (CAM)

The Confusion Assessment (CAM) tool is used to identify and recognize patients' experiencing Delirium or Dementia. CAM is a part of the **required documentation for patients over the age of 65** that present to the ED.

CAM Documentation for Nurses

In the Patients Chart

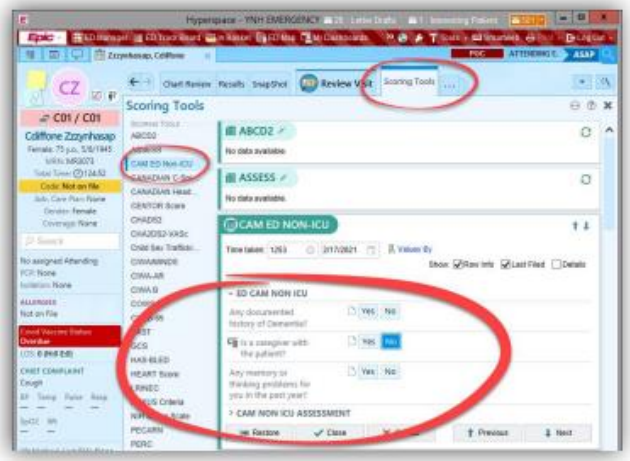
1. **Click** Required Documentation from the Storyboard or **Open** the ED Narrator.
2. In Required/Essential Documentation, **Click** CAM Screen or CAM (non-icu) .
3. **Complete** the ED Assessment Questions.
4. **Continue** to the CAM Non ICU Assessment to **complete** the remainder of the documentation. *Please note that each question in this section contains a definition, assessment and result. These elements can be used in the screening of the patient to better define an answer of Yes or No. Please read Carefully.*



CAM Assessment - Providers

In the Patient Chart

1. **Open** the Scoring Tools Activity Tab.
2. Open the CAM ED Non-ICU Section.
3. Complete ED CAM Non-ICU and CAM Non-ICU Assessment.



Documented CAM Assessments

1. **Documented** CAM Assessments will be located in the Summary or SnapShot Activity tab in the report *ED Encounter Summary.*

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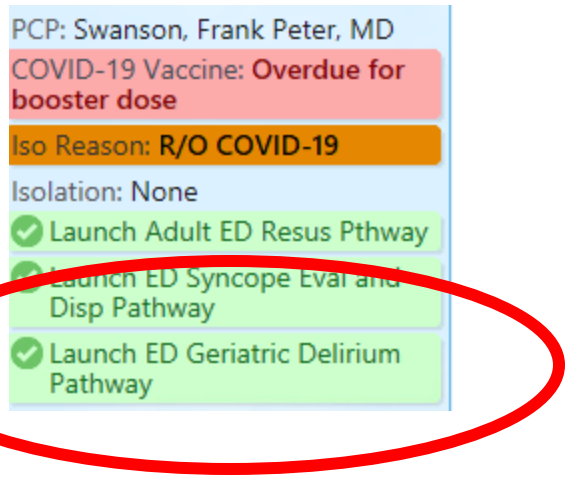
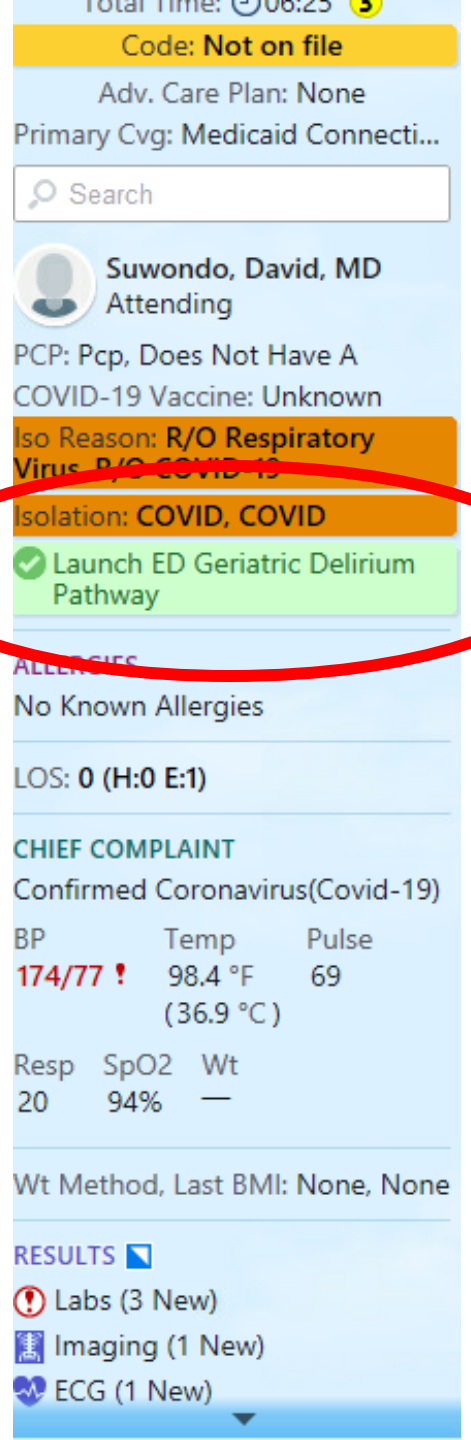
Storyboard Reminders: Geriatric Delirium





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Pathways

New pathways features. Learn more

BACK

Geriatric Delirium: Adult ED

For screening, workup, treatment and prevention of geriatric delirium

Pathway Context

- Goal Metrics / Authors
- References
- Suggestion Criteria
- Restraint Guidance

These recommendations reflect YNHHS consensus based on review of existing evidence and guidelines. They do not replace clinical judgement.

DELIRIUM assessment for everyone over age 65

LINK TO CAM NON ICU SCORING TOOL

Note: History of dementia or evidence of memory or thinking problem increases risk.

Delirium Negative

Delirium Positive

Initiate work-up

- ADEPT Tool (ACEP Delirium Identification and Treatment Tool)
- Common geriatric HPI/PE to obtain in delirious patients

Place GEMS CONSULT: BH/MC or SRC only: Availability

- **Go to quicklist and place orders**
- Common delirium workups and labs

- Place in ED Observation

Delirium prevention

- Perform delirium screen every shift
- Ambulate patient (to bathroom or to chair)
- Offer food to patient
- Assist with feeding

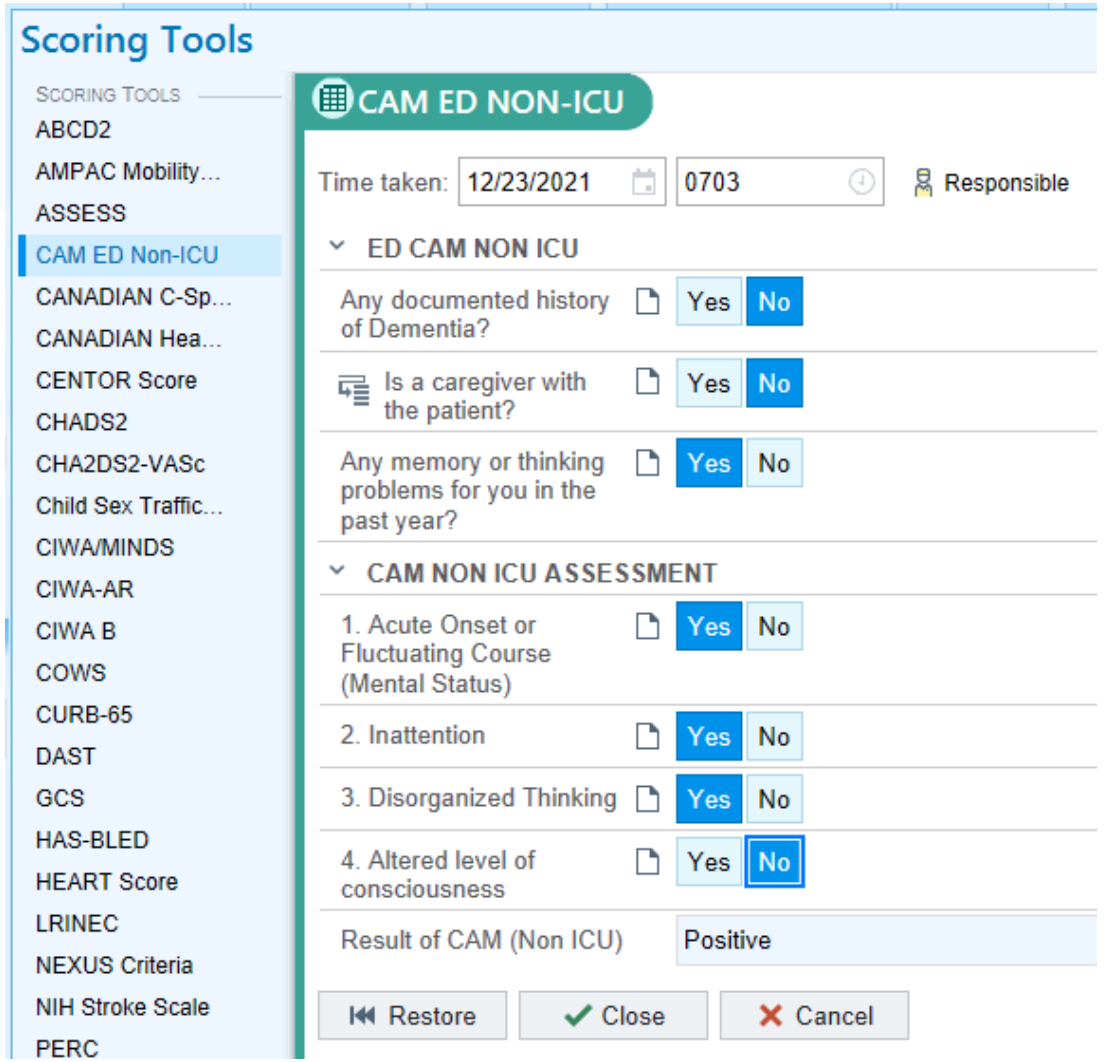
Prioritize patient placement into preferred setting / geriatric-friendly part of the ED (i.e.,move from hallway), calm, low traffic, quiet,

PERFORM SIMULTANEOUSLY

What type of delirium do they have?

