GEDC | THE GERIATRIC EMERGENCY DEPARTMENT COLLABORATIVE

EDUCATE IMPLEMENT EVALUATE

Indian Health Service and Tribal Hospitals

GEDC BOOTCAMP

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

ACEP Geriatric Emergency Department Accreditation

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

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THE GERIATRIC EMERGENCY DEPARTMENT COLLABORATIVE
EDUCATE IMPLEMENT EVALUATE

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

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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.

JOINT ACCREDITATION™
INTERPROFESSIONAL CONTINUING EDUCATION

Credit Statement(s)

AMA

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

CPD

ANCC

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

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Learning Objectives

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

- 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

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ce.mayo.edu, About Us, Disclosures - or - https://ce.mayo.edu/content/disclosures

IHS and Tribal Hospitals GEDC Geri-ED Boot Camp

May 19,2022 1:00p – 3:30p EST

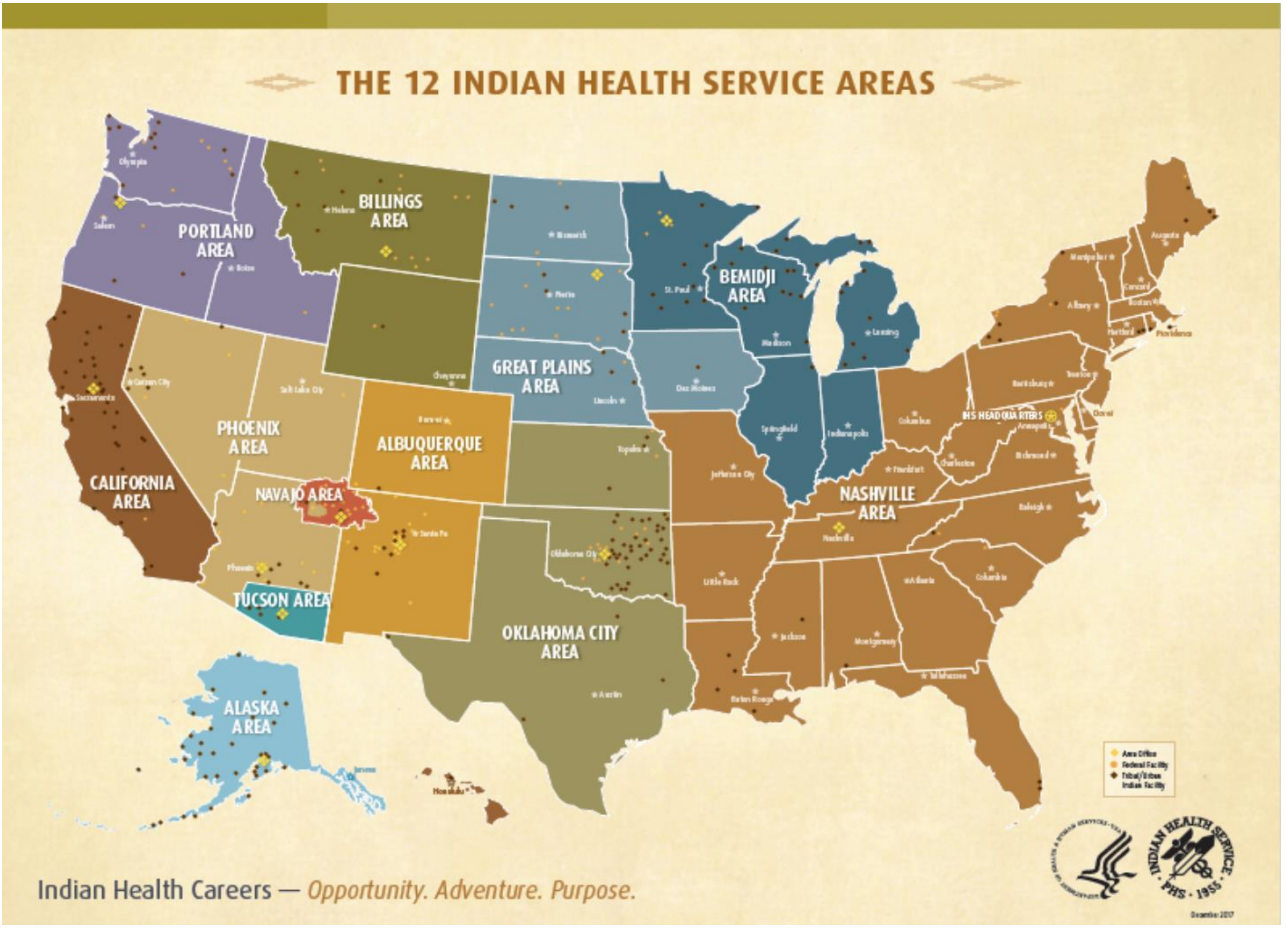
Time pm (EST)	Topic	Presenter(s)
1:00-1:15 (15 mins)	Welcome & Introductions	IHS / GEDC
1:15-1:25 (10 mins)	Program Awards & Grant Opportunities	Dr. Bruce Finke
1:25-1:45 (15 mins)	Why GEDs & Accreditation Criteria	Dr. Kevin Biese
1:45-2:00 (15 mins) 2:00-2:15 (15 mins)	Case Studies (Breakout Rooms) 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



Blackfeet 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

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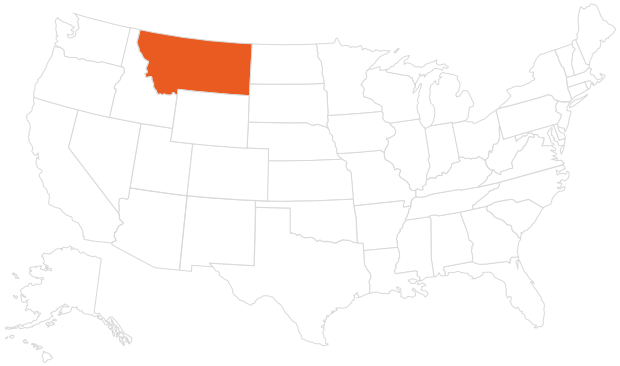
Blackfeet Community Hospital

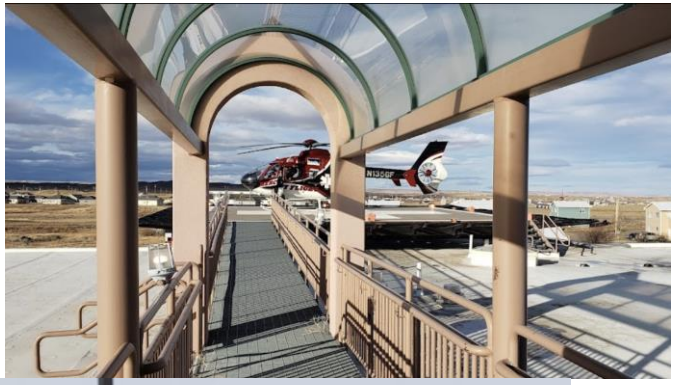
IHS

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 it's 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.

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Cherokee Indian Hospital

CHEROKEE INDIAN HOSPITAL AUTHORITY

TRIBAL

TRIBAL EMERGENCY DEPARTMENT

OLDER ADULTS SERVED

Annually in the ED

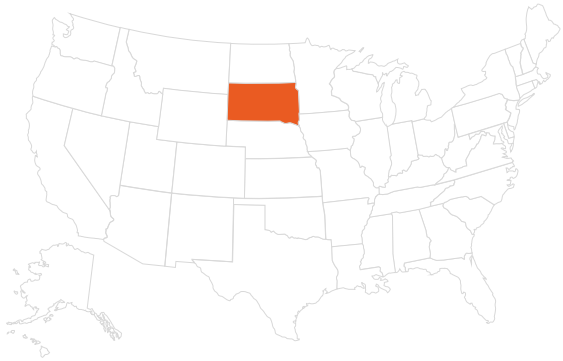
TEAM MEMBERS

GEDC

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 it's 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.

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Crow Agency/Northern Cheyenne Hospital

IHS

EMERGENCY DEPARTMENT

Critical Access Hospital

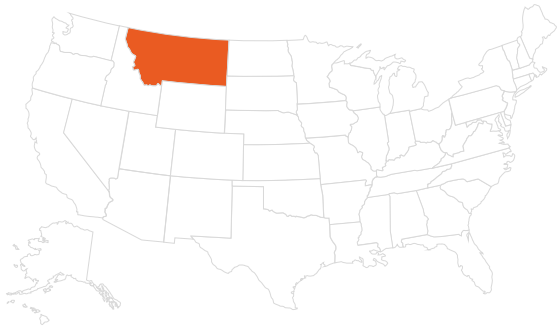
Serves 2 tribes – Crow and Northern Cheyenne

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.

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Gallup Indian Medical Center

IHS

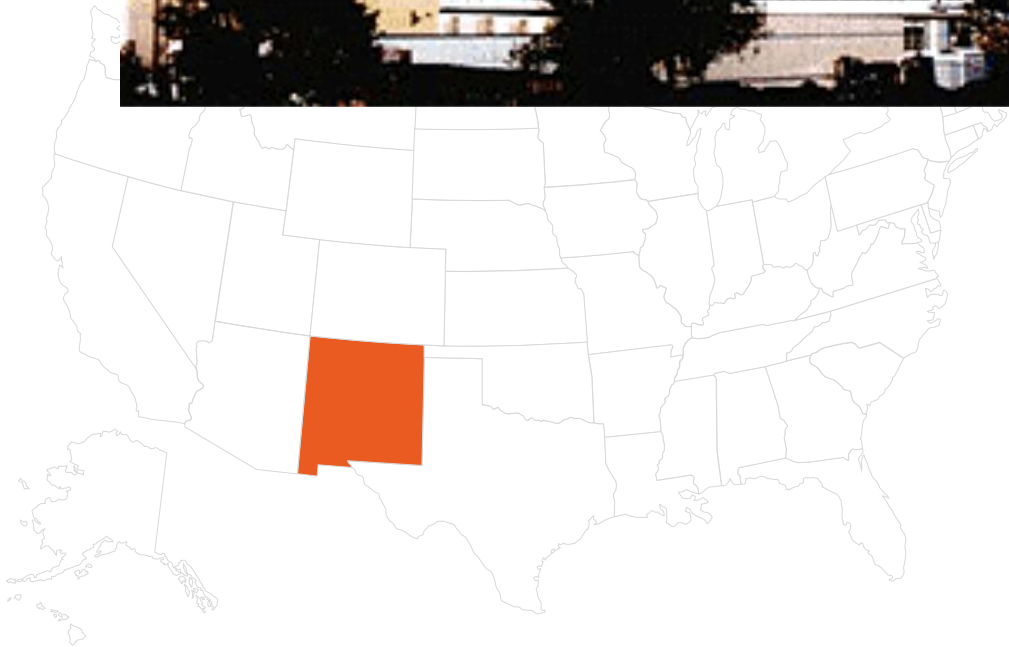
EMERGENCY DEPARTMENT

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

250,000

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.

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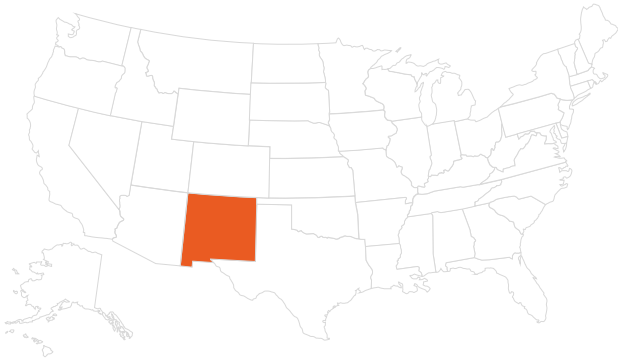
Northern Navajo Medical Center

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.

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Parker Indian Health Center

IHS

EMERGENCY DEPARTMENT

Critical Access Hospital

Serves 4 communities

7,850

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 it's 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.

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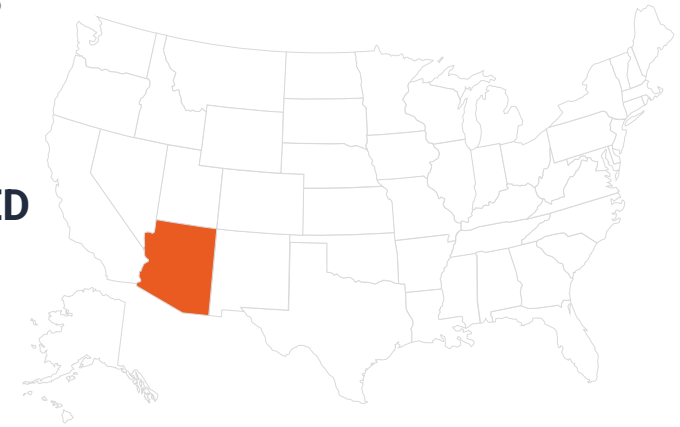
San Carlos Apache Healthcare

Izeé Baa Gowąh
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.

