



GEDDC

THE GERIATRIC
EMERGENCY DEPARTMENT
COLLABORATIVE

EDUCATE IMPLEMENT EVALUATE

Indian Health Service and Tribal Hospitals GEDDC BOOTCAMP

Thursday, May 19, 2022
1:00 PM – 3:30 PM EST
11:00 AM – 1:30 PM MT



WELCOME

- ❖ Cheyenne River Health Center
- ❖ Crow Agency/Northern Cheyenne Hospital
- ❖ San Carlos Apache Healthcare Corporation
- ❖ Parker Indian Health Center
- ❖ Blackfeet Community Hospital
- ❖ Gallup Indian Medical Center
- ❖ Cherokee Indian Hospital
- ❖ Northern Navajo Medical Center

gedcollaborative.com

 @theGEDC

Our Vision

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

Our Mission

We bring best practice into action.

We transform and evaluate interdisciplinary best practice in geriatric emergency medicine, and then build and distribute practical, evidence-based clinical curriculum and quality improvement tools that support sustainable, quality care for older adults.



GEDC Faculty



Kevin Biese
MD, MAT, Co-P
University of North
Carolina



Pamela Martin
APRN
Yale University



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



Laura Stabler
MPH
Program Director
GEDC



Conor Sullivan
Program Coordinator
GEDC

Indian Health Service Geriatric ED Workgroup



Ardith Aspaas, RN

Nurse Consultant, Division of Nursing Services,
Office of Clinical and Preventive Services, IHS
Geri ED Project Manager, IHS



Bruce Finke, MD

IHS Elder Health Consultant



CAPT Carol S. Lincoln

Director, Division of Nursing Services, IHS



Shawn D'Andrea, MD, MPH

Chief Clinical Consultant,
Emergency Medicine, IHS



Blythe Winchester, MD, MPH

Chief Clinical Consultant,
Geriatrics & Palliative Care, IHS
Geriatrician, Cherokee Indian Hospital
Certified Medical Director, Tsali Care Center



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:

- 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 IHS and Tribal Hospitals
- Identify problems and opportunities in ED regarding care of their older patients
- Identify a specific, focused quality improvement project that can be implemented over the next six months to improve care for older patients in their own ED



Disclosure Summary

As a provider accredited by Joint Accreditation Interprofessional Continuing Education, Mayo Clinic College of Medicine and Science (Mayo Clinic School of CPD) must ensure balance, independence, objectivity and scientific rigor in its educational activities. Course Director(s), Planning Committee Members, Faculty, and all others who are in a position to control the content of this educational activity are required to disclose all relevant financial relationships with any commercial interest related to the subject matter of the educational activity. Safeguards against commercial bias have been put in place. Faculty also will disclose any off label and/or investigational use of pharmaceuticals or instruments discussed in their presentation. Disclosure of these relevant financial relationships will be published in activity materials so those participants in the activity may formulate their own judgments regarding the presentation.

Relevant Financial Relationship(s):

Kevin James Biese, MD is a consultant for Third Eye Telehealth

No Relevant Financial Relationship(s)

Aaron Malsch, RN, MSN

Pamela Martin, APRN

Laura Stabler, MPH

Off Label/Investigational Usage: None

For additional disclosure information regarding Mayo Clinic School of Continuous Professional Development accreditation review committee members visit:

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IHS and Tribal Hospitals GEDC Geri-ED Boot Camp

May 19,2022 1:00p – 3:30p EST

<i>Time pm (EST)</i>	Topic	Presenter(s)
1:00-1:15 (15 mins)	Welcome & Introductions	IHS / GEDC
1:15-1:25 (10 mins)	Program Awards & Grant Opportunities	Dr. Bruce Finke
1:25-1:45 (15 mins)	Why GEDs & Accreditation Criteria	Dr. Kevin Biese
1:45-2:00 (15 mins) 2:00-2:15 (15 mins)	Case Studies (Breakout Rooms) Recap Case Studies	All
2:15-3:00 (45 mins)	GED Implementation – GEDC QI Resources	GED Protocols - Pam Martin Falls & Mobility - Aaron Malsch Tips & Initiatives - Dr. Kevin Biese
3:00-3:25 (25 mins)	Closing Remarks	IHS
3:25-3:30 (5 mins)	Wrap Up & Next Steps	Laura Stabler

Technical difficulties

Please text:

- Laura Stabler: 919-937-0411
- Conor Sullivan: 910-200-1312
- Lorraine Trecroce: 289-242-8936

Welcome



**Blackfoot
Community Hospital**
North Browning, Montana

**Cherokee
Indian Hospital**
Cherokee, NC

**Gallup Indian
Medical Center**
Gallup, New Mexico

**Parker Indian
Health Center**
Parker, Arizona

**Northern Navajo
Medical Center**
Shiprock, New Mexico

**San Carlos
Apache Healthcare**
Peridot, Arizona

**Crow Agency/Northern
Cheyenne Hospital**
Lame Deer, Montana

**Cheyenne River
Health Center**
Eagle Butte, South Dakota

Blackfeet Community Hospital

IHS

EMERGENCY DEPARTMENT

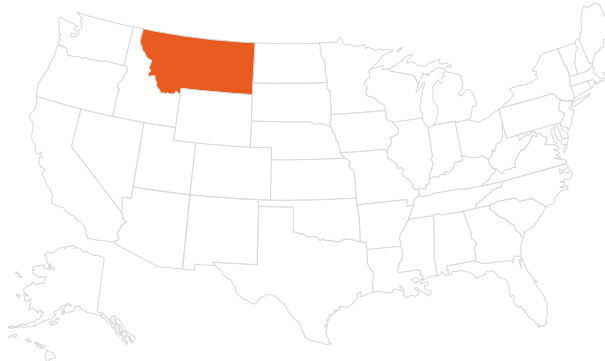
Serves 4 communities

Supports 1 Health Station

4,000

OLDER ADULTS SERVED

Annually in the ED



TEAM MEMBERS

- Neil Sun Rhodes, MD, Medical Supervisor
- Jami Crawford, RN, ED Nurse Supervisor
- Alfonso Torres, MD, EM Physician
- Jeanette Walker, RN, ED Lead Nurse
- Lorissa Hannon, QA/PI Specialist



Unique Aspect of Blackfeet Community Hospital and its community:

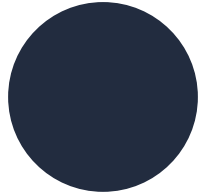
Delivers emergent and urgent care for slightly more than 131,000 patient encounters, with approximately 21,000 ED visits per annum.

As the fifth busiest ED in the state of Montana, we are nestled right against Glacier National Park and the U.S./Canadian border, which lends itself to a fair number of elderly tourists.

Cherokee Indian Hospital



TRIBAL EMERGENCY DEPARTMENT



OLDER ADULTS SERVED

Annually in the ED



TEAM MEMBERS



The Cherokee Indian Hospital: Where Healing and Modern Medicine Intersect.



Cheyenne River Health Center

IHS

EMERGENCY DEPARTMENT

Serves 27 communities

798

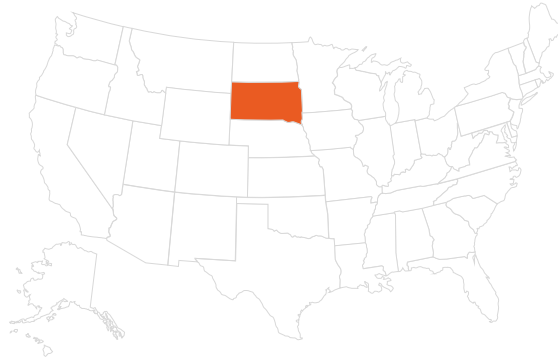
OLDER ADULTS SERVED

Annually in the ED



TEAM MEMBERS

- Marlene Wakefield, Acting Chief Executive Officer
- Dr. John Rozehnal, Clinical Consultant, Department of Emergency Medicine at CRHC and Mount Sinai Hospital
- Dr. Yeisabeth Jimenez, Clinical Lead, Department of Emergency Medicine at CRHC
- Heather Sierra, RN, Geriatric Nursing Lead
- Johnna Watt, RN, Coordinator, Quality and Process Improvement



Unique Aspect of Cheyenne River Health Center and its community:

The Cheyenne River Health Center is the only Emergency Department in a 90 mile radius.

CRHC is working with Mount Sinai Hospital in New York to develop an educational and administrative partnership. Accessing their expertise in developing and sustaining clinical initiatives focused on the care of the elderly.

Crow Agency/Northern Cheyenne Hospital

IHS

EMERGENCY DEPARTMENT

Critical Access Hospital

Serves 2 tribes – Crow and Northern Cheyenne

Supports 1 health Clinic and 1 Health Station

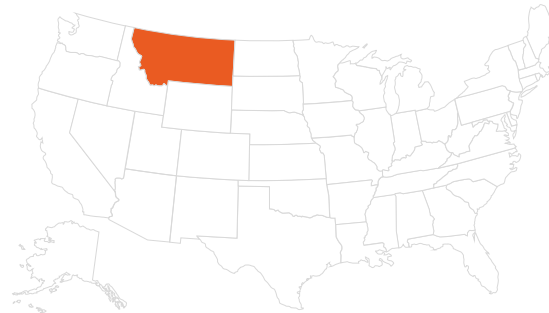
1,000

OLDER ADULTS SERVED

Annually in the ED

TEAM MEMBERS

- Dr. Charles Lambiotte, Clinical Director
- Dr. Lindsay Carlson, ED Director
- Dr. Cody Grace, ED Physician
- Dr. Zachary Zemore, ED Physician
- Dr. Thomas Olejnik, ED Physician
- Patricia Naillon, ED RN
- Virjama Williamson, Health Unit Coordinator



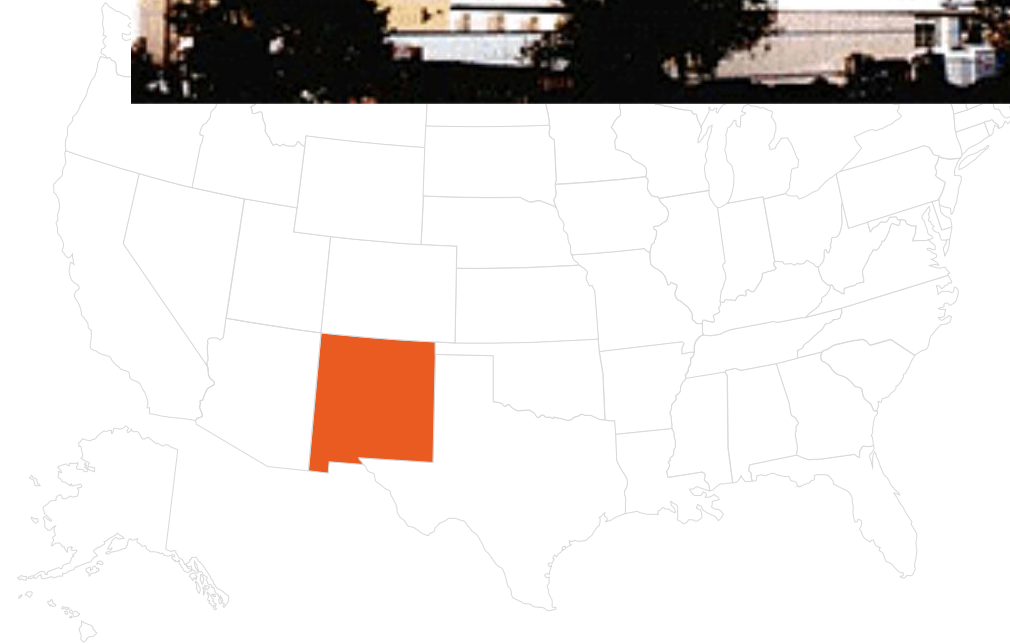
Unique Aspect of Crow Northern Cheyenne Hospital and it's community:

The Crow Service Unit sits within the valley of the Little Big Horn, below the Little Big Horn Battlefield Monument, the site of Custer's last stand.

The Crow Reservation is made up of 2.2 million acres.

User population is approximately 14,000 in county, serving an even larger population in Billings and surrounding area.

Gallup Indian Medical Center



EMERGENCY DEPARTMENT

Serves beneficiaries primarily from the Navajo Nation and the Pueblo of Zuni



OUTPATIENT ENCOUNTERS

Annually



TEAM MEMBERS

- Dr. Paula Mora, Chief Medical Officer
- Dr. Paul Charlton, ED Director
- Dr. Safia Rubaii, ED Physician
- Dr. Jamie Newberry, ED Physician
- Dr. Jacquelyn Simonis, Palliative Care Physician
- Alvina Rosales, RN, Supervisory Clinical Nurse
- Cheryl Smith, RN, Supervisory Clinical Nurse

Unique Aspect of GIMC and it's community:



The workload at GIMC is one of the largest in the IHS with 250,000 outpatient encounters and 5,800 inpatient admissions annually. GIMC has the largest staff of all Navajo Area IHS facilities.

Gallup Indian Medical Center (GIMC) is the first IHS facility to be designated as a Level III Trauma Center.

Northern Navajo Medical Center



IHS

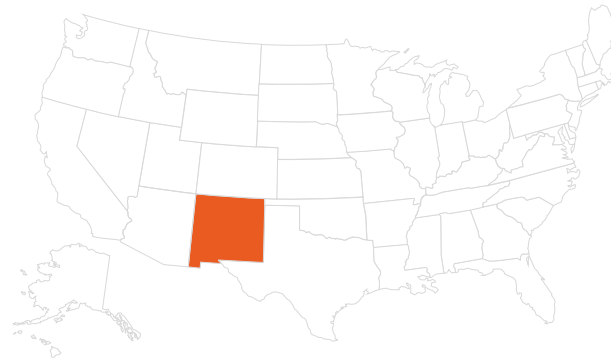
EMERGENCY DEPARTMENT

Serves beneficiaries from NM, AZ, CO, and UT. Serves 22 chapters and Supports 2 Health Centers

399

OLDER ADULTS SERVED

Annually in the ED



TEAM MEMBERS



- Dr. Ouida Vincent, Clinical Director
- Dr. Jeanie Ringelberg, ED Director
- Dr. Carl Smith, ED Deputy Director
- Melanie Barber, RN, Supervisory Clinical Nurse
- Dr. Wiley Thuet, ED Physician
- Eirin Ward, RN, Assistant Supervisory Clinical Nurse and GED Champion
- Cara Balderrama, RN, Patient Family Advocate



Unique Aspect of NNMC and it's community:

Shiprock Service Unit is the largest geographical service unit of the Navajo Area IHS, serving 80,837 beneficiaries.