Does workup reveal a cause of acute worsening in cognition?

Delirium via Confusion Assessment Method (CAM)



Link to CAM NON ICU SCORING TOOL

- Brings you directly to Delirium Screen
- Dementia / Memory problems is a risk factor
- All patients 65+ should be screened
- Complete every shift (like a vital sign)

4 Features of Delirium :

1. ***ACUTE Onset (new)***
2. ***Inattention – "spell WORLD backwards"***
3. ***Disorganized Thinking – "Does a rock float in water? Are there fish in the sea?"***
4. ***Altered consciousness***

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PERFORM SIMULTANEOUSLY

What type of delirium do they have?

Hyperactive delirium: restless, agitated, hallucinating

Hypoactive delirium: lethargic, somnolent

Place Hyperactive Delirium Orders

- Utilize non-pharmacological and pharmacological treament in tandem throughout the course
  - Maintain safety
  - Assess and address unmet needs/triggers
  - Communication and sensory techniques
- Involve family as appropriate (caregiver at bedside when available)

If delirium with agitation

GERIATRIC ED AGITATION PANEL
Obtain EKG if not already completed (QTc)

- Activity apron
- Provide assist devices (hearing amplifier and headphones)
- SRC only-Reading glasses

Place Hypoactive Delirium Orders

- Up in chair
- Ambulate patient (to bathroom or to chair)
- Offer food to patient
- Assist with feeding

Discuss with bed management prioritizing patient to inpatient setting.

What is hypoactive delirium?

Does workup reveal a cause of acute worsening in cognition?

NO

Disposition planning

- Ambulate with assistive device (baseline mobility assessment)
- If no treatable cause identified, consider coordination with GEMS vs SW vs CM to determine if discharge home with willing and able caregiver is possible/safe.

ED Observation Orders (if not done already)

- Place in ED Observation / Vitals per routine / Offer food to patient / Activity as tolerated

YES

Treat common underlying causes

- Pneumonia pathway
- ICH
- UTI: Community | Hospital
- Return to main care sig screen for alternative pathways

Reassess response to treatment

Consider coordination with GEMS vs SW vs CM to determine if discharge home with willing and able caregiver is possible/safe

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- SRC only-Reading glasses

If behavior emergent and not improving after initial dose consider additional medication (*at least 30min before additional dose*)

- Sufficient time has passed since the first dose to know the effect (see table for dosing interval) i.e., will not cause harmful somnolence etc. This will allow for consideration of redosing the medication or administering another medication
- EKG has been obtained/considered to assess for QTc prolongation

Medication	Dosing Interval (hours)
Risperidone oral	0.5 - 2
Aripiprazole oral	2 - 3
Quetiapine oral	0.5 - 2
Olanzapine oral	0.5 - 2
Olanzapine IM/IV	0.5 - 1
Haloperidol IM/IV	1 - 4
Loazapam IM/IV	1 - 4
Ziprasidone IM	2 - 4

Response to current medication (If)	Treatment (Then)
Some response	Repeat same medication at same or increased dose
No response	Try another oral agent

Admit

- Medicine admission order
- SDU admission order
- ICU admission order
- Medicine OBSERVATION admission order

Discharge

Good discharge instructions based on discharge planning conversations

If you feel they have baseline memory or thinking problems, please refer to Adler Center Referral

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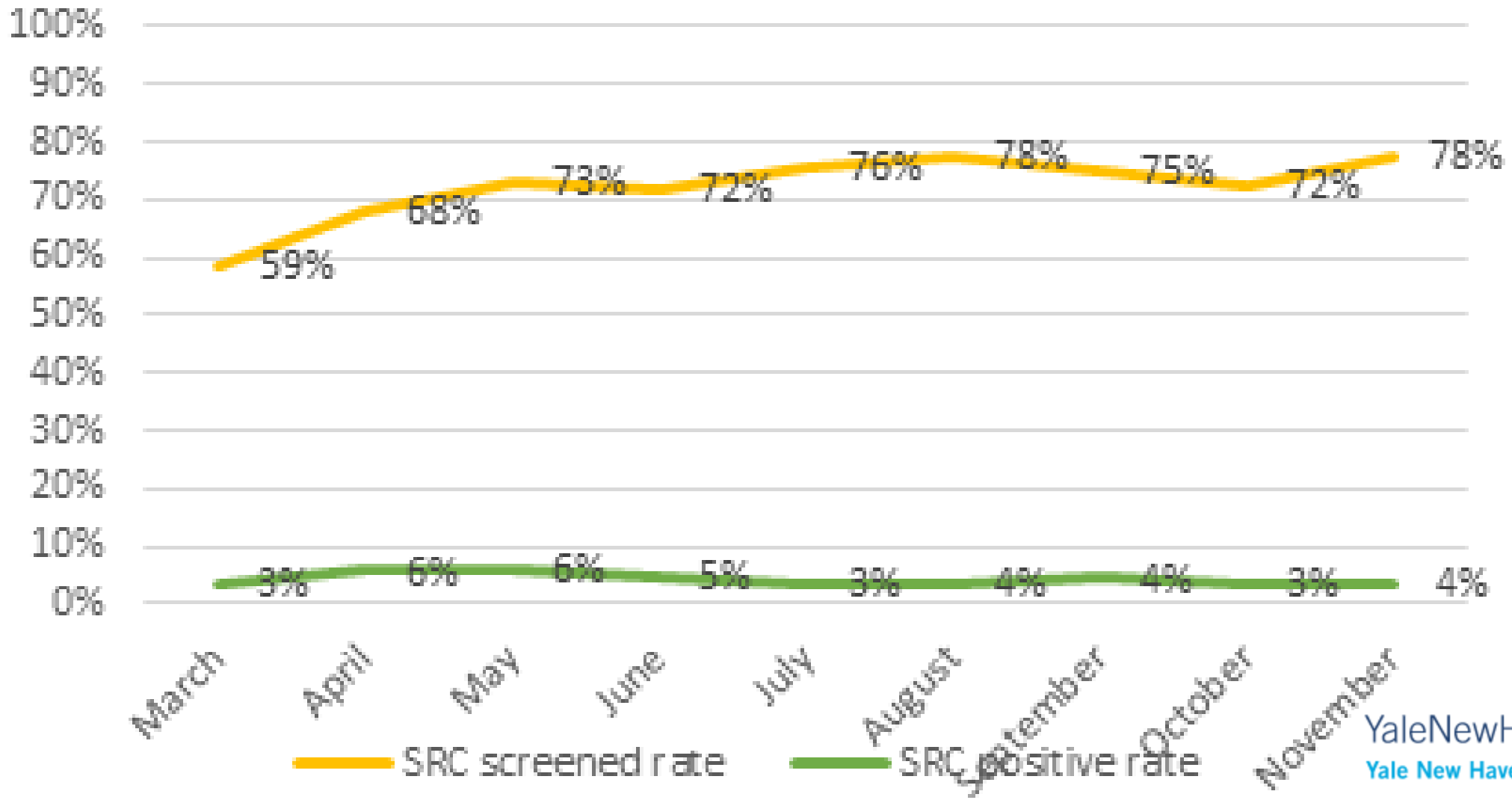
SRC ED CAM non-ICU rates (patients 65+ age)



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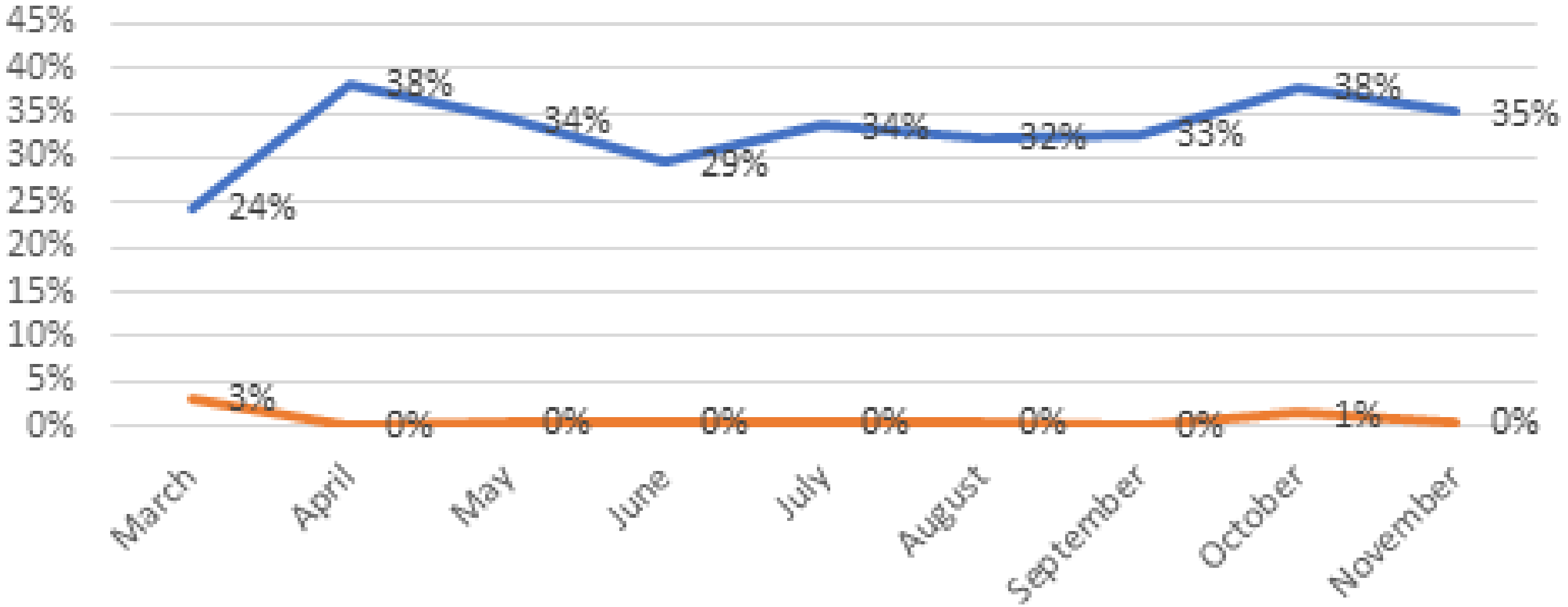
SMC ED CAM non-ICU rates (patients 65+ age)



