



Welcome to:

HANYS

Geriatric ED

Bootcamp



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



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.

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.

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.



JOINT ACCREDITATION[™]
INTERPROFESSIONAL CONTINUING EDUCATION



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



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	<p>Don Melady (Moderator & Presenter)</p> <p>Tess Hogan, Pam Martin, Aaron Malsch, Kevin Biese, Kira Gossack-Keenan (Presenters)</p>								
2:15-2:25 (10 mins)	Break									
2:25- 3:25 (60 mins)	GED Implementation & GEDC QI Resources	<table border="0"> <tr> <td>ISAR Screening</td> <td>Aaron Malsch</td> </tr> <tr> <td>Delirium</td> <td>Pam Martin</td> </tr> <tr> <td>Falls & Mobility</td> <td>Aaron Malsch</td> </tr> <tr> <td>Tips & Resources</td> <td>Kevin Biese</td> </tr> </table>	ISAR Screening	Aaron Malsch	Delirium	Pam Martin	Falls & Mobility	Aaron Malsch	Tips & Resources	Kevin Biese
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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

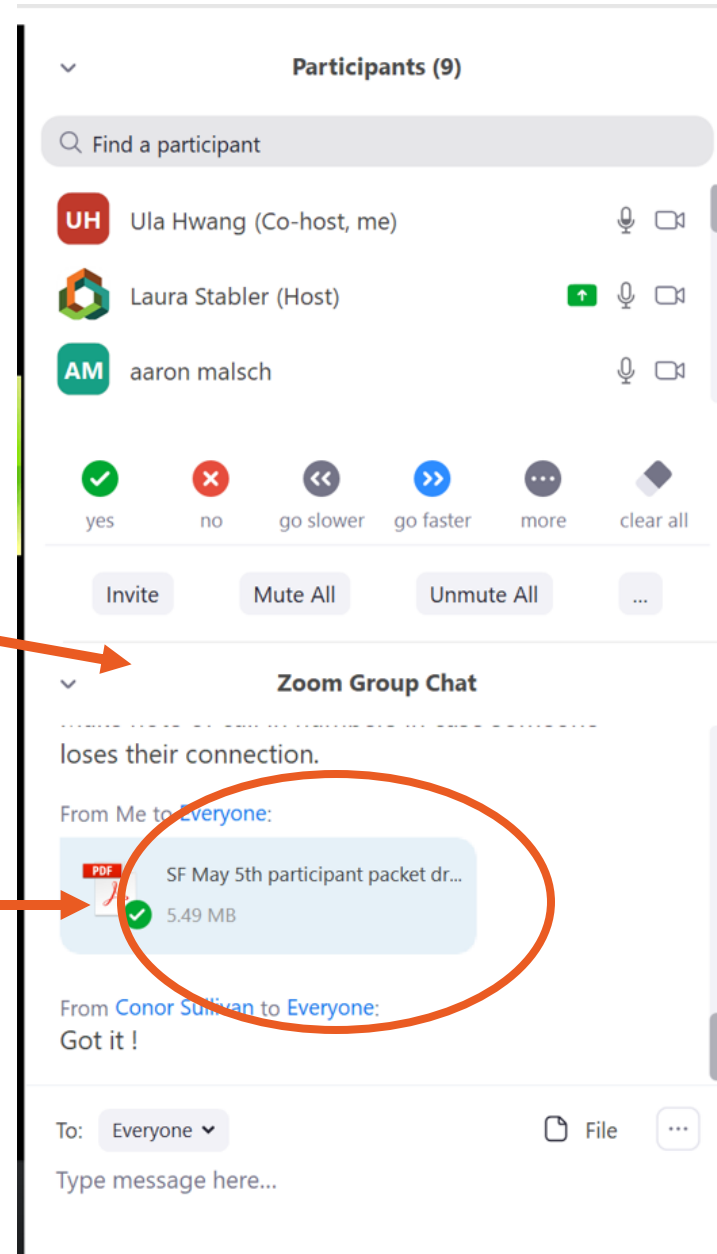
Open your zoom chat! (bottom toolbar)

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:

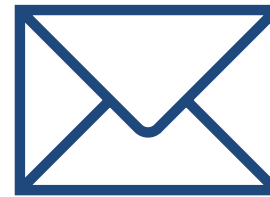
Please text Conor Sullivan: 910-200-1312
or Heather Wojtarowicz: 501-504-4406



What if I have Questions!?

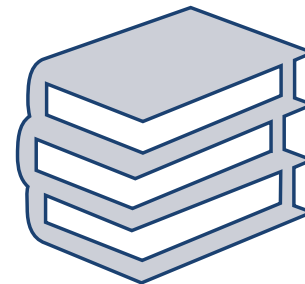


Use the Zoom Chat feature! The chat will be monitored and we will try to answer questions there.



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

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



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)





Bronze - Level 3

Pursuing Level 3



- ❖ 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)
- ❖ NYC Health + Hospitals – Queens (Queens, NY)
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- ❖ 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





Silver - Level 2

- ❖ 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 – 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)



Gold - Level 1

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

Pursuing Level 2

Pursuing Level 1



- ❖ 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)

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Geriatric EDs: The Why?

Kevin Biese
MD, MAT



Geriatric Emergency Department
Collaborative Implementation PI

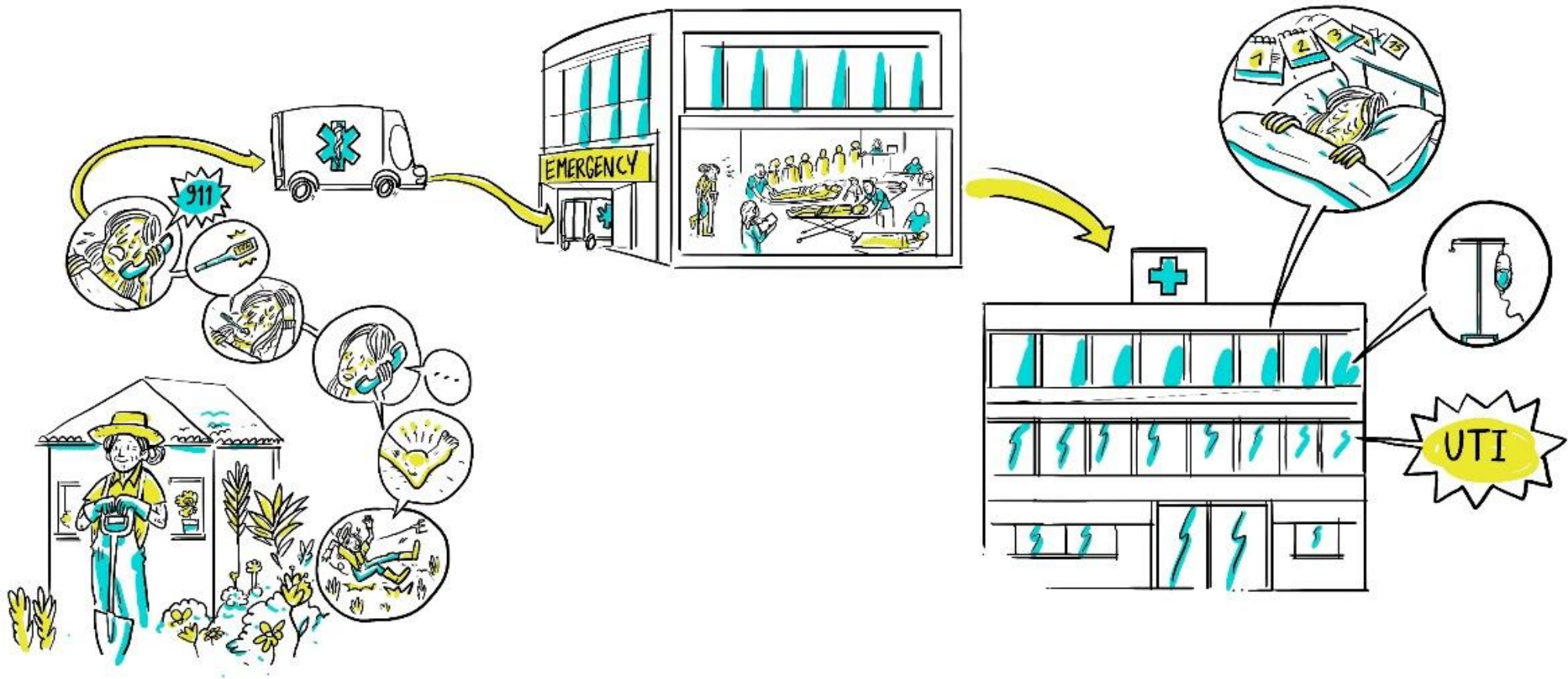
Chair, Geriatric Emergency
Department Accreditation