NNMC is a 60 bed medical center and is designated as a Level IV Trauma Center and is certified as Peds Ready by the New Mexico Emergency Medical Services for children and the University of New Mexico Child Ready Program.

Parker Indian Health Center



EMERGENCY DEPARTMENT

Critical Access Hospital
Serves 4 communities



PATIENTS SERVED

Annually



TEAM MEMBERS

- Michael Dickerson, MD, Clinical Director
- Jermaine Bridges, MD, ED Physician
- Adam Patch, ED RN



Unique Aspect of Parker Indian Health Center and its community:

Parker Indian Health Center in Parker, Arizona is the only hospital for the service unit and is the main hub for federal clinics located in Peach Springs, Chemehuevi, Moapa, and Supai.

The Colorado River Indian Tribes (CRIT) include four distinct tribes- the Mohave, Chemehuevi, Hopi, and Navajo



San Carlos Apache Healthcare



Izee' Baa Gowah
San Carlos Apache Healthcare

TRIBAL

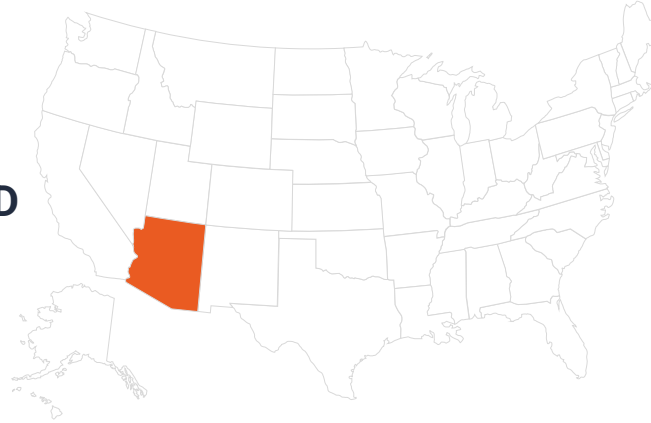
EMERGENCY DEPARTMENT

Serves 4 communities

1,544

OLDER ADULTS SERVED

Annually in the ED



TEAM MEMBERS

- Dr. Charles Schnorr, ED Director
- Felita Jackson, RN
- Bonnie Bird, RN
- Dana Nosie, ER Tech



Unique Aspect of SCAHC and it's community:

SCAHC is moving forward with building and operationalizing a 100-bed LTC-SNF facility on the SCAHC campus by December 2024.

The elders of this community are the protectors of Apache language, tradition and culture.

Alzheimers Grant Program Funding Opportunities

Application deadline: July 18, 2022

<https://www.ihs.gov/dccs/alzheimers/>

Cooperative Agreements

- Funding Announcement Number: [HHS-2022-IHS-ALZ-0001](#)
- **Eligibility:** Tribes, Tribal Organizations, and Urban Indian Organizations
- **Federal Register Publication:** [Addressing Dementia in Indian Country: Models of Care](#)
- **Funding Amount:** Awards of between \$100,000 and \$200,000 per year for 2 years
- Anticipate 5 awards

Program Awards

- **Eligibility:** IHS Service Units working in partnership with the Tribe(s) and Nations that they serve under the condition that the Tribe(s) or Nations served by the IHS Service Unit have elected not to apply for a Cooperative Agreement (above)
- **Application Materials:** [Program Award Application](#)
- **Funding:** Awards of up to \$150,000 per year for two years
- Anticipate 3 awards



Geriatric EDs: The Why?

Kevin Biese
MD, MAT



Geriatric Emergency Department
Collaborative Implementation PI

Chair, Geriatric Emergency
Department Accreditation

COVID-19 Stressing Health Systems and the Emergency Department Safety Net

Emergency Departments (ED) are experiencing unprecedented levels of stress and our vulnerable patients and clinical teams are suffering. In the last few months, we have witnessed the clash of increasing patient volumes and acuity, with multilevel decreasing resources. ED staff are stretched thin from a severe national nursing shortage, unprecedented tension, and significant PTSD.

- COVID-19 is a geriatric emergency
- Exacerbation of ED challenges (communication, delirium, crowding, etc.)
- Goals of care conversations / palliative care (esp. around ventilation)
- High risk of delirium for older adults during COVID
- Care transitions and support between EDs and “home” (including SNFs)