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Pam’s Pearls

- Have all stakeholders at table
  - What screen will be utilized
  - Who will screen
  - Where will screening occur (triage/room)
  - Where will screen be located: paper, EMR, where in EMR
- Are there other initiatives occurring simultaneously?
- Metrics and how to obtain
- Remember principles of adult learning
  - Model ideal behaviors
  - Reward high achievers
  - Frequent review of data/metrics/comparisons/stories

Resources

Delirium_EDImplementationToolkit.pdf

ACEP // ADEPT

(gedcollaborative.com)

Non-pharmacologic interventions improve comfort and experience among older adults in the Emergency Department – ScienceDirect

Management of Older Adult Falls and Mobility in the Emergency Department & Lessons Learned

Aaron Malsch, MS, RN, GCNS-BC

Advocate Aurora Health
Senior Services Department
Geri ED Program Manager

GEDC

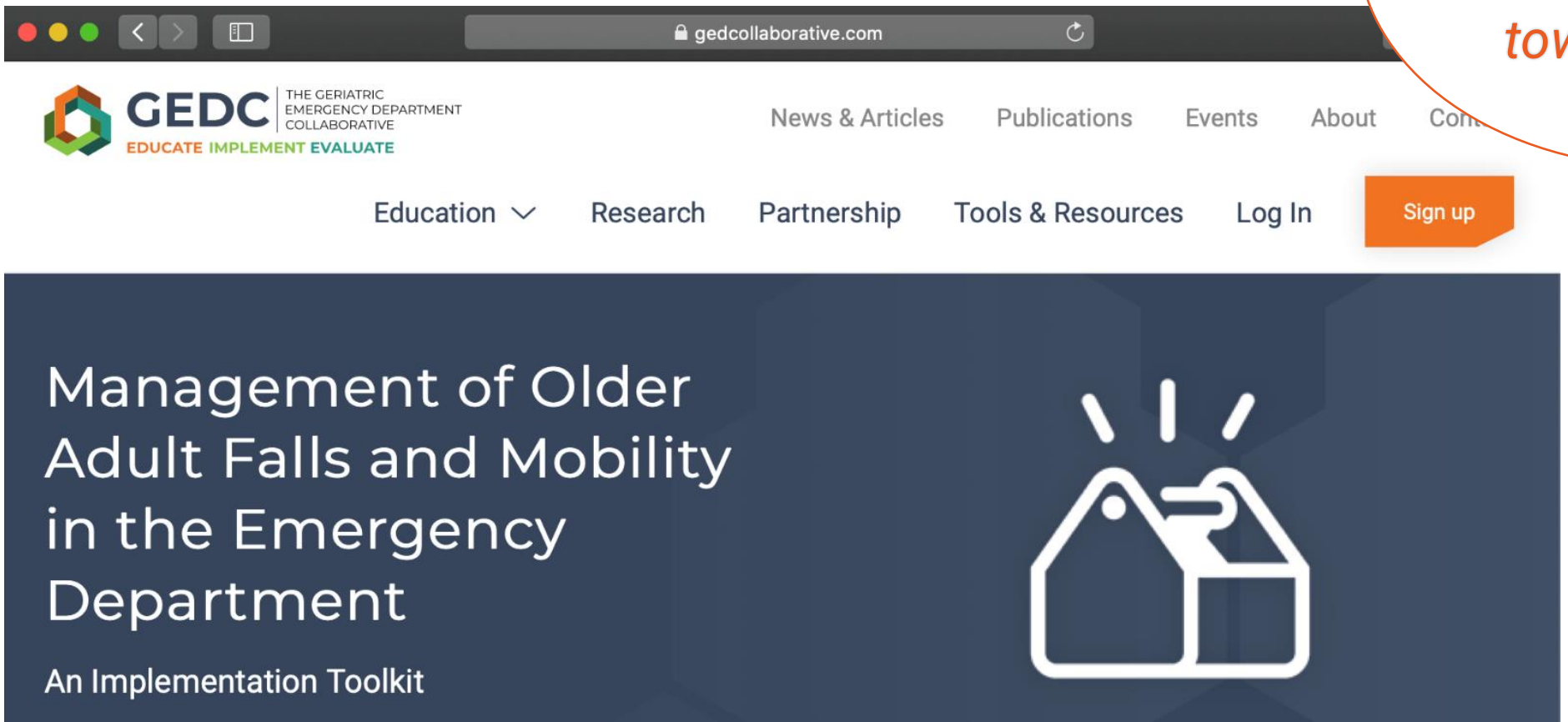
Falls & Mobility Implementation Tool Kit

WEST HEALTH GEDC FALLS & MOBILITY TOOLKIT

gedcollaborative.com/toolkit/falls-and-safe-mobility/

...pssst...

...it counts for TWO procedures towards GEDA



FOAM Protocol

INITIATING AT BEDSIDE

Note: Tailor to your specific needs and resources

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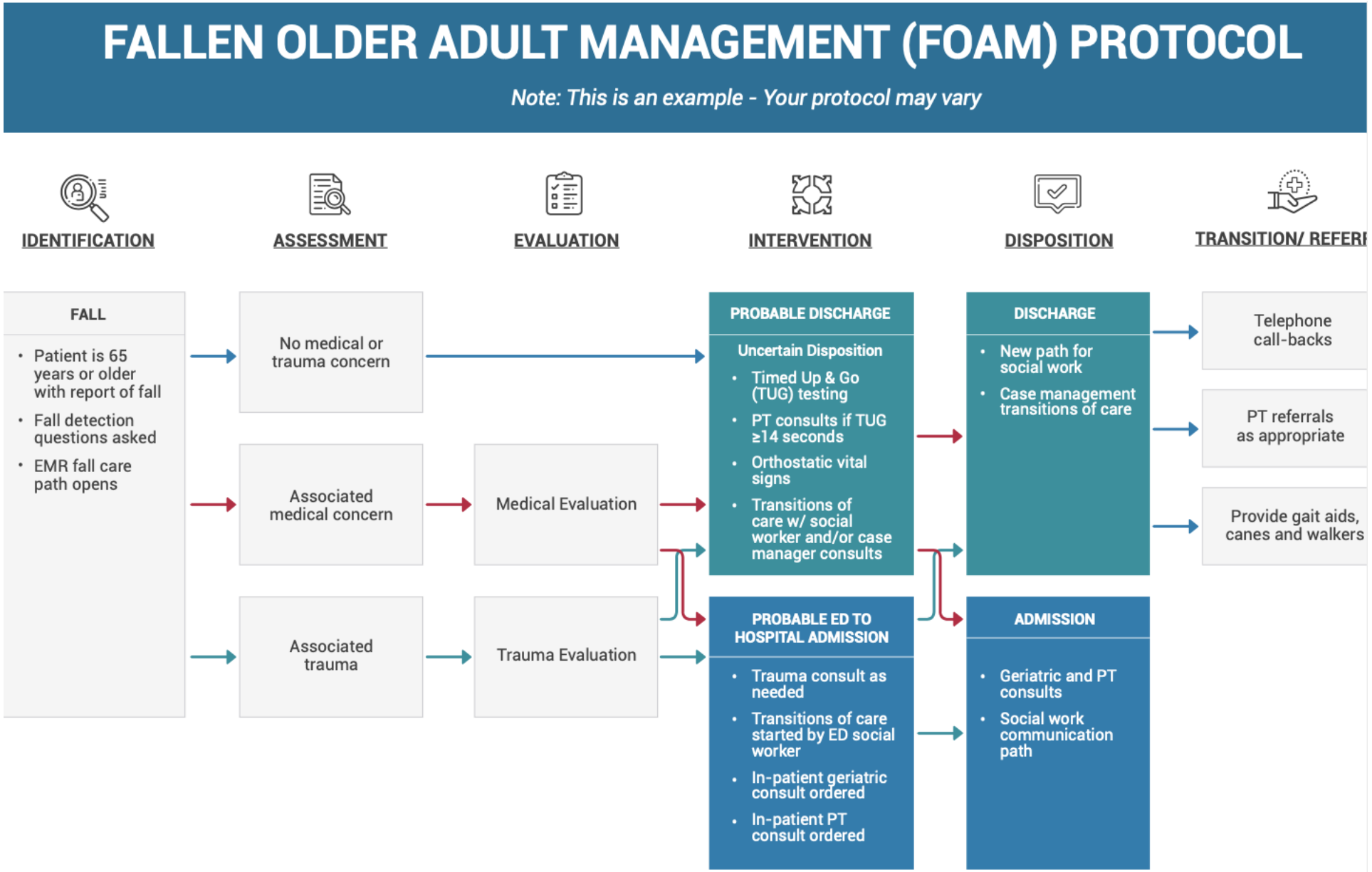
GEDC