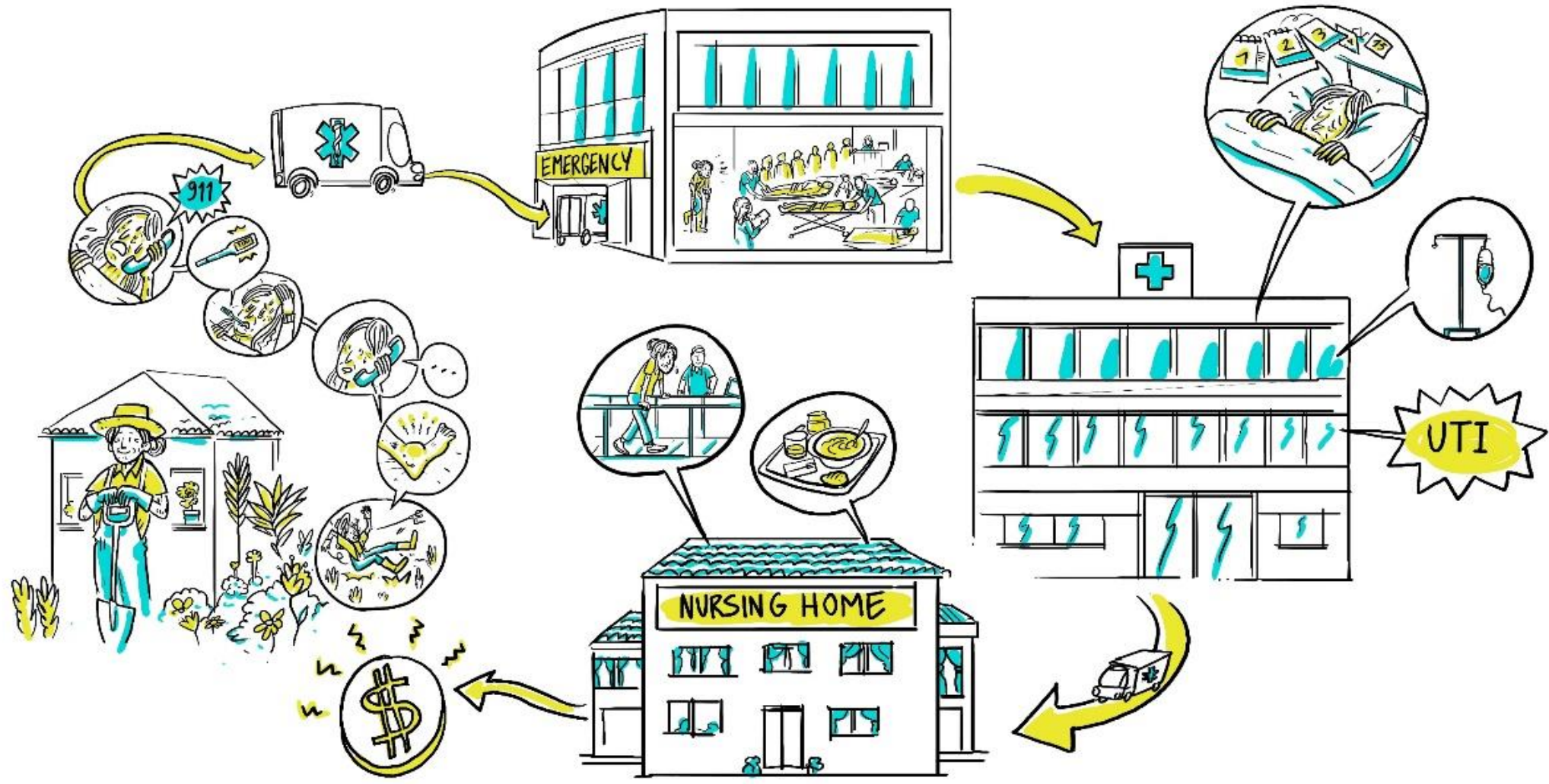








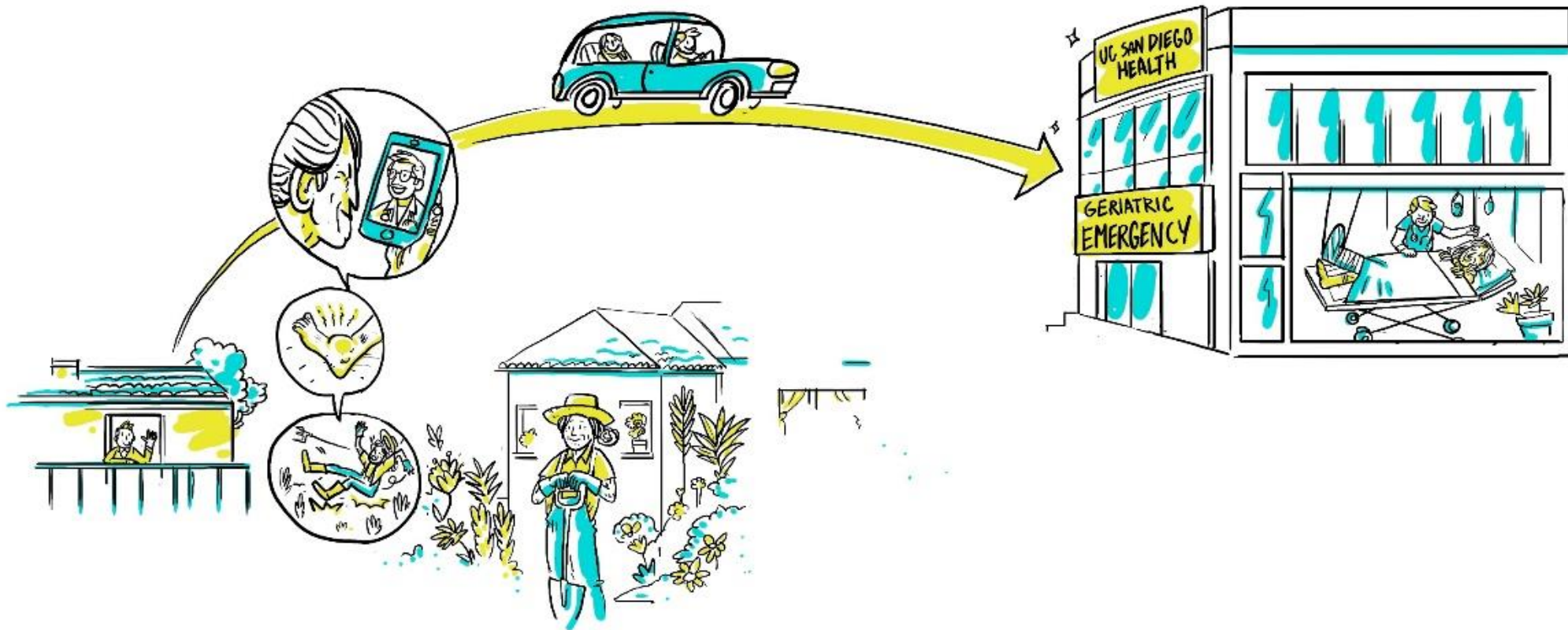


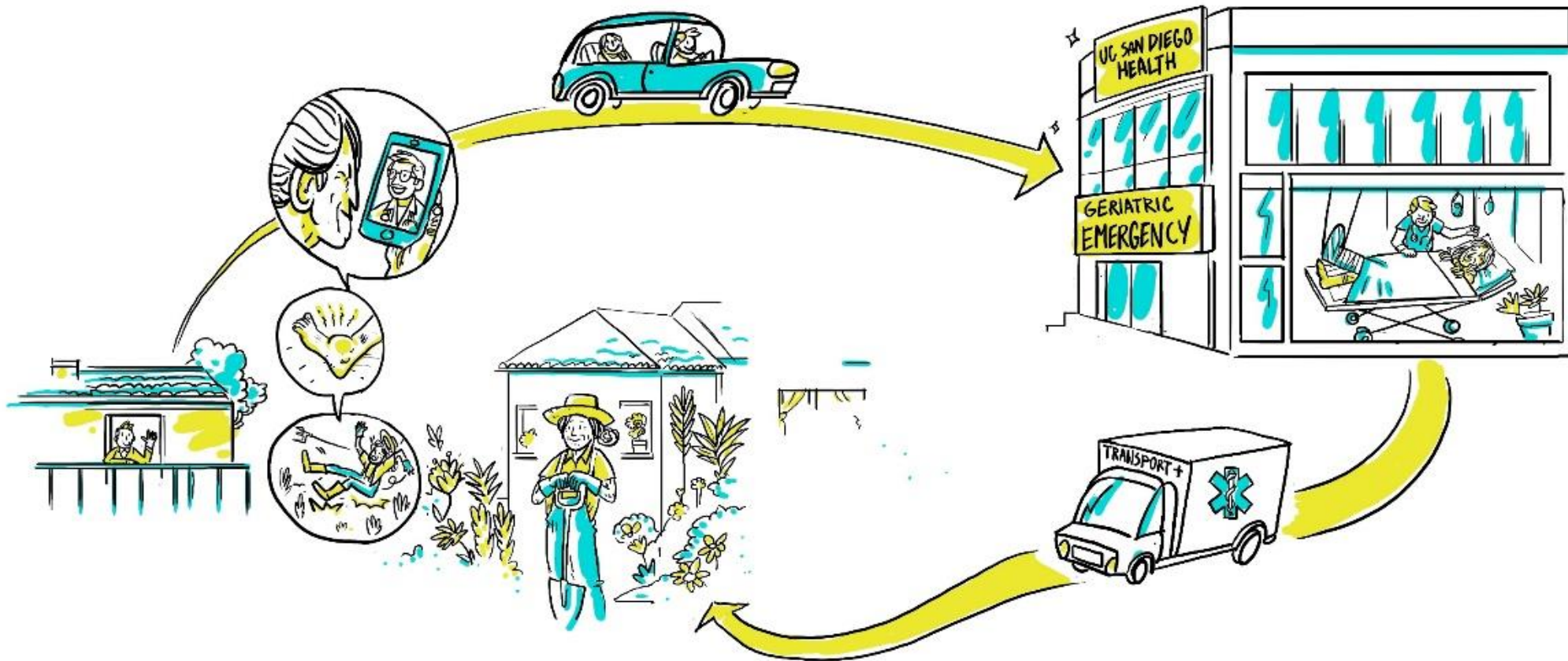


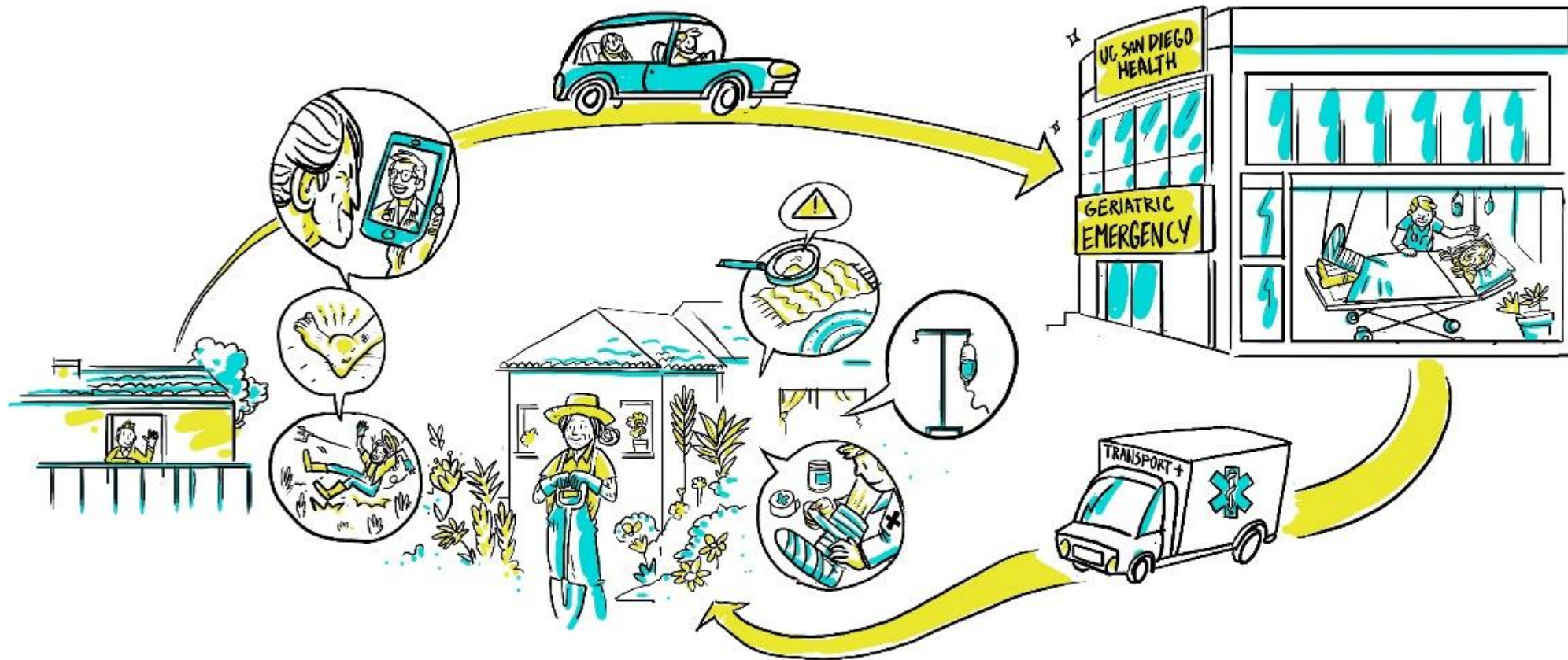


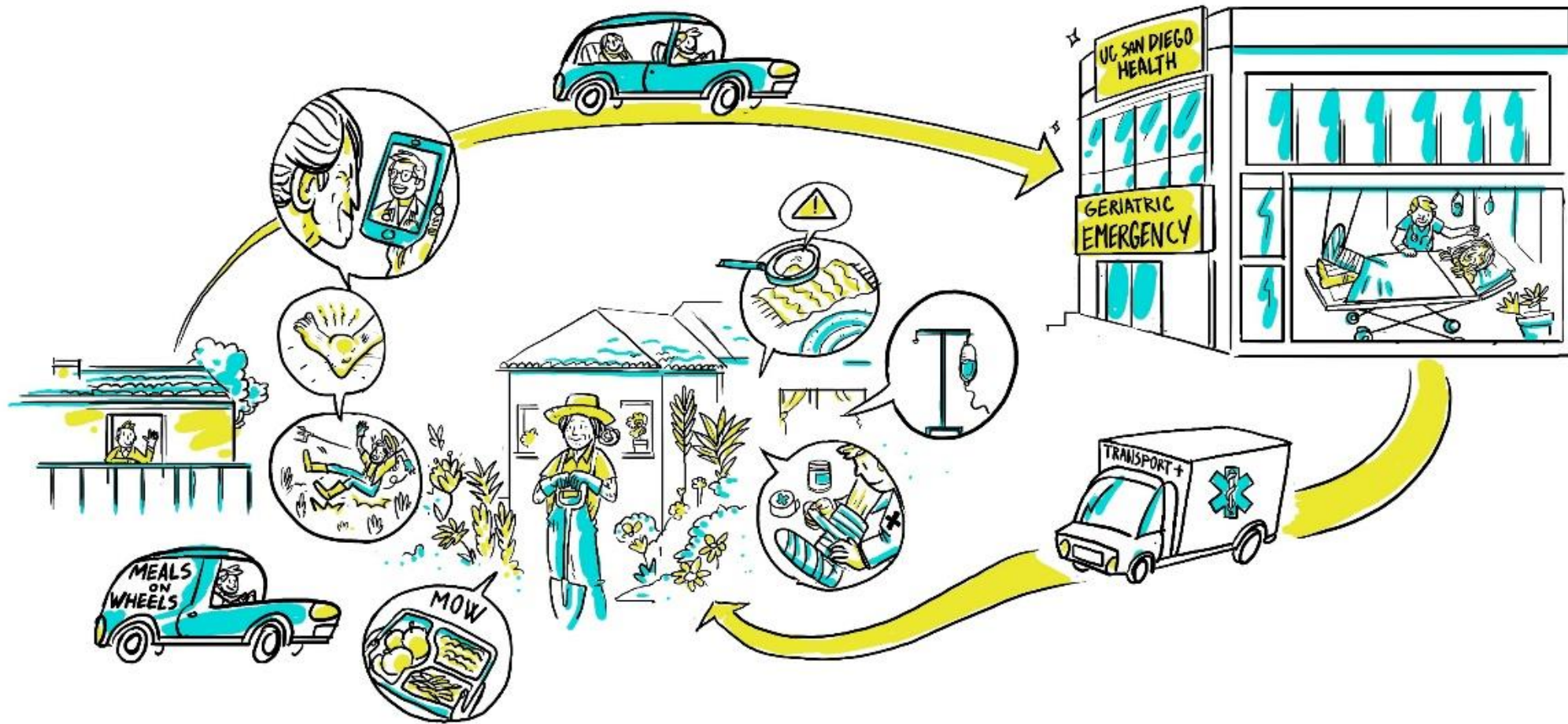






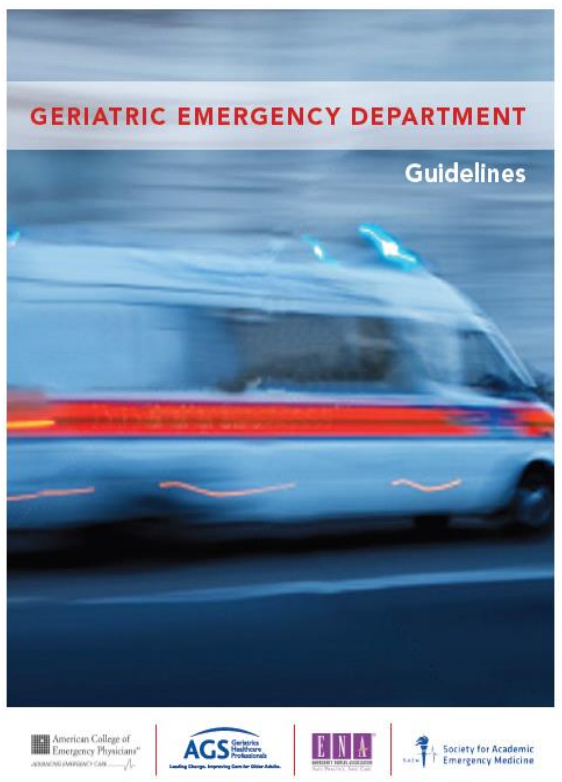




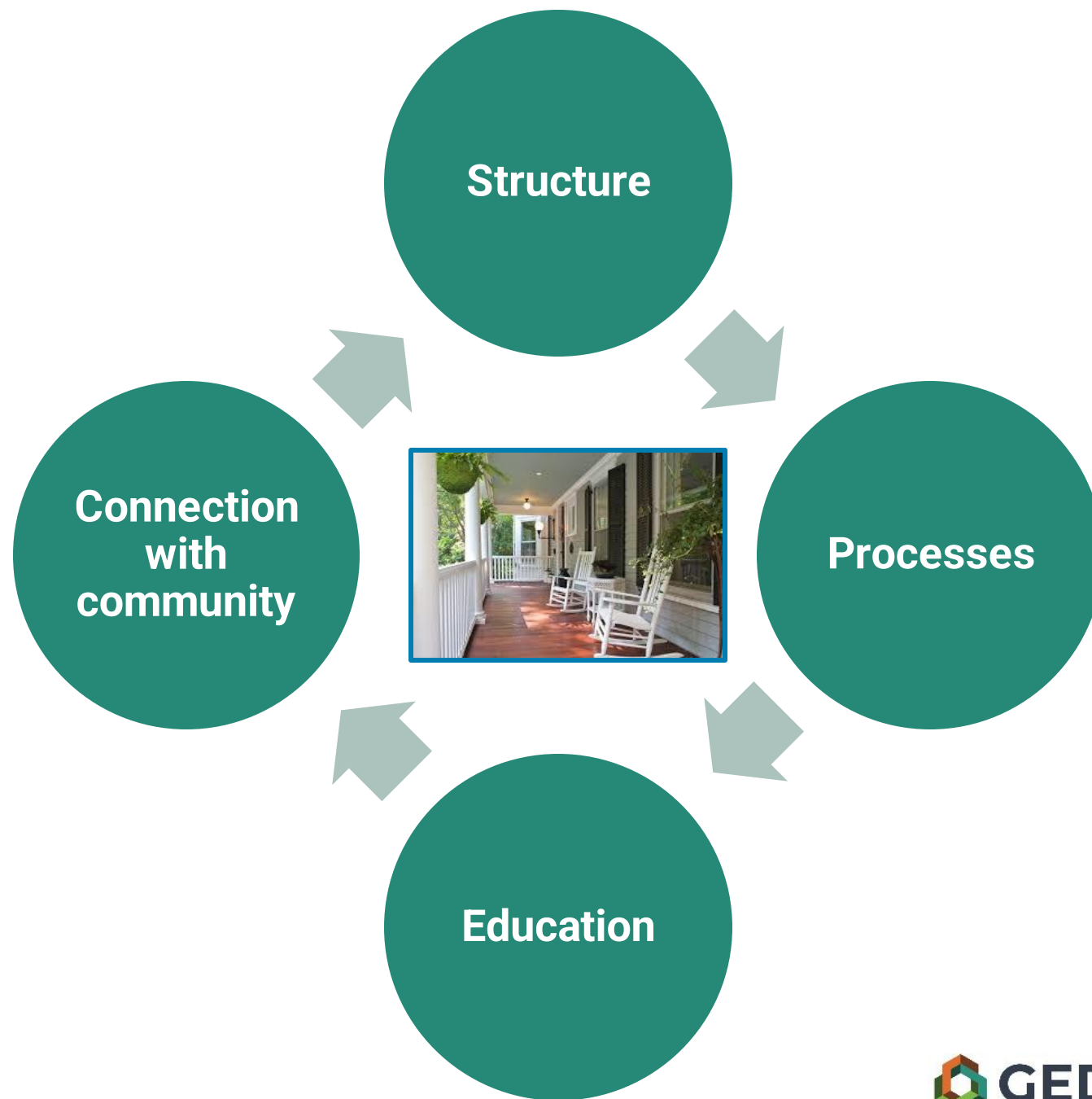


Geriatric ED Guidelines

Four Critical Components of a Geriatric-Appropriate ED

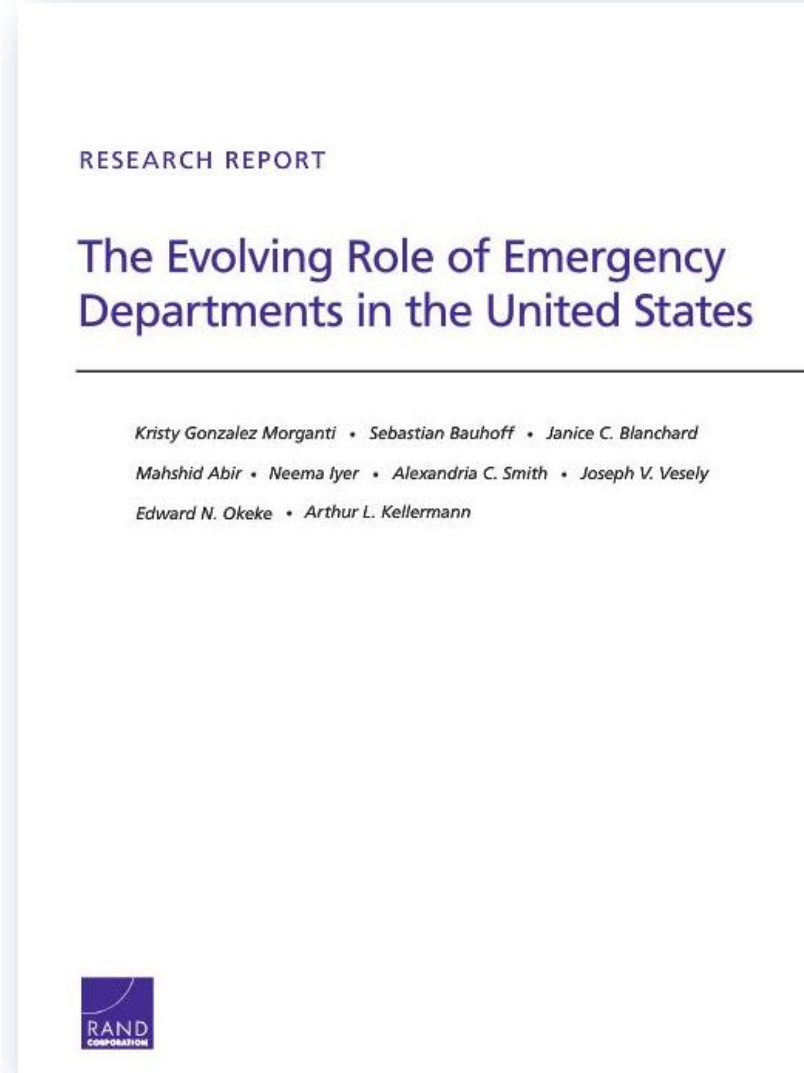


Geriatric ED Guidelines 2014



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

HealthAffairs
TOPICS JOURNAL BLOG
HEALTH AFFAIRS BLOG DIFFUSION OF INNOVATION

The Journey of Geriatric Emergency Medicine: Acceleration, Diffusion, and Collaboration As Keys To Continued Growth
Early Ho, Adriano Levant, Kevin Biese, Ula Hsiang, Christopher Carpenter
July 16, 2013

Geriatric Emergency Department Guidelines
06449-5ee front matter
Copyright © 2014 by the American College of Emergency Physicians.
http://dx.doi.org/10.1016/j.annemergmed.2014.05.008

RELATED ARTICLE, P. e1.
This document is the product of two years of consensus-based work that included representatives from the American College of Emergency Physicians, The American Geriatrics Society, Emergency Nurses Association, and the Society for Academic Emergency Medicine.

INTRODUCTION
According to the 2010 Census, more than 40 million Americans were over the age of 65, which was "more people than in any previous census." In addition, between 2000 and 2010, the population 65 years and older increased at a faster rate than the total U.S. population. The census data also demonstrated that the population 85 and older is growing at a rate almost three times the general population. The subsequent increased need for health care for this burgeoning geriatric population represents an unprecedented and overwhelming challenge to the American health care system and is unique to emergency departments (EDs) specifically.¹ Geriatric EDs began appearing in the United States in 2008 and have become increasingly common.² The ED is uniquely positioned to play a role in improving care to the geriatric population.³ As our ever-increasing acute care medical care, the ED sits at a crossroads between inpatient and outpatient care (Figure 1).⁴ Specifically, the ED represents 57% of hospital admissions in the United States, of which almost 70% receive a non-surgical diagnosis. The expertise which an ED staff can bring to an encounter with a geriatric patient can meaningfully impact not only a patient's condition, but can also impact the decision to utilize relatively expensive inpatient resources, or to expensive outpatient treatment.^{5,6} Emergency medicine experts recognize similar challenges around the world.⁷ Geriatric ED care principles have been described in the United Kingdom.⁸

Furthermore, as the initial site of care for both inpatient and outpatient events, the care provided in the ED has the opportunity to "set the stage" for subsequent care provided. More accurate diagnosis and improved therapeutic measures can not only expedite and improve inpatient care and outcomes, but can effectively guide the allocation of resources toward a patient population that, in general, utilizes significantly more resources per event than younger populations.⁹ Geriatric ED patients

MODELS OF GERIATRIC CARE, QUALITY IMPROVEMENT AND PROGRAM DISSEMINATION

A Geriatric Emergency Service for Acutely Ill Elderly Patients: Pattern of Use and Comparison with a Conventional Emergency Department in Italy

Fabio Salvi, MD,* Valeria Morichi, MD,* Annalisa Grilli, MD,* Raffaella Giorgi, MD,* Lina Spadolini, MD,* Stefano Polonara, MD,* Giuseppe De Tommaso, MD,* Alessandro Rappelli, MD,* and Paolo Dess-Fulgheri, MD*

The current disease-oriented, episodic model of emergency care does not adequately address the complex needs of older adults presenting to emergency departments (EDs). Dedicated ED facilities with a specific organization (e.g., geriatric EDs [GEDs]) have been described. One of the few GED experiences in the world is described and its outcomes compared with those of a conventional ED (CED). In a secondary analysis of a prospective observational cohort of 200 acutely ill elderly patients presenting to two urban EDs in Ancona, Italy, identifiers and triage, clinical, and social data were collected and the following outcomes considered: early (30-day) and late (6-month) ED revisit, frequent ED hospital admission, hospitalization, death, functional decline, any ED revisit and any hospital admission were also considered as a composite outcome. Odds ratios and 95% confidence intervals (CIs) were calculated. Overall, CED patients were older and frailer than CED patients. The two EDs did not differ in terms of early, late,

SPECIAL CONTRIBUTION
A Profile of Acute Care in an Aging America: Snowball Sample Identification and Characterization of United States Geriatric Emergency Department Patients in 2013
Teresaita M. Hogan, MD, Tolulope Oyejemi Olade, and Christopher R. Carpenter, MD, MSc

Abstract
America poses a challenge to emergency departments (EDs). Studies show that outcomes despite increased testing, prolonged periods of observation, and response, emergency medicine (EM) leaders have implemented strategies including response, equipment, policies, and protocols. One example is the use of a snowball sampling method to identify United States geriatric emergency department patients in 2013. We report on the characteristics of geriatric emergency department patients in 2013, with particular emphasis on geriatric emergency department patients who were admitted to the ED, but not admitted to the hospital. We report on the characteristics of geriatric emergency department patients who were admitted to the ED, but not admitted to the hospital. We report on the characteristics of geriatric emergency department patients who were admitted to the ED, but not admitted to the hospital.

MODELS OF GERIATRIC CARE, QUALITY IMPROVEMENT AND PROGRAM DISSEMINATION

The Geriatric Emergency Department

Ula Hsiang, MD, MPH,^{1,2} and R. Sean Morrison, MD^{1†}