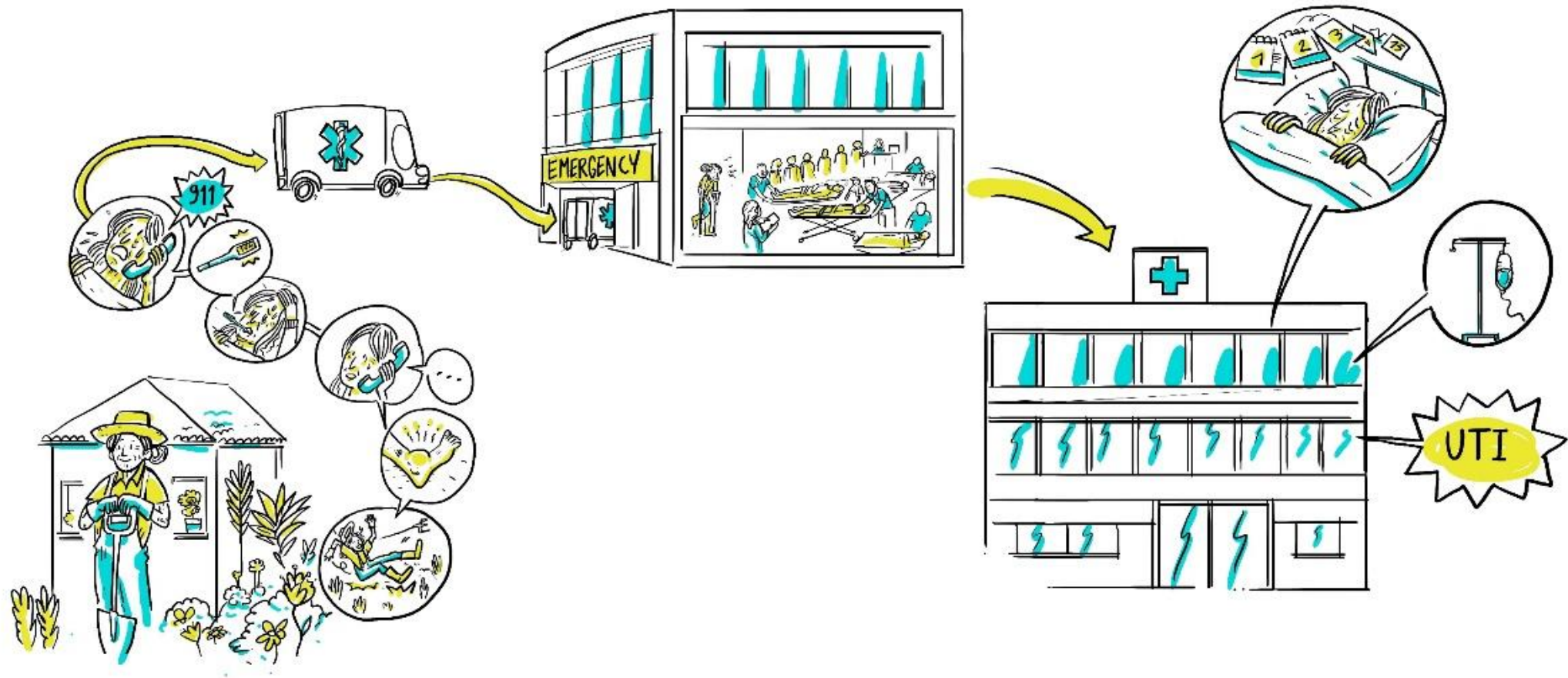


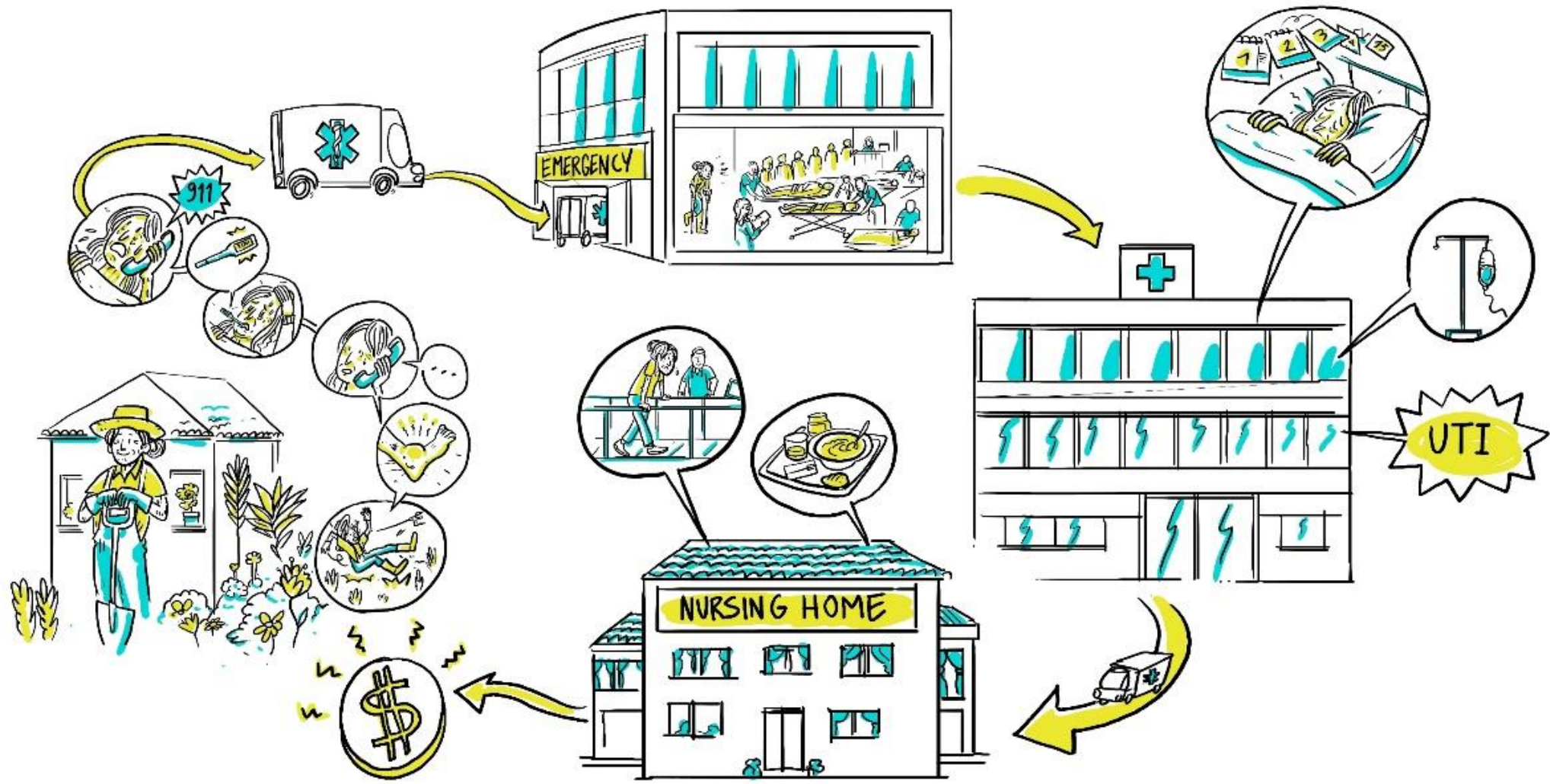








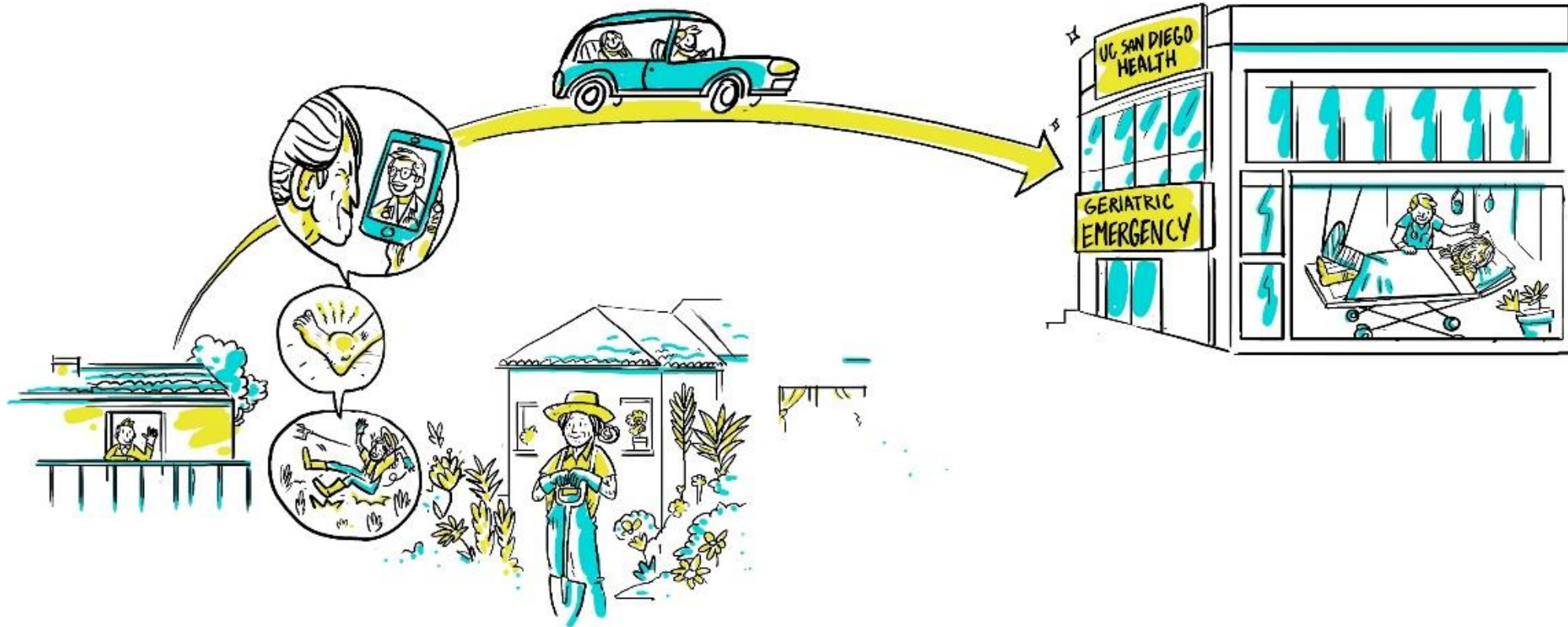


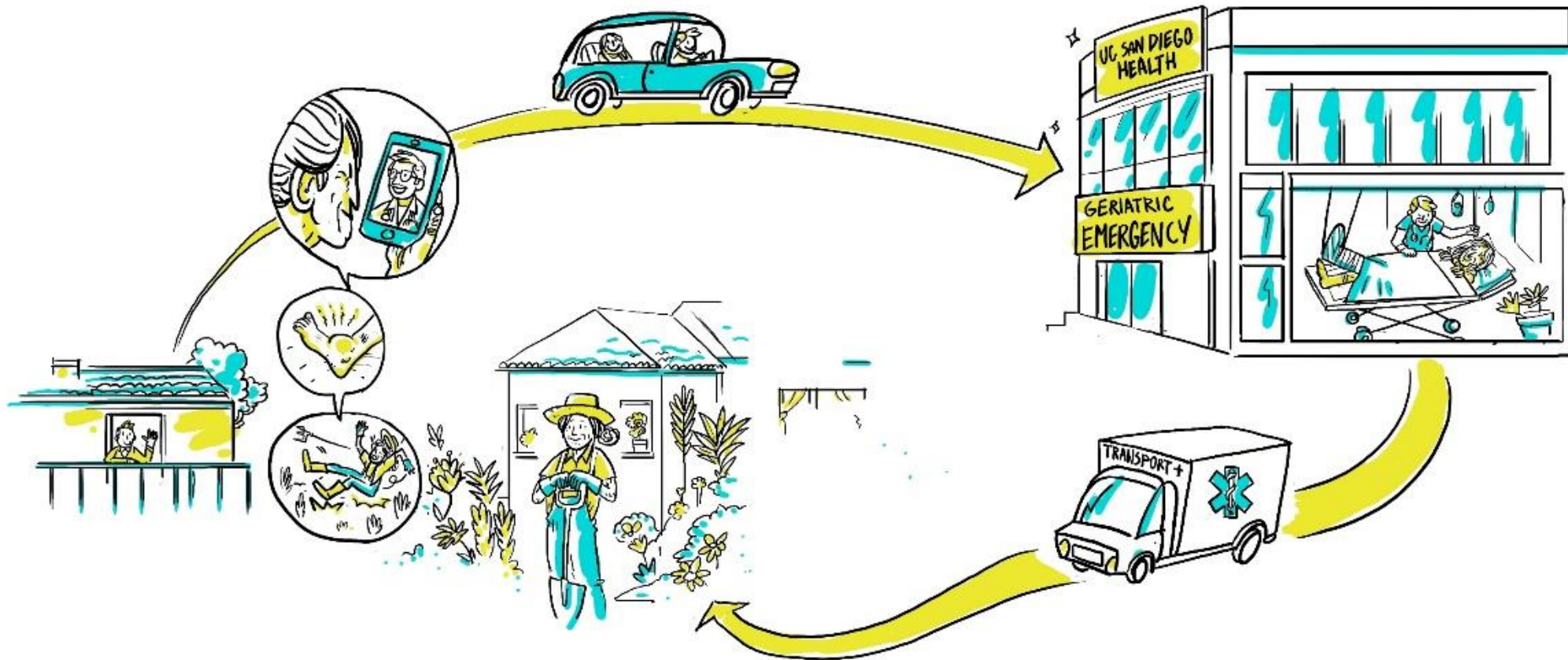


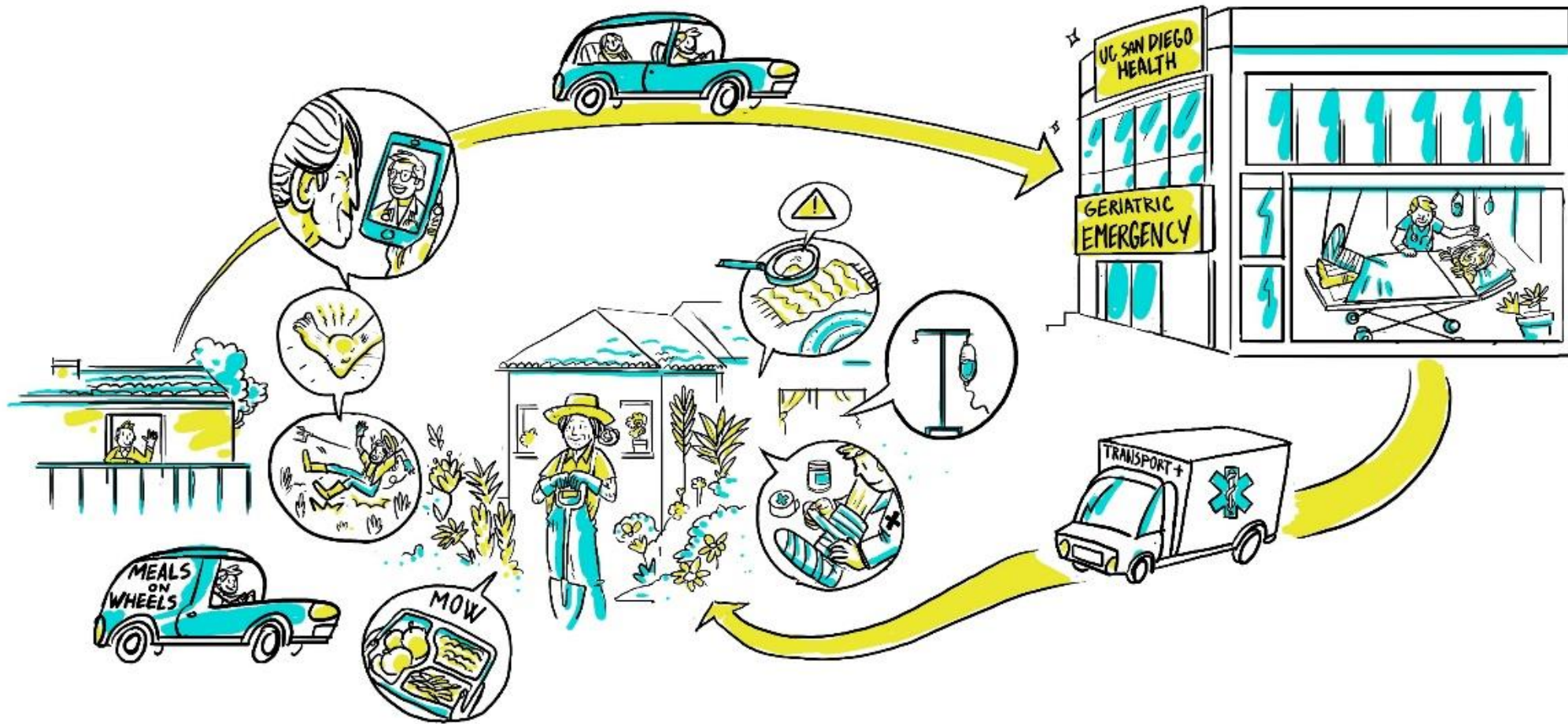






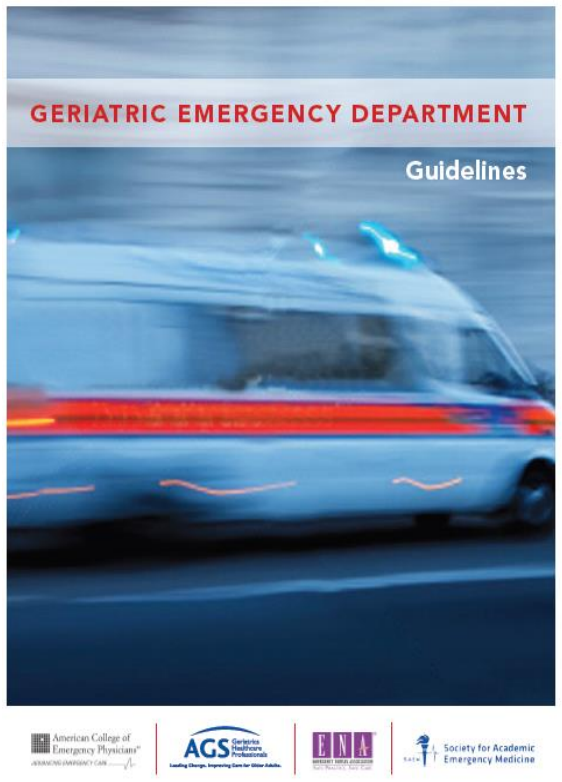




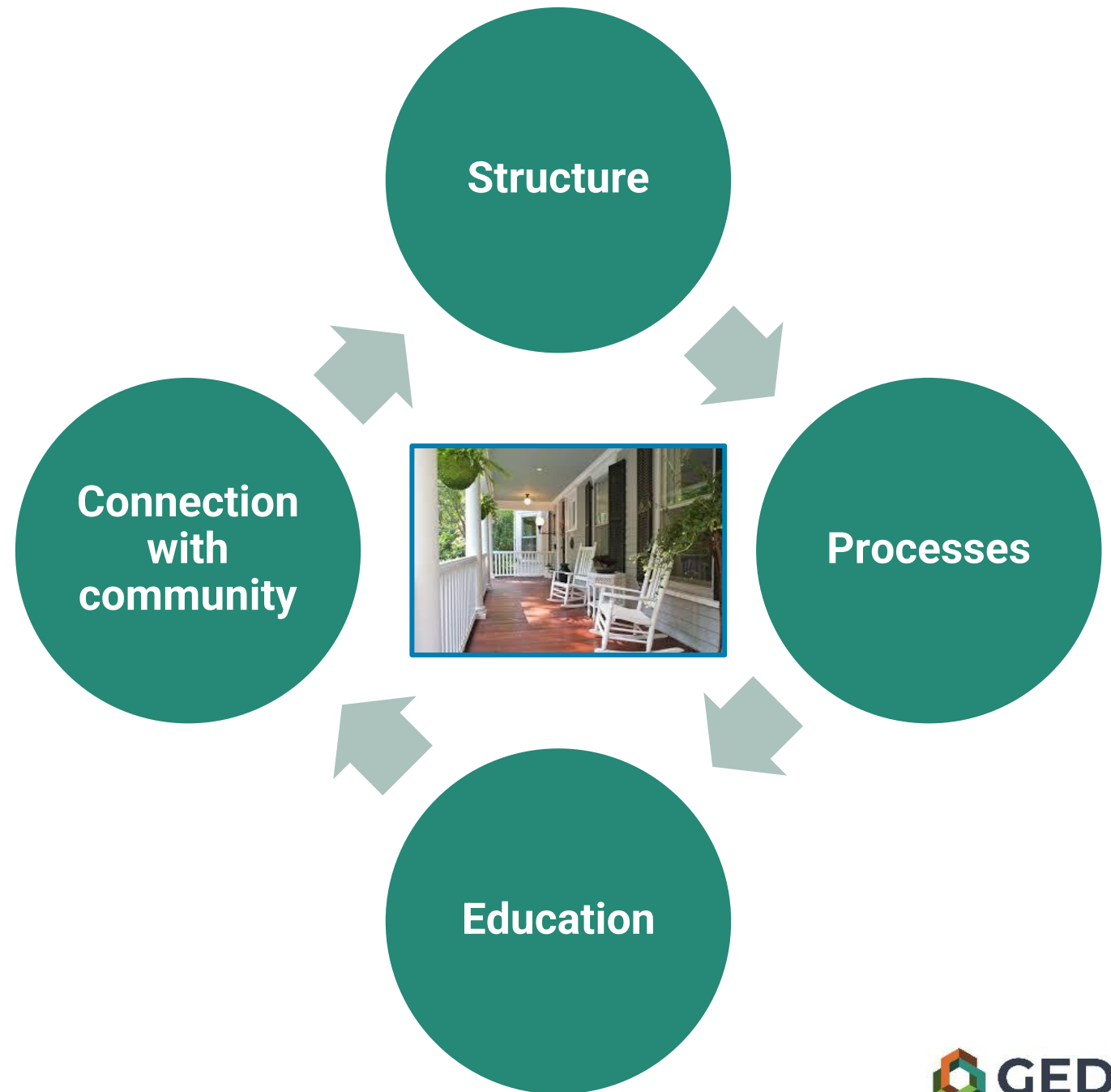


Geriatric ED Guidelines

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?