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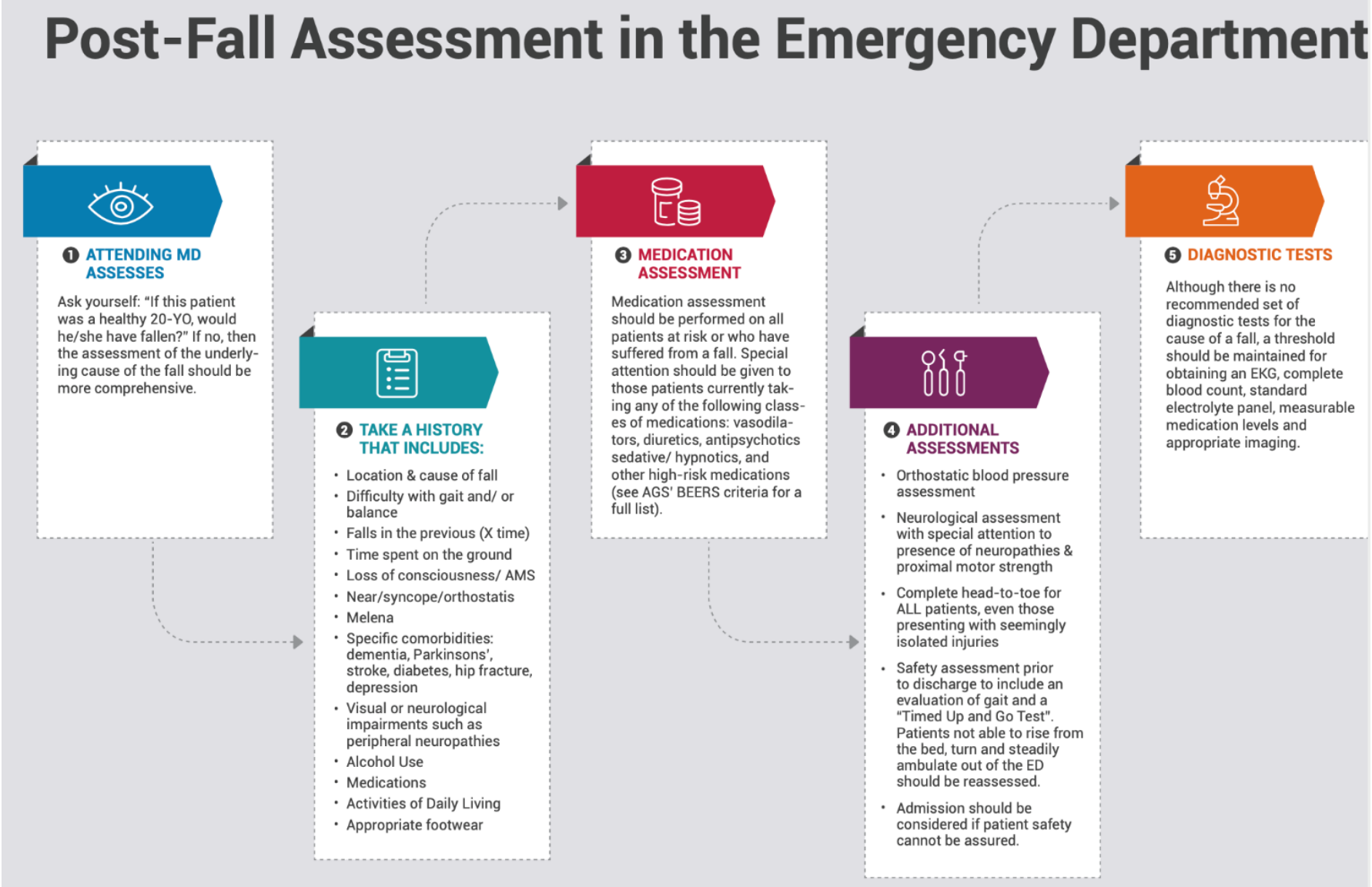
Post-Fall Assessment

INITIATING AT BEDSIDE

Note: Example of potential assessments



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GEDC

GEDC

TUG Test & Interpretation

INITIATING AT BEDSIDE

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TIMED UP & GO TEST

This is a quick and simple test to measure mobility and fall risk for older adults who can walk on their own.

Before you begin, make sure you have measured 3 meters (about 10 feet) and marked that distance with a landmark that the older adult can see. Be sure you have a stopwatch and a standard armchair.

INSTRUCTIONS:

- Begin with the senior sitting in an armchair with hips and back at the back of the seat and arms resting on the arm rests. Make sure the senior is wearing their usual footwear and has any normal assistive device that he/she would typically use.
- Ask the senior to stand up by saying, "When I say 'go' I want you to stand up and walk to the line [or insert appropriate landmark], turn, walk back to the chair and then sit down again. Walk at your regular pace."
- Start timing as you say the word "Go" and stop timing when the senior is seated again.

Podsiadlo, D., Richardson, S. The timed "Up & Go": A Test of Basic Functional Mobility for Frail Elderly Persons. Journal of American Geriatric Society, 1991; 39(2):142-148.

Expected Gait Speed

AGE	DESCRIPTION	RATING	SD
60-69	Overall	7.9 seconds	0.9
70-79	Overall	7.7 seconds	2.3
80-89	Without device With device Overall	11.0 seconds 19.9 seconds 13.6 seconds	2.2 6.4 5.6
90-101	Without device With device Overall	14.7 seconds 19.9 seconds 17.7 seconds	7.9 2.5 5.8

Lusardi, M.M. (2004). Functional Performance in Community Living Older Adults. Journal of Geriatric Physical Therapy, 26(3):14-22.

Predictive Interpretation

SECONDS	RATING
< 10	Normal, freely mobile
< 20	Mostly independent, can go out alone
20-29	Variable mobility, requires assistance
> 30	Mobility impaired

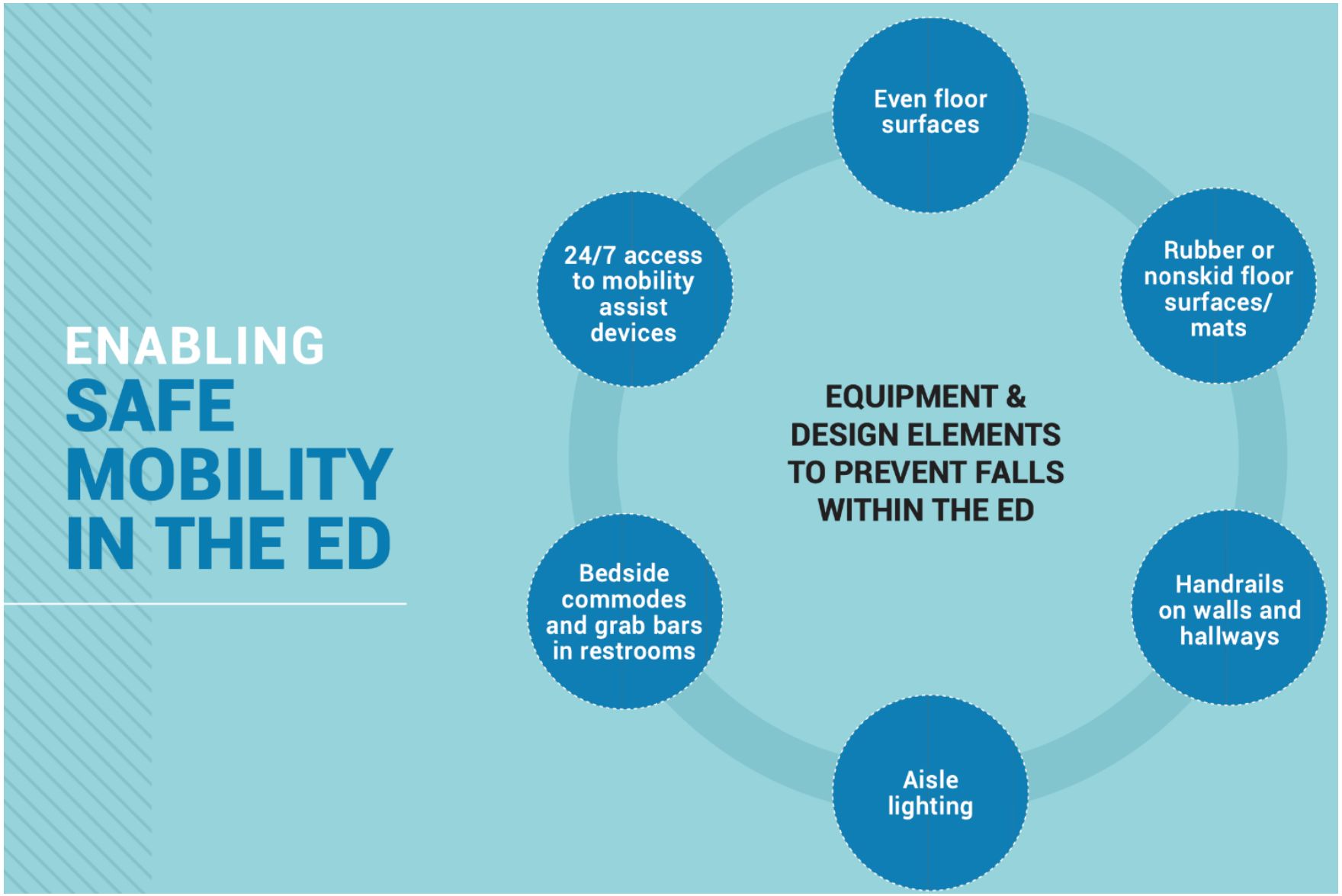
A score >14 seconds is associated with a higher risk of falls

Shumway-Cook, A., Brauer, S. Woollacott, M. Predicting the probability of falls in community-dwelling older adults using the timed up & go test. Physical Therapy, 2000; 80(9):896-903.

GEDC

Safe Mobility in the ED

ED-WIDE IMPLEMENTATION



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GEDC

AAH Falls & Mobility Protocol

Example of tailoring the FOAM Protocol, Assessment, & Interventions

AdvocateAuroraHealth

Falls & Mobility 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?