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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

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Geriatric EDs: The Why?

Kevin Biese
MD, MAT

Geriatric Emergency Department Collaborative Implementation PI

Chair, Geriatric Emergency Department Accreditation

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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)

GEDC https://gedcollaborative.com/resources/

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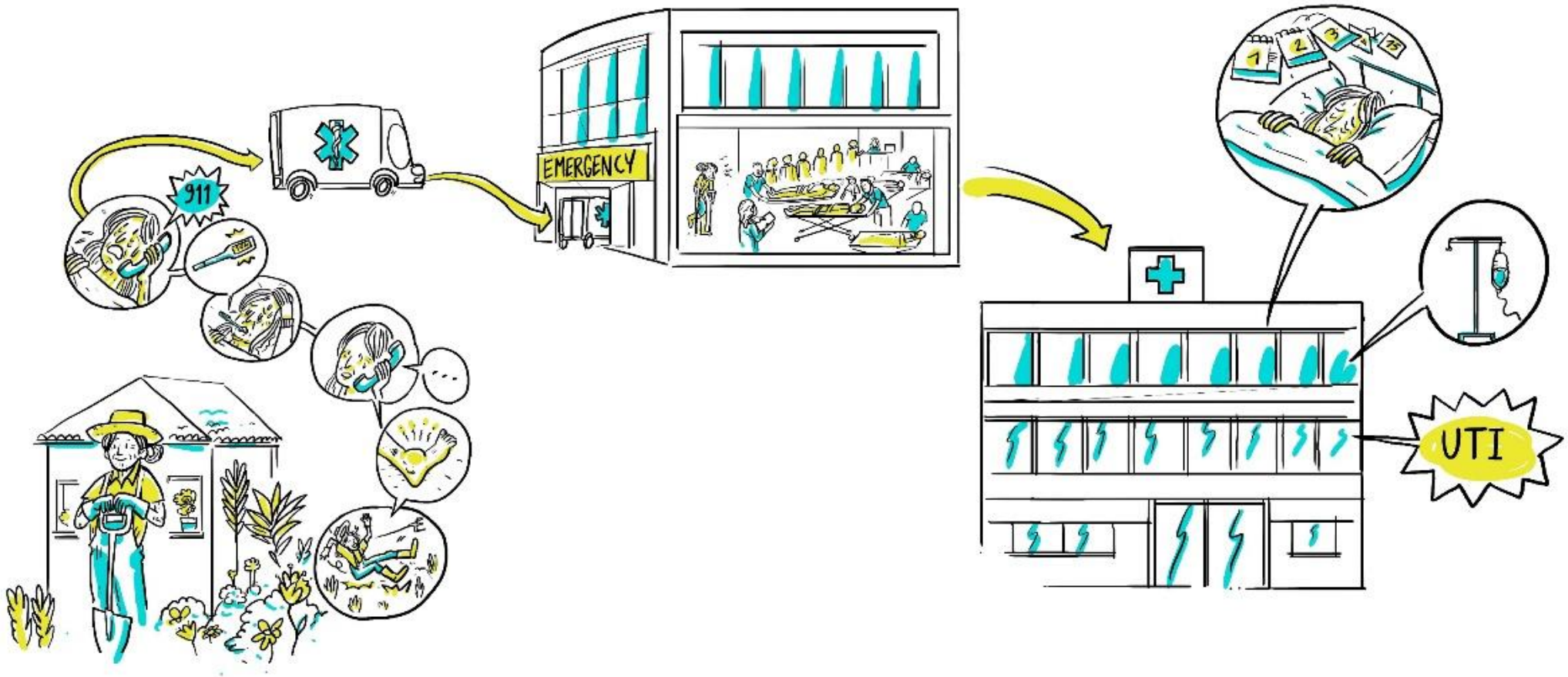

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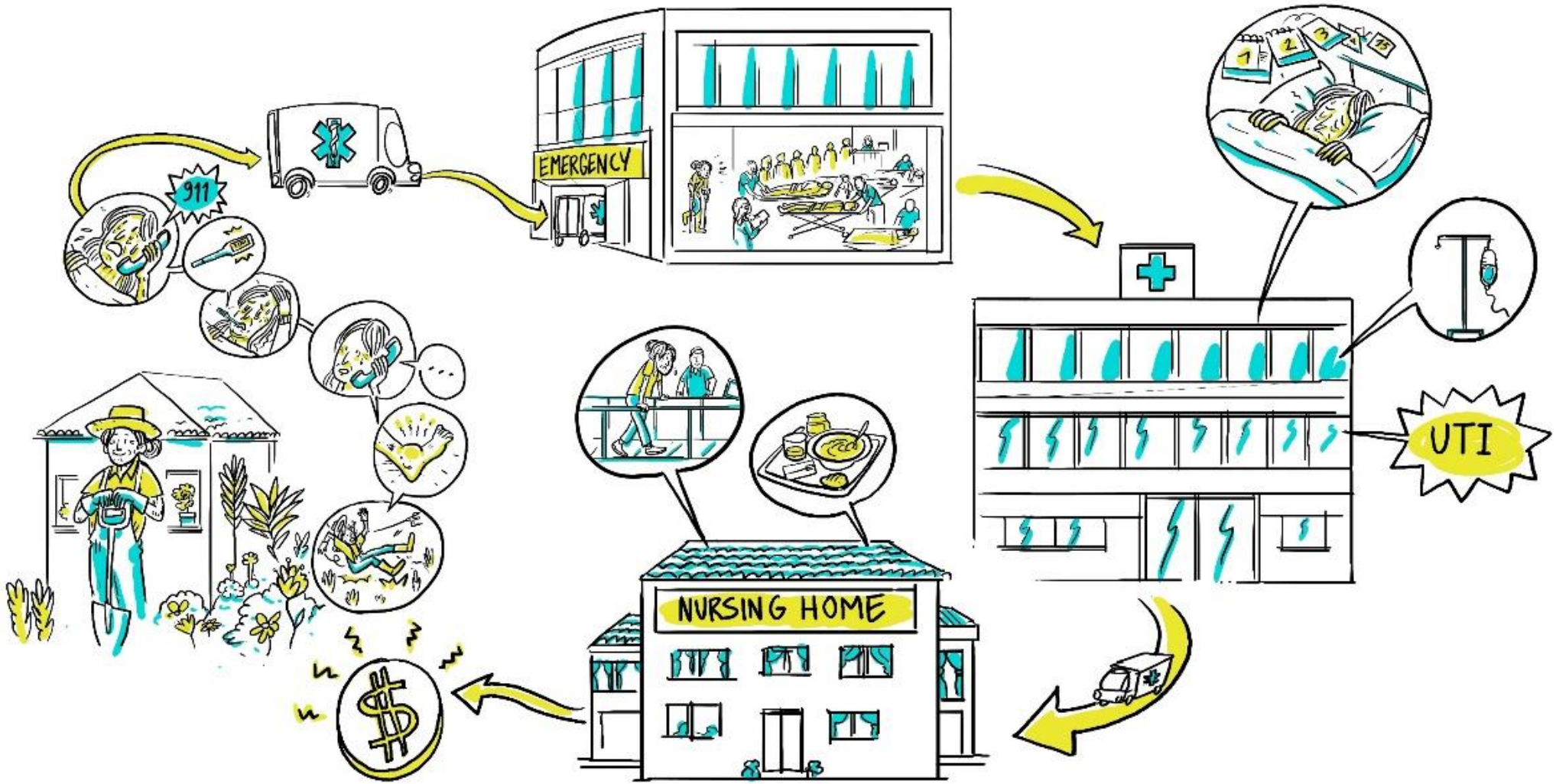

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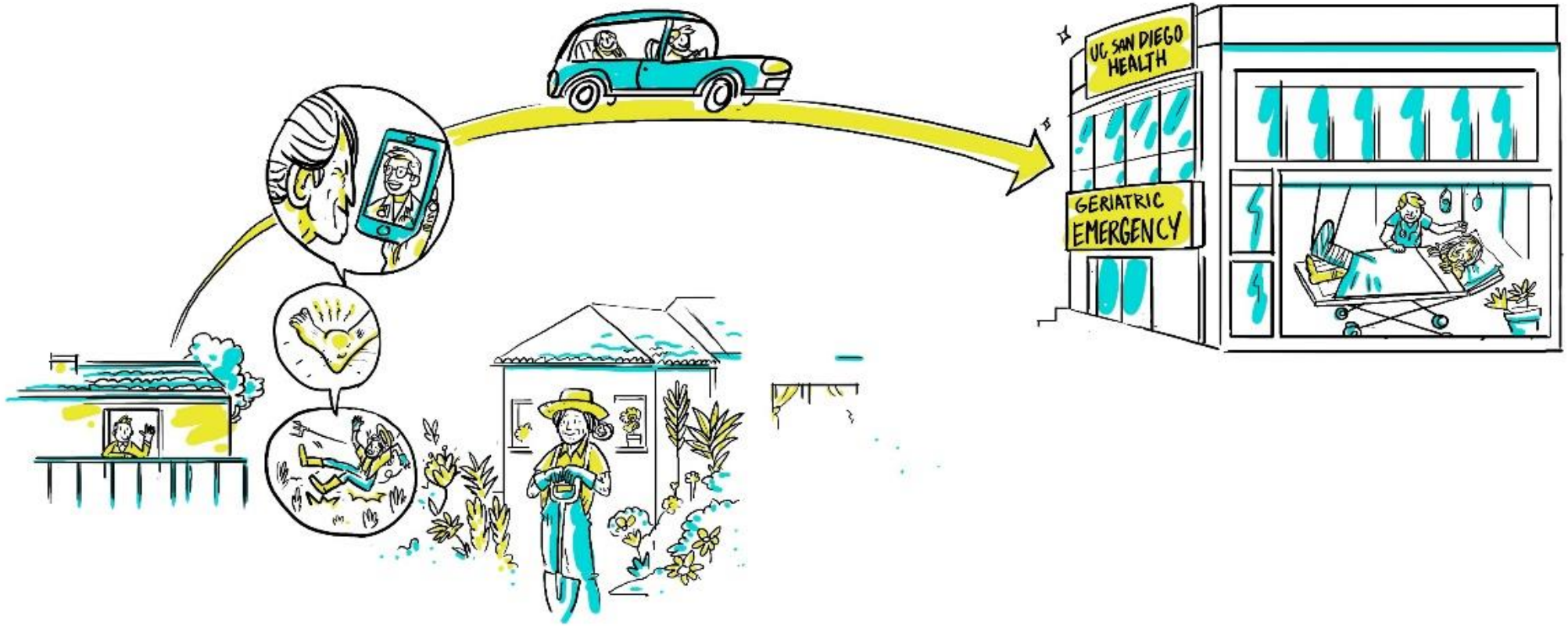

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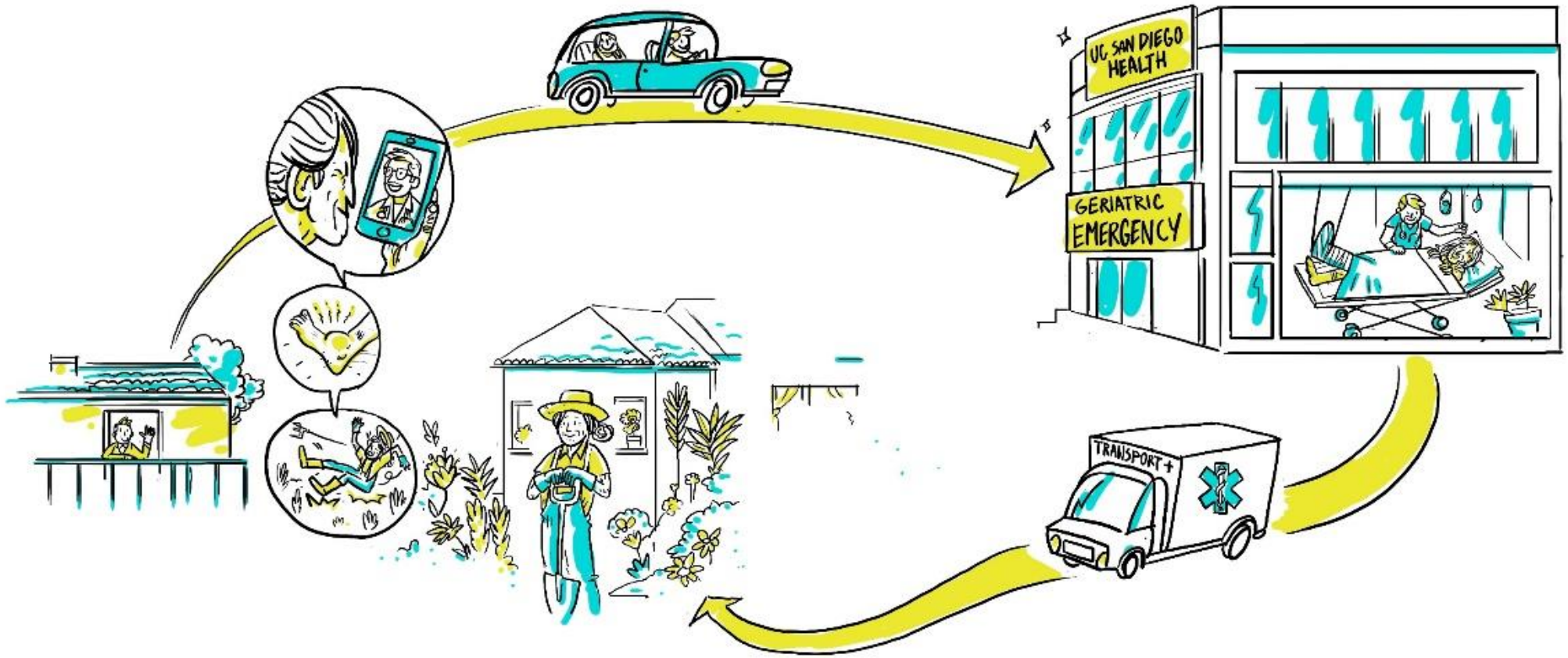