RESEARCH REPORT

The Evolving Role of Emergency Departments in the United States

Kristy Gonzalez Morganti • Sebastian Bauhoff • Janice C. Blanchard

Mahshid Abir • Neema Iyer • Alexandria C. Smith • Joseph V. Vesely

Edward N. Okeke • Arthur L. Kellermann



The Journey of Geriatric Emergency Medicine: Acceleration, Diffusion, and Collaboration As Keys To Continued Growth

Kelly Ko, Adriane Lesser, Kevin Biese, Ula Hwang, Christopher Carpenter

September 12, 2017

10.1377/hlq.20170912.061810



Academic Emergency Medicine

SPECIAL CONTRIBUTION

A Profile of Acute Care in an Aging America: Snowball Sample Identification and Characterization of United States Geriatric Emergency Departments in 2013

Teresa M. Hogan, MD, Tolulope Oyeoyemi Olade, and Christopher R. Carpenter, MD, MS

Abstract

Background: The United States faces a challenge in emergency departments (EDs). Studies show...

POLICY STATEMENT

Geriatric Emergency Department Guidelines

2016-16-1660 front matter Copyright © 2016 by the American College of Emergency Physicians...

RELATED ARTICLE, P. e1.

This document is the product of two years of consensus-based work 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."

GERIATRIC ED-PURPOSE

The purpose of these Geriatric Emergency Department Guidelines is to provide a standardized set of guidelines that can effectively support the care of elderly patients and which is feasible to implement in the ED.

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,* Lia Spazzafumo, MD,* Stefano Palomara, 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).

It is widely agreed that the current disease-oriented, episodic model of emergency care does not adequately address the complex needs of older patients.

MODELS OF GERIATRIC CARE, QUALITY IMPROVEMENT AND PROGRAM DISSEMINATION

The Geriatric Emergency Department

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

With the aging of the population and the demographic shift of older adults in the healthcare system, the emergency department (ED) will be increasingly challenged with complexities of providing care to geriatric patients.

Although the aging population will affect all areas of health care, the ED is likely to be disproportionately affected.

The ED is a unique environment where highly specialized care is delivered to the acutely ill and injured and safety net care is provided to disenfranchised and vulnerable populations.

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 the US population continues to age, the healthcare system will need to face and embrace the challenges of caring for older adults.

The special care needs of older adults unfortunately are not aligned with the intent of quick patient evaluation and turnover of the physical layout of a traditional ED.

The special care needs of older adults unfortunately are not aligned with the priorities of how ED physical space is designed and how ED care is rendered.

From the *Department of Emergency Medicine, Brookdale Department of Geriatrics and Palliative Care, and the Center for Geriatric Research, Palliative Care Institute, Mount Sinai School of Medicine, New York, New York.

Address correspondence to Ula Hwang, Department of Emergency Medicine, Mount Sinai School of Medicine, One Gustav L. Levy Place, PO Box 1633, New York, NY 10029. E-mail: ula.hwang@mssm.edu

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

Adriane Lesser, MS, Juhli Israni, MS, Tyler Kent, and Kelly J. Ko, PhD

ABSTRACT: OBJECTIVES: To determine whether providing physical therapy (PT) services at the emergency department (ED) improves outcomes for older adults who fall.

SETTING: We analyzed national 2012-13 Medicare claims data for individuals aged 65 and older.

PARTICIPANTS: This was a cross-sectional analysis. We defined an index visit as any ED claim that included an International Classification of Diseases, Ninth Revision, Clinical Modification (ICD) code indicating a physical fall.

MEASUREMENTS AND MAIN RESULTS: We calculated the proportion of MA beneficiaries who had a subsequent ED visit within 30 days of their index visit.

CONCLUSION: Targeted assessment of care staff may facilitate reduction in ED revisits for older adult fallers.

Geriatric Emergency Department Innovations: Transitional Care Nurses and Hospital Unit

Ula Hwang, MD, MPH,*†, Scott M. Dresner, MD, MS,†, Mark S. Rosenberg, MD, Melissa M. Garrido, PhD,*†, George Loo, MPA, MPH, DPH,*†, Jeremy Sze, BGS,†, Graeover, MBA,†, D. Mark Crutcher, MD,†, Raymond Kang, MA,*†, Carolyn Vargas-Torres, MA,*†, Corita R. Gaudin, MD, MSHS,*† and Lynne D. Richardson, MD, MS,†

Background: The United States faces a challenge in emergency departments (EDs). Studies show...

OBJECTIVE: To describe the implementation of a geriatric emergency department (GED) transitional care unit.

DESIGN: A descriptive study of a geriatric emergency department (GED) transitional care unit.

SETTING: A geriatric emergency department (GED) transitional care unit.

PARTICIPANTS: A geriatric emergency department (GED) transitional care unit.

MEASUREMENTS AND MAIN RESULTS: A geriatric emergency department (GED) transitional care unit.

CONCLUSION: A geriatric emergency department (GED) transitional care unit.

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POLICY STATEMENT

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,* Marjorie Bromberg, BS, Jeffrey M. Cantorino, MD, MPH, Kathy Chou, MD, Lowell W. Gorton, PhD, James Gumpert, MD, the Honorable MD David P. Jahn, MD, William L. Larrivée, MD, Timothy F. Platts-Mills, MD, MSc, Barry R. Mittman, PhD, Laura Riegelman, MD, MPH, Mark Rosenberg, MD, MSc, Scott T. Wilton, MD, MPH, for the ACEP Geriatric Emergency Medicine Section, American Geriatrics Society, Emergency Nurses Association, and Society for Academic Emergency Medicine

OBJECTIVE: To provide a standardized set of guidelines that can effectively support the care of elderly patients and which is feasible to implement in the ED.

DESIGN: A descriptive study of a geriatric emergency department (GED) transitional care unit.

SETTING: A geriatric emergency department (GED) transitional care unit.

PARTICIPANTS: A geriatric emergency department (GED) transitional care unit.

MEASUREMENTS AND MAIN RESULTS: A geriatric emergency department (GED) transitional care unit.

CONCLUSION: A geriatric emergency department (GED) transitional care unit.

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A growing body of literature supports Geriatric EDs as a solution

Advertisement for 'Care for the Older Adult in the Emergency Department' featuring a photograph of a patient and text about geriatric emergency medicine. Includes Elsevier logo and date August 2018.



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 CONSENSUS 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

We Recover

In Beauty Before Us We Walk

Holy Beings Take Us

INFORMATION DESK SECURITY





Level III

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

Case Studies: Three Older Adults

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

For a video of Mrs. Cado:
geri-em.com/functional-assessment/mrs-cado/

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

Mr. Ivanhoe 87 year old male “familiar face”

Case Study Breakout Rooms

25-MINUTE SMALL GROUP DISCUSSION

Mrs. Cado

78-year-old woman with a broken wrist “ready for discharge”

WITH YOUR GEDC EXPERT

Kevin Beise



Mr. Shwach

80-year-old woman, not feeling right “Mom seems a little off”

WITH YOUR GEDC EXPERT

Aaron Malsch



Mr. Ivanhoe

87-year-old man “familiar face”

WITH YOUR GEDC EXPERT

Pam Martin



Joining Breakout Rooms

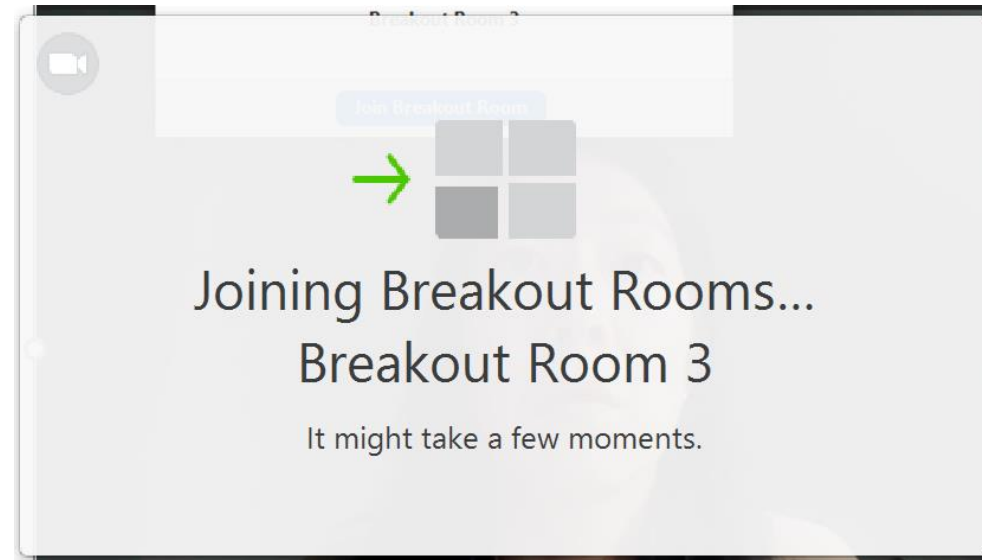
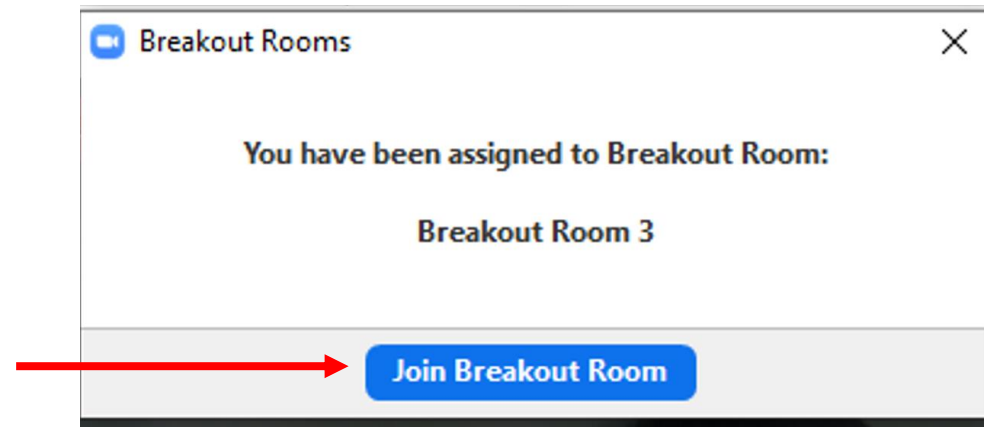
QUICK OVERVIEW

You have already been assigned to your breakout room.

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

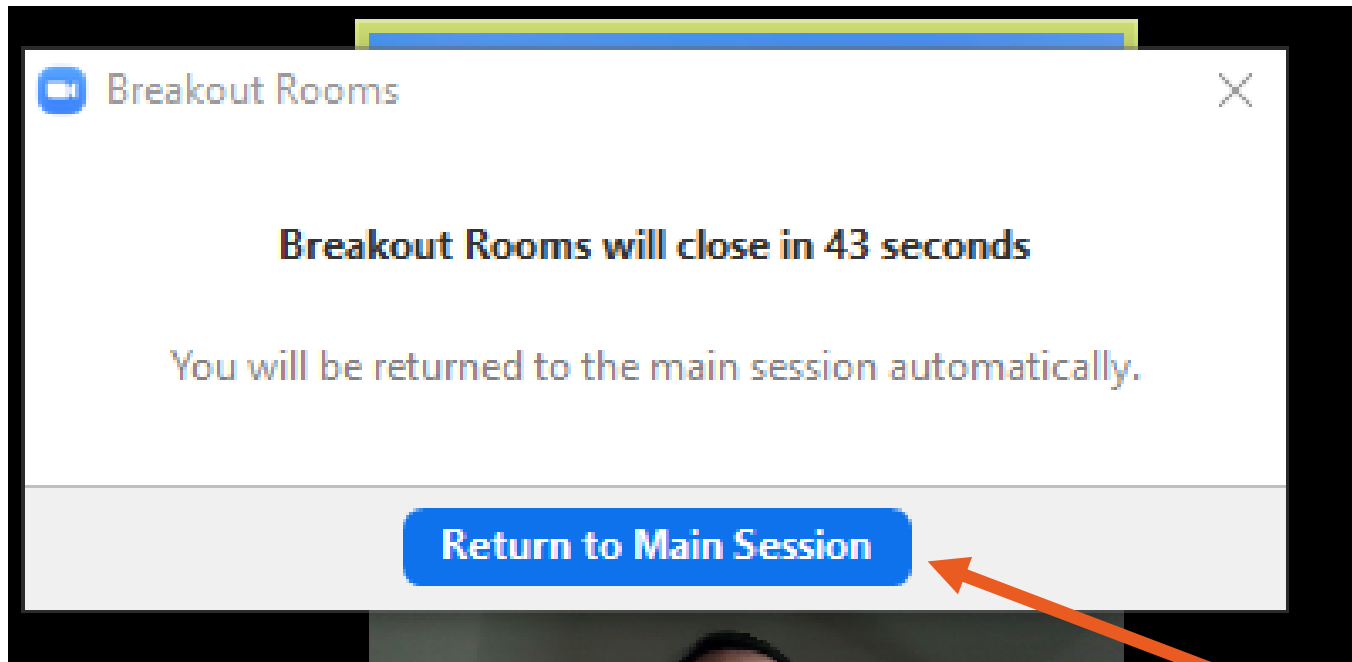
Please be patient.

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



Leaving Breakout Rooms

DON'T EXIT THE WHOLE MEETING! RETURN TO MAIN SESSION.



When your case discussion time is over (15 minutes), you will receive a 2-minute countdown warning. After 2 minutes you will be automatically returned to the Main Session.