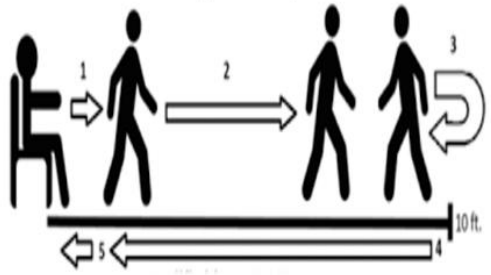
If No Fall **or** Low Risk then, initiate Mobility Procedure while in ED

Screening:

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

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

Timed Get Up and Go (TUG) Test:



Version 10.0
January 29, 2019
Advocate Aurora Health

Assessment:

ED nursing staff-
As soon as patient deemed stable for weight bearing:
a) Complete set of Orthostatic VS
b) Complete 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

Intervention:

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

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

TUG >14 seconds

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 home safety checklist
5. Med reconciliation by Pharm. Tech
6. Pharmacist to send Epic Phone msg to primary care provider

TUG <14 seconds

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 F/U
2. **Referral to outpatient physical therapy** (order can come from the initial ED physician & subsequent plan of care from the PCP) or
3. **Referral to home care physical therapy** / OT/ home safety evaluation.
4. **Primary care F/U for:**
a. Med review/management
b. Assess osteoporosis risk & Vitamin D supplements
c. Assess vision impairment
d. Manage feet/foot ware problems
e. Complete home care order
f. Review home safety checklist

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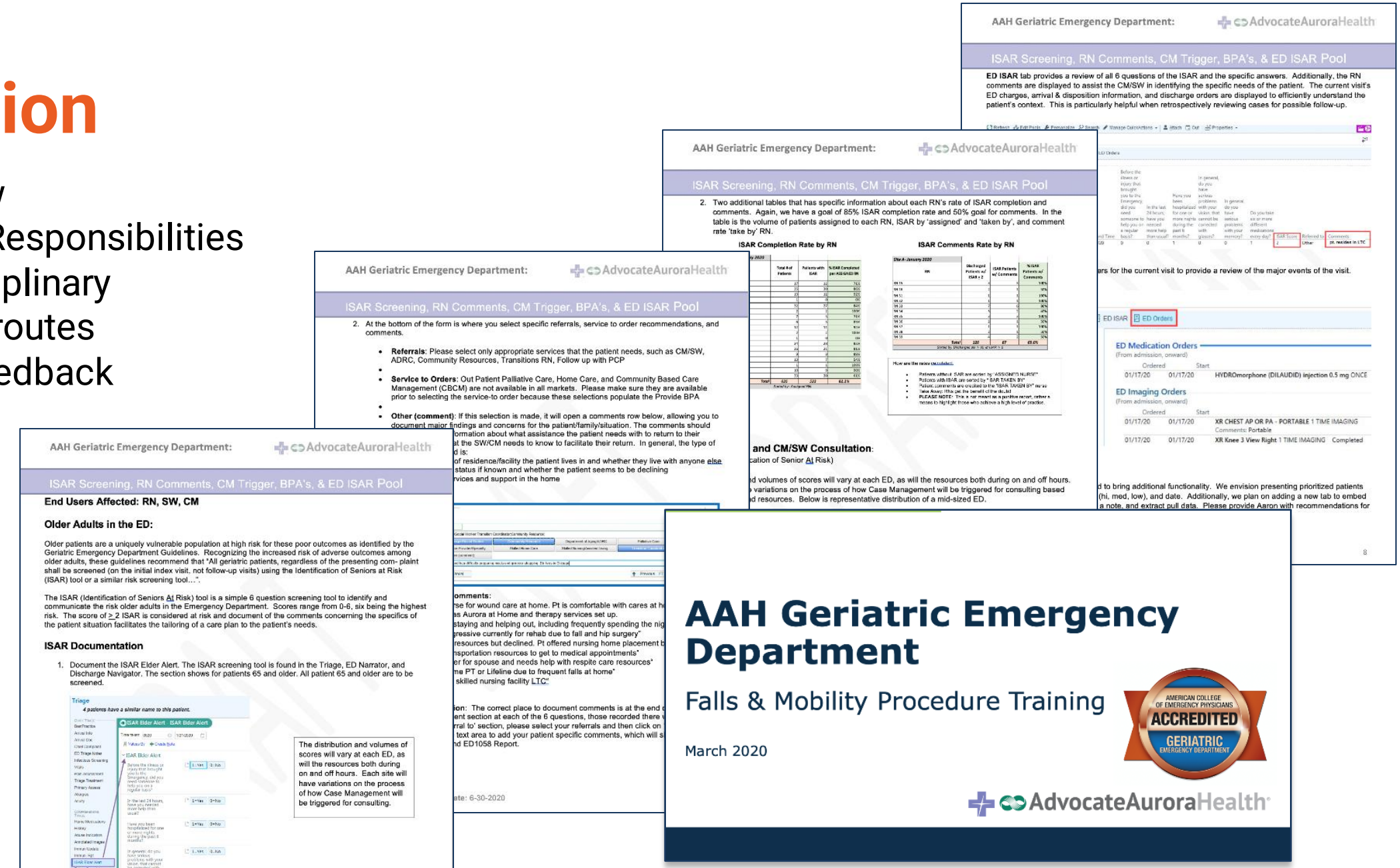
Key Points in Implementation

- Form an interdisciplinary team of champions
- Educate staff on protocol
- Develop tools and workflow in EHR
- Collaborate with community partners
  - Health Depts., EMS, Assisted Living etc., Stepping On/Falls Prevention programs
- Collaborate with stakeholder along the continuum
  - Pharmacy on medication reconciliation & management
  - Primary care follow up and continuity of care
  - Home care
  - Population Health
- Metrics & Report
- Continuous Improvement

Education

- Workflow
- Roles & Responsibilities
- Interdisciplinary
- Multiple routes
- PDSA Feedback



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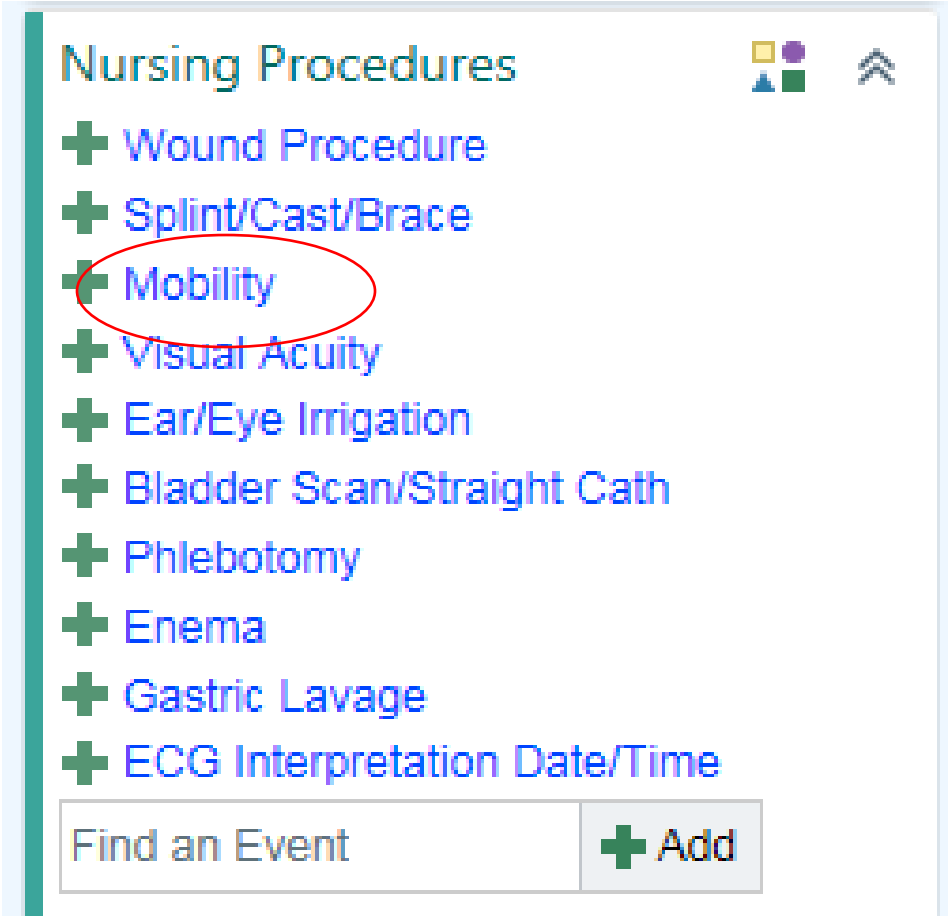
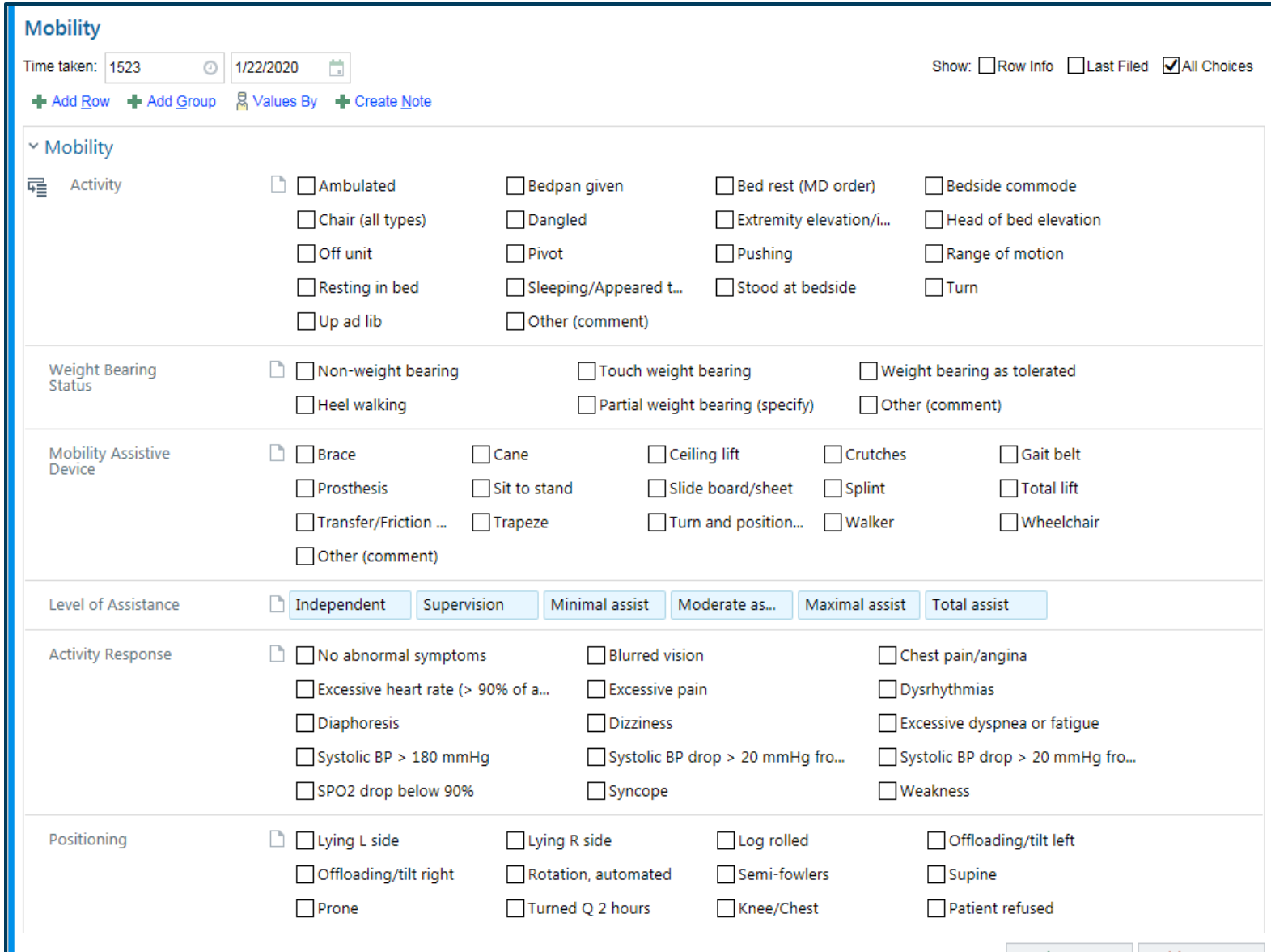
Mobility Documentation