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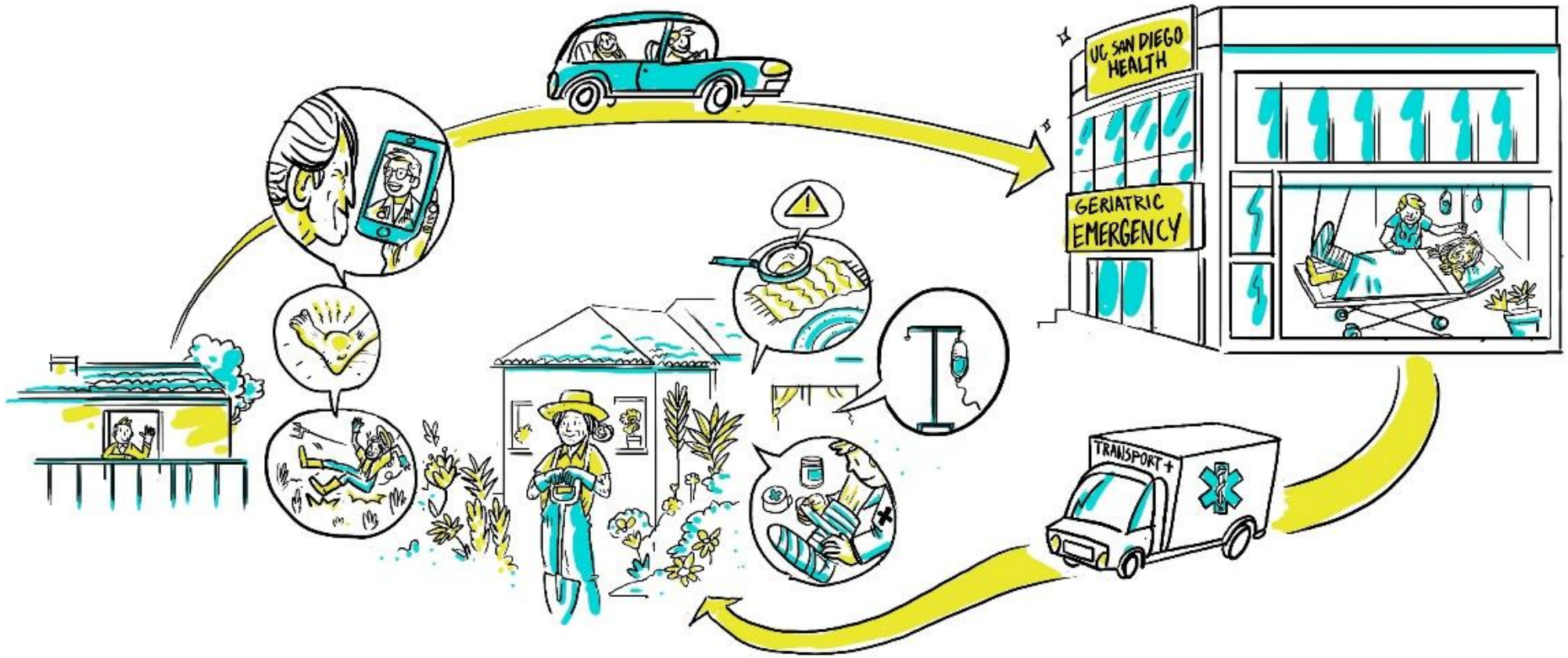

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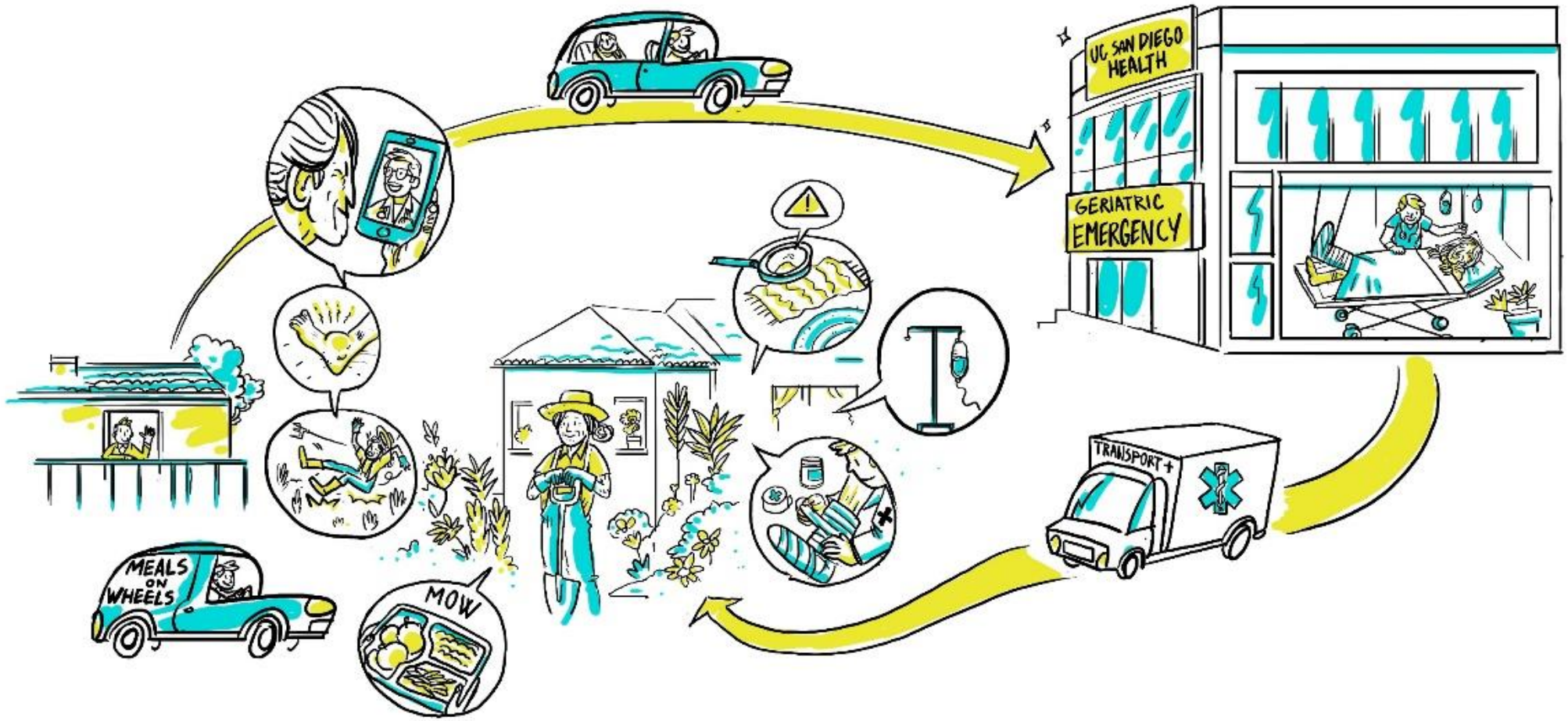

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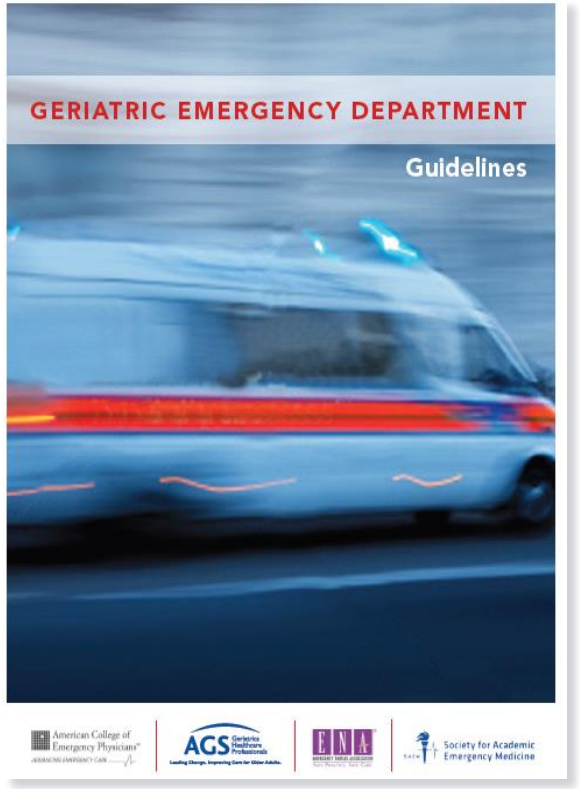
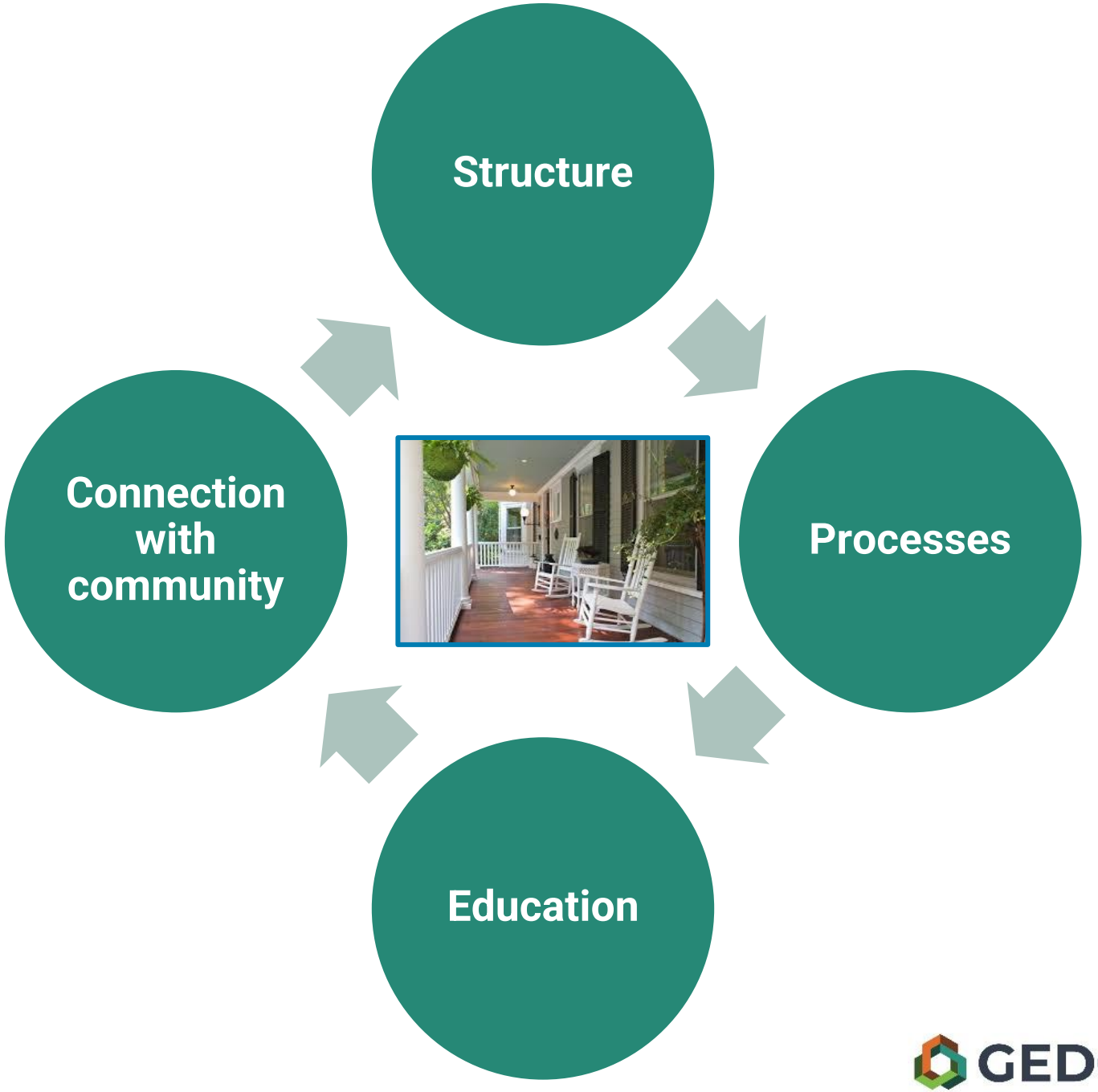
Geriatric ED Guidelines