With the aging of the population and the demographic shift of older adults in the health-care 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 (GEDI) and other interventions designed to address the special care needs of older patients, may help to address these challenges. *J Am Geriatr Soc* 55:1875-1876, 2007.

Key words: emergency medicine; geriatric health services

For most of the 20th century, the growth of the population aged 65 and older has far outpaced other age groups, and this trend will continue well into the 21st century. As a result of this demographic shift and an increase in longevity resulting from gains in lifestyles, health, and medical advances, one in five Americans will be aged 65 and older in 2010. By 2030, nearly 25% of Medicare beneficiaries will be aged 85 and older.¹

As the U.S. population continues to age, the health-care system will need to face and embrace the challenges of caring for older adults. Care for elderly people is increasingly being sought in emergency departments (EDs), where older patients typically present with complex medical conditions, stay longer for more extensive diagnostic testing and treatment regimens, and require special needs during their visit.²

The use of Geriatric Emergency Department Interventions (GEDI) and other interventions designed to address the special care needs of older patients, may help to address these challenges and thereby improve the quality of care of elderly people in the ED.

MODELS OF GERIATRIC CARE, QUALITY IMPROVEMENT AND PROGRAM DISSEMINATION

Association Between Physical Therapy in the Emergency Department and Emergency Department Revisits for Older Adult Fallers: A Nationally Representative Analysis

Adrian Lazar, MS, John Janak, MS, Tyler King, and Eddy E. Li, PhD

OBJECTIVE: To determine whether providing physical therapy (PT) services in the emergency department (ED) reduces the risk of ED revisits for older adult fallers. We also determined if ED revisits were associated with ED revisits for older adult fallers. We hypothesized that older adult fallers who received PT services in the ED would have lower rates of ED revisits compared with those who did not receive PT services in the ED.

SETTING: We analyzed national 2012 US Medicare data to determine whether older adult fallers who received PT services in the ED had lower rates of ED revisits compared with those who did not receive PT services in the ED.

PARTICIPANTS: The study population included older adult fallers who were admitted to the ED and received PT services in the ED. We analyzed data from the Medicare Provider and Reimbursement Data File for the years 2010 through 2012.

RESULTS: We found that older adult fallers who received PT services in the ED had lower rates of ED revisits compared with those who did not receive PT services in the ED. We also found that ED revisits were associated with ED revisits for older adult fallers.

Geriatric Emergency Department Innovations: Transitional Care Nurses and Hospital Use

Ula Hsiang, MD, MPH,^{1,2} Acar M. Dvorkan, MD, MS,¹ Mark S. Rosenberg, MD, MPH,¹ Matthew J. Gorman, PhD,¹ Qi Gongyi, MD, MPH, DrPH,¹ Jeremy Scott, MD, MPH,¹ D. Mark Cooper, MD,¹ Raymond Kang, MD,¹ Carolyn Yargan-Torres, MA,¹ Conita R. Gendron, MD, MMS,¹ and Lynne D. Richardson, MD, MSc¹

Emergency departments (EDs) are 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 (GEDI) and other interventions designed to address the special care needs of older patients, may help to address these challenges. *J Am Geriatr Soc* 55:1875-1876, 2007.

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Optimal Older Adult Emergency Care: Introducing Multidisciplinary Geriatric Emergency Department Guidelines From the American College of Emergency Physicians, American Geriatrics Society, Emergency Nurses Association, and Society for Academic Emergency Medicine

Christopher R. Carpenter, MD, MSc,¹ Marilyn Bromberg, RN, Jeffrey M. Cantorio, MD, MPH, Ashley Chen, MD, Lowell W. Gerson, PhD, Jason Gumpert, MD, Ula Hsiang, MD, David P. Jahn, MD, William L. Levin, MD, Timothy J. Pflaum, MD, MSc, Barry Morrison, PhD, Laura Roggehoj, MD, MPH, Mark Rosenberg, MD, MSc, Scott T. Wilson, MD, MPH, for the ACEP Geriatric Emergency Medicine Section, American Geriatrics Society, Emergency Nurses Association, and Society for Academic Emergency Medicine

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RELATED ARTICLE, P. e5.
[Am Emerg Med. 2014;63:e1-5.]

In the United States and around the world, efficient, effective strategies to provide emergency care to aging adults (geriatric emergency departments [GEDs]) and a care system. In response, geriatric emergency medicine, education, and research collaborative with the American College of Emergency Physicians (ACEP), Emergency Nurses Association (ENA), and Society for Academic Emergency Medicine (SAEM) to develop guidelines intended to improve ED care for older adults. The guidelines focus on patient assessment, equipment, policies, and protocols. The emergency department (ED) and hospital use of geriatric emergency medicine (GEM) is increasing. The guidelines are intended to improve ED care for older adults. The guidelines are intended to improve ED care for older adults. The guidelines are intended to improve ED care for older adults.

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Clinics Review Articles
Clinics in Geriatric Medicine

CARE FOR THE OLDER ADULT IN THE EMERGENCY DEPARTMENT

EDITORS
MICHAEL L. MALONE
KEVIN BIESE

August 2018
August 2018
Volume 34, Issue 3



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%

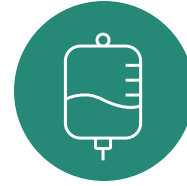
Reduced risk of
hospital
readmission



**LOWER
RISK**

Of 30-day fall-
related ED
revisits

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

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



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

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

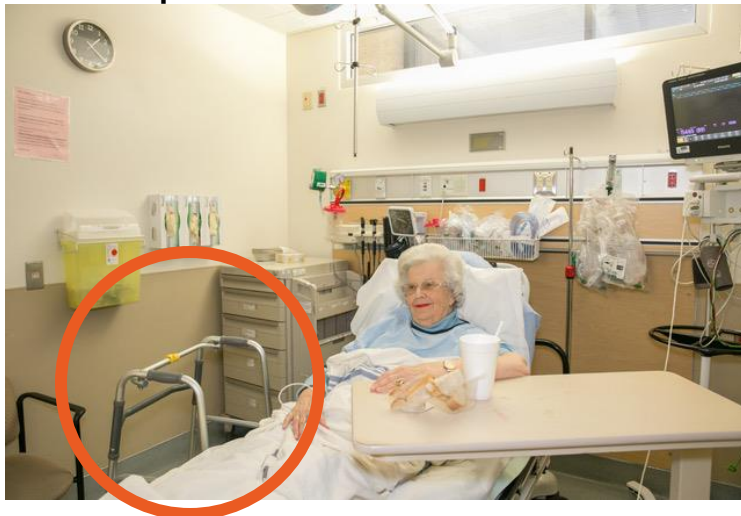
Evaluation

- 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!