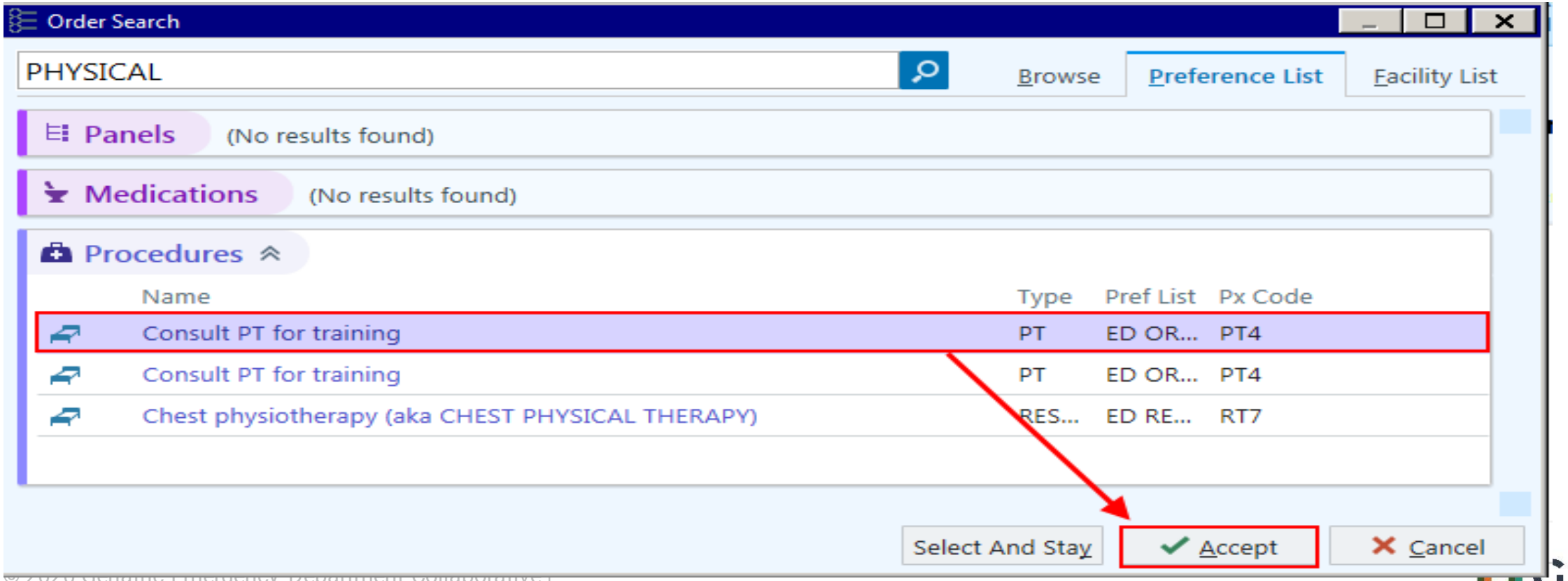
- Go to the nursing procedures toolbox





How To Order EMERGENCY DEPARTMENT PHYSICAL THERAPY Consult?

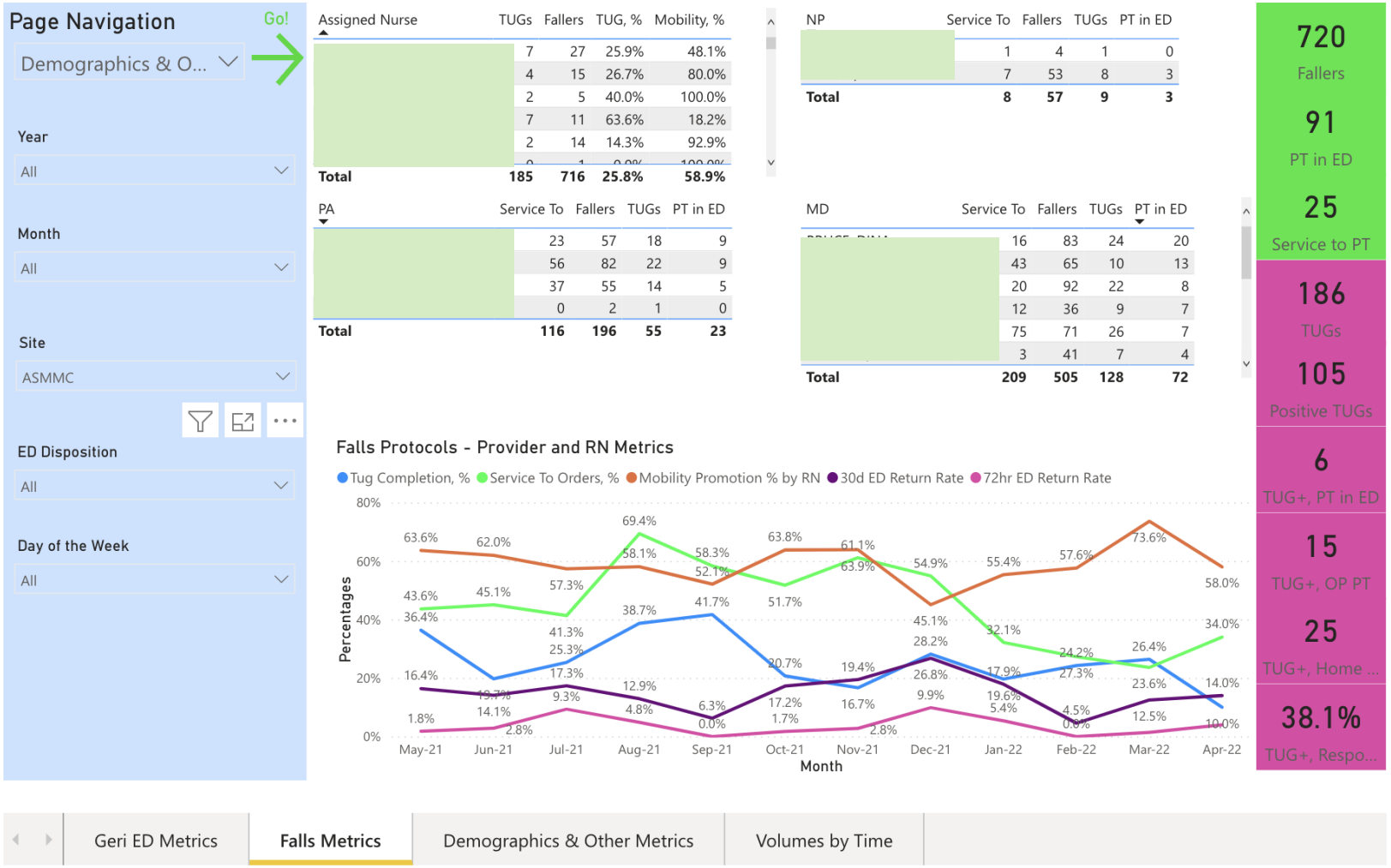
- ED Provider orders “Consult PT for training”
- (Optional site specific)RN or Tech calls and request PT assessment in the ED



Metrics & Reports

Example of AAH Falls & Mobility Dashboard (SharePoint)

- Easy Access
- Key process & outcomes
- Slice & Dice
- Interdisciplinary
- Broad Access



Lessons Learned

- Multi-component, Multi-discipline Protocols can be difficult
- Embed & Align & Augment existing processes
- Listen to front line stakeholders
- Develop robust metrics and reports for feedback
- Continuously Improve
- Celebrate accomplishments

THANK YOU!

Questions?

aaron.malsch@aah.org

Geriatric EDs: Implementation Tips & QI resources

Kevin Biese
MD, MAT

Geriatric Emergency Department Collaborative Implementation

Geriatric Emergency Department Accreditation

GEDC

General Tips for Success

It's a JOURNEY not a destination

It's not going to be perfect at the start …Ongoing, continuous improvement.