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

When You Come Back

CASE DEBRIEFS – CONNECTING CASE STUDIES

Assign someone in your group to describe:

- One barrier to quality care for your patient at your ED now *and*
- One opportunity for improvement that you could implement.
- 5 minutes per group

Case Studies

CASE DEBRIEF

CONNECTING CASE STUDIES

BARRIER TO QUALITY CARE

Group 1: Older adult with fall

- Multiple antihypertensive
- Pain
- Support at Home

Group 2: “ Not feeling right”

- Vague complaints
- Multiple delays
- Incomplete information
- NPO, immobility for 10hrs

Group 3: CPOD

- Vague know services
- Poor documentation
- Geographic distance

OPPORTUNITY FOR IMPROVEMENT THAT YOU COULD IMPLEMENT

Follow up with PCP

Standardized processes for discharge

- ambulation, eating, mental status

Highlights:

4M's Framework

Mobility, Medication, Matters,

Mentation



Creating older-adult specific policies based on existing generic hospital policies

Pam Martin, MS, RN, GCNS-BC

Yale New Haven Health

To satisfy accreditation criteria:

Policy needs to be **ED and Older Adult** specific

Example:

NPO:

In the ED, all patients ≥ 65 years of age is allowed to have clear liquids unless actively vomiting



To satisfy accreditation criteria:

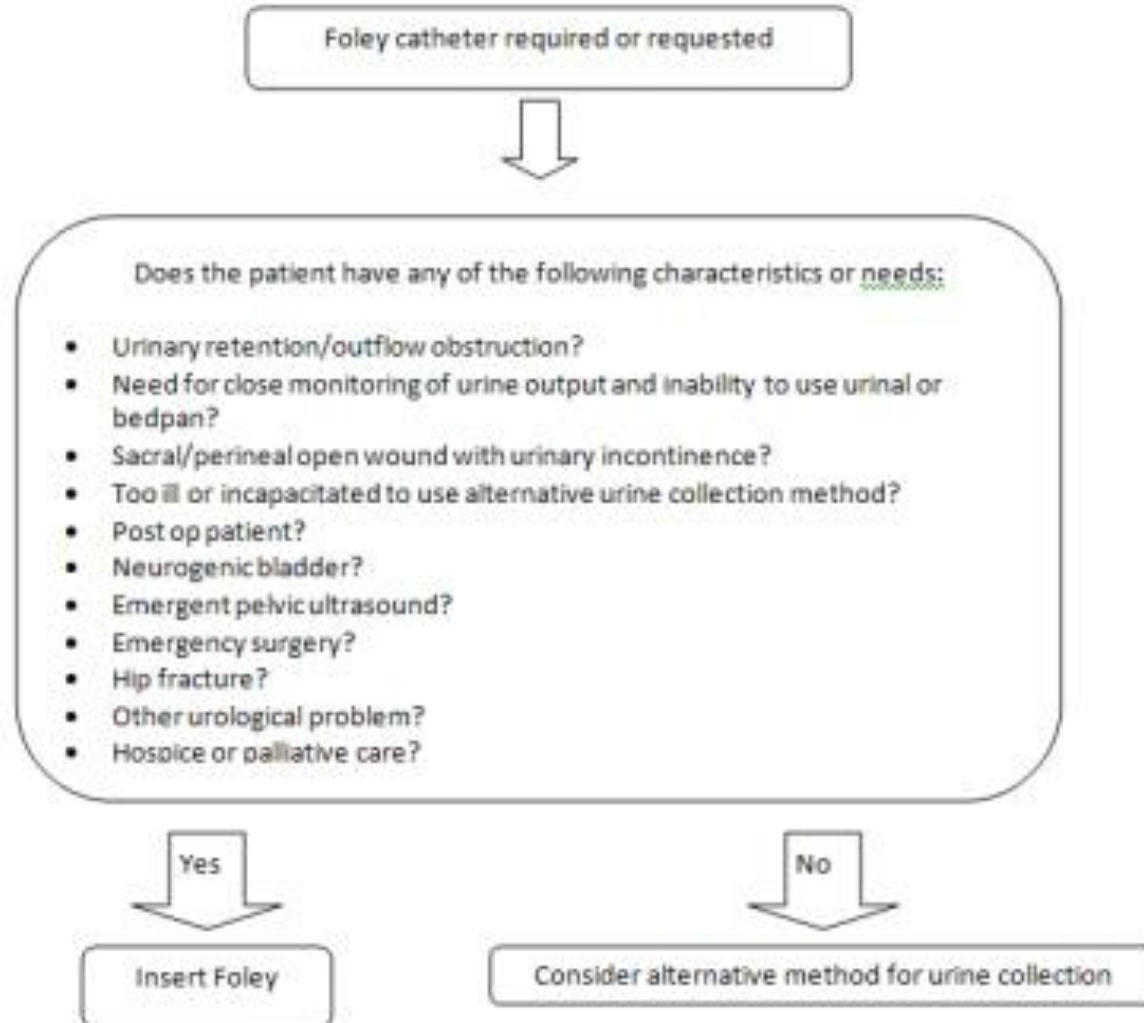
Policy needs to be **ED and Older Adult** specific

Example:

Urinary Catheter:

For ED patients age > 65

introduce decision algorithm



To satisfy accreditation criteria:

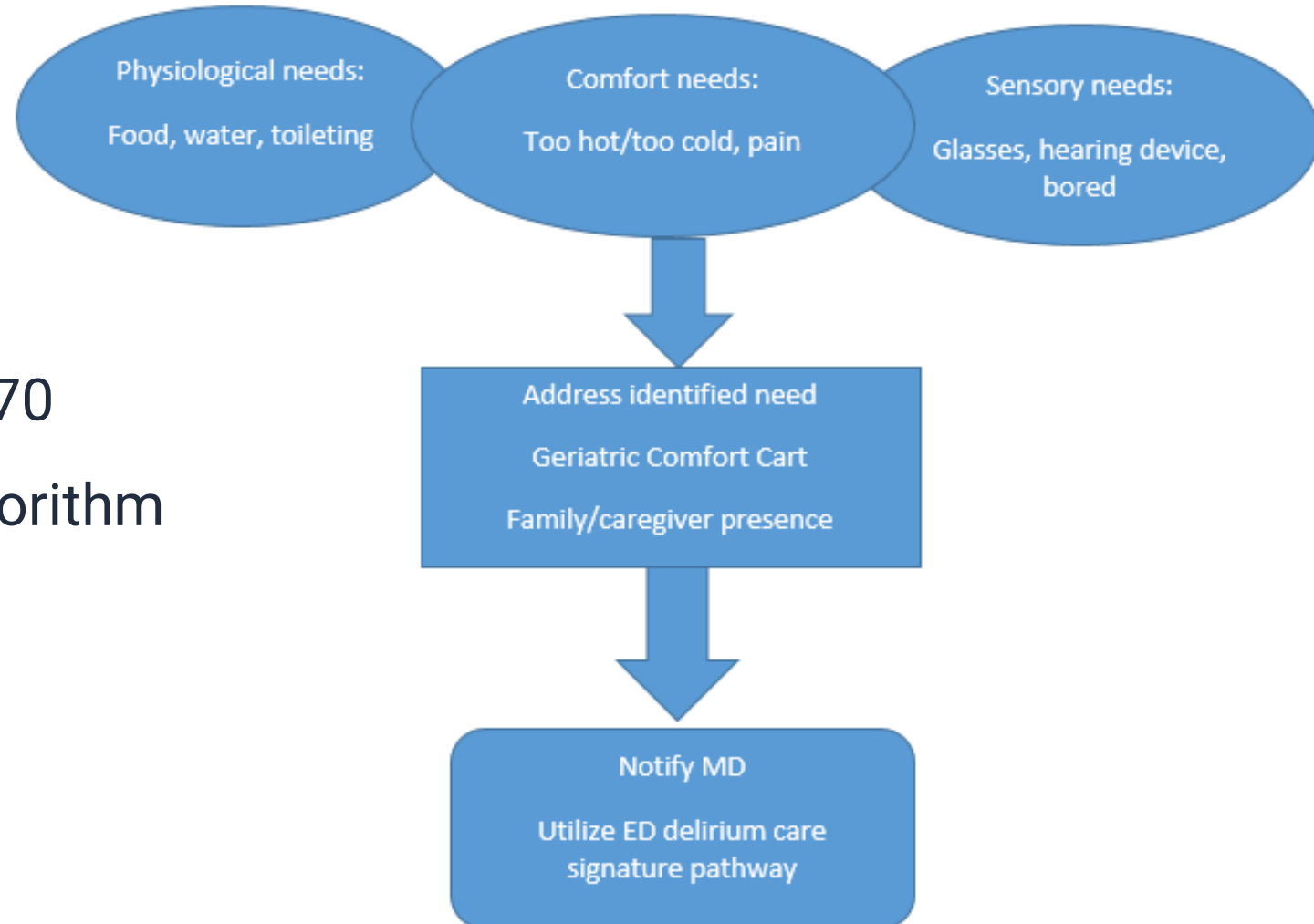
Policy needs to be **ED and Older Adult** specific

Example:

Use of Restraints:

For ED patients age > 70

introduce decision algorithm



Pam's Pearls

When developing your policies ask yourself:

- What age
- What inclusion/exclusion criteria will you use
- Do frequent small tests of change (PDSA cycles)
- Offer education to all involved in process (nursing, techs, MD, APP)

A standardized delirium screening guideline (DTS, CAM 4AT, other)

with appropriate follow-up

- Under recognition
- Increased Morbidity & Mortality
- Increased Costs
 - Revisits/readmissions
 - Increased LOS >> ED boarding

[Delirium_EDImplementationToolkit.pdf](#)
(gedcollaborative.com)

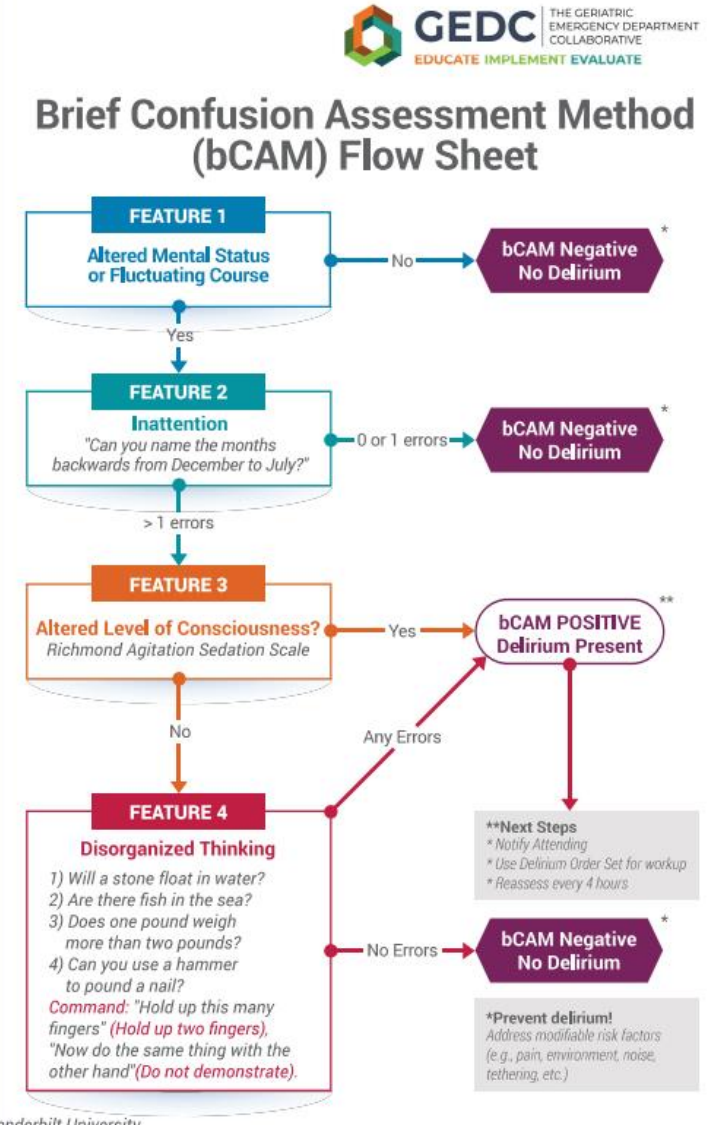
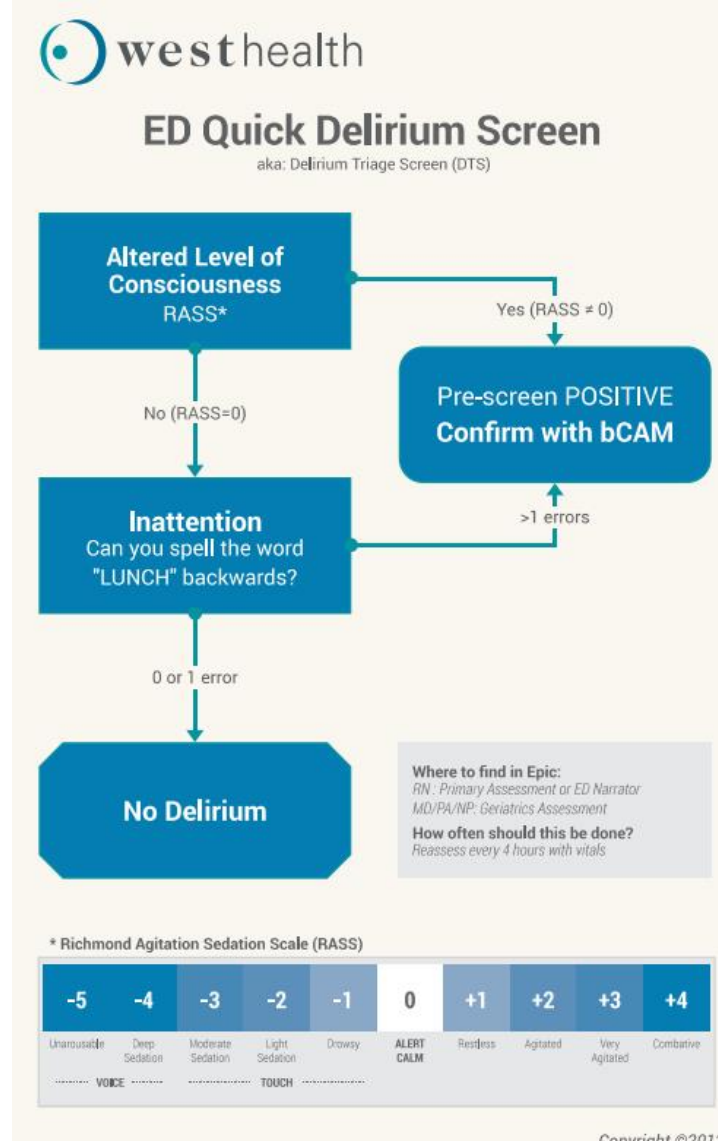


Screening Tools

Delirium Triage Screen (DTS)

Pam's Pearls

- Nursing involved in choosing screening tool
- Who will screen
- Where will you screen (triage/room)
- Where will screen be located: paper, EMR, where in EMR



Copyright ©2012 Vanderbilt University

Appropriate Follow-up

What are you doing with the information?