Four Critical Components of a Geriatric-Appropriate ED



Geriatric ED Guidelines 2014



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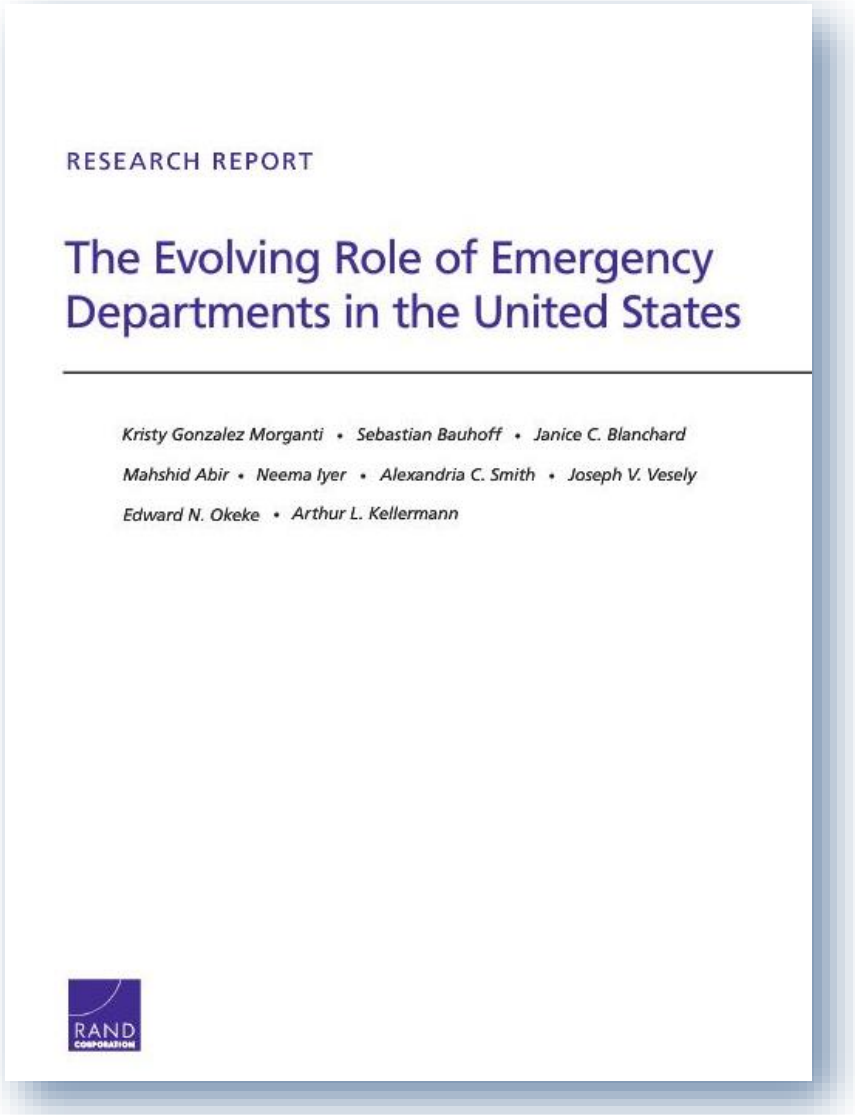
Critical Role of ED in Cost and Care Trajectory

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



A growing body of literature supports Geriatric EDs as a solution

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Greater than 90% of Accredited GEDs launched without external funding

INITIAL OUTCOMES AT A GLANCE

GREATER

Patient Satisfaction

LOWER COSTS

Leveraging interdisciplinary team

16.5%

Reduced risk of hospital readmission

LOWER RISK

Of 30-day fall-related ED revisits

westhealth

What can a Geriatric Emergency Department do for my hospital?

DECREASE READMISSIONS

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

DECREASE ED REVISITS IN HIGH-RISK POPS.

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

INCREASE MARKET SHARE

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

BETTER 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

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We Recover
In Beauty Before Us We Walk
Holy Beings Take Us
INFORMATION DESK
SECURITY
PINK

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

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Case Studies: Three Older Adults

Mrs. Cado	78-year-old woman with a broken wrist “ready for discharge”
Mrs. Schwach	80-year-old woman, not feeling right “Mom seems a little off”
Mr. Ivanhoe	87 year old male “familiar face”

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

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

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Joining Breakout Rooms

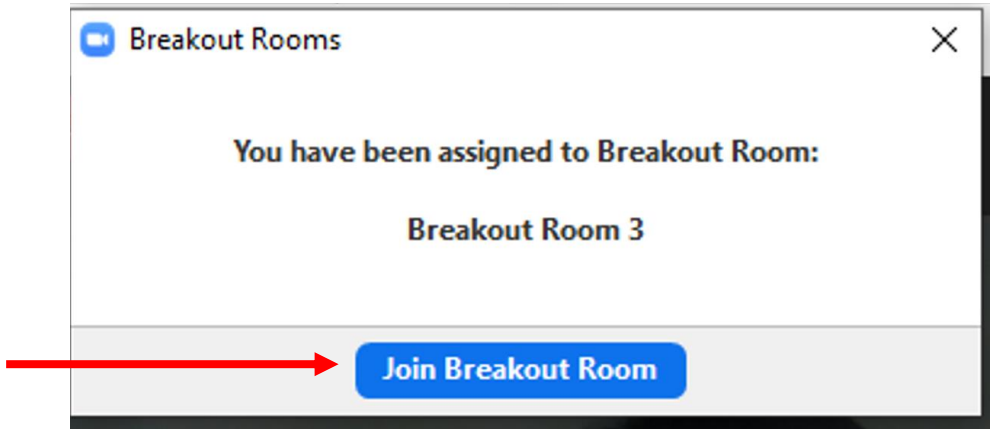
QUICK OVERVIEW

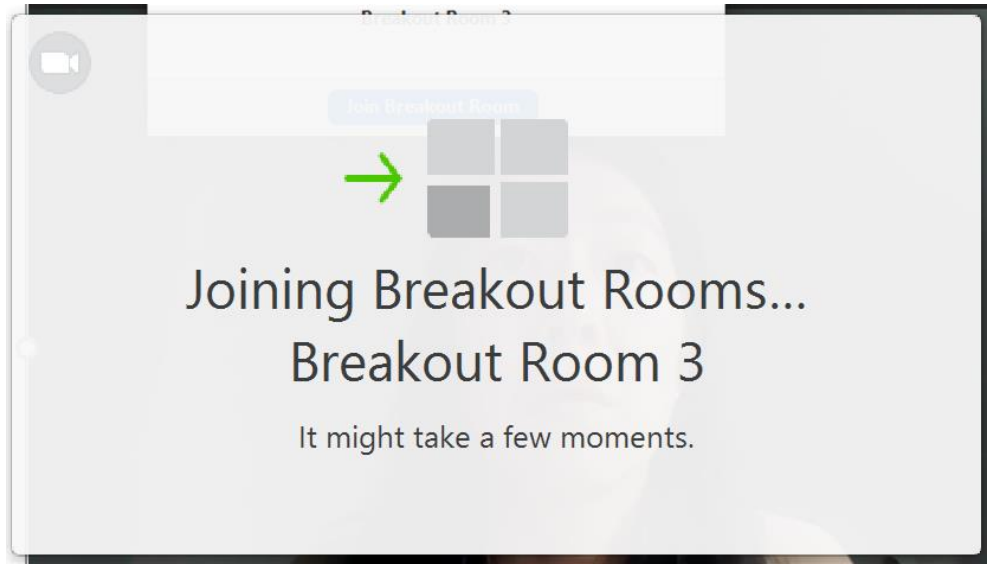
You have already been assigned to your breakout room.

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

Please be patient.

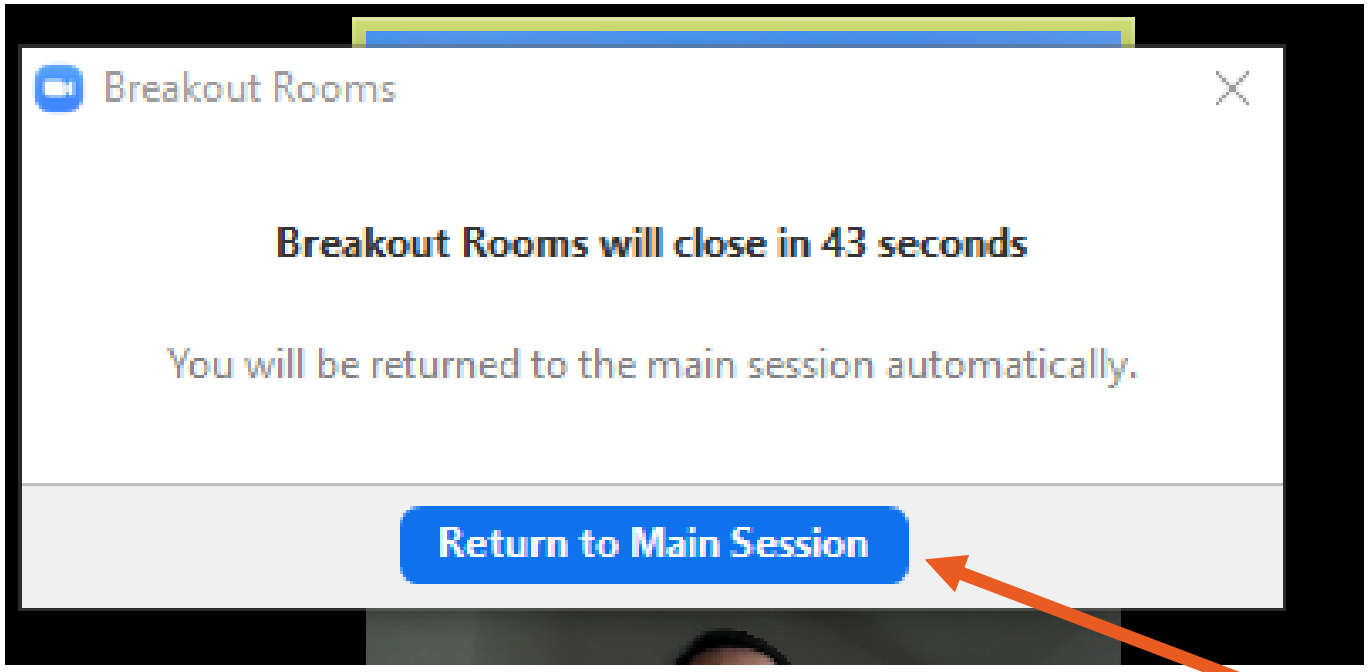
It can take a little while for all the connections to come through.