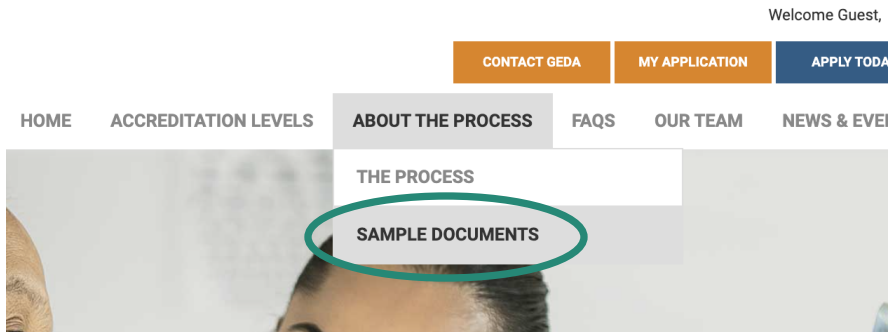
Access to Nutrition

- 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



Welcome Guest, [Log In](#)

[CONTACT GEDA](#)

[MY APPLICATION](#)

[APPLY TODAY](#)

[HOME](#)

[ACCREDITATION LEVELS](#)

[ABOUT THE PROCESS](#)

[FAQS](#)

[OUR TEAM](#)

[NEWS & EVENTS](#)

Sample Documents

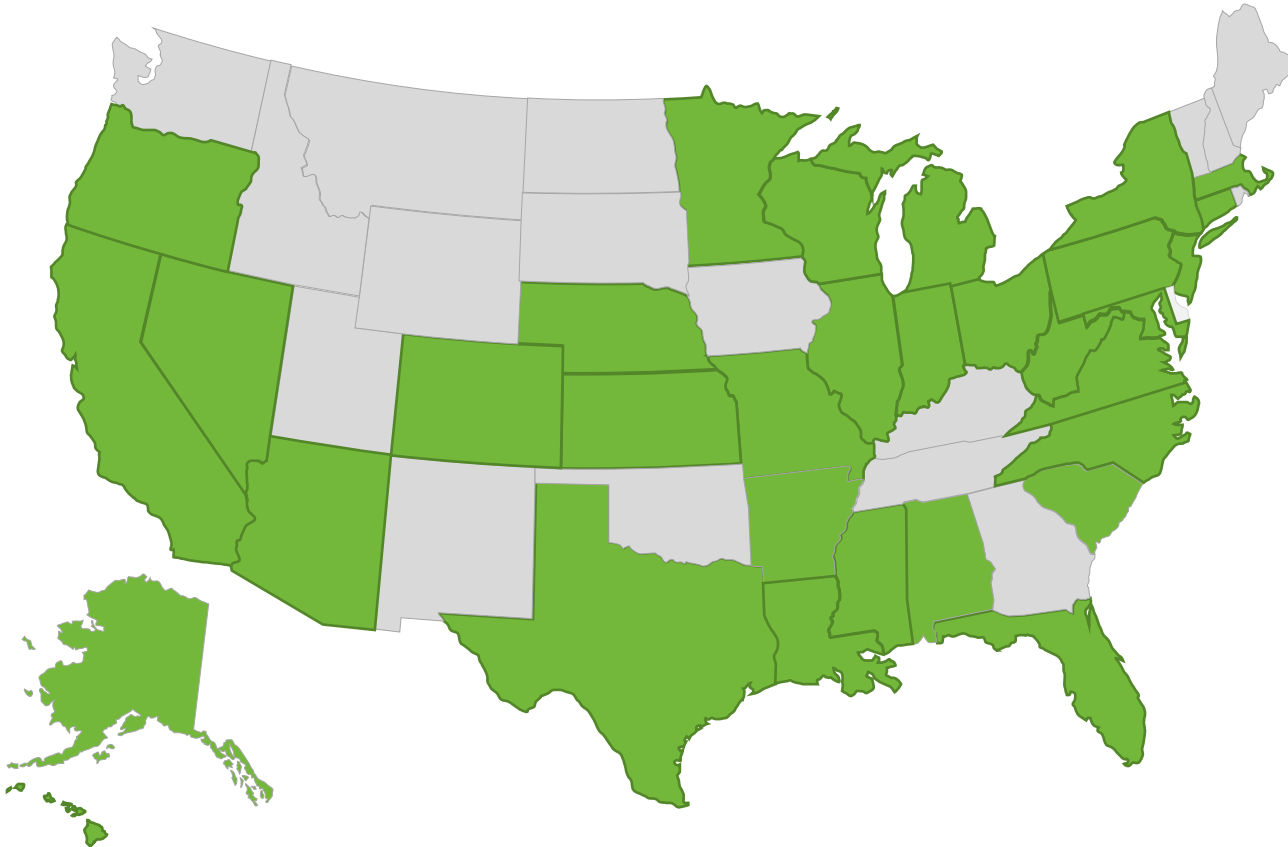
To facilitate the application process, we recommend that you gather the appropriate documentation before beginning the application. Below is a checklist of some of the documents needed to complete the application. Sample documents for these items have been provided below. Documents must be uploaded in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



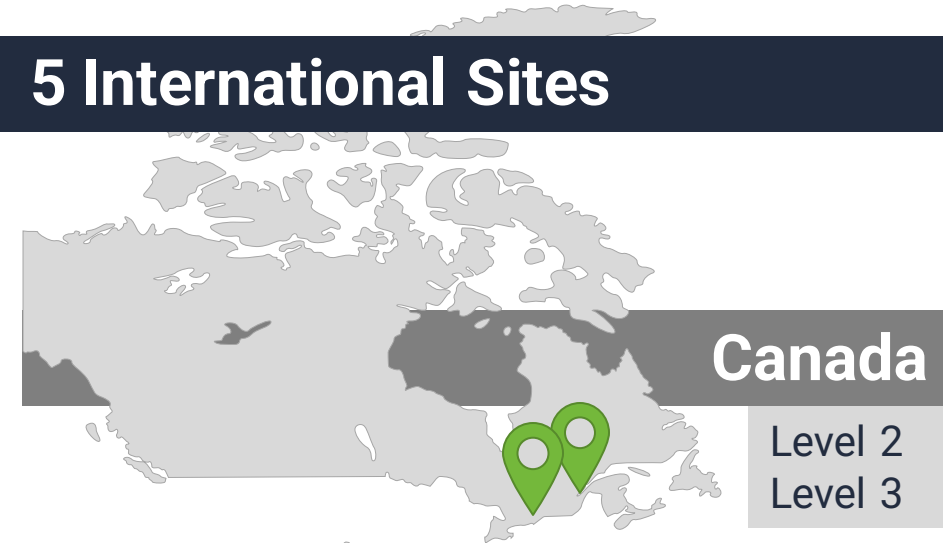
	Level 3	Level 2	Level 1
Staffing	↓	↓	↓
Education	↓	↓	↓
Policies / Protocols Guidelines & Procedures	↓	↓	↓
Quality Improvement		↓	↓
Outcome Measures		↓	↓
Equipment & Supplies		↓	↓
Physical Environment	↓	↓	↓

412 Accredited Sites

Nationally: 412 across 45 states



5 International Sites



Canada

Level 2
Level 3



Brazil

Level 3



Spain

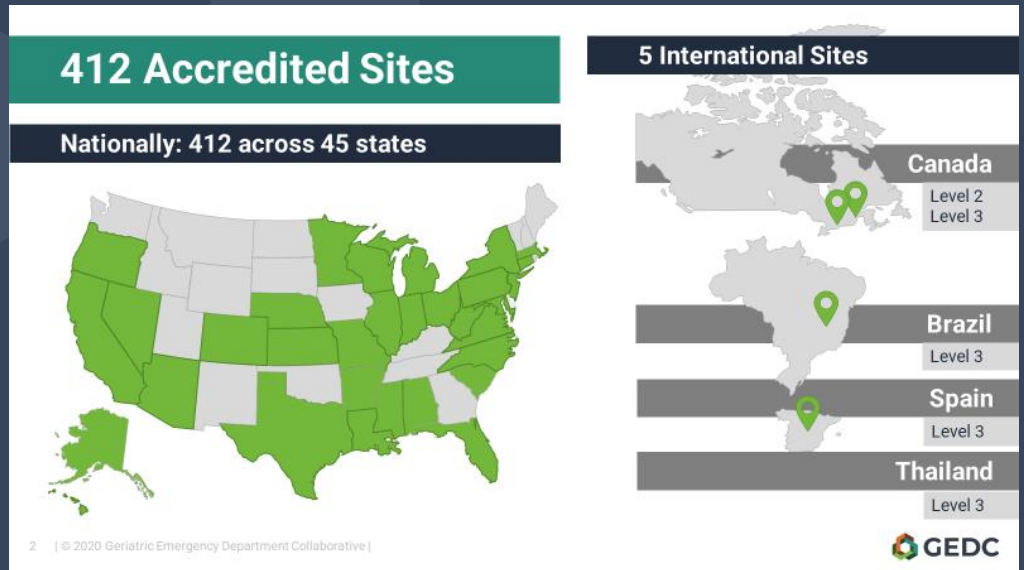
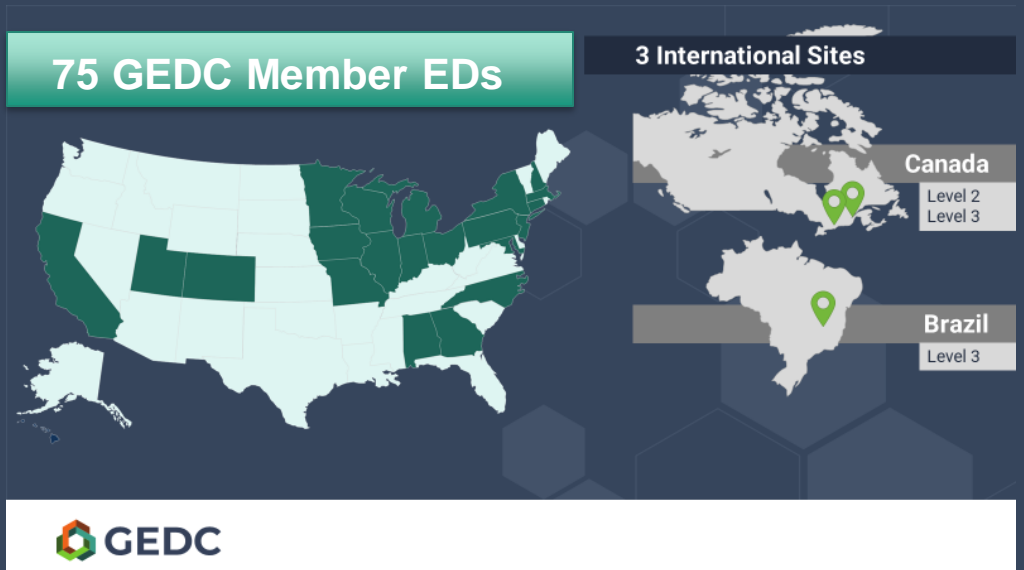
Level 3



Thailand

Level 3

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

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
Pam Martin



Mrs. Cado
78-year-old woman
with a broken wrist
“ready for discharge”
With your GEDC Expert
Don Melady



Mrs. Schwach
80-year-old woman,
not feeling right
“Mom seems a
little off”
With your GEDC Expert
Tess Hogan



Mrs. Perdito
79-year-old
woman, unclear
reasons for visit;
“must be a UTI”
With your GEDC Expert
Kira Gossack-Keenan

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

Mrs. Schwach

Challenges?

Care processes?

Mrs. Perdito

Challenges?

Care processes?

The background is a solid teal color with a repeating pattern of light teal hexagons. Each hexagon is connected to its neighbors by thin lines, creating a honeycomb-like structure.

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

Geriatric Emergency Department Processes

ISAR Screening Tool:

Identification of Senior At Risk (ISAR)

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



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

Triage
4 patients have a similar name to this patient.

QUICK TRIAGE
BestPractice
Arrival Info
Arrival Doc
Chief Complaint
ED Triage Notes
Infectious Screening
Vitals
Pain Assessment
Triage Treatment
Primary Assess
Allergies
Acuity

COMPREHENSIVE TRIAGE
Home Medications
History
Abuse Indicators
Annotated Images
Immun Update
Immun. Rpt
ISAR Elder Alert
Triage Complete

ADVANCED DIRECTIVES
AD History
Documentation

SCREENING
Columbia Suicide
Suicide Interventi...
Sepsis Report
Sepsis Screening

ISAR Elder Alert - ISAR Elder Alert

Time taken: 0820 1/21/2020

Values By + Create Note

ISAR Elder Alert

Before the illness or injury that brought you to the Emergency, did you need someone to help you on a regular basis?

In the last 24 hours, have you needed more help than usual?

Have you been hospitalized for one or more nights during the past 6 months?

In general, do you have serious problems with your vision, that cannot be corrected with glasses?

In general, do you have serious problems with your memory?

Do you take six or more different medications every day?

ISAR Score

Restore Close Cancel

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.”

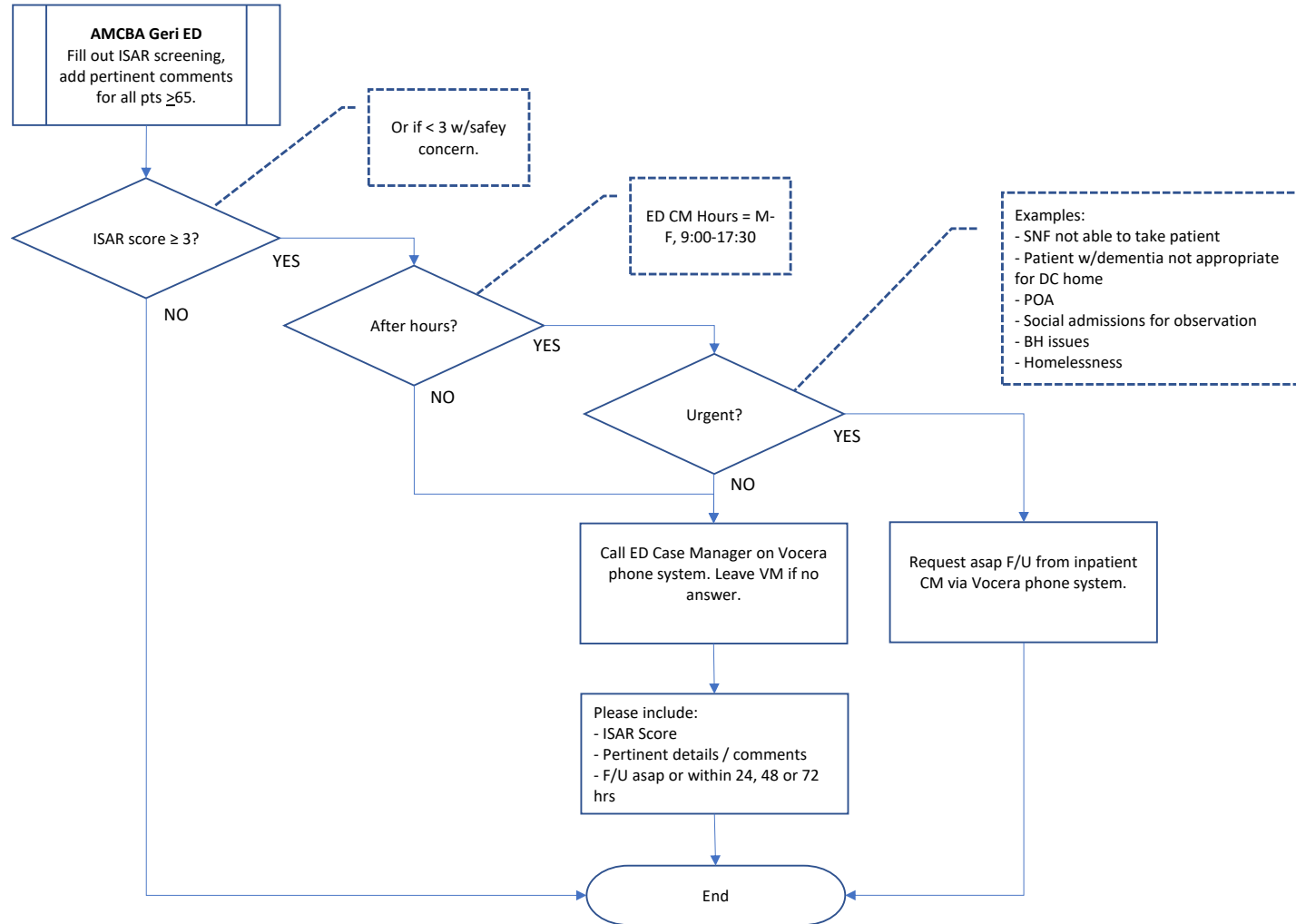
“Family has been staying and helping out, including frequently spending the night there.”