Provider notification

Delirium Prevention Strategies

- Geri Comfort Cart/ Delirium Prevention Cart/ Dementia Cart: [Non-pharmacologic interventions improve comfort and experience among older adults in the Emergency Department – ScienceDirect](#)

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

Outpatient referral

Pam's Pearl's

- Make it easy
- Have items accessible
- Model ideal behavior
- Reward high achievers
- Determine your metrics and how to obtain
- Can you tie the outpatient referral to other policy/protocol (access to geriatric specific follow up)



A guideline for standardized assessment of function and functional decline

(ISAR, AUA, interRAI screen, TRST)

with appropriate follow-up

- Identify high-risk patients
 - Functional decline
 - Admission/readmission
- Can be used in conjunction with ESI to identify patients for geriatric team



Screening Tools

Choose a tool

ISAR

1) Before the illness or injury that brought you to the Emergency, did you need someone to help you on a regular basis?	<input type="checkbox"/> Yes	01
	<input type="checkbox"/> No	00
<hr/>		
2) In the last 24 hours, have you needed more help than usual?	<input type="checkbox"/> Yes	01
	<input type="checkbox"/> No	00
<hr/>		
3) Have you been hospitalized for one or more nights during the past six months?	<input type="checkbox"/> Yes	01
	<input type="checkbox"/> No	00
<hr/>		
4) In general, do you see well?	<input type="checkbox"/> Yes	00
	<input type="checkbox"/> No	01
<hr/>		
5) In general, do you have serious problems with your memory?	<input type="checkbox"/> Yes	01
	<input type="checkbox"/> No	00
<hr/>		
6) Do you take six or more medications every day?	<input type="checkbox"/> Yes	01
	<input type="checkbox"/> No	00
<hr/>		
Positive test is 2 or more	Total	/6

N/A not applicable

TRST

1.	<input type="checkbox"/>	History of cognitive impairment (poor recall or not oriented)
2.	<input type="checkbox"/>	Difficulty walking / transferring or recent falls
3.	<input type="checkbox"/>	Five or more medications
4.	<input type="checkbox"/>	ED use in previous 30 days or hospitalization in previous 90 days
5.	<input type="checkbox"/>	Lives alone and/or no available caregiver
6.	<input type="checkbox"/>	ED staff professional recommendations:
	<input type="checkbox"/>	Nutrition / weight loss
	<input type="checkbox"/>	Incontinence
	<input type="checkbox"/>	Failure to cope
	<input type="checkbox"/>	Medication issues
	<input type="checkbox"/>	Sensory deficits
	<input type="checkbox"/>	Depression / low mood
	<input type="checkbox"/>	Other _____

Appropriate follow up

What are you doing with the information?

- CM
- GEMS nurse/APRN
- SW
- PT/OT consult

Pam's Pearls

- Who, where, when will screen be completed
- Determine age that you will begin screen
- What “number” will you use to trigger additional interventions
- Check for and obtain ISAR copyright



A standardized dementia screening process

(Ottawa 3 DY; Mini Cog, SIS, Short Blessed Test; other)

with appropriate follow-up

- Increased risk for delirium
- Discharge planning
- Obtaining H & P / Medical workup
- Fits into system goals
- Opportunity for potential grant funding



Screening tools

Multiple available but MINI COG fits into IHS

west health | GEDC EDUCATE IMPLEMENT EVALUATE

THE MINI-COG™ DEMENTIA SCREENING INSTRUMENT

Step 1: Three Word Registration

Look directly at person and say, "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies. 1-3 For repeated administrations, use of an alternative word list is recommended.

Version 1	Version 2	Version 3	Version 4	Version 5	Version 6
Banana Sunrise Chair	Leader Season Table	Village Kitchen Baby	River Nation Finger	Captain Garden Picture	Daughter Heaven Mountain

Step 2: Clock Drawing

Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11."

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

Step 3: Three Word Recall

Ask the person to recall the three words you stated in Step 1. Say: "What were the three words I asked you to remember?" Record the word list version number and the person's answers below.

Word List Version: _____ Person's Answers: _____

Scoring

Word Recall: _____ (0-3 points)	point for each word spontaneously recalled without cueing.
Clock Draw: _____ (0 or 2 points)	Normal clock = 2 points. A normal clock has all numbers placed in the correct sequence and approximately correct position (e.g., 12, 3, 6 and 9 are in anchor positions) with no missing or duplicate numbers. Hands are pointing to the 11 and 2 (11:10). Hand length is not scored. Inability or refusal to draw a clock (abnormal) = 0 points.
Total Score: _____ (0-5 points)	Total score = Word Recall score + Clock Draw score. A cut point of <3 on the Mini-Cog™ has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of <4 is recommended as it may indicate a need for further evaluation of cognitive status.

Pam's Pearls

- Who, where, when will screen be completed
- Determine age that you will begin screen
- What other criteria will be used for patient selection
 - Will all patients get screened
 - Only patients with AMS, etc
- Have a plan to use the information. Do not have it be JUST ANOTHER screen
- ED specific education on why this matters

geriatricfastfacts.com/fast-facts/creating-dementia-friendly-emergency-departmen

#71

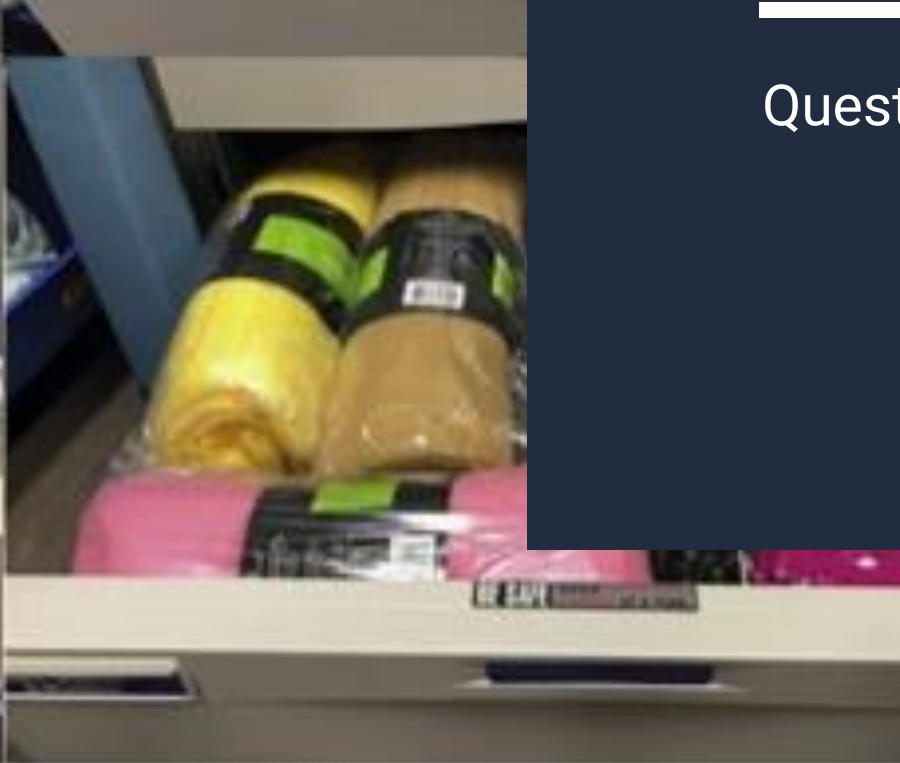
geriatricfastfacts.com/fast-facts/assessment-dementia-patients-emergency-department

#72

Pam's Program Pearls

As you begin your quality improvements, remember:

- Assess culture and readiness for new ED initiative
- Learn system priorities and how this fits into those
- What processes/projects are occurring simultaneously
- Engage ALL stakeholders early in process
- Review processes frequently (share data)
- Keep process front and center
 - educational opportunities
 - Newsletters
- Reward high achievers



THANK YOU!

Questions?



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

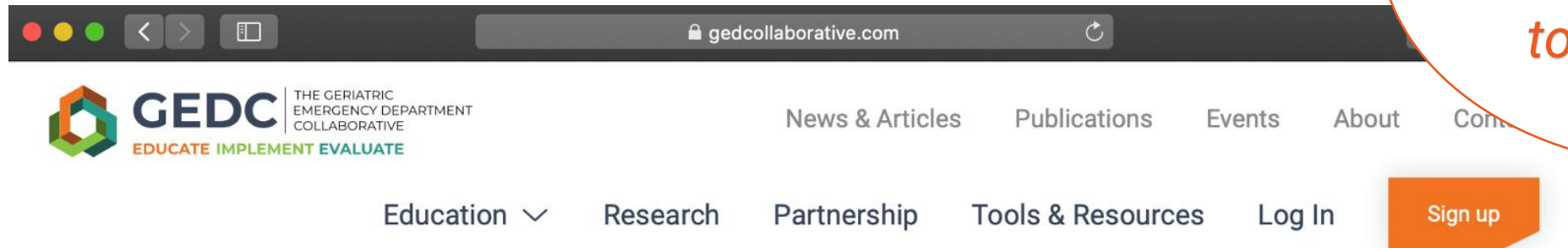
Aaron Malsch, MS, RN, GCNS-BC

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/



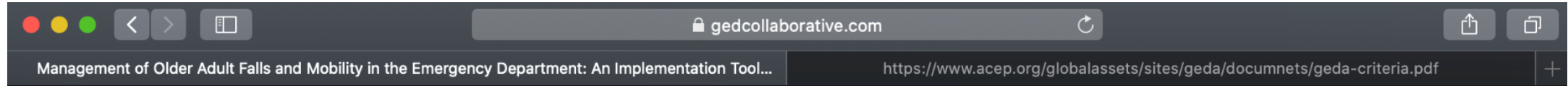
...pssst...
...it counts for TWO procedures towards GEDA

Management of Older Adult Falls and Mobility in the Emergency Department



An Implementation Toolkit

Falls & Mobility Implementation Tool Kit



Education ▾

Research

Partnership

Tools & Resources

Log In

Sign up

What's Inside

Falls are a common presentation for older ED patients. Promoting safe mobility is a key goal of ED discharge. This toolkit provides helpful resources for making changes in your ED to enhance the assessment of older patients who have fallen and to ensure safe mobility post-discharge. It includes resources and tools and links to the evidence to support their implementation.