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)

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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

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

Pam Martin, MS, RN, GCNS-BC

Yale New Haven Health

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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:

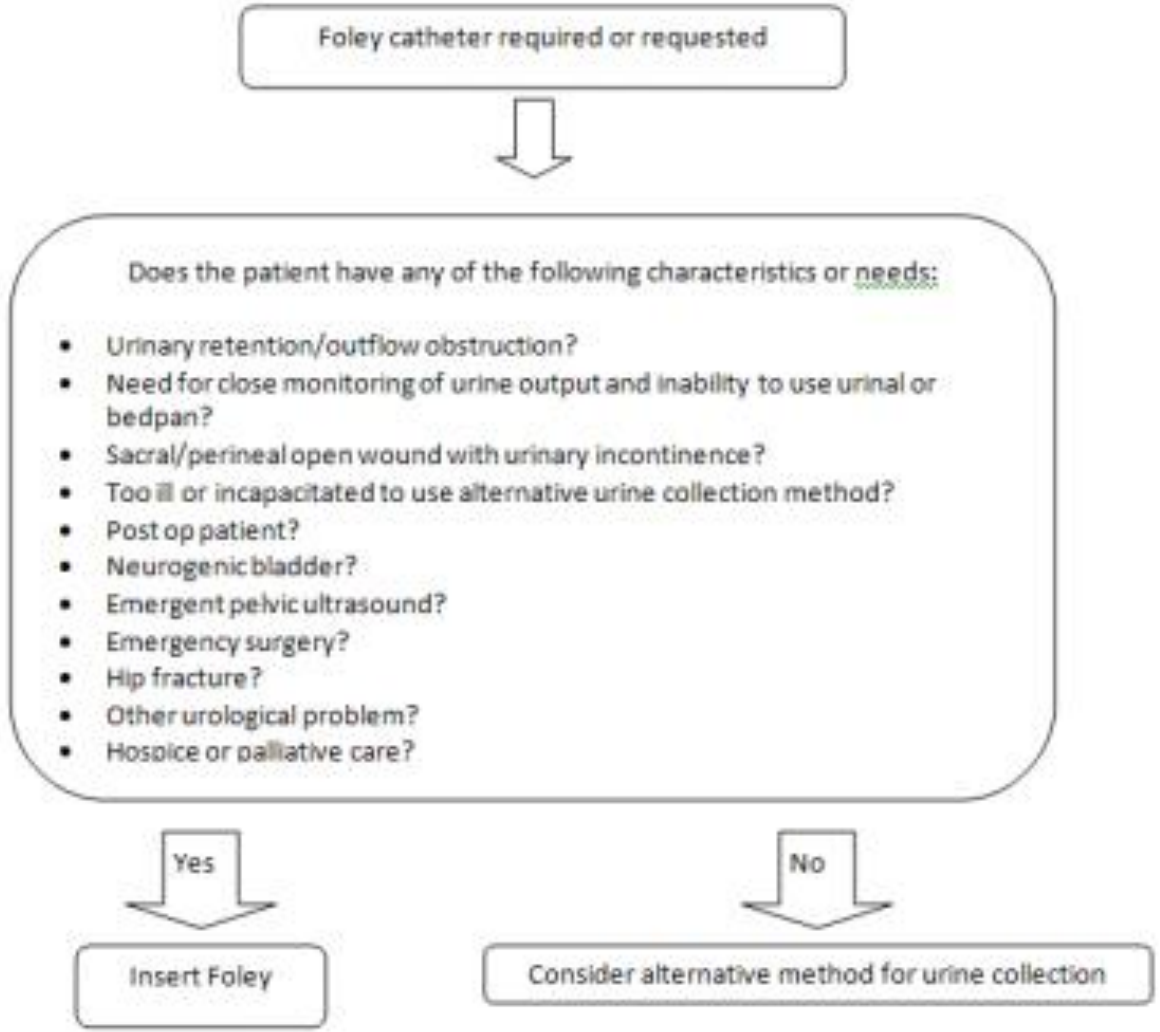
Policy needs to be **ED and Older Adult** specific

Example:

<u>Urinary Catheter:</u>

For ED patients age > 65

introduce decision algorithm



To satisfy accreditation criteria:

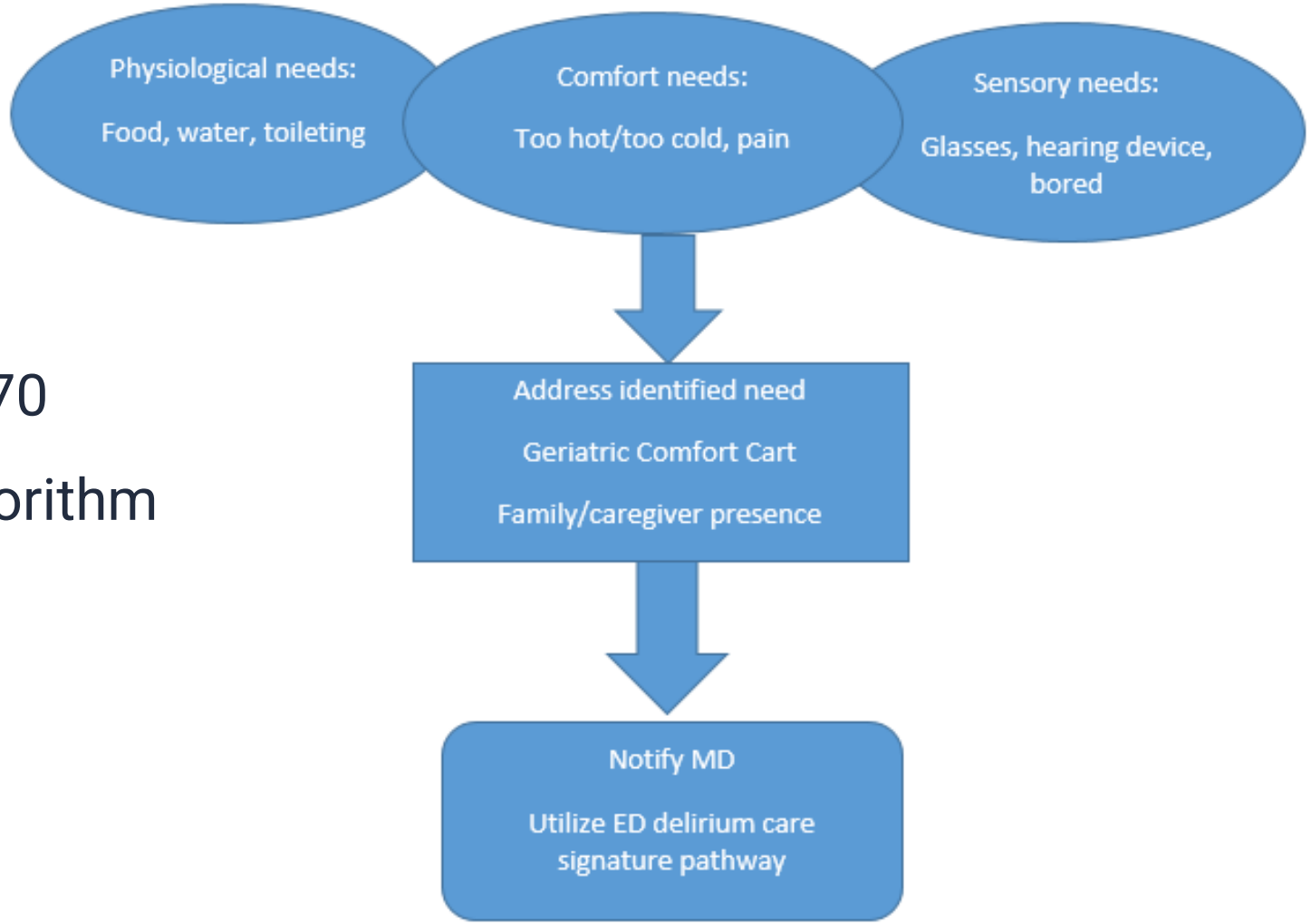
Policy needs to be **ED and Older Adult** specific

Example:

<u>Use of Restraints:</u>

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

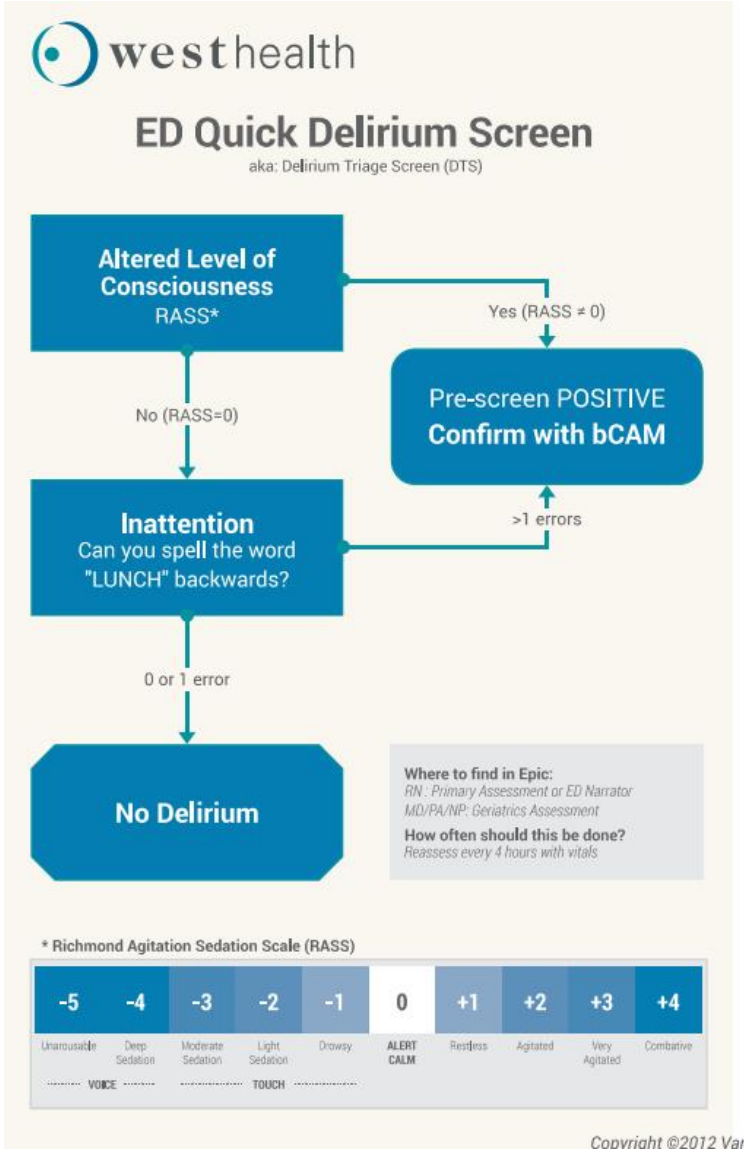
[Delirium_EDImplementationToolkit.pdf (gedcollaborative.com)]

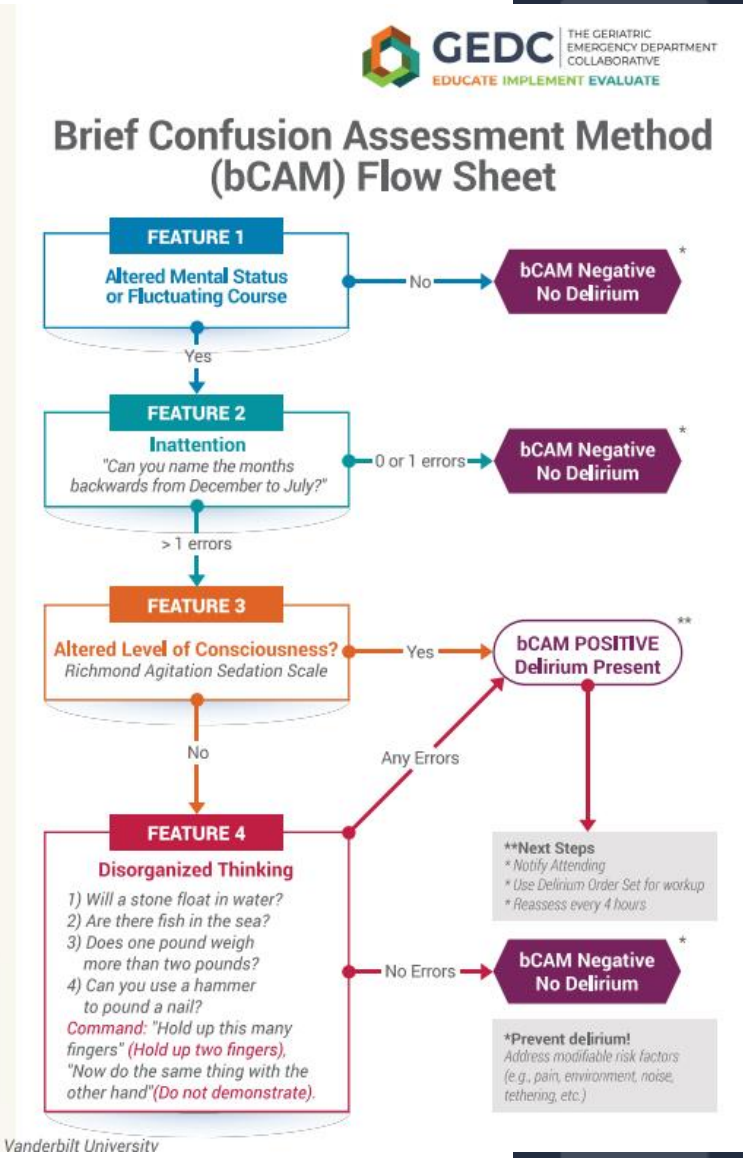
Screening Tools

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





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?	☐ Yes ☐ No	01 00
2) In the last 24 hours, have you needed more help than usual?	☐ Yes ☐ No	01 00
3) Have you been hospitalized for one or more nights during the past six months?	☐ Yes ☐ No	01 00
4) In general, do you see well?	☐ Yes ☐ No	00 01
5) In general, do you have serious problems with your memory?	☐ Yes ☐ No	01 00
6) Do you take six or more medications every day?	☐ Yes ☐ No	01 00
Positive test is 2 or more	Total	/6