Assigned Nurse	ISAR, %	ISAR, totals	Comments, %	Comments, totals
	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

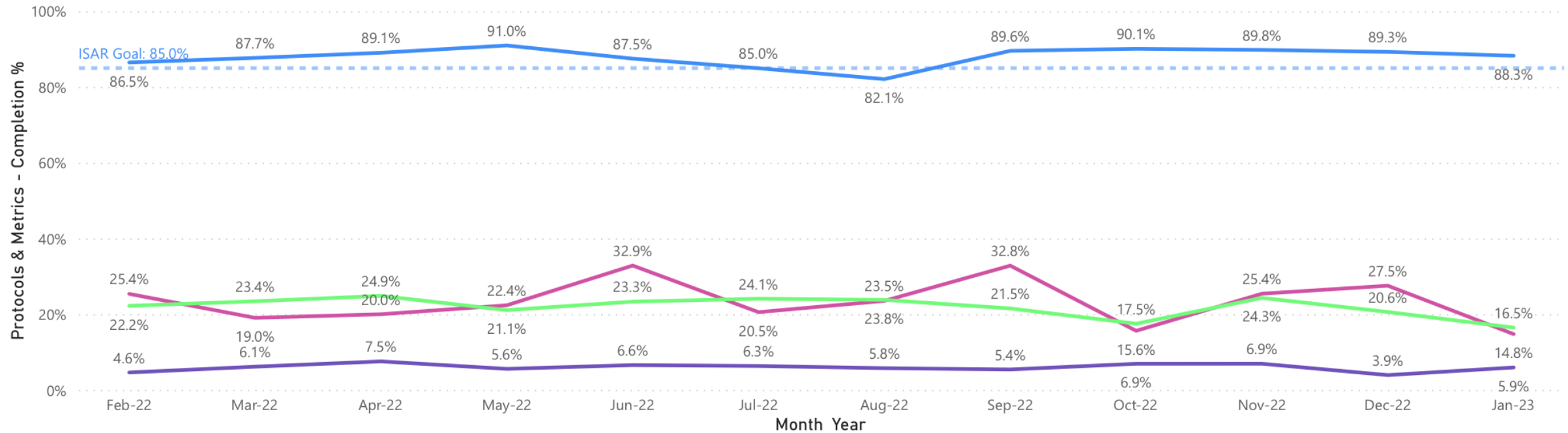
ISAR: RN-CM Workflow Example



ISAR : Metrics & Dashboard Example

Trend Lines - Geri ED Protocols & Metrics

● ISAR Complete ● Comments Complete ● 30 Day Returns ● 72 Hr Returns



◀ ▶
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

21% Reduction in ED revisits!!

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

Pre CM FTE (April 2022)

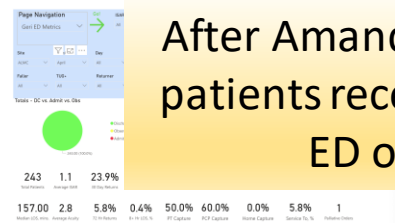
n= 243

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 condition¹



Delirium is associated with **2 million** emergency department visits per year^{2,3}



2

Days increased length of stay with delirium in the ED³

37%

Mortality in patients with ED delirium vs. 14% in patients without⁴

2x

Risk of nursing home or post-acute placement⁵



\$8 BILLION

Medicare yearly hospital expenditures related to delirium⁶

\$150 BILLION

Estimated yearly post-acute care costs due to delirium⁶

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

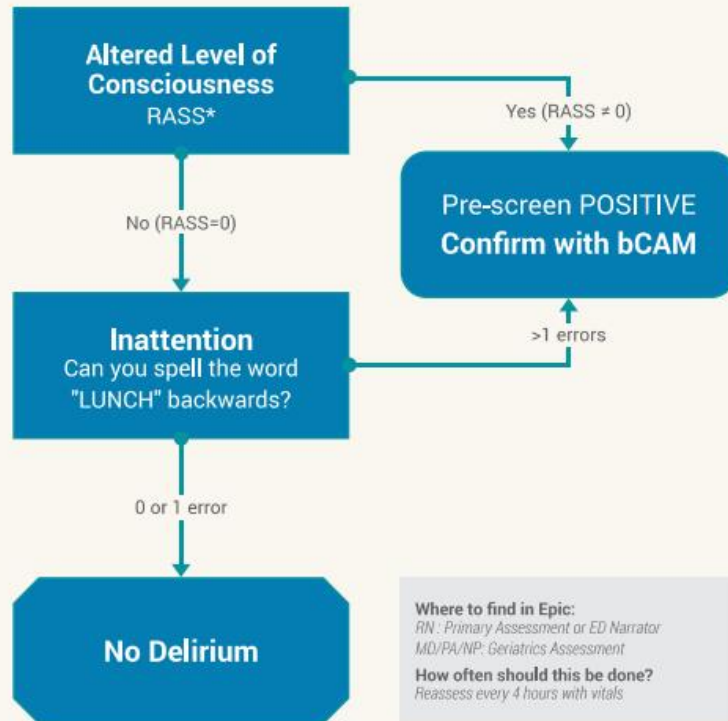
*DTS is a modified version of the Confusion Assessment Method (CAM) instrument. †UB-2 is a modified version of the Confusion Assessment Method (CAM) instrument.

DELIRIUM SCREENING - DTS + BCAM



ED Quick Delirium Screen

aka: Delirium Triage Screen (DTS)

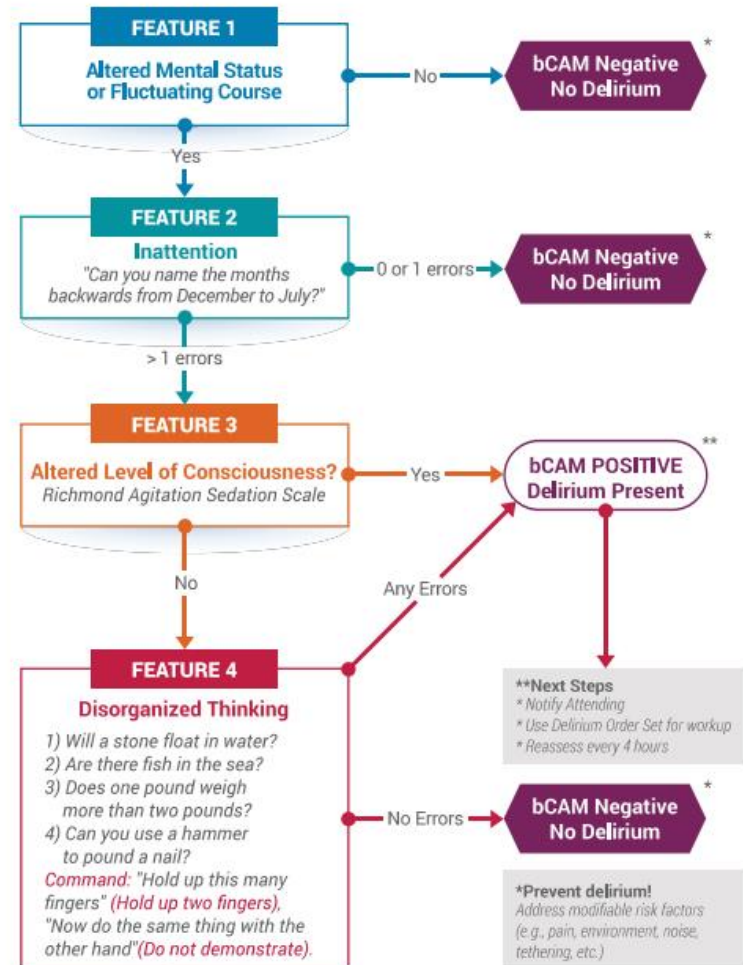


* Richmond Agitation Sedation Scale (RASS)

-5	-4	-3	-2	-1	0	+1	+2	+3	+4
Unarousable	Deep Sedation	Moderate Sedation	Light Sedation	Drowsy	ALERT CALM	Restless	Agitated	Very Agitated	Combative
VOICE					TOUCH				



Brief Confusion Assessment Method (bCAM) Flow Sheet



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

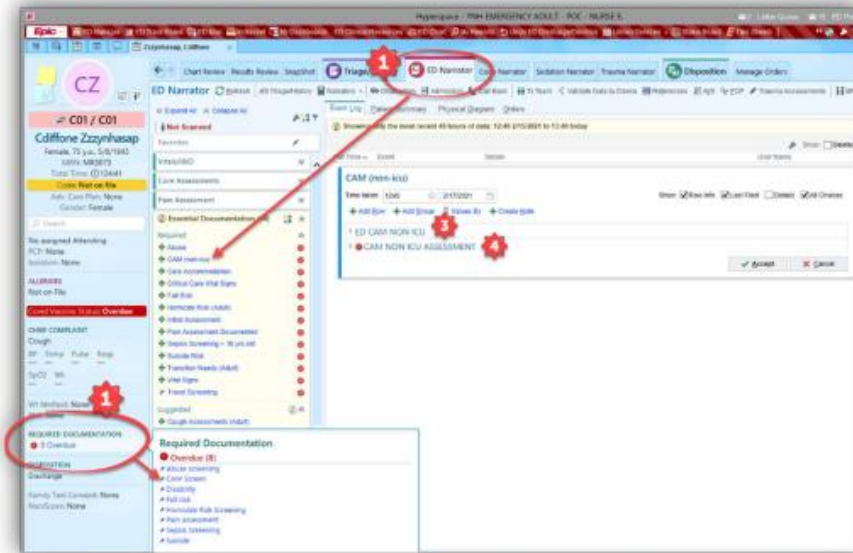
Yale New Haven Health System Process

- Geri – ED strategic team meetings
- Care signature pathways

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.



Epic, Emergency Department - Confusion Assessment Method (CAM)

The Confusion Assessment Method (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.

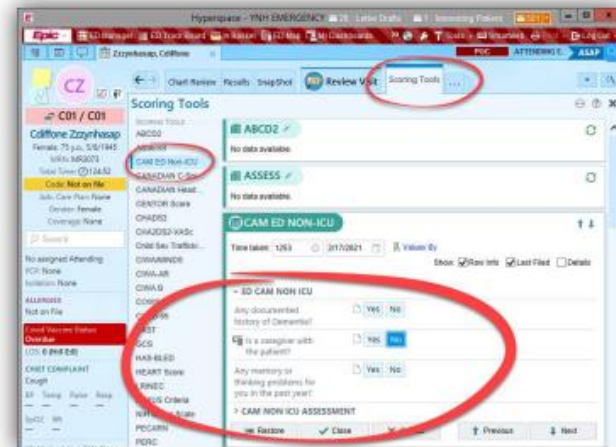
CAM Assessment - Providers

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.



Storyboard Reminders: Geriatric Delirium

PCP: Swanson, Frank Peter, MD
COVID-19 Vaccine: Overdue for booster dose
Iso Reason: R/O COVID-19
Isolation: None

- ✓ Launch Adult ED Resus Pthway
- ✓ Launch ED Syncope Eval and Disp Pathway
- ✓ Launch ED Geriatric Delirium Pathway

Total Time: 06:25

Code: Not on file

Adv. Care Plan: None
Primary Cvg: Medicaid Connecti...

Search

Suwondo, David, MD
Attending

PCP: Pcp, Does Not Have A
COVID-19 Vaccine: Unknown
Iso Reason: R/O Respiratory
Virus, R/O COVID-19
Isolation: COVID, COVID

✓ Launch ED Geriatric Delirium Pathway

ALLERGIES
No Known Allergies

LOS: 0 (H:0 E:1)

CHIEF COMPLAINT
Confirmed Coronavirus(Covid-19)

BP	Temp	Pulse
174/77 !	98.4 °F (36.9 °C)	69

Resp	SpO2	Wt
20	94%	—

Wt Method, Last BMI: None, None

RESULTS ▾

- 🚨 Labs (3 New)
- 📺 Imaging (1 New)
- 📶 ECG (1 New)

Pathways

New pathways features. [Learn more](#)

BACK

Geriatric Delirium: Adult ED

For screening, workup, treatment and prevention of geriatric delirium



Pathway Context

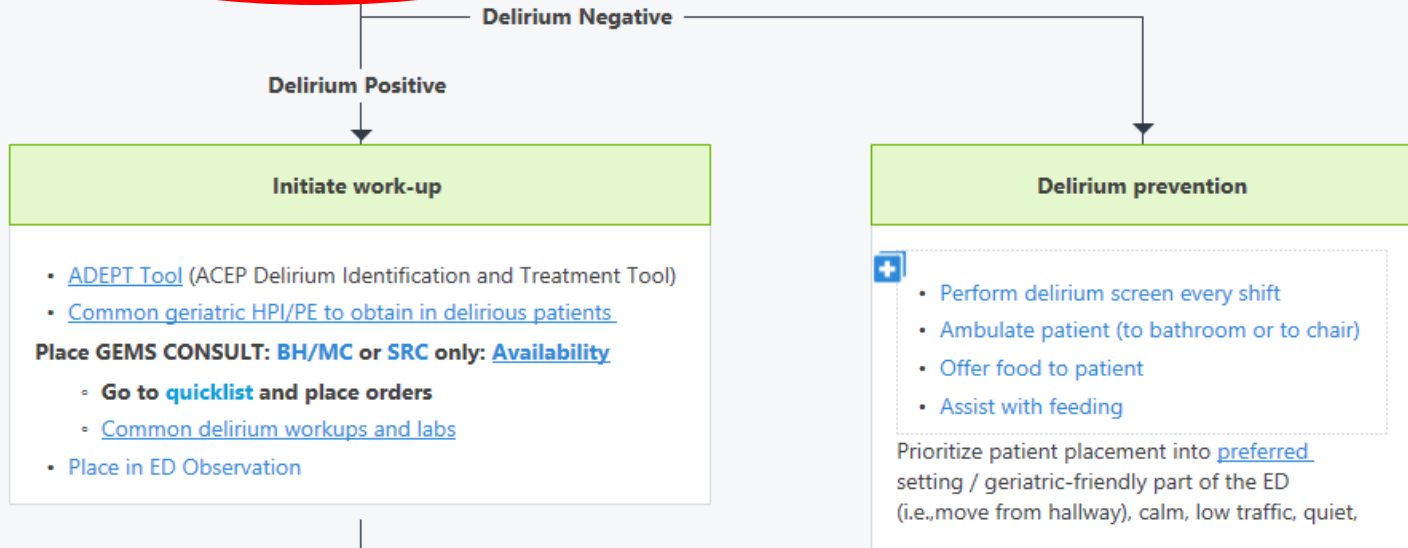
- [Goal Metrics / Authors](#)
- [References](#)
- [Suggestion Criteria](#)
- [Restraint Guidance](#)

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.



What type of delirium do they have?

Does workup reveal a cause of acute worsening in cognition?