Staffing



Policies, Procedures & Protocols



Screening & Assessment



Physical Environment



FOAM Protocol

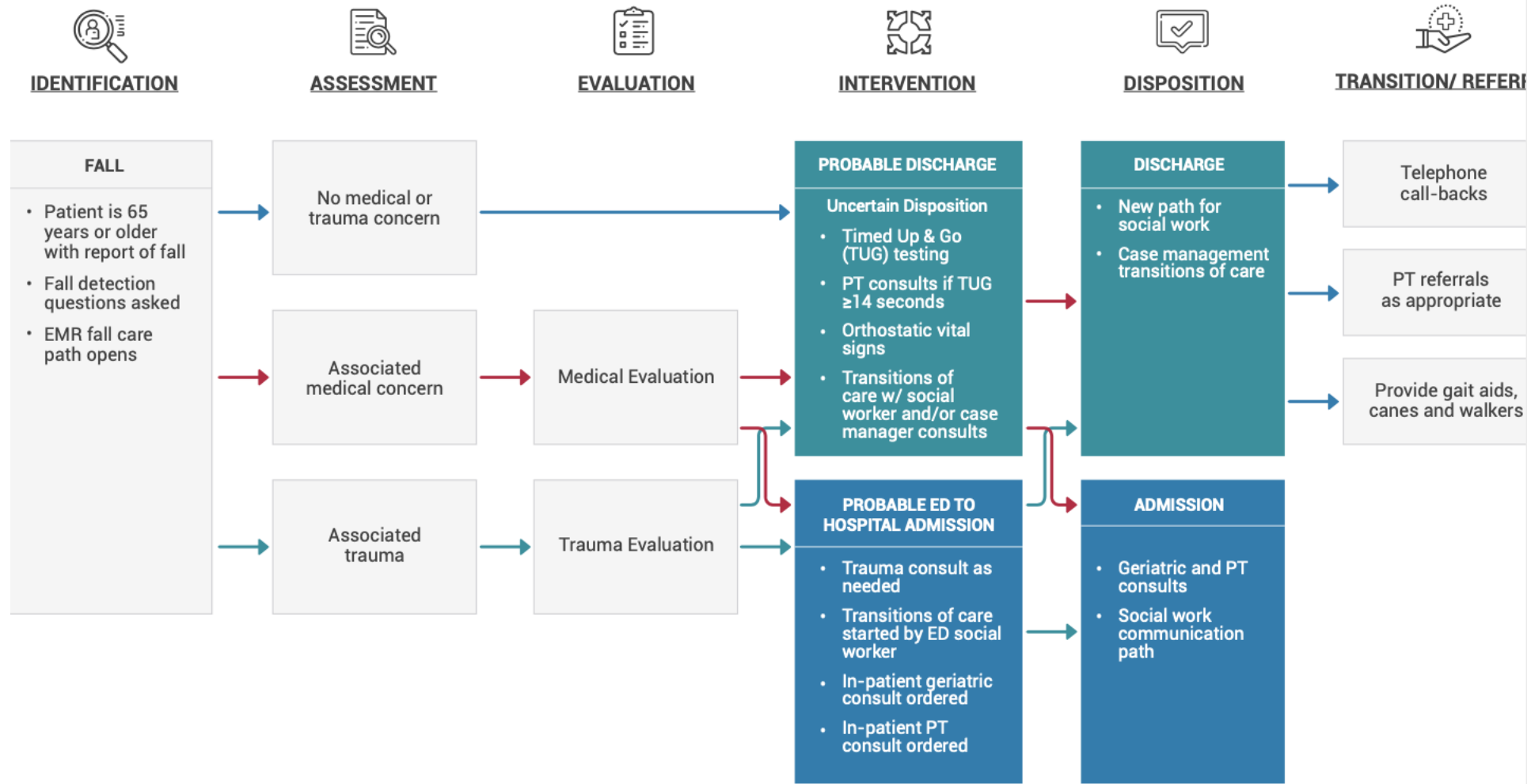
INITIATING AT BEDSIDE

Note: Tailor to your specific needs and resources



FALLEN OLDER ADULT MANAGEMENT (FOAM) PROTOCOL

Note: This is an example - Your protocol may vary



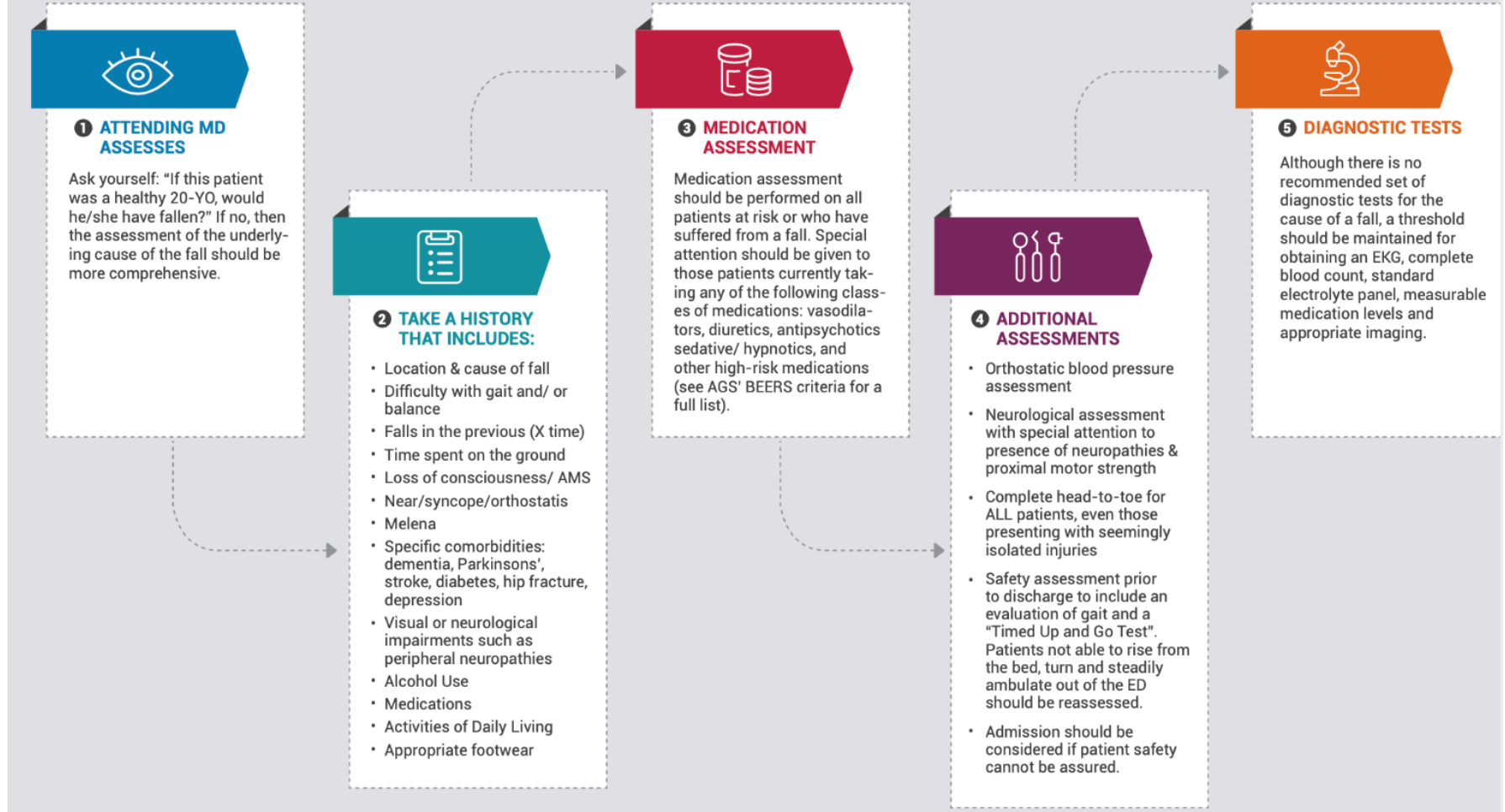
Post-Fall Assessment

INITIATING AT BEDSIDE

Note: Example of potential assessments



Post-Fall Assessment in the Emergency Department



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

Handrails
on walls and
hallways

Aisle
lighting

24/7 access
to mobility
assist
devices

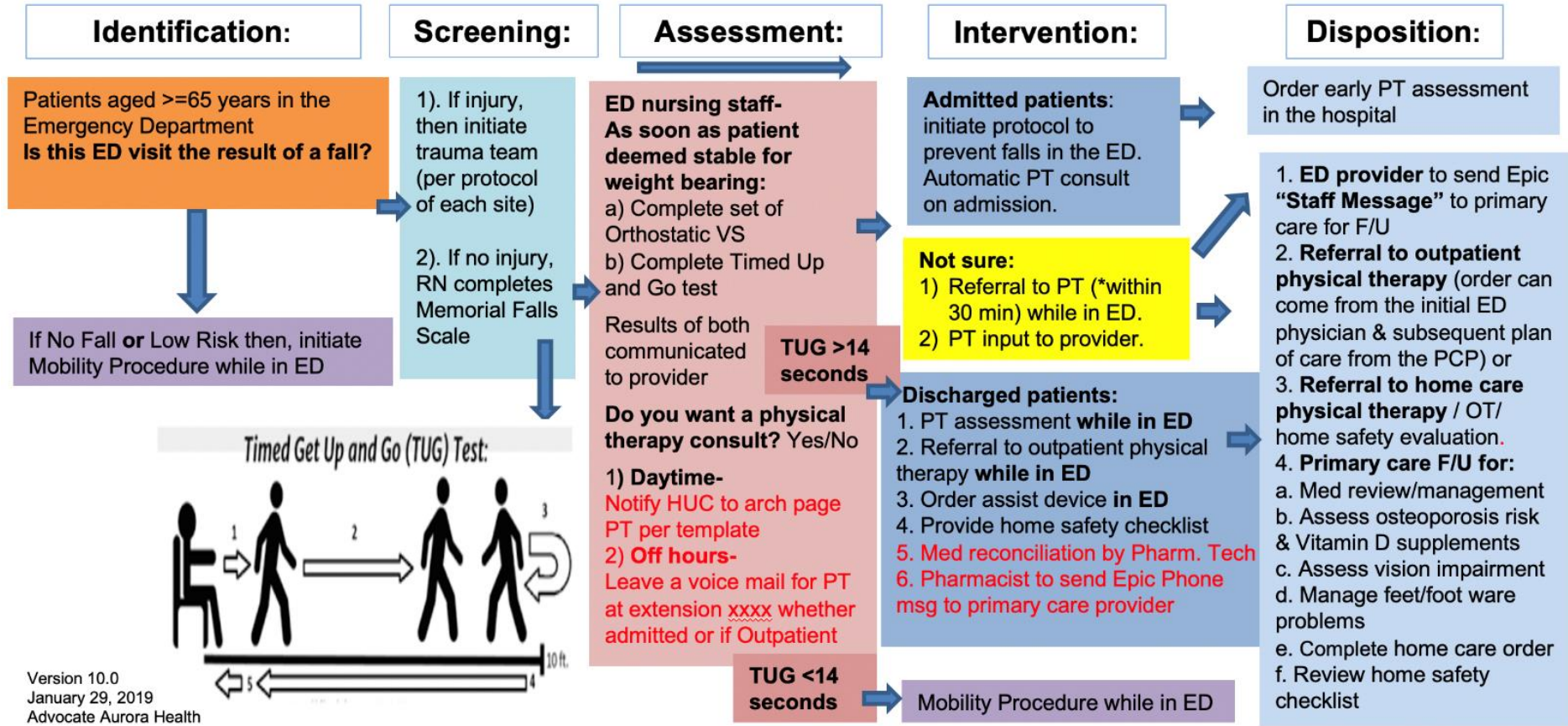
Bedside
commodes
and grab bars
in restrooms



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

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	<input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Minimal assist <input type="checkbox"/> Moderate as... <input type="checkbox"/> Maximal assist <input type="checkbox"/> 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

The screenshot shows the 'Order Search' window with the search term 'PHYSICAL'. The 'Preference List' tab is active. Under the 'Procedures' section, a table lists three items. The first item, 'Consult PT for training', is highlighted in purple and has a red border. A red arrow points from this row to the 'Accept' button at the bottom right of the window.

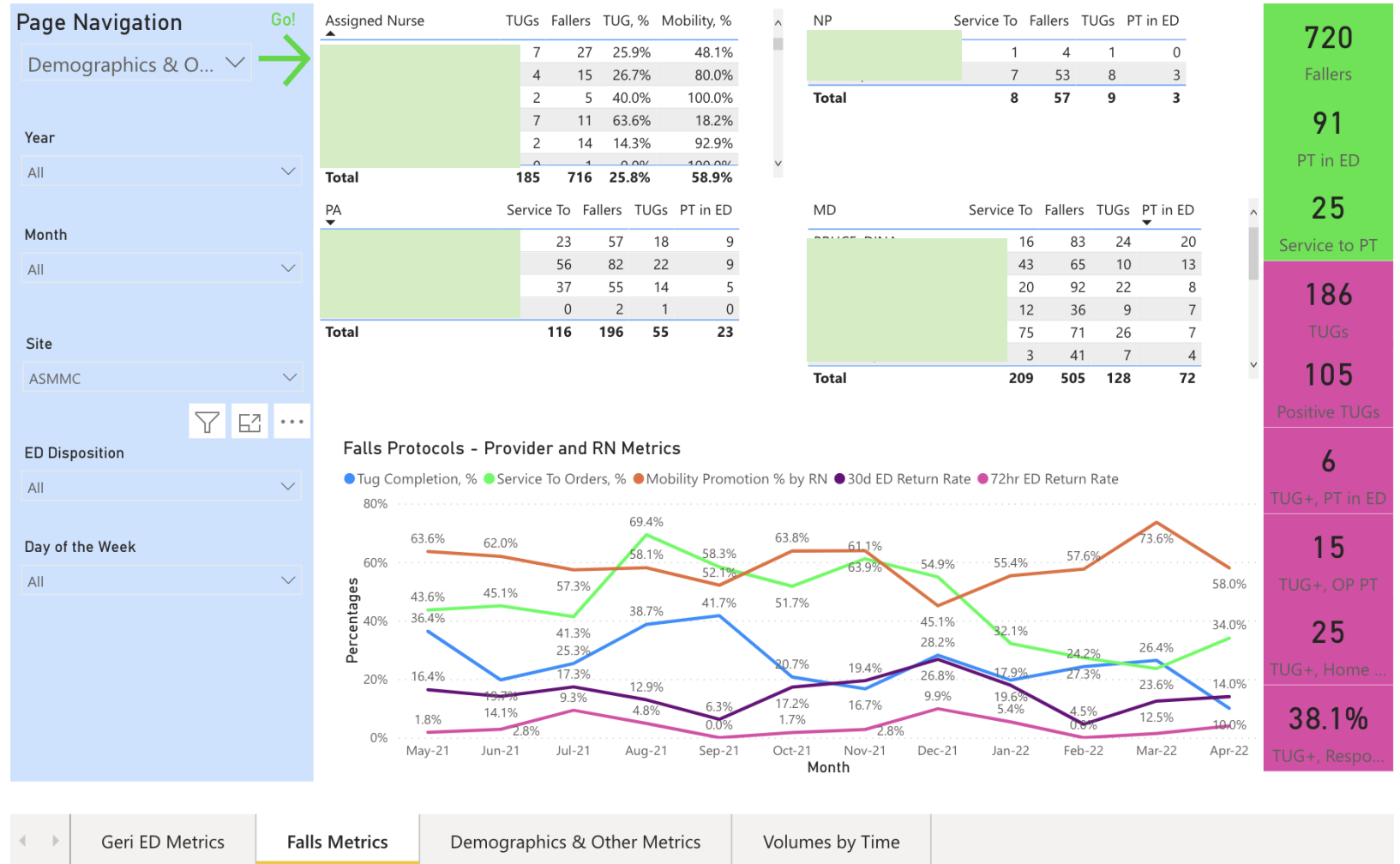
Name	Type	Pref List	Px Code
Consult PT for training	PT	ED OR...	PT4
Consult PT for training	PT	ED OR...	PT4
Chest physiotherapy (aka CHEST PHYSICAL THERAPY)	RES...	ED RE...	RT7

Buttons at the bottom: 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



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

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

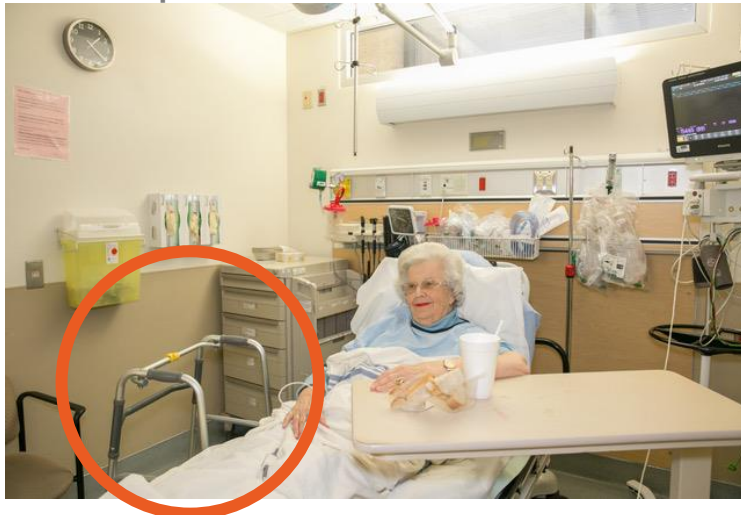
Evaluation

- 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!