N/A, not applicable

TRST

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

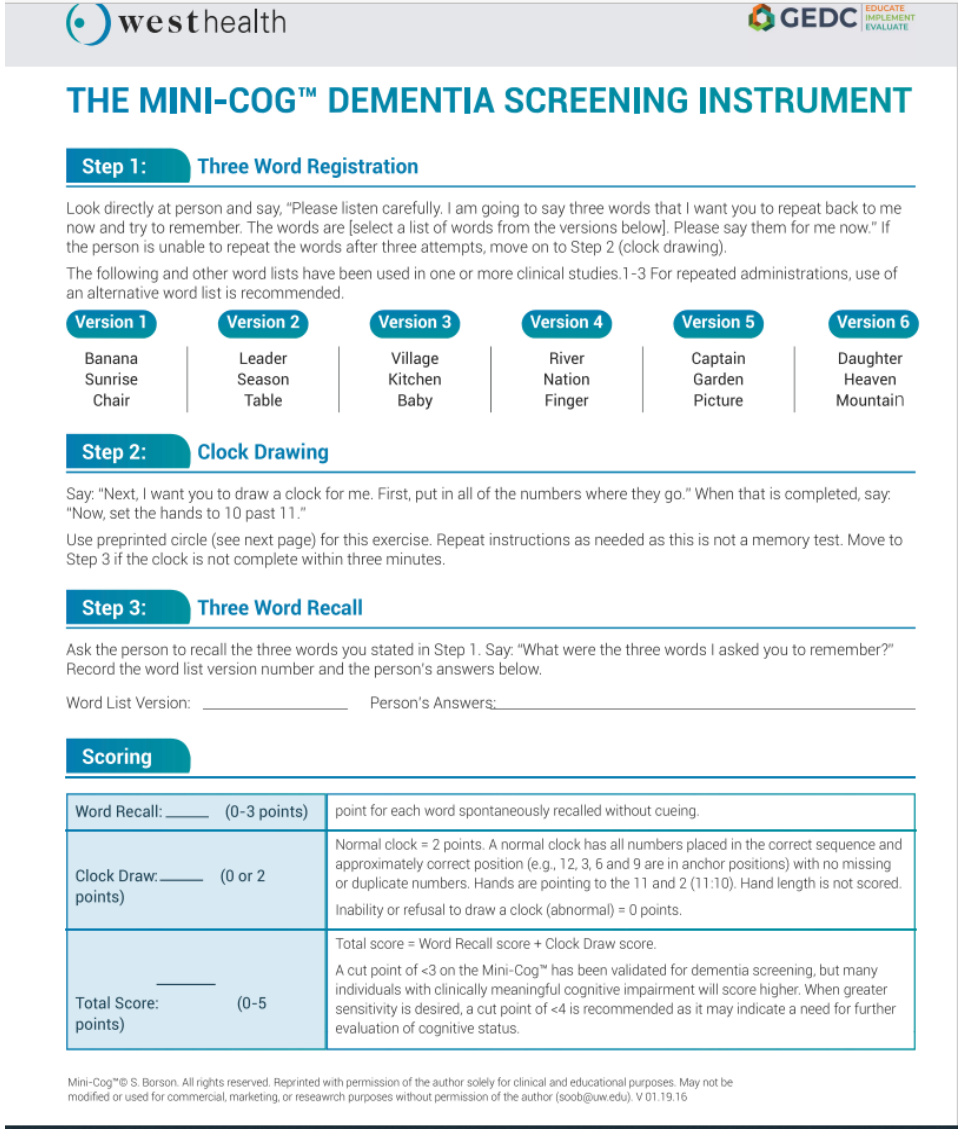
with appropriate follow-up

- 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

gedcollaborative.com/toolkit/dementia-2/



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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	Leader	Village	River	Captain	Daughter
Sunrise	Season	Kitchen	Nation	Garden	Heaven
Chair	Table	Baby	Finger	Picture	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

GEDC

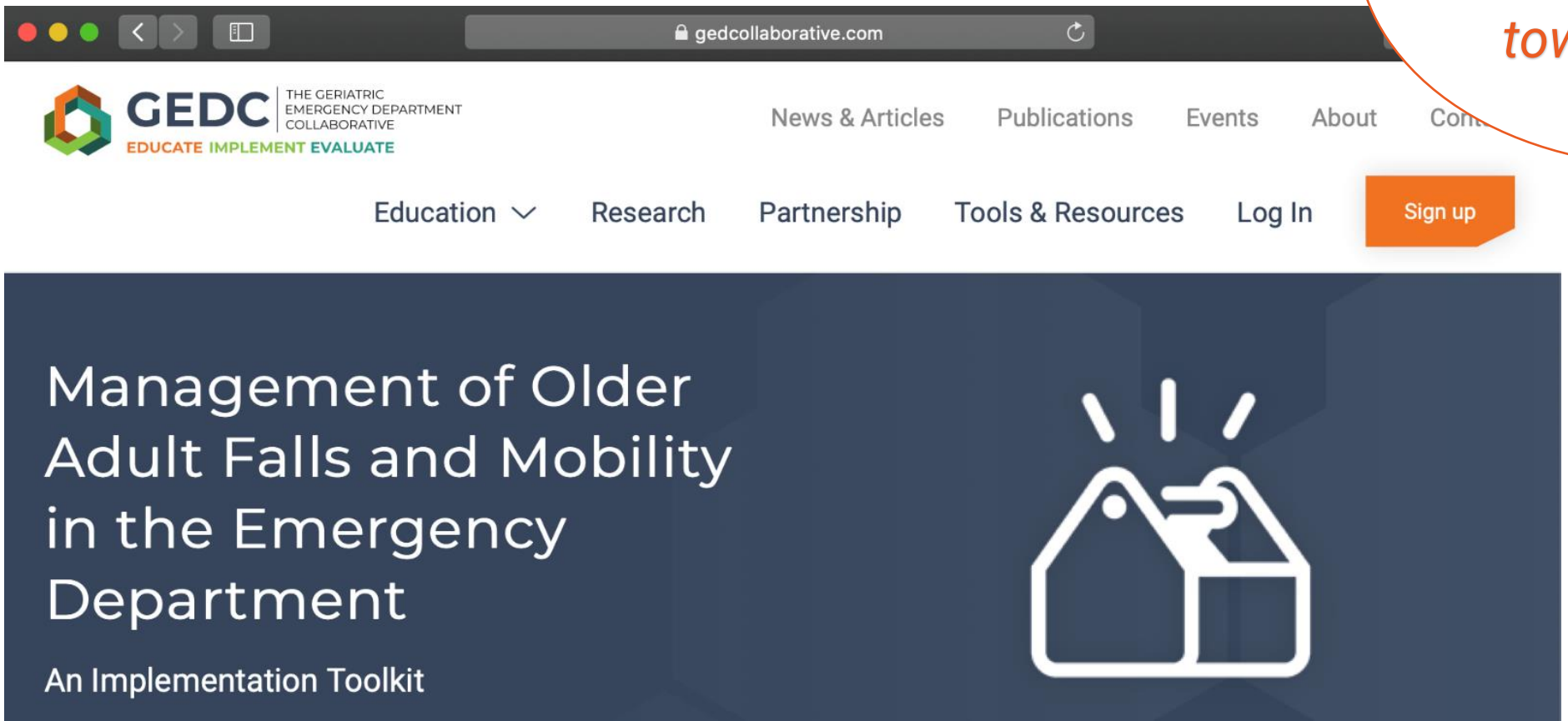
Falls & Mobility Implementation Tool Kit

WEST HEALTH GEDC FALLS & MOBILITY TOOLKIT

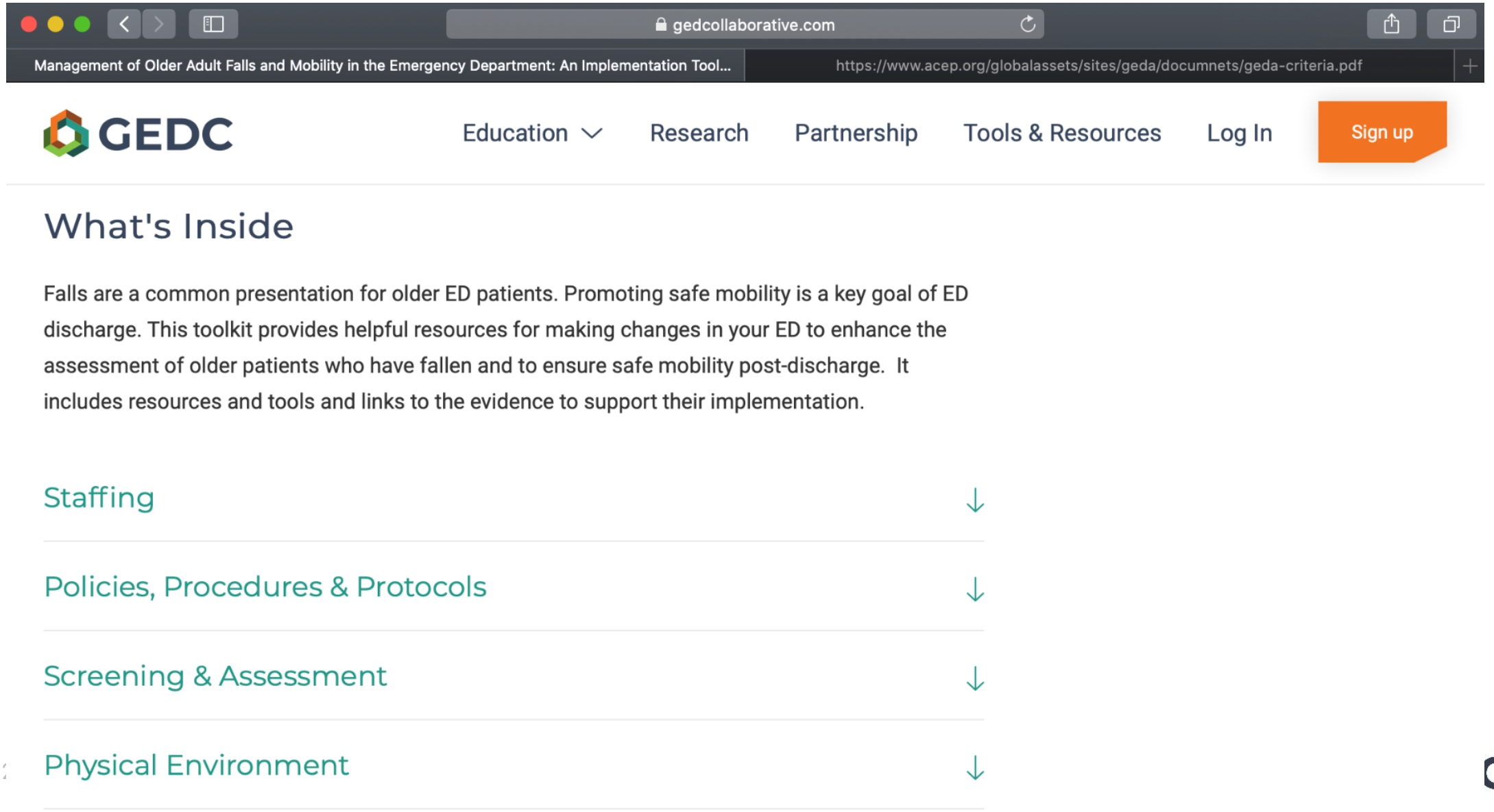
gedcollaborative.com/toolkit/falls-and-safe-mobility/

...pssst...