Delirium via Confusion Assessment Method (CAM)

The screenshot shows the 'Scoring Tools' interface for the CAM ED NON-ICU tool. On the left is a sidebar with a list of scoring tools, including ABCD2, AMPAC Mobility..., ASSESS, CAM ED Non-ICU (highlighted), CANADIAN C-Sp..., CANADIAN Hea..., CENTOR Score, CHADS2, CHA2DS2-VASc, Child Sex Traffic..., CIWA/MINDS, CIWA-AR, CIWA B, COWS, CURB-65, DAST, GCS, HAS-BLED, HEART Score, LRINEC, NEXUS Criteria, NIH Stroke Scale, and PERC. The main panel is titled 'CAM ED NON-ICU' and contains the following information:

- Time taken: 12/23/2021 0703 Responsible
- ED CAM NON ICU
- Any documented history of Dementia? Yes No
- Is a caregiver with the patient? Yes No
- Any memory or thinking problems for you in the past year? Yes No
- CAM NON ICU ASSESSMENT
- 1. Acute Onset or Fluctuating Course (Mental Status) Yes No
- 2. Inattention Yes No
- 3. Disorganized Thinking Yes No
- 4. Altered level of consciousness Yes No
- Result of CAM (Non ICU) Positive
- Buttons: Restore, Close, Cancel

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***

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 treatment 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

YES

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

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

- 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
Lozapam 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

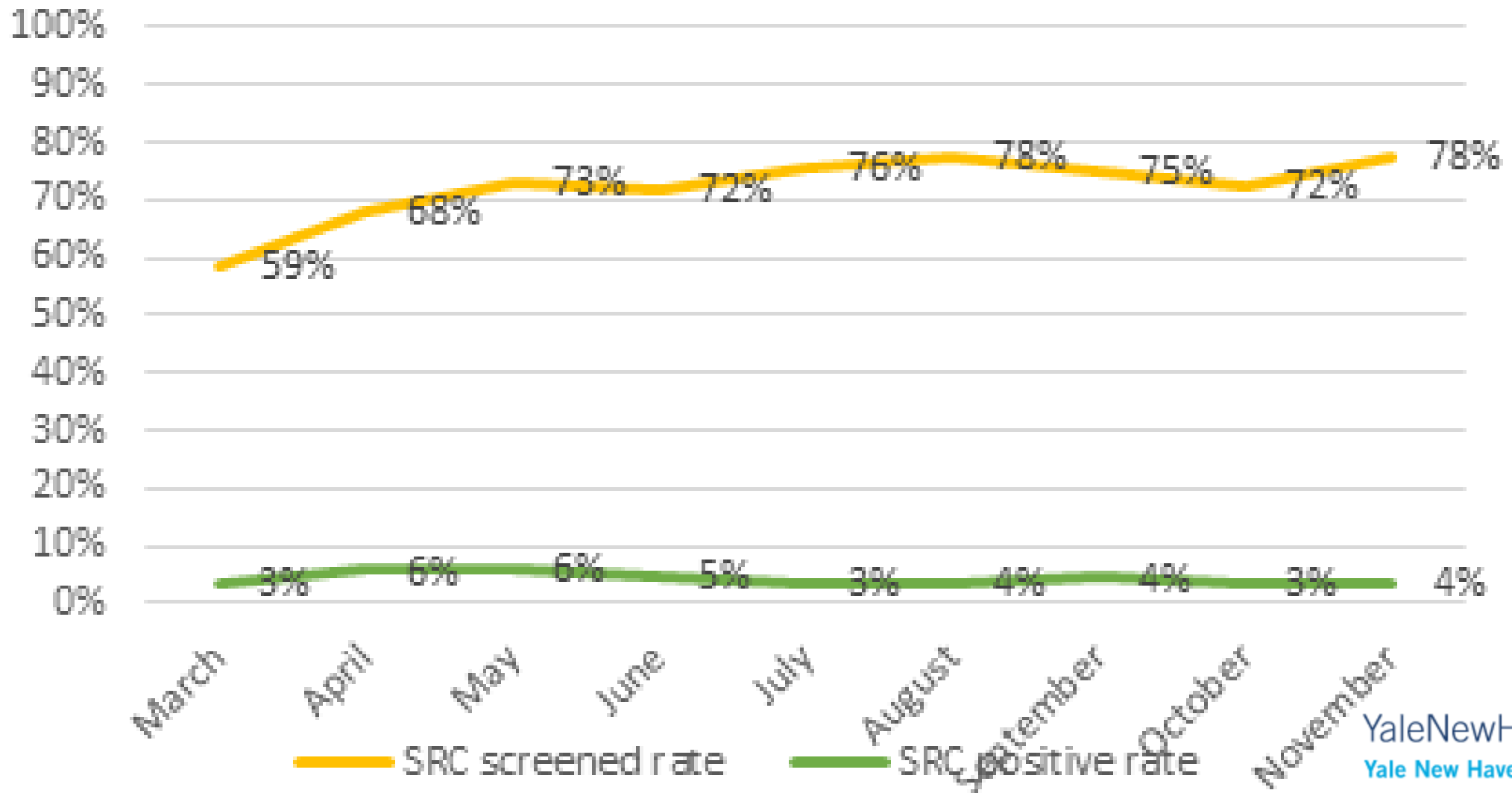
- [Medicine admission order](#)
- [SDU admission order](#)
- [ICU admission order](#)
- [Medicine OBSERVATION admission order](#)

Discharge

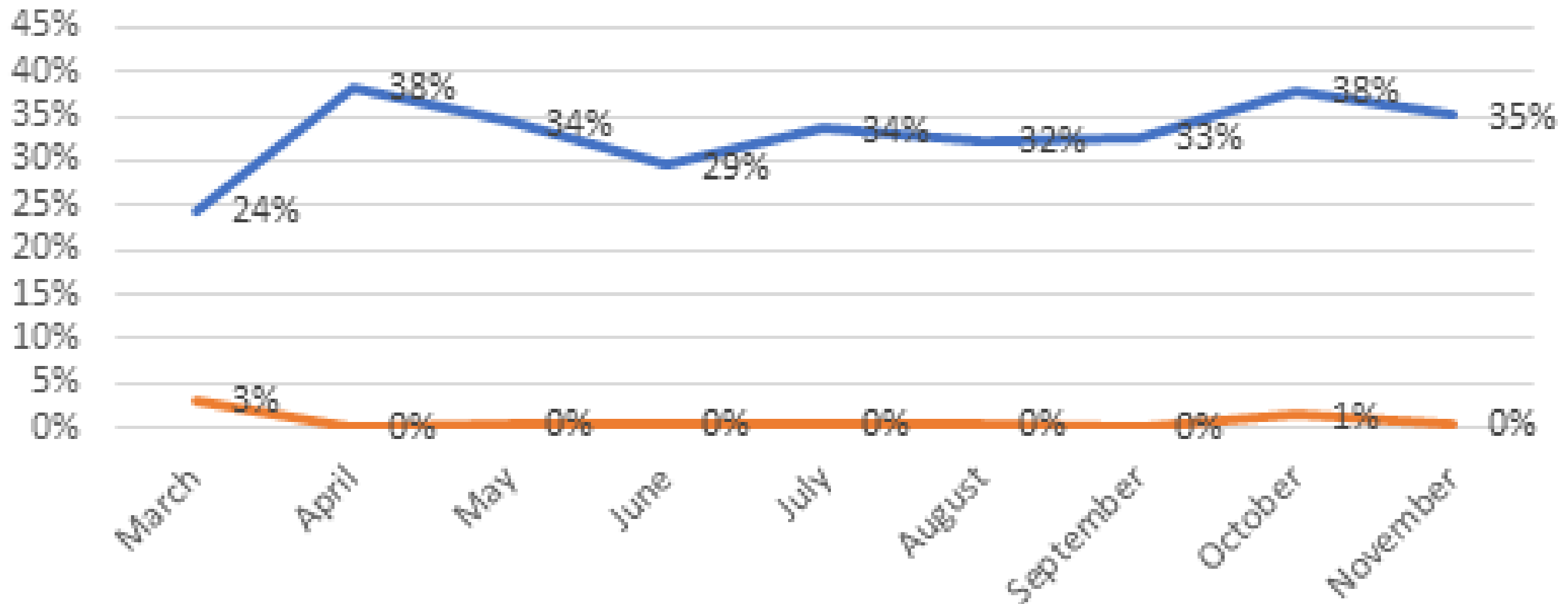
Good discharge instructions based on discharge planning conversations

If you feel they have baseline memory or thinking problems, please refer to [Adler Center Referral](#)

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



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



— SMC screened rate

— SMC positive rate

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

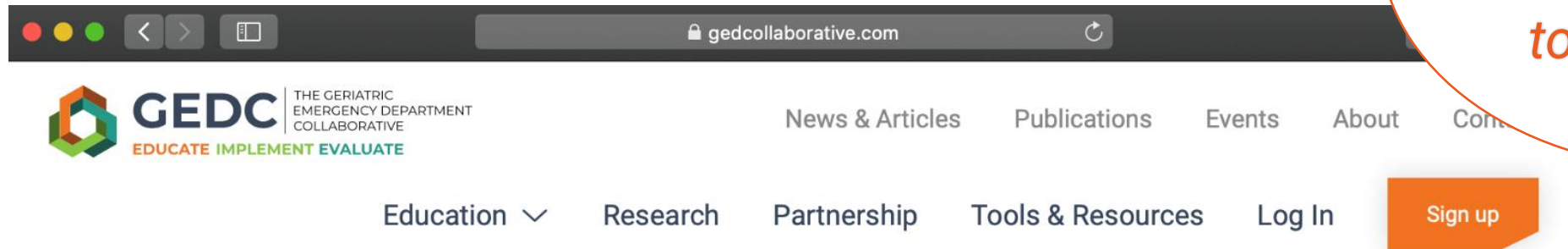
Aaron Malsch, MS, RN, GCNS-BC

Advocate Aurora Health
Senior Services Department
Geri ED Program Manager

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*

Management of Older
Adult Falls and Mobility
in the Emergency
Department



An Implementation Toolkit

FOAM Protocol

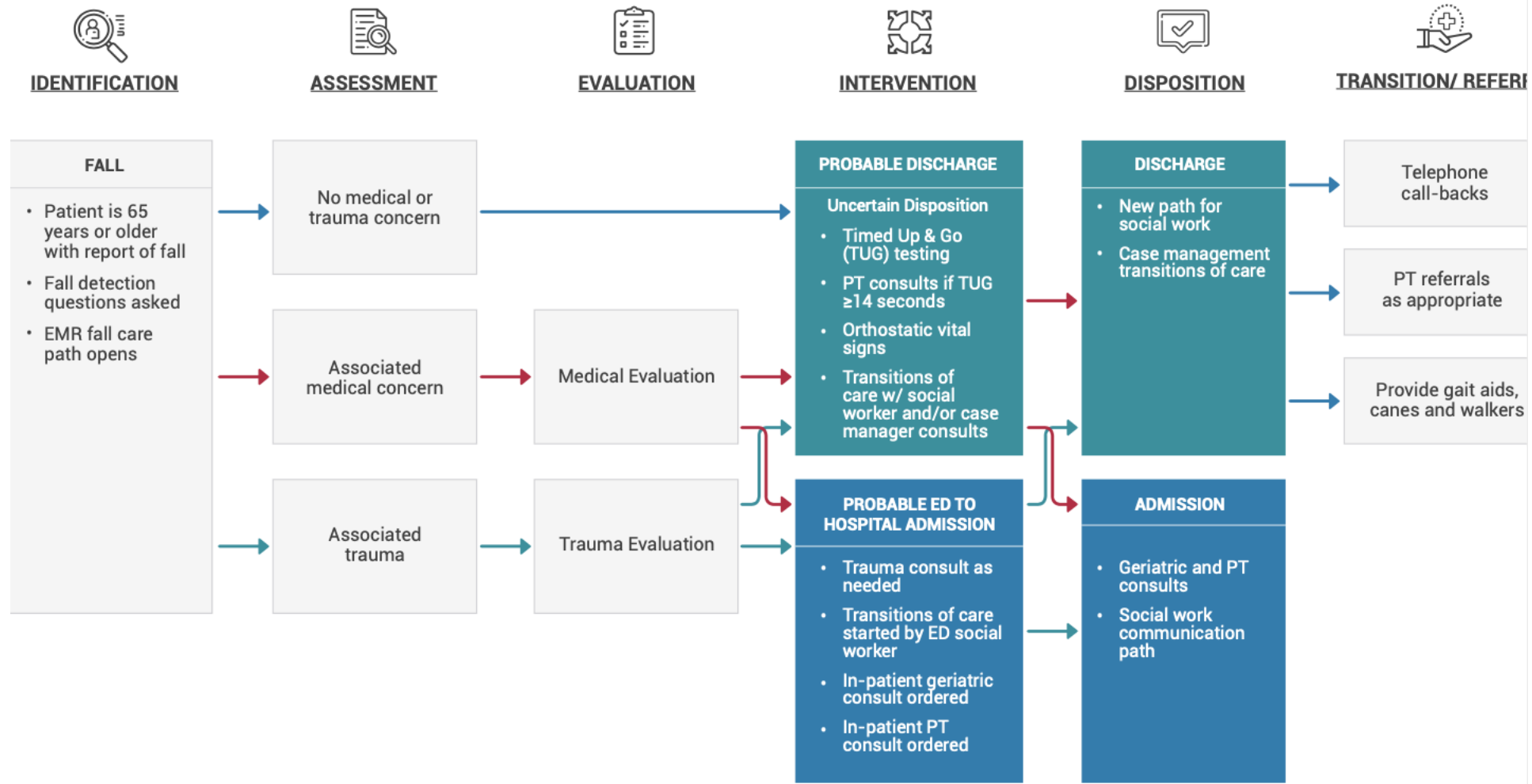
INITIATING AT BEDSIDE

Note: Tailor to your specific needs and resources



FALLEN OLDER ADULT MANAGEMENT (FOAM) PROTOCOL

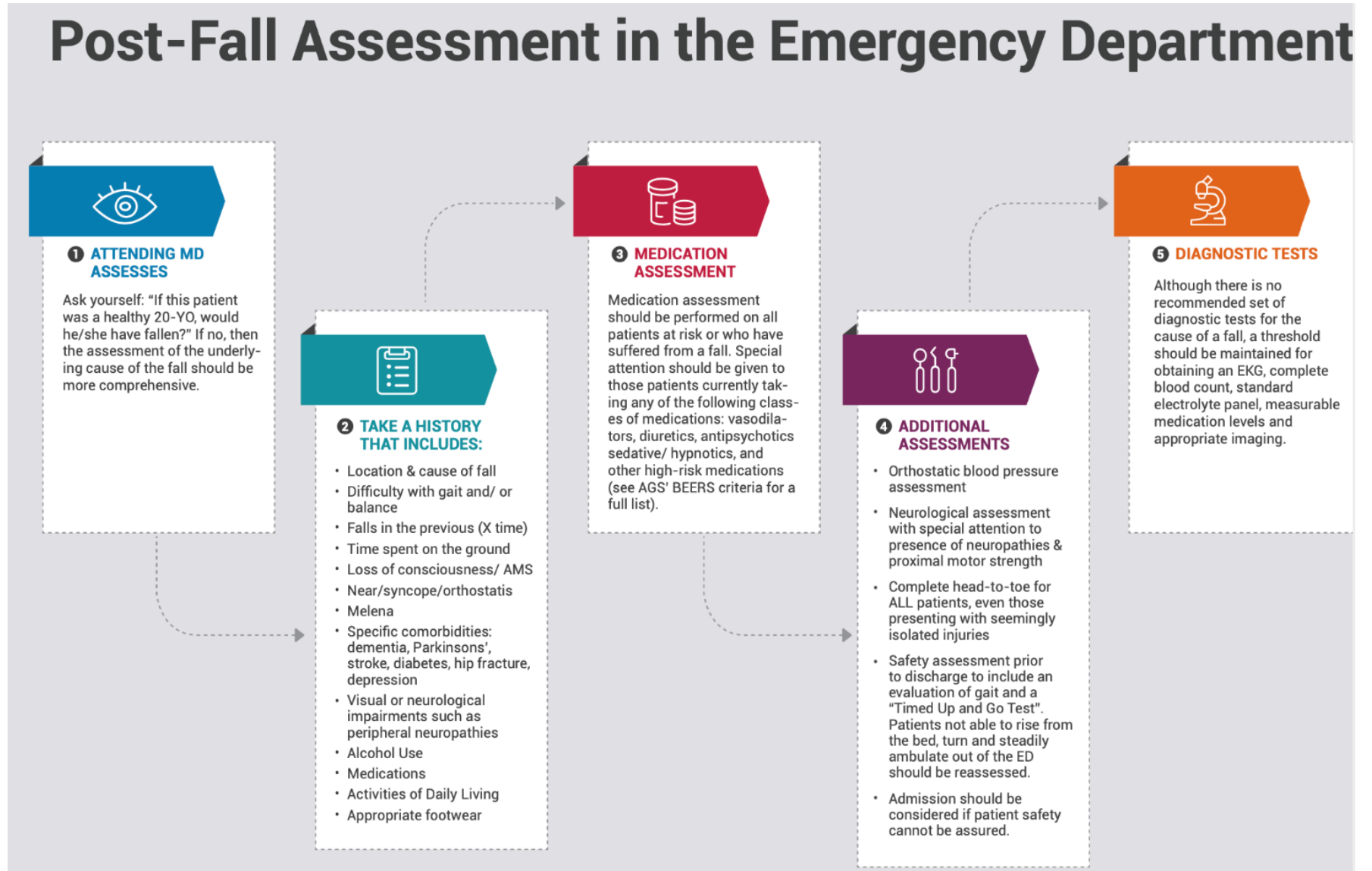
Note: This is an example - Your protocol may vary



Post-Fall Assessment

INITIATING AT BEDSIDE

Note: Example of potential assessments



TUG Test & Interpretation

INITIATING AT BEDSIDE



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	11.0 seconds	2.2
	With device	19.9 seconds	6.4
	Overall	13.6 seconds	5.6
90-101	Without device	14.7 seconds	7.9
	With device	19.9 seconds	2.5
	Overall	17.7 seconds	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.