Interprofessional

Empower all disciplines at all levels

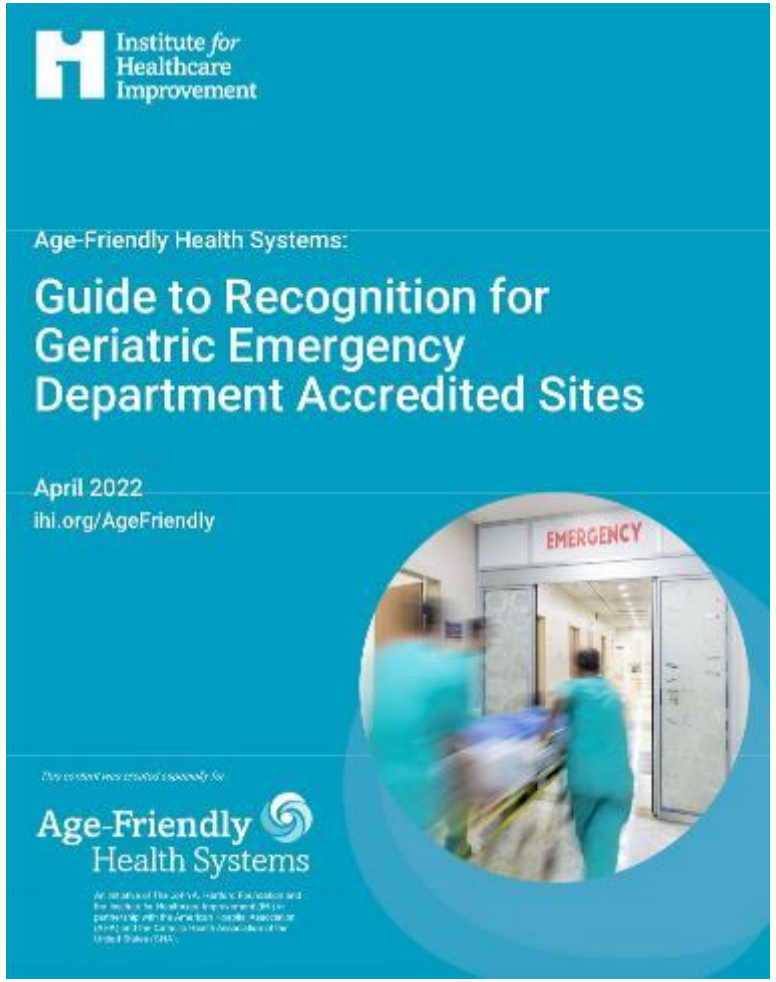
Economies of Scale at Prime:

- Multiple Sites & 1 Goal
- Organize multi-site work teams
- Leverage teams for Protocol development, Metrics, Job descriptions, Charter

Align with Existing Resources

- Shared governance
- Quality
- ACO's

AFHS and Geri EDs



GEDA Elements Aligned with the 4Ms

Policies, Protocols, Guidelines, and Procedures as a Component of ACEP Geriatric ED Accreditation Criteria	What Matters	Medication	Mentation	Mobility
A standardized delirium screening guideline (examples: DTS, CAM, 4AT, other) with appropriate follow-up			X	
A guideline for standardized fall assessment (including mobility assessment, e.g., TUG or other) with appropriate follow-up				X
A guideline to minimize the use of potentially inappropriate medications (Beers' list, or other hospital-specific strategy, access to an ED-based pharmacist)		X		
Development and implementation of at least three order sets for common geriatric ED presentations developed with particular attention to geriatric-appropriate medications and dosing and management plans (e.g., delirium, hip fracture, sepsis, stroke, ACS)		X		
A guideline to promote mobility				X

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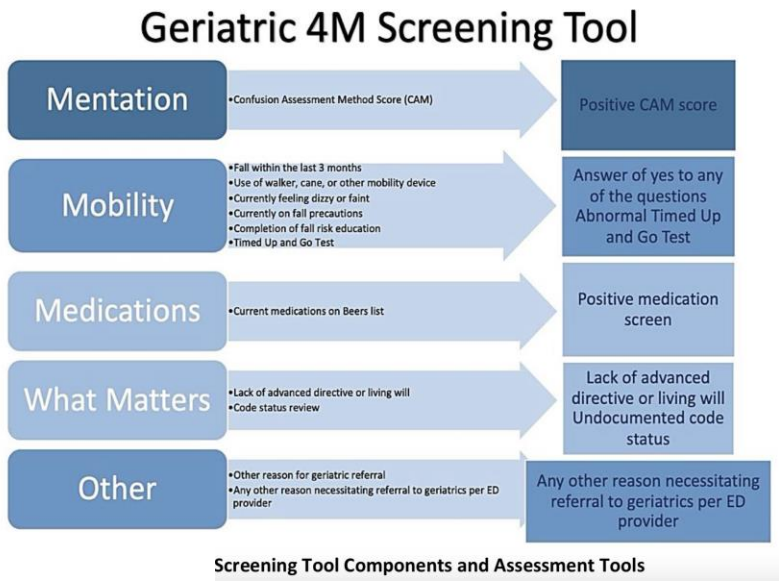
JGEM The Journal of Geriatric Emergency Medicine

Using the 4M Model to Screen Geriatric Patients in the Emergency Department

Martinus Megalla, BA, Roopa Avula, MD, Christopher Manners, BA, Portia Chinnery, RN, Lindsey Perrella, RN, Douglas Finefrock, DO



Screening Tool Components and Assessment Tools

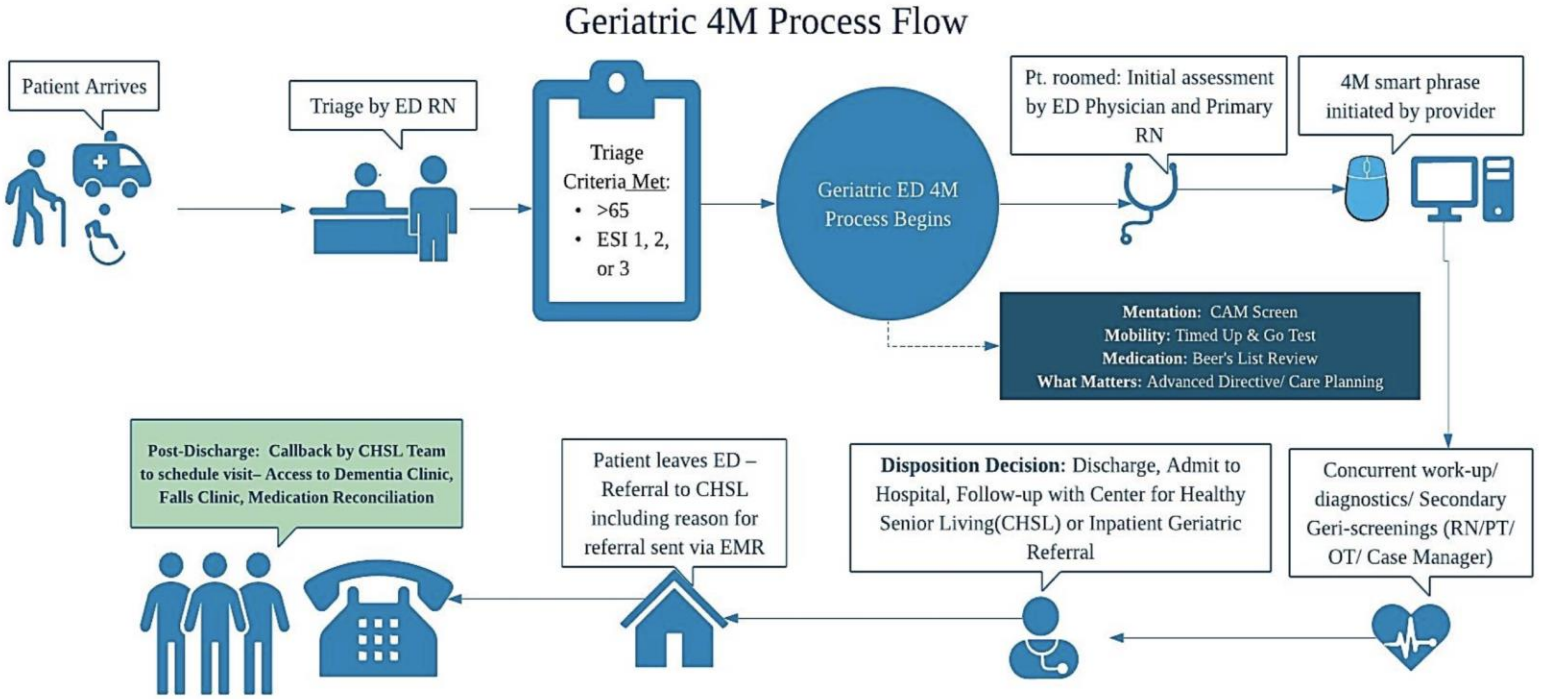


Figure 2: Geriatric Emergency Department Screening Workflow at a Level 1 Geriatric Emergency Department

Legend: ED = Emergency Department. RN = Registered Nurse. ESI = Emergency Severity Index. Pt = Patient. PT = Physical Therapy. OT = Occupational Therapy

GEDC Website Resources

The Home for Geri-ED QI Implementation

Our information architecture re-design allows for growth within our resource library. Our content development team is working to bring together resources that support QI Implementation

- Online Learning
  *Geri-EM
  *Skills Fair Modules
- Implementation Toolkits
- On Demand Webinars
- Podcast
- Blogs
- On Demand Webinars

gedcollaborative.com

Mentation RESOURCES

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Patterns of Care Partner Communication for Persons Living with Dementia in the Emergency Department

Acute Brain Failure in Older Emergency Department Patients

With Debra Eagles and Danya Khoujah

JGEM | The Journal of Geriatric Emergency Medicine

AdvocateAuroraHealth

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Pitfalls of Delirium Screening in Older Adults