...it counts for TWO procedures towards GEDA



Falls & Mobility Implementation Tool Kit



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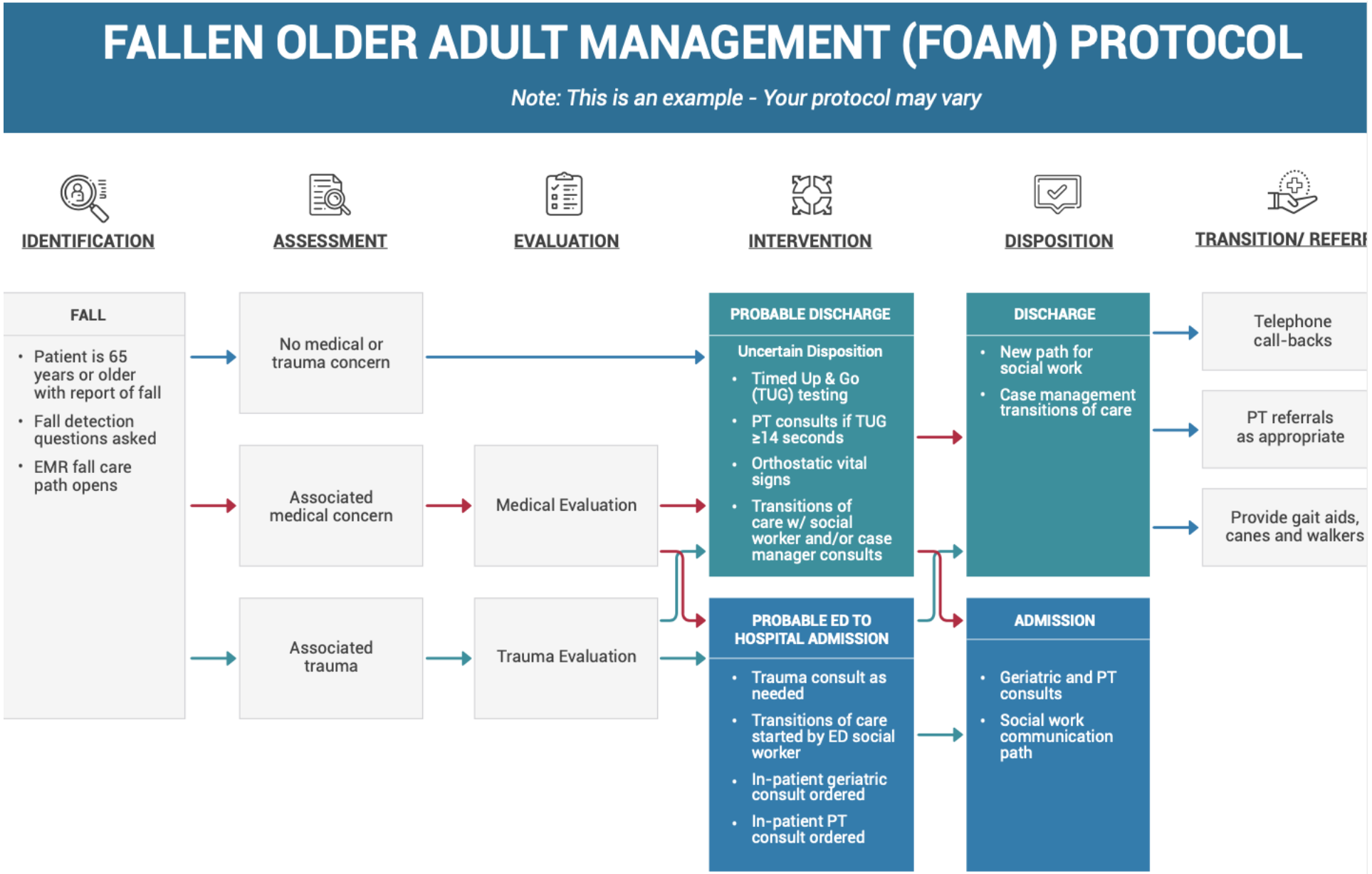
FOAM Protocol

INITIATING AT BEDSIDE

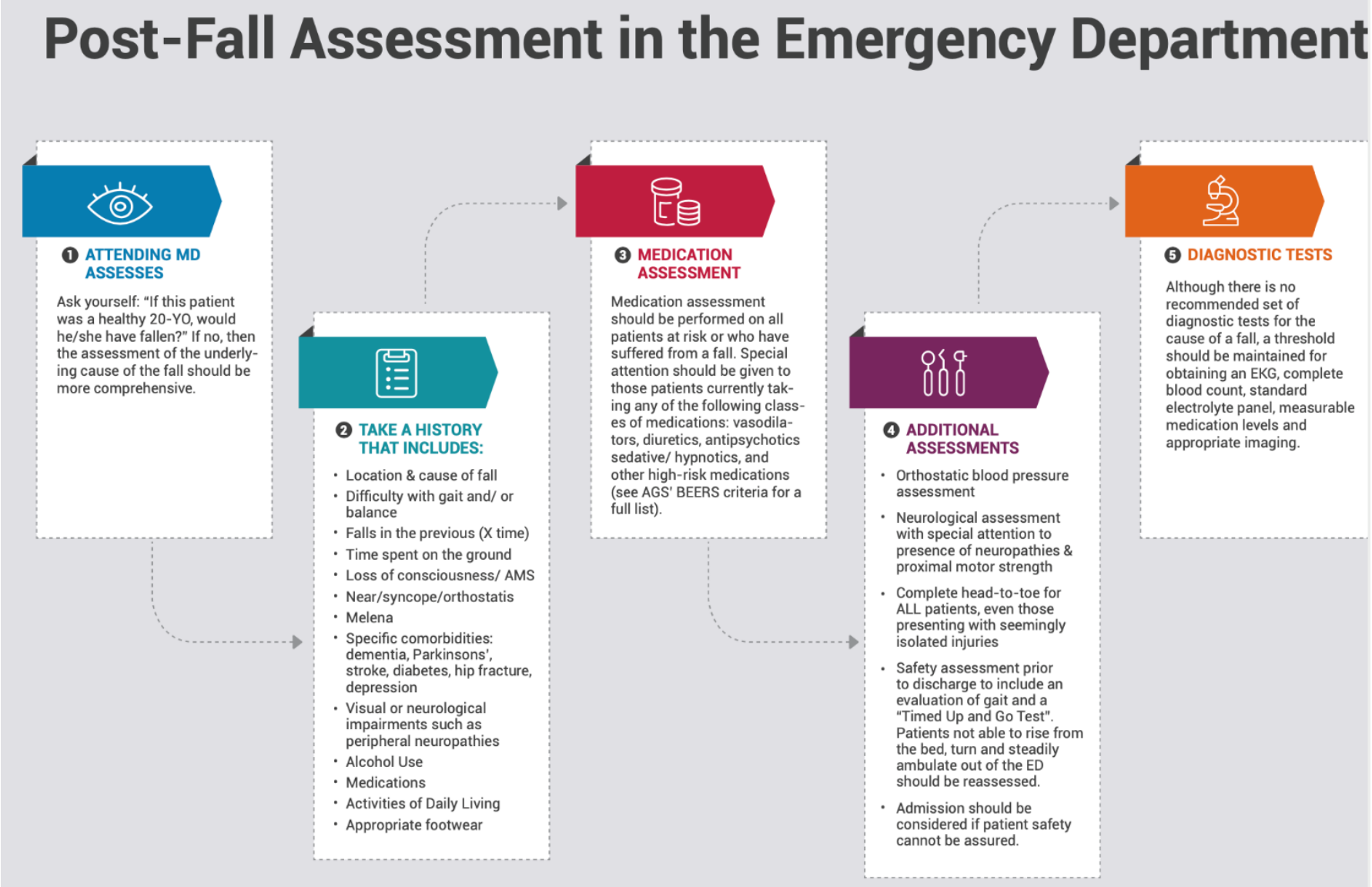
Note: Tailor to your specific needs and resources



Post-Fall Assessment

INITIATING AT BEDSIDE

Note: Example of potential assessments



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GEDC

GEDC

TUG Test & Interpretation

INITIATING AT BEDSIDE

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GEDC

TIMED UP & GO TEST

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

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

INSTRUCTIONS:

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

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

Expected Gait Speed

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

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

Predictive Interpretation

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

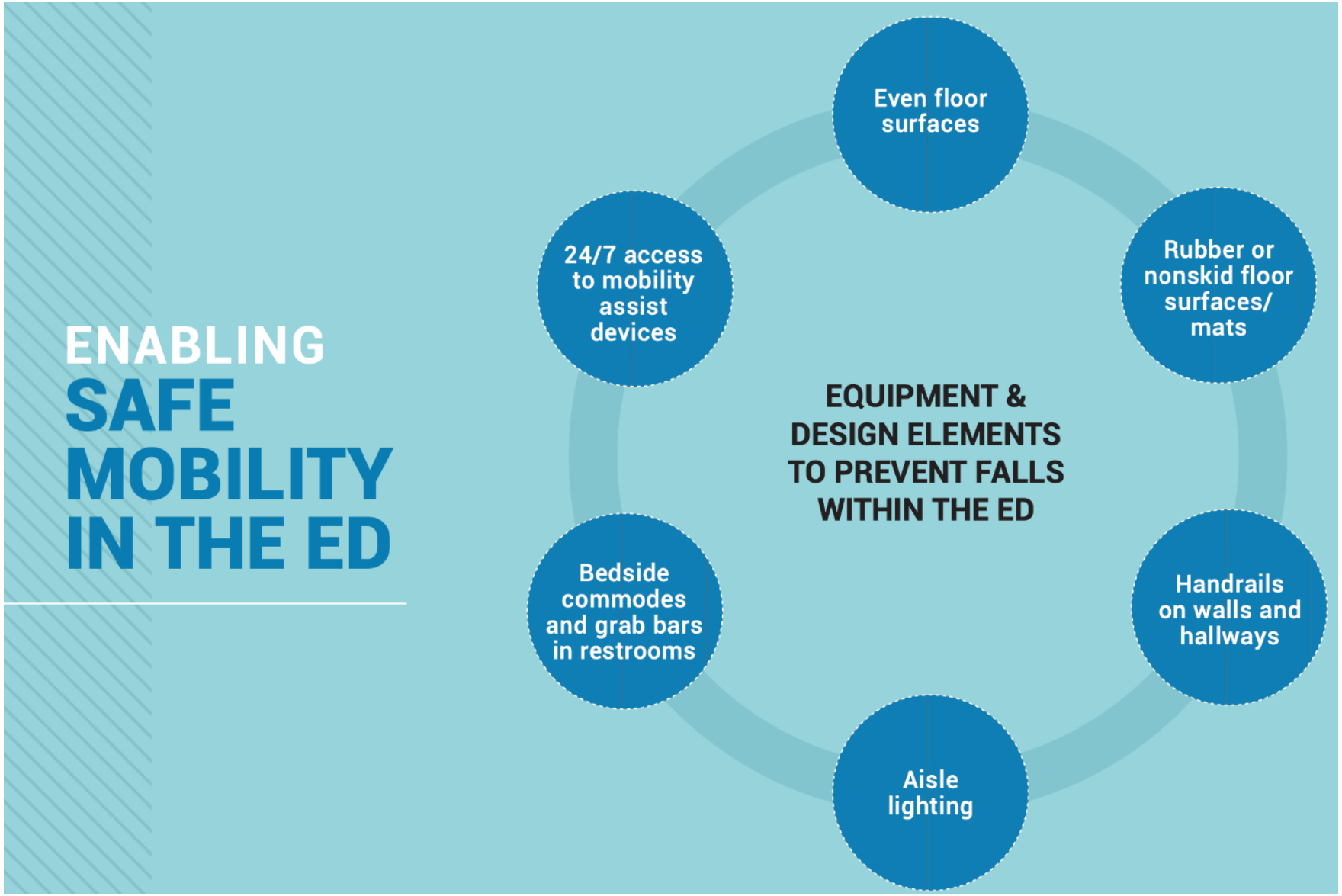
A score >14 seconds is associated with a higher risk of falls

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

GEDC

Safe Mobility in the ED

ED-WIDE IMPLEMENTATION



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AAH Falls & Mobility Protocol

Example of tailoring the FOAM Protocol, Assessment, & Interventions

AdvocateAuroraHealth

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

Identification:

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

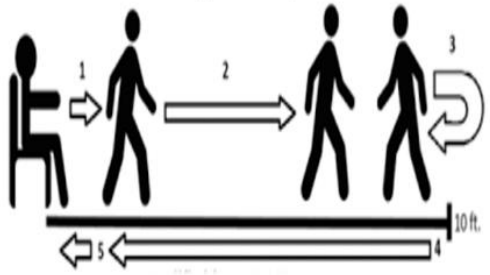
If No Fall **or** Low Risk then, initiate Mobility Procedure while in ED

Screening:

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

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

Timed Get Up and Go (TUG) Test:



Version 10.0
January 29, 2019
Advocate Aurora Health

Assessment:

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

Results of both communicated to provider

TUG >14 seconds

Do you want a physical therapy consult? Yes/No

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

TUG <14 seconds

Intervention:

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

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

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

Mobility Procedure while in ED

Disposition:

Order early PT assessment in the hospital

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

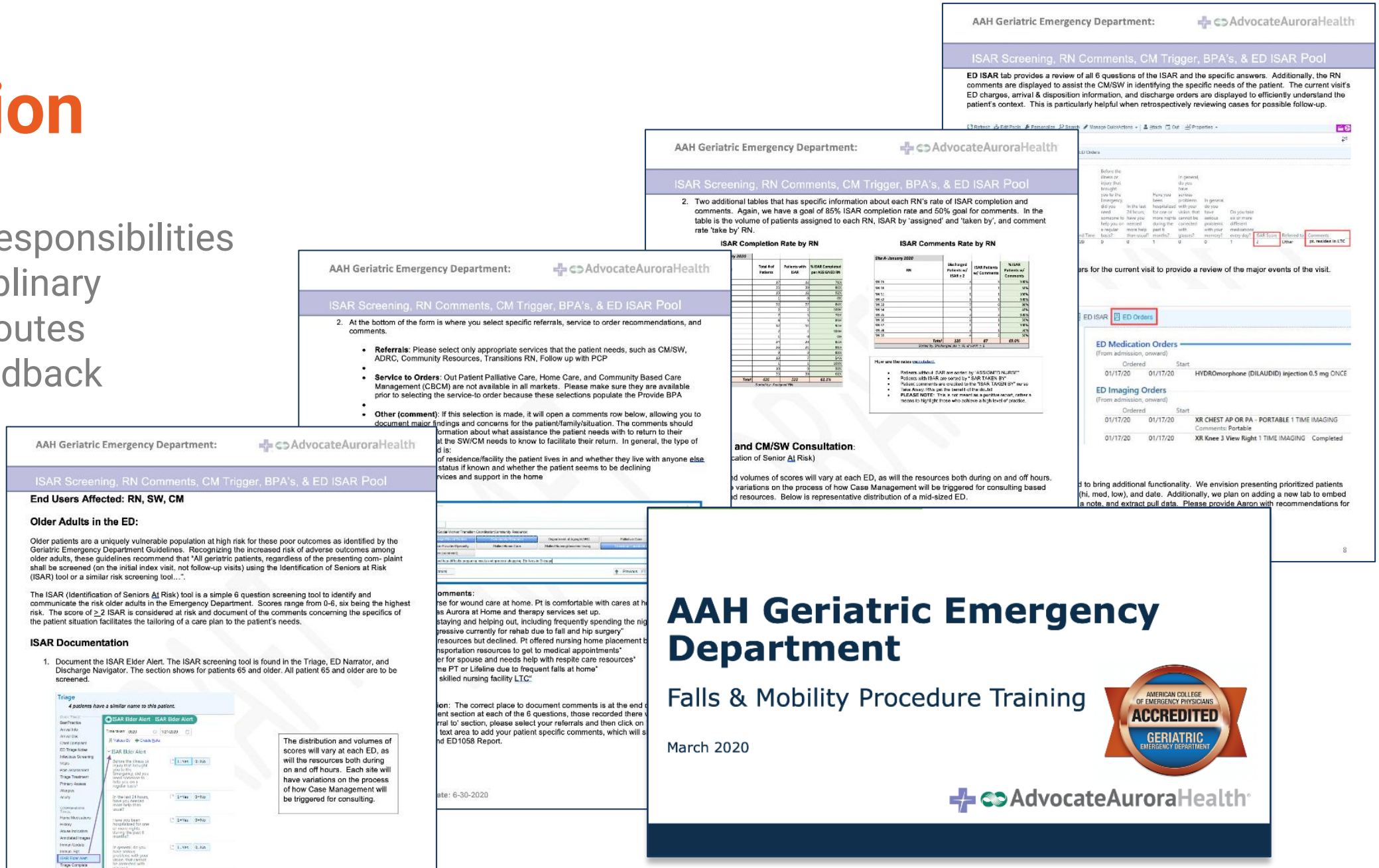
GEDC

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

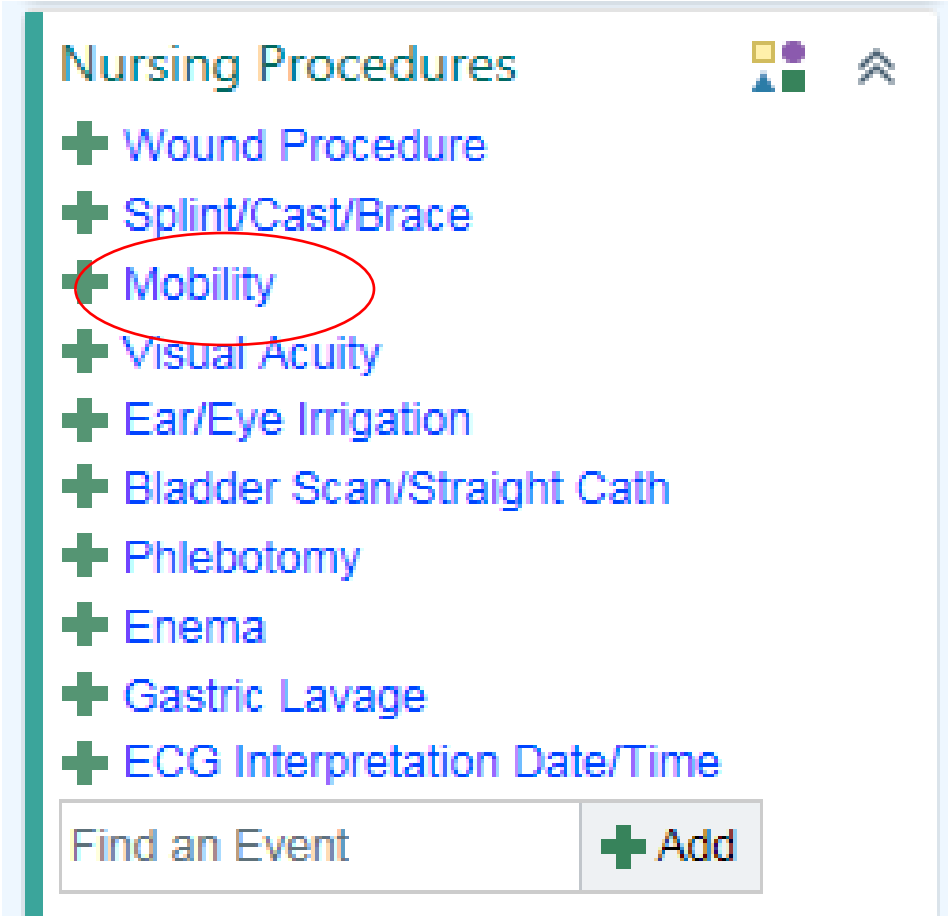
Education

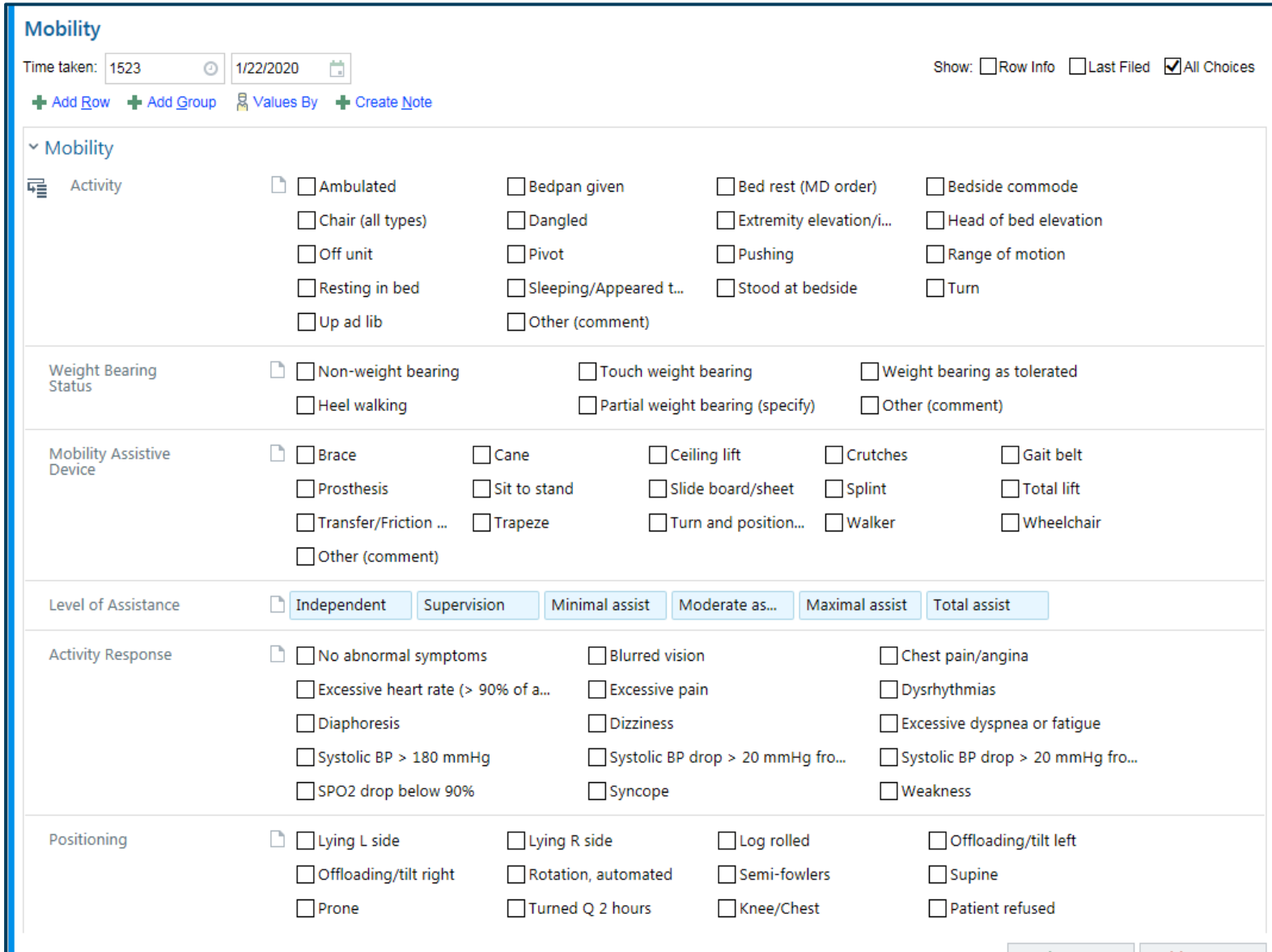
- Workflow
- Roles & Responsibilities
- Interdisciplinary
- Multiple routes
- PDSA Feedback



Mobility Documentation

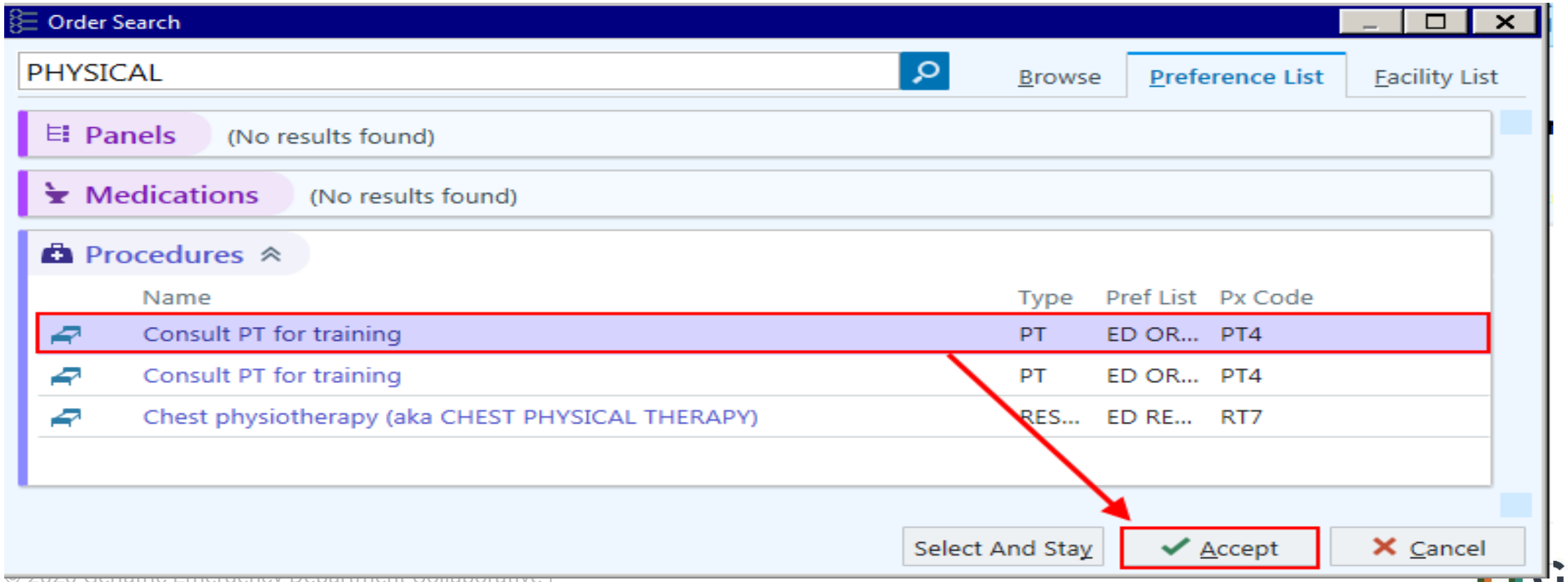
- Go to the nursing procedures toolbox





How To Order EMERGENCY DEPARTMENT PHYSICAL THERAPY Consult?