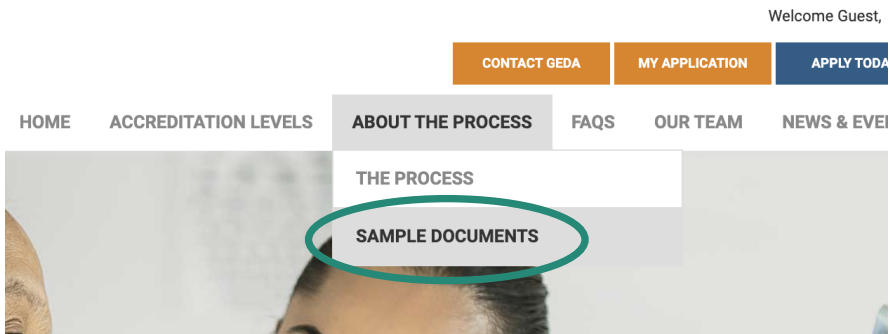
Access to Nutrition

- 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](#)

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[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	↓	↓	↓

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

GEDCollaborative.com

Resources



Resources Events Research

Resource Library

Implementation Toolkits

Clinical Curriculum

Journal of Geriatric Emergency Medicine

On-Demand Webinars

GEMCast Podcast

Blog

Search

JOURNAL OF GERIATRIC EMERGENCY MEDICINE

September 27, 2021

Volume 2, Issue 11, Review Article



Can an Emergency Department Adequately Address an Older Adult who has Complex Needs?

Rami Tarabay, MD, Adam Perry, MD, Riwa Al Aridi, PharmD, Michael Malone, MD

INTRODUCTION

The Emergency Department (ED) is a critical component of the geriatric continuum of care. Older adults comprise up to 25% of ED attendance and 38% of patients transported by emergency medical services (EMS).¹⁻⁴ Despite this, the traditional rapid linear ED treatment framework remains ill-equipped to meet the complex care needs of many vulnerable older adults.^{5,6} Upon discharge, the ED-to-home transition is a high-risk time for older adults. About one third of older adults will suffer an adverse result including ED revisit, eventual hospital referral, admission to a long-term care institution, or death within 3 months of the ED visit.⁶ Moreover, extended or frequent ED visits and repeated hospitalizations are costly. It



Teresita Hogan MD



Michael Malone MD



Elder Mistreatment Emergency Department Toolkit

1 in 10



people ages 60 and older experience some form of mistreatment



GEMCAST
Creating a Geriatric Emergency Department



778

GEMCAST - Creating a Geriatric Emergency Department

GEDC WEBINARS

Expert Panel Webinars

Healthcare providers & participants from across the nation and world

...a, Ireland, Australia,



Resources Events Research

Implementation Toolkits

EXPERT PANEL

Scott Wilber, MD, MPH
Chief Medical Officer,
Mount Carmel Health System,
Columbus, Ohio

Uta Huang, MD, MPH
GEDC Evaluation PI
Yale School of Medicine
Professor of Emergency
Medicine, Vice Chair for
Research, Emergency
Medicine

Kevin Blase, MD, MAT
GEDC Implementation PI
UNC School of Medicine
Director of the Division of
Geriatric Emergency
Medicine

For more details, please visit <https://gedcollaborative.com/>

Delirium in the Older Emergency Department Patient (ED-DEL)

Change Package and Toolkit





THANK YOU!

Questions?

Closing Remarks



**Blackfoot
Community Hospital**
North Browning, Montana

**Cherokee
Indian Hospital**
Cherokee, NC

**Gallup Indian
Medical Center**
Gallup, New Mexico

**Parker Indian
Health Center**
Parker, Arizona

**Northern Navajo
Medical Center**
Shiprock, New Mexico

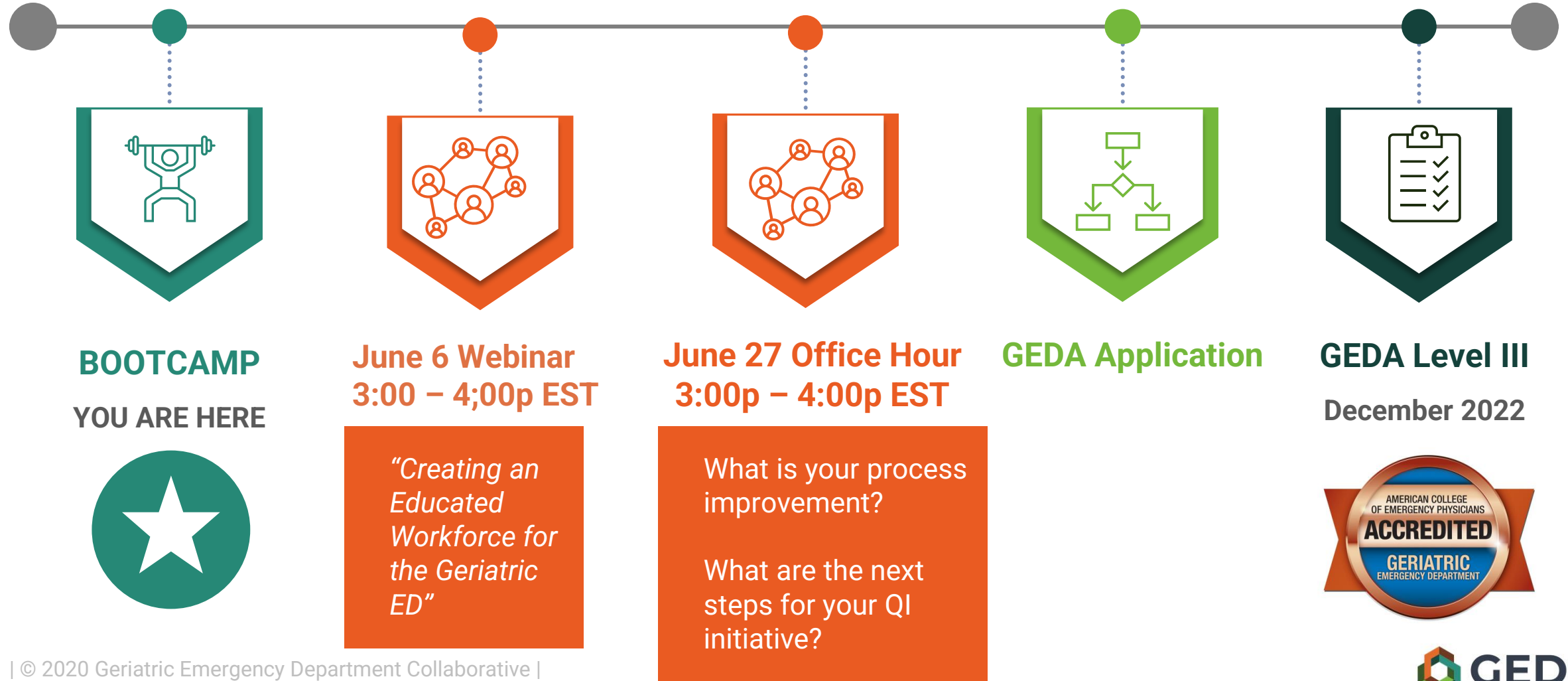
**San Carlos
Apache Healthcare**
Peridot, Arizona

**Crow Agency/Northern
Cheyenne Hospital**
Lame Deer, Montana

**Cheyenne River
Health Center**
Eagle Butte, South Dakota

Your Path to Process Improvements

NEXT STEPS



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/IHS/

And click on the Course Evaluation button

A rectangular button with a white background and a subtle drop shadow. The text "Course Evaluation" is written in a white, sans-serif font and is centered on the button. The button has a slight 3D effect with a shadow underneath.

Course Evaluation

Use your phone to scan this QR code:



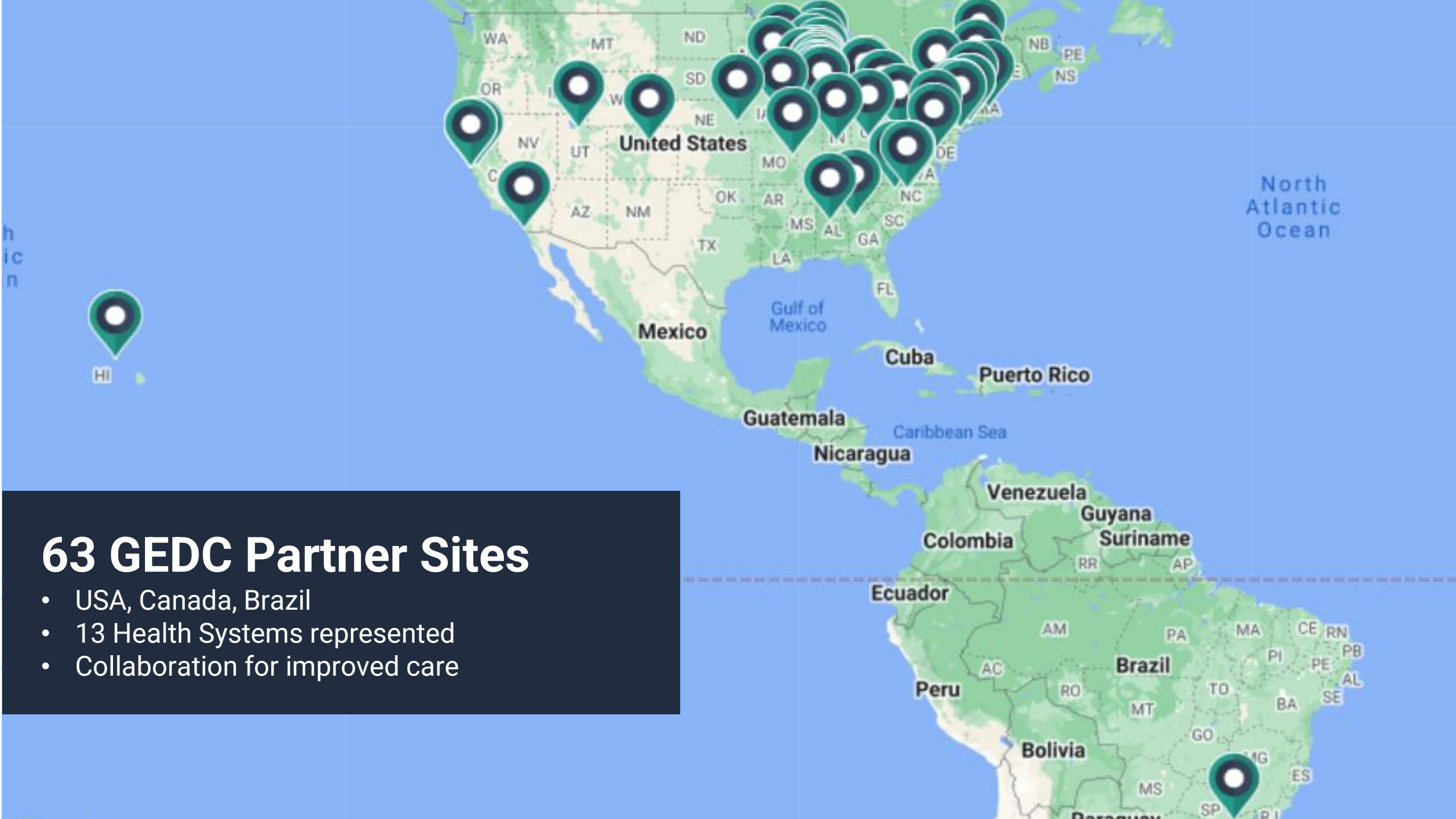
GEDC Partner Sites

gedcollaborative.com/partnership

Partnership

GEDC Partners work together to transform ED care of older adults; catalyze action at local and national levels to support these care transformations; and evaluate the impact of these new models of care for older people.

GEDC is comprised of Emergency Departments dedicated to accomplishing these goals together, and sharing best practices in order to accelerate the evolutions in care models needed to improve emergency care for older adults.



63 GEDC Partner Sites

- USA, Canada, Brazil
- 13 Health Systems represented
- Collaboration for improved care



GEDC

THE GERIATRIC
EMERGENCY DEPARTMENT
COLLABORATIVE

EDUCATE IMPLEMENT EVALUATE

Partnership

GEDC Partners work together to transform ED care of older adults; catalyze action at local and national levels to support these care transformations; and evaluate the impact of these new models of care for older people.



Join the GEDC

- Become a partnering member site
- Access to GEDC community forum
- Share best Geri-ED practices
- Access to education, implementation and evaluation resources

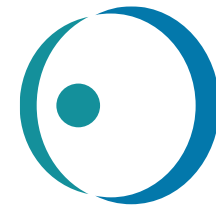
gedcollaborative.com/hospital-application/

gedcollaborative.com/hcs-partnership-application/

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