Danya Khoujah MBBS, MEHP, Debra Eagles MD, MSc., FRCPC

Delirium in the Geriatric ED: Processes and Possibilities

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Mobility RESOURCES

Indication of Mobility Aids and Training of Older Patients in a Geriatric Emergency Department: Abiding by International Guidelines

Volume 3 | Issue 4 | Article 6 - Education & Training

Identification of Older Adult Fall Occurrence by Brief Emergency Department Triage Screen

Mobility Risks and Falls: The Gravity of Mobility Risks and Falls

The GEDC Skills Fair - Falls & Mobility Module 1

Falls and Safe Mobility

Educational Course developed in collaboration with the American Geriatrics Society

Hip fracture management in the ED and in the hospital

Management of Older Adult Falls and Mobility in the Emergency Department

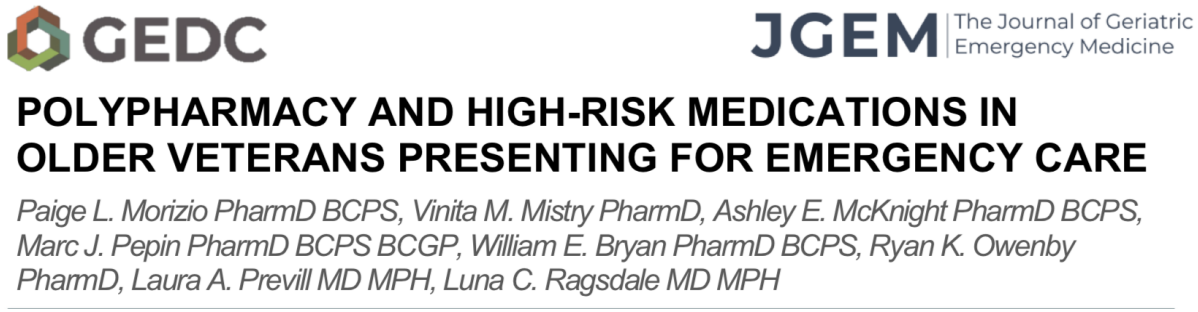
An Implementation Toolkit

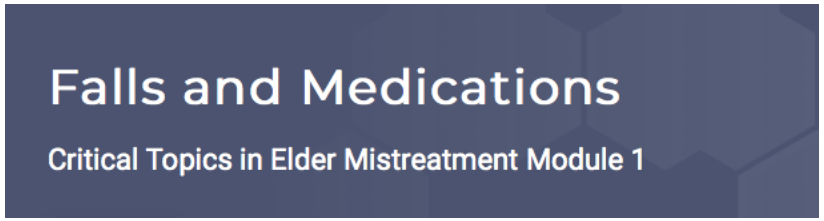
May 20, 2020

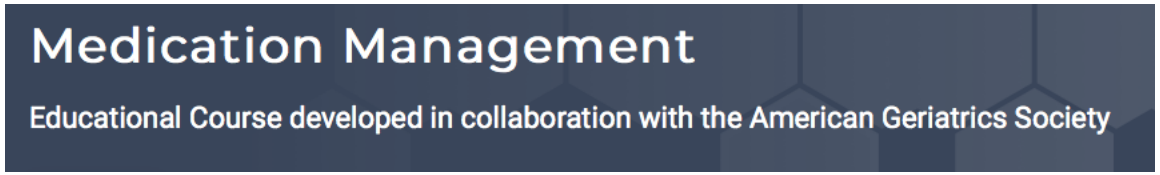
Falls and Medications

Critical Topics in Elder Mistreatment Module 1

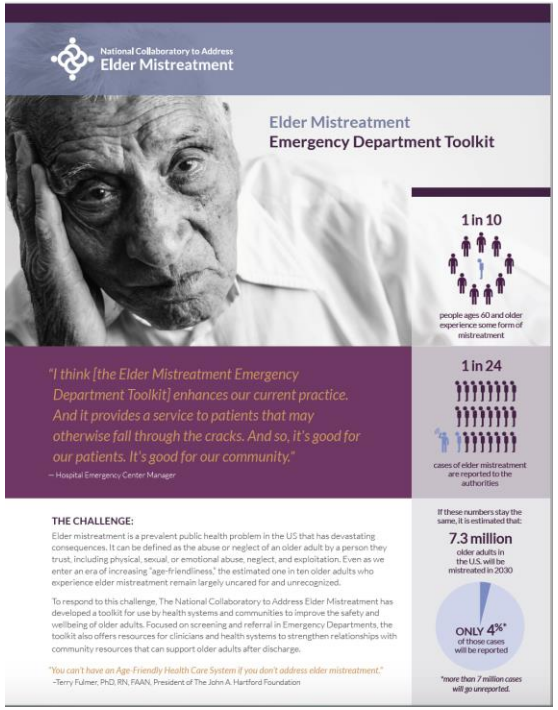
Medication RESOURCES







Elder Mistreatment RESOURCES



Using the Elder Mistreatment Brief Screen

Elder Mistreatment Toolkit Training – Module #2

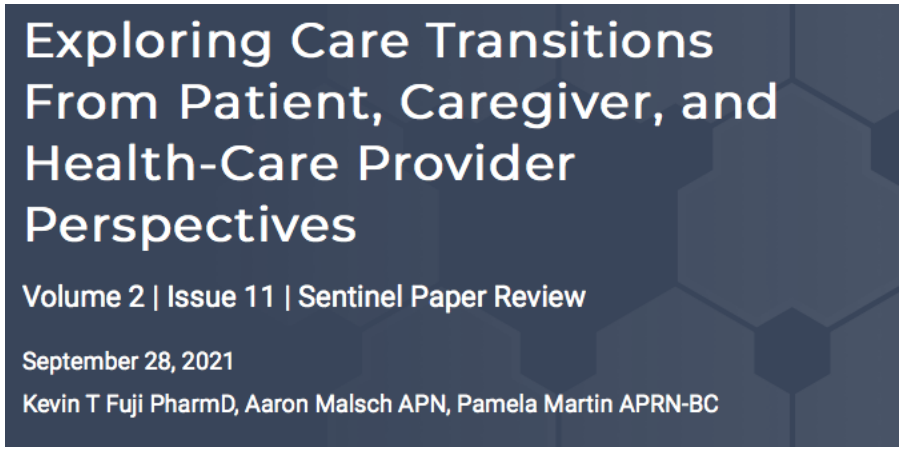
Elder Mistreatment Emergency Department Toolkit Training Program

Four e-learning modules developed by the National Collaboratory to Address Elder Mistreatment

How to Identify and Intervene in Cases of Elder Abuse

With Dr. Tony Rosen

Care Transitions RESOURCES



THANK YOU!

Questions?

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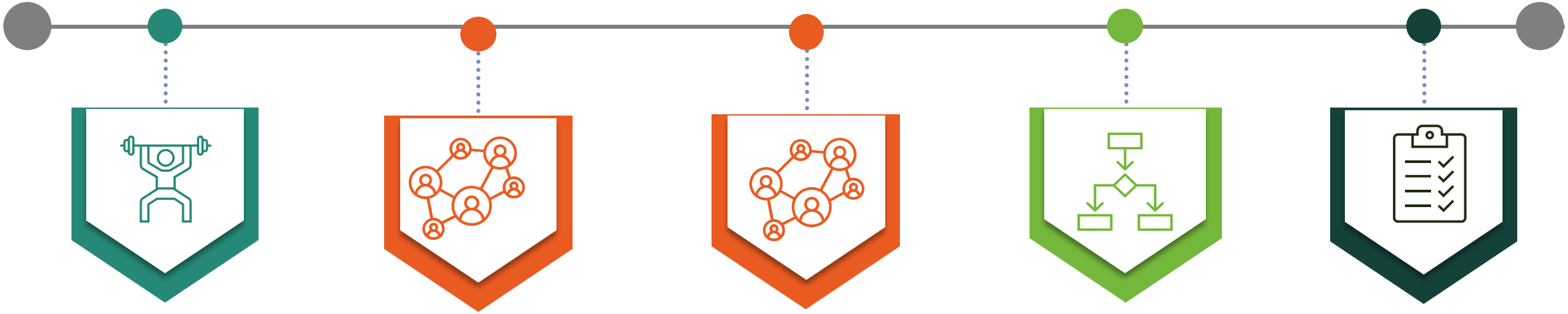
Wrap Up and Next Steps

Dora Fisher, MPH, CPHQ
Director, Post-Acute and Continuing Care

Your Path to Process Improvements

NEXT STEPS



BOOTCAMP

YOU ARE HERE

QI Implementation & Application Prep

Office Hour May 8 @ 12n CST

GEDA Application (June 30, 2023) =/> July 1, 2023 (new guidelines)

GEDA Level III

Your Geri ED Landing Page:

gedcolllaborative.com/hanys

Congratulations!
You've just completed 2.5 hours of Continuing Professional Development

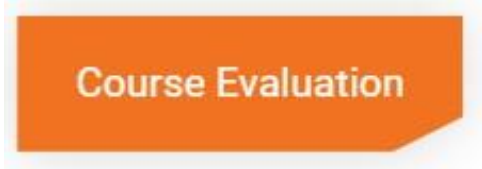
To receive credit, must complete the course evaluation.

TWO WAYS TO ACCESS THE EVALUATION:

GO TO:

Gedcollaborative.com/HANYS/

And click on the Course Evaluation button



Use your phone to scan this QR code:

The GEDC Community

LinkedIn Group

The GEDC Community is an exclusive forum for members of the GEDC to ask questions and share best practices in geriatric emergency care with each other through ongoing, interactive conversations. Here, we can share materials and improve the quality of care for older adults in the emergency department (ED) with the goal of reducing harm and improving healthcare outcomes.

Scan QR Code to join the LinkedIn Group Discussion

https://www.linkedin.com/groups/12784892/

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GEDC THE GERIATRIC EMERGENCY DEPARTMENT COLLABORATIVE

EDUCATE IMPLEMENT EVALUATE

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/application/

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

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