Safe Mobility in the ED

ED-WIDE
IMPLEMENTATION

ENABLING SAFE MOBILITY IN THE ED

EQUIPMENT & DESIGN ELEMENTS TO PREVENT FALLS WITHIN THE ED

Even floor
surfaces

Rubber or
nonskid floor
surfaces/
mats

24/7 access
to mobility
assist
devices

Handrails
on walls and
hallways

Bedside
commodes
and grab bars
in restrooms

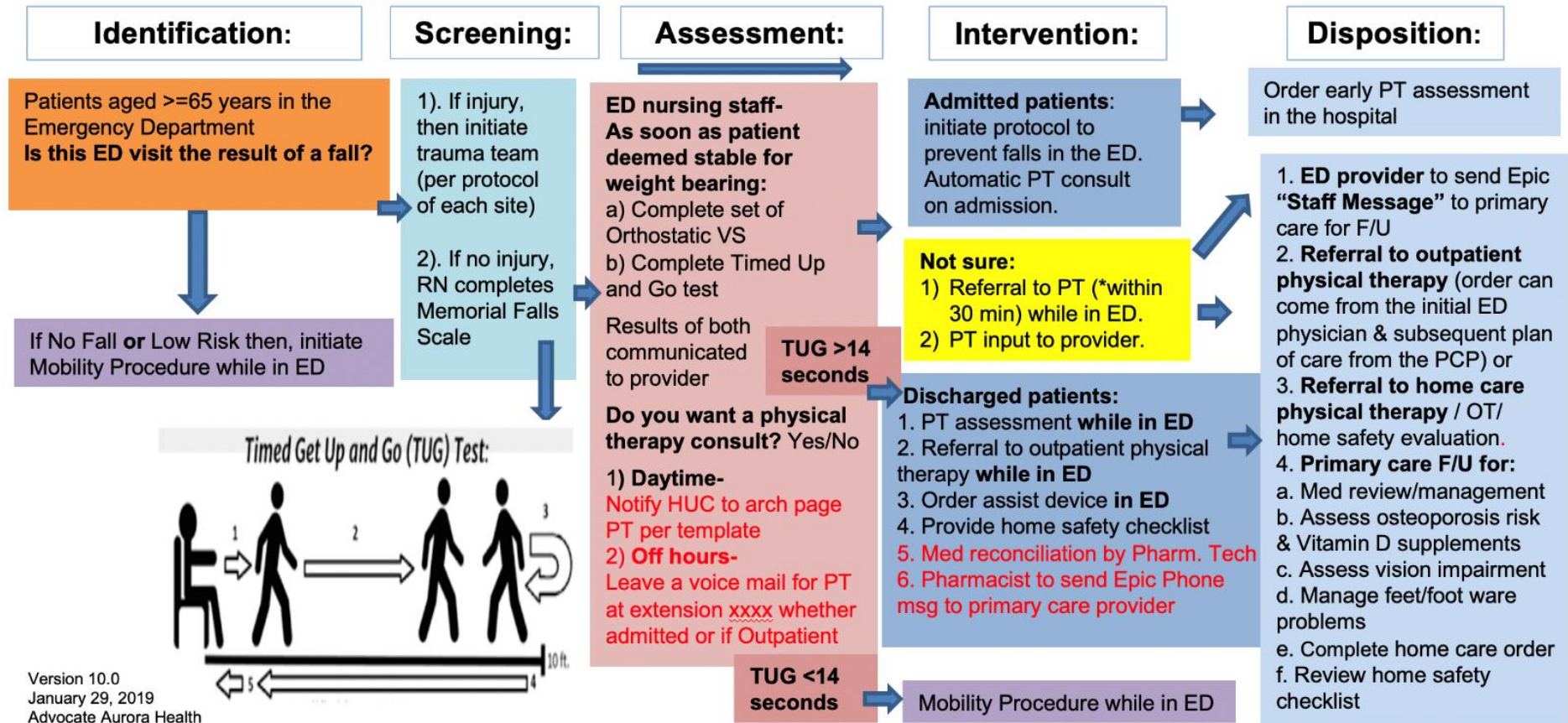
Aisle
lighting



AAH Falls & Mobility Protocol

Example of tailoring the FOAM Protocol, Assessment, & Interventions

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



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

AAH Geriatric Emergency Department: AdvocateAuroraHealth

ISAR Screening, RN Comments, CM Trigger, BPA's, & ED ISAR Pool

ED ISAR tab provides a review of all 6 questions of the ISAR and the specific answers. Additionally, the RN comments are displayed to assist the CM/SW in identifying the specific needs of the patient. The current visit's ED charges, arrival & disposition information, and discharge orders are displayed to efficiently understand the patient's context. This is particularly helpful when retrospectively reviewing cases for possible follow-up.

AAH Geriatric Emergency Department: AdvocateAuroraHealth

ISAR Screening, RN Comments, CM Trigger, BPA's, & ED ISAR Pool

2. Two additional tables that has specific information about each RN's rate of ISAR completion and comments. Again, we have a goal of 85% ISAR completion rate and 50% goal for comments. In the table is the volume of patients assigned to each RN, ISAR by 'assigned' and 'taken by', and comment rate 'take by' RN.

RN	Total # of Patients	Patients with ISAR	% ISAR Completed per Assignment
1	25	20	80%
2	25	20	80%
3	25	20	80%
4	25	20	80%
5	25	20	80%
6	25	20	80%
7	25	20	80%
8	25	20	80%
9	25	20	80%
10	25	20	80%
11	25	20	80%
12	25	20	80%
13	25	20	80%
14	25	20	80%
15	25	20	80%
16	25	20	80%
17	25	20	80%
18	25	20	80%
19	25	20	80%
20	25	20	80%
21	25	20	80%
22	25	20	80%
23	25	20	80%
24	25	20	80%
25	25	20	80%
Total	625	500	80%

RN	Total # of Patients	ISAR Taken by	% ISAR Taken by	% Comments
1	25	10	40%	10%
2	25	10	40%	10%
3	25	10	40%	10%
4	25	10	40%	10%
5	25	10	40%	10%
6	25	10	40%	10%
7	25	10	40%	10%
8	25	10	40%	10%
9	25	10	40%	10%
10	25	10	40%	10%
11	25	10	40%	10%
12	25	10	40%	10%
13	25	10	40%	10%
14	25	10	40%	10%
15	25	10	40%	10%
16	25	10	40%	10%
17	25	10	40%	10%
18	25	10	40%	10%
19	25	10	40%	10%
20	25	10	40%	10%
21	25	10	40%	10%
22	25	10	40%	10%
23	25	10	40%	10%
24	25	10	40%	10%
25	25	10	40%	10%
Total	625	250	40%	50%

How are the tables calculated:

- Patients without ISAR are sorted by "ASSIGNED NUMBER"
- Patients with ISAR are sorted by "ISAR TAKEN BY"
- Patient comments are calculated by the "ISAR TAKEN BY" RN
- New Key: This table is based on the table
- PLEASE NOTE: This is not meant to be a punitive report, rather a means to highlight those who achieve a high level of practice.

and CM/SW Consultation: Consultation of Senior At Risk)

ed volumes of scores will vary at each ED, as will the resources both during on and off hours. Variations on the process of how Case Management will be triggered for consulting based on resources. Below is representative distribution of a mid-sized ED.

to bring additional functionality. We envision presenting prioritized patients (high, med, low), and date. Additionally, we plan on adding a new tab to embed a note, and extract pull data. Please provide Aaron with recommendations for

AAH Geriatric Emergency Department: AdvocateAuroraHealth

ISAR Screening, RN Comments, CM Trigger, BPA's, & ED ISAR Pool

End Users Affected: RN, SW, CM

Older Adults in the ED:

Older patients are a uniquely vulnerable population at high risk for these poor outcomes as identified by the Geriatric Emergency Department Guidelines. Recognizing the increased risk of adverse outcomes among older adults, these guidelines recommend that "All geriatric patients, regardless of the presenting complaint shall be screened (on the initial index visit, not follow-up visits) using the Identification of Seniors at Risk (ISAR) tool or a similar risk screening tool..."

The ISAR (Identification of Seniors At Risk) tool is a simple 6 question screening tool to identify and communicate the risk older adults in the Emergency Department. Scores range from 0-6, six being the highest risk. The score of ≥ 2 ISAR is considered at risk and document of the comments concerning the specifics of the patient situation facilitates the tailoring of a care plan to the patient's needs.

ISAR Documentation

1. Document the ISAR Elder Alert. The ISAR screening tool is found in the Triage, ED Narrator, and Discharge Navigator. The section shows for patients 65 and older. All patient 65 and older are to be screened.

The distribution and volumes of scores will vary at each ED, as will the resources both during on and off hours. Each site will have variations on the process of how Case Management will be triggered for consulting.

AAH Geriatric Emergency Department

Falls & Mobility Procedure Training

March 2020

AdvocateAuroraHealth

Mobility Documentation

- Go to the nursing procedures toolbox

Nursing Procedures

- + Wound Procedure
- + Splint/Cast/Brace
- + **Mobility**
- + Visual Acuity
- + Ear/Eye Irrigation
- + Bladder Scan/Straight Cath
- + Phlebotomy
- + Enema
- + Gastric Lavage
- + ECG Interpretation Date/Time

Find an Event

+ Add

Mobility

Time taken: 1523 1/22/2020

Show: Row Info Last Filed All Choices

+ Add Row + Add Group Values By + Create Note

▼ Mobility

Activity

<input type="checkbox"/> Ambulated	<input type="checkbox"/> Bedpan given	<input type="checkbox"/> Bed rest (MD order)	<input type="checkbox"/> Bedside commode
<input type="checkbox"/> Chair (all types)	<input type="checkbox"/> Dangled	<input type="checkbox"/> Extremity elevation/i...	<input type="checkbox"/> Head of bed elevation
<input type="checkbox"/> Off unit	<input type="checkbox"/> Pivot	<input type="checkbox"/> Pushing	<input type="checkbox"/> Range of motion
<input type="checkbox"/> Resting in bed	<input type="checkbox"/> Sleeping/Appeared t...	<input type="checkbox"/> Stood at bedside	<input type="checkbox"/> Turn
<input type="checkbox"/> Up ad lib	<input type="checkbox"/> Other (comment)		

Weight Bearing Status

<input type="checkbox"/> Non-weight bearing	<input type="checkbox"/> Touch weight bearing	<input type="checkbox"/> Weight bearing as tolerated
<input type="checkbox"/> Heel walking	<input type="checkbox"/> Partial weight bearing (specify)	<input type="checkbox"/> Other (comment)

Mobility Assistive Device

<input type="checkbox"/> Brace	<input type="checkbox"/> Cane	<input type="checkbox"/> Ceiling lift	<input type="checkbox"/> Crutches	<input type="checkbox"/> Gait belt
<input type="checkbox"/> Prosthesis	<input type="checkbox"/> Sit to stand	<input type="checkbox"/> Slide board/sheet	<input type="checkbox"/> Splint	<input type="checkbox"/> Total lift
<input type="checkbox"/> Transfer/Friction ...	<input type="checkbox"/> Trapeze	<input type="checkbox"/> Turn and position...	<input type="checkbox"/> Walker	<input type="checkbox"/> Wheelchair
<input type="checkbox"/> Other (comment)				

Level of Assistance

Independent Supervision Minimal assist Moderate as... Maximal assist Total assist

Activity Response

<input type="checkbox"/> No abnormal symptoms	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Chest pain/angina
<input type="checkbox"/> Excessive heart rate (> 90% of a...	<input type="checkbox"/> Excessive pain	<input type="checkbox"/> Dysrhythmias
<input type="checkbox"/> Diaphoresis	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Excessive dyspnea or fatigue
<input type="checkbox"/> Systolic BP > 180 mmHg	<input type="checkbox"/> Systolic BP drop > 20 mmHg fro...	<input type="checkbox"/> Systolic BP drop > 20 mmHg fro...
<input type="checkbox"/> SPO2 drop below 90%	<input type="checkbox"/> Syncope	<input type="checkbox"/> Weakness

Positioning

<input type="checkbox"/> Lying L side	<input type="checkbox"/> Lying R side	<input type="checkbox"/> Log rolled	<input type="checkbox"/> Offloading/tilt left
<input type="checkbox"/> Offloading/tilt right	<input type="checkbox"/> Rotation, automated	<input type="checkbox"/> Semi-fowlers	<input type="checkbox"/> Supine
<input type="checkbox"/> Prone	<input type="checkbox"/> Turned Q 2 hours	<input type="checkbox"/> Knee/Chest	<input type="checkbox"/> Patient refused

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

Order Search

PHYSICAL

Browse Preference List Facility List

Panels (No results found)

Medications (No results found)

Procedures

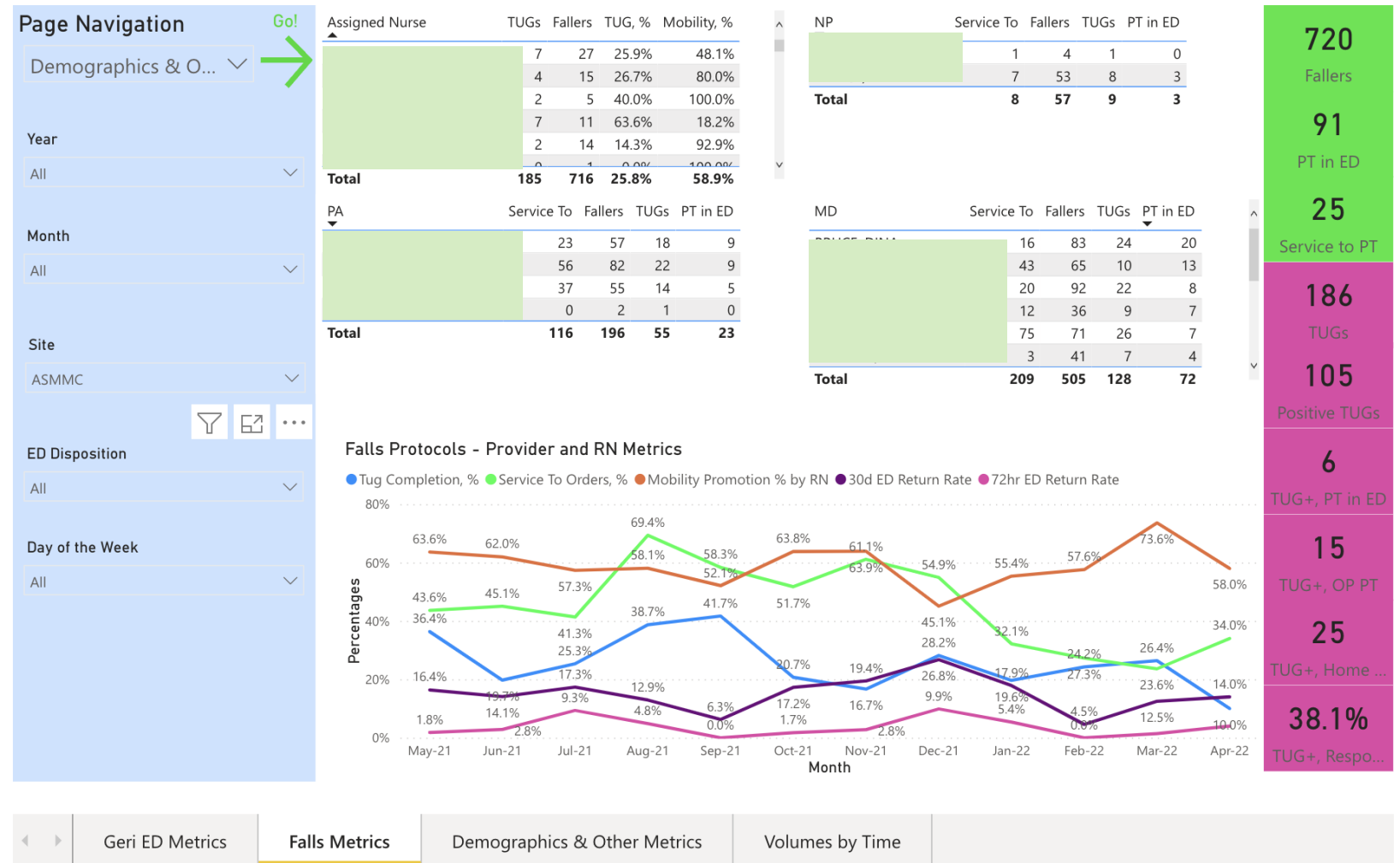
Name	Type	Pref List	Px Code
Consult PT for training	PT	ED OR...	PT4
Consult PT for training	PT	ED OR...	PT4
Chest physiotherapy (aka CHEST PHYSICAL THERAPY)	RES...	ED RE...	RT7

Select And Stay Accept Cancel

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



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

Institute for Healthcare Improvement

Age-Friendly Health Systems:

Guide to Recognition for Geriatric Emergency Department Accredited Sites

April 2022
ihi.org/AgeFriendly



Age-Friendly Health Systems

An initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI) in partnership with the American Hospital Association (AHA), United States Catholic Conference (USCC), and the Catholic Health Association of the United States (CHA).

GEDA Elements Aligned with the 4Ms

Policies, Protocols, Guidelines, and Procedures as a Component of ACEP Geriatric ED Accreditation Criteria



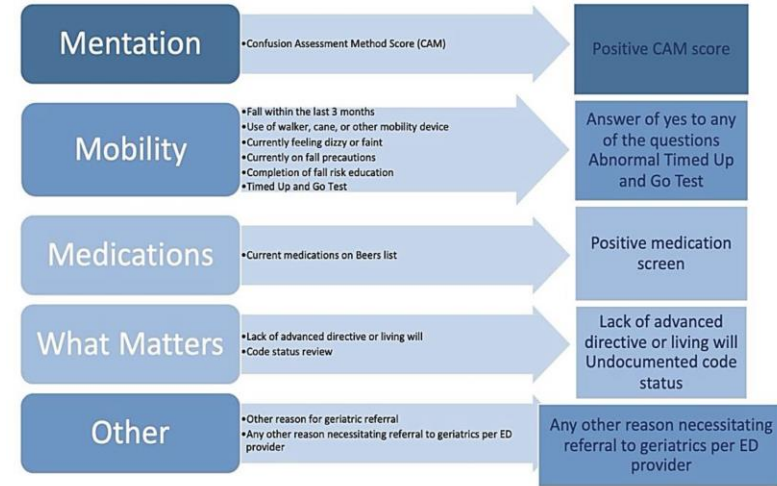
	What Matters	Medication	Mentation	Mobility
A standardized delirium screening guideline (examples: DTS, CAM, 4AT, other) with appropriate follow-up			X	
A guideline for standardized fall assessment (including mobility assessment, e.g., TUG or other) with appropriate follow-up				X
A guideline to minimize 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



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 Finebrock, DO

Geriatric 4M Screening Tool



Screening Tool Components and Assessment Tools

Geriatric 4M Process Flow

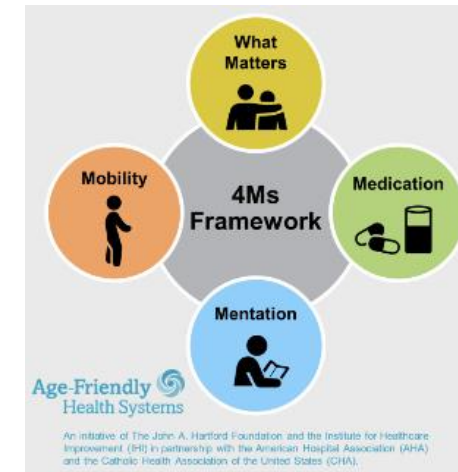
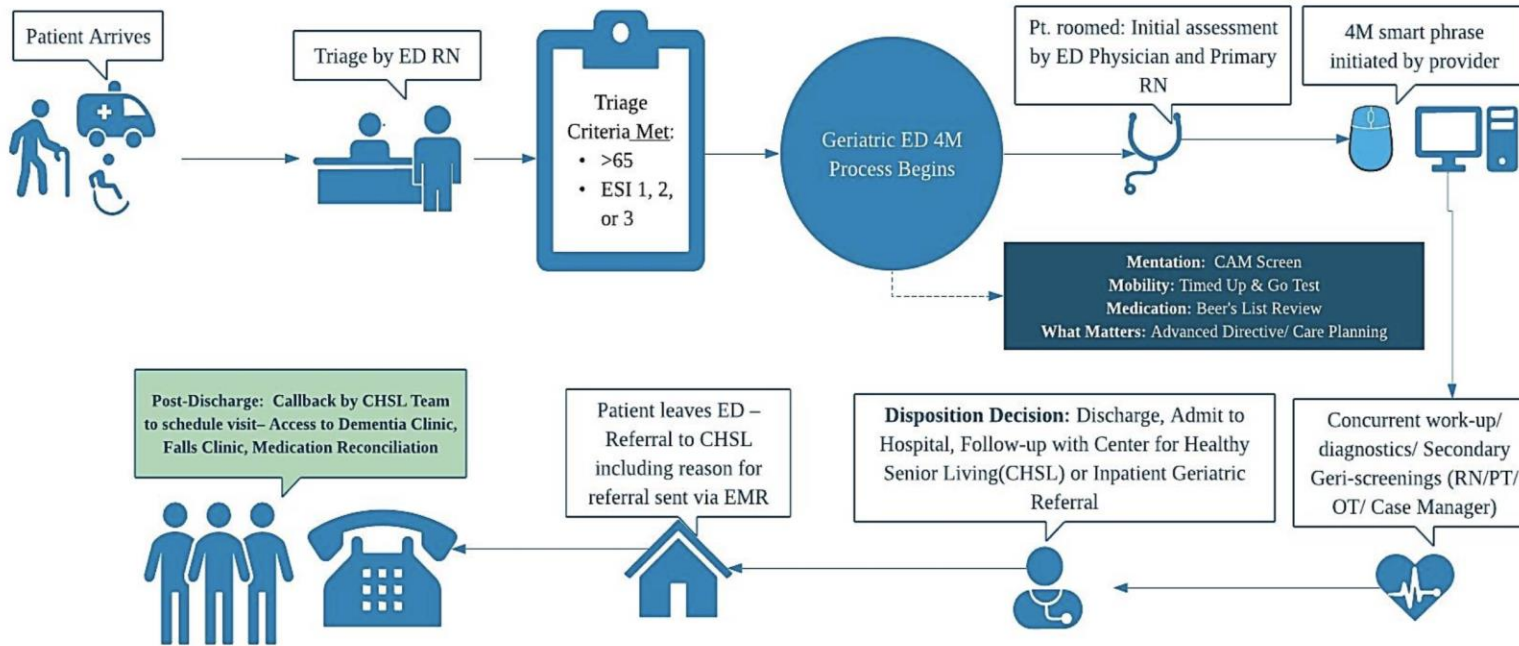


Figure 2: Geriatric Emergency Department Screening Workflow at a Level 1 Geriatric Emergency Department

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

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





Mentation RESOURCES

GEMCast Podcast

GEMCAST
Acute Brain Failure in Older Emergency Department Patients

SOUNDCLOUD
Share

26:49



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



Pitfalls of Delirium Screening in Older Adults

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

Delirium in the Geriatric ED: Processes and Possibilities



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

Medication Management in the Older ED Patient
A Geri-EM.com E-learning Module

Sign up LOG IN →

You must be logged in to complete this module.

Share on



JGEM | The Journal of Geriatric
Emergency Medicine

POLYPHARMACY AND HIGH-RISK MEDICATIONS IN OLDER VETERANS PRESENTING FOR EMERGENCY CARE

Paige L. Morizio PharmD BCPS, Vinita M. Mistry PharmD, Ashley E. McKnight PharmD BCPS, Marc J. Pepin PharmD BCPS BCGP, William E. Bryan PharmD BCPS, Ryan K. Owenby PharmD, Laura A. Preville MD MPH, Luna C. Ragsdale MD MPH

Falls and Medications

Critical Topics in Elder Mistreatment Module 1

Medication Management

Educational Course developed in collaboration with the American Geriatrics Society

Ten Practical Tips for a Best Possible Medication History

Updated: March 30, 2021

Wenya Miao, BScPhm, PharmD, ACPR and Chris Fan-Lun (BScPhm, ACPR, BCGP)

Polypharmacy and High-risk Medications in Older Veterans Presenting for Emergency Care

Volume 2 | Issue 12 | Article 3 - Original Research

December 12, 2021

Paige L. Morizio PharmD BCPS, Vinita M. Mistry PharmD, Ashley E. McKnight PharmD BCPS, Marc J. Pepin PharmD BCPS BCGP, William E. Bryan PharmD BCPS, Ryan K. Owenby PharmD, Laura A. Preville MD MPH, Luna C. Ragsdale MD MPH



Effect of Pharmacist Intervention on Emergency Department Geriatric Patients with Polypharmacy

Volume 3 | Issue 3 | Article 5 - Original Research

November 23, 2022

Rachael Sheehan, PharmD, Ashley Stajkowski, PharmD, Lee Hruby, PharmD, Melanie Mommaerts, PharmD, Tyler Nichols, PharmD, Marisa Nichols, PharmD, Alex Beuning, MD, Victor Warne, PharmD



Elder Mistreatment RESOURCES

Using the Elder Mistreatment Response Protocol

Elder Mistreatment Toolkit Training – Module #4

Sign up LOG IN →

You must be logged in to complete this module.

Share on [f](#) [t](#) [in](#)



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

WHAT'S IN THE TOOLKIT?

The toolkit has four key elements.



HOW DOES IT WORK?



WHO SHOULD USE THE TOOLKIT?

The toolkit is available, free of charge, to any institution interested in improving their response to elder mistreatment. It has been tested in a range of health care settings—urban and rural, private and safety-net, academic and religiously affiliated—and found to be feasible to use and to improve rates of screening for elder mistreatment in every case. The toolkit will be available in digital format in early 2022, in partnership with the Geriatric Emergency Department Collaborative (www.getcollaborative.com). Use of the toolkit can be counted toward accreditation as a Geriatric Emergency Department.

ABOUT THE NATIONAL COLLABORATORY TO ADDRESS ELDER MISTREATMENT AND EDC

With funding from The John A. Hartford Foundation and The Gordon and Betty Moore, The National Collaboratory to Address Elder Mistreatment was founded in 2016 with a charge to develop a scalable response to the prevalence of elder mistreatment. This group is comprised of national experts in elder mistreatment from the University of Southern California Keck School of Medicine, University of Massachusetts Medical School, the University of Texas, and Weill-Cornell College of Medicine, with Education Development Center (EDC) serving as the Collaboratory convener. EDC is a global nonprofit with more than 60 years of experience designing, testing, and implementing innovative programs addressing critical challenges in health, education, and economic inequality.

Contact: Kristin Lenz Haggerty, Project Director, klenz@edc.org



Scan this code to learn more.



The National Collaboratory to Address Elder Mistreatment is supported by a grant to EDC from:

Elder Mistreatment Emergency Department Toolkit

1 in 10 people ages 60 and older experience some form of mistreatment.

1 in 24 cases of elder mistreatment are reported to the authorities.

THE CHALLENGE: Elder mistreatment is a prevalent public health problem in the US that has devastating consequences. It can be defined as the abuse or neglect of an older adult by a person they trust, including physical, sexual, or emotional abuse, neglect, and exploitation. Even as we enter an era of increasing "age-friendliness," the estimated one in ten older adults who experience elder mistreatment remain largely uncared for and unrecognized.

To respond to this challenge, The National Collaboratory to Address Elder Mistreatment has developed a toolkit for use by health systems and communities to improve the safety and wellbeing of older adults. Focused on screening and referral in Emergency Departments, the toolkit also offers resources for clinicians and health systems to strengthen relationships with community resources that can support older adults after discharge.

7.3 million older adults in the US will be mistreated in 2030.

ONLY 4% of those cases will be reported.

"You can't have an Age-Friendly Health Care System if you don't address elder mistreatment."
—Terry Fulmer, PhD, RN, FAAN, President of The John A. Hartford Foundation

"I think [the Elder Mistreatment Emergency Department Toolkit] enhances our current practice. And it provides a service to patients that may otherwise fall through the cracks. And so, it's good for our patients. It's good for our community."
—Hospital Emergency Center Manager

GEMCAST

How to Identify and Intervene in Cases of Elder Abuse

SOUNDCLOUD Share

35:22



Care Transitions RESOURCES

Functional Assessment and Transitions of Care for Older ED Patients

A Geri-EM.com E-learning Module

[Sign up](#) [LOG IN](#) →

You must be logged in to complete this module.

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COVID-19 in Older Adults: Transfers Between Nursing Homes and Hospitals

Transitions of Care in the Geriatric Emergency Department

Reflections in Practice



"I'm Not Staying in the Hospital Tonight" - How Emergency Departments Can Leverage Health and Social Services at Home to Support Care Transitions for Older Patients

Volume 2 | Issue 8 | Original Research

August 17, 2021

Emily Franzosa, DrPH, MA; Ula Hwang, MD, MPH; Maya Genovesi, LCSW, MPH; Orna Intrator, PhD; Thomas Edes, MD, MS; Michael Malone, MD



Exploring Care Transitions From Patient, Caregiver, and Health-Care Provider Perspectives

Volume 2 | Issue 11 | Sentinel Paper Review

September 28, 2021

Kevin T Fuji PharmD, Aaron Malsch APN, Pamela Martin APRN-BC



THANK YOU!

Questions?

Wrap Up and Next Steps

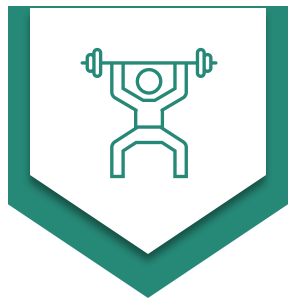


Dora Fisher, MPH, CPHQ
Director, Post-Acute and Continuing Care



Your Path to Process Improvements

NEXT STEPS



BOOTCAMP

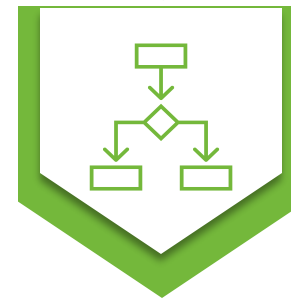
YOU ARE HERE



**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:
gedcollaborative.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/](https://gedcollaborative.com/HANYS/)

And click on the Course Evaluation button

An orange button with a white border and a slight shadow, containing the text "Course Evaluation" in white.

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/>

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**

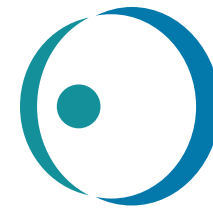


**Join
the
GEDC**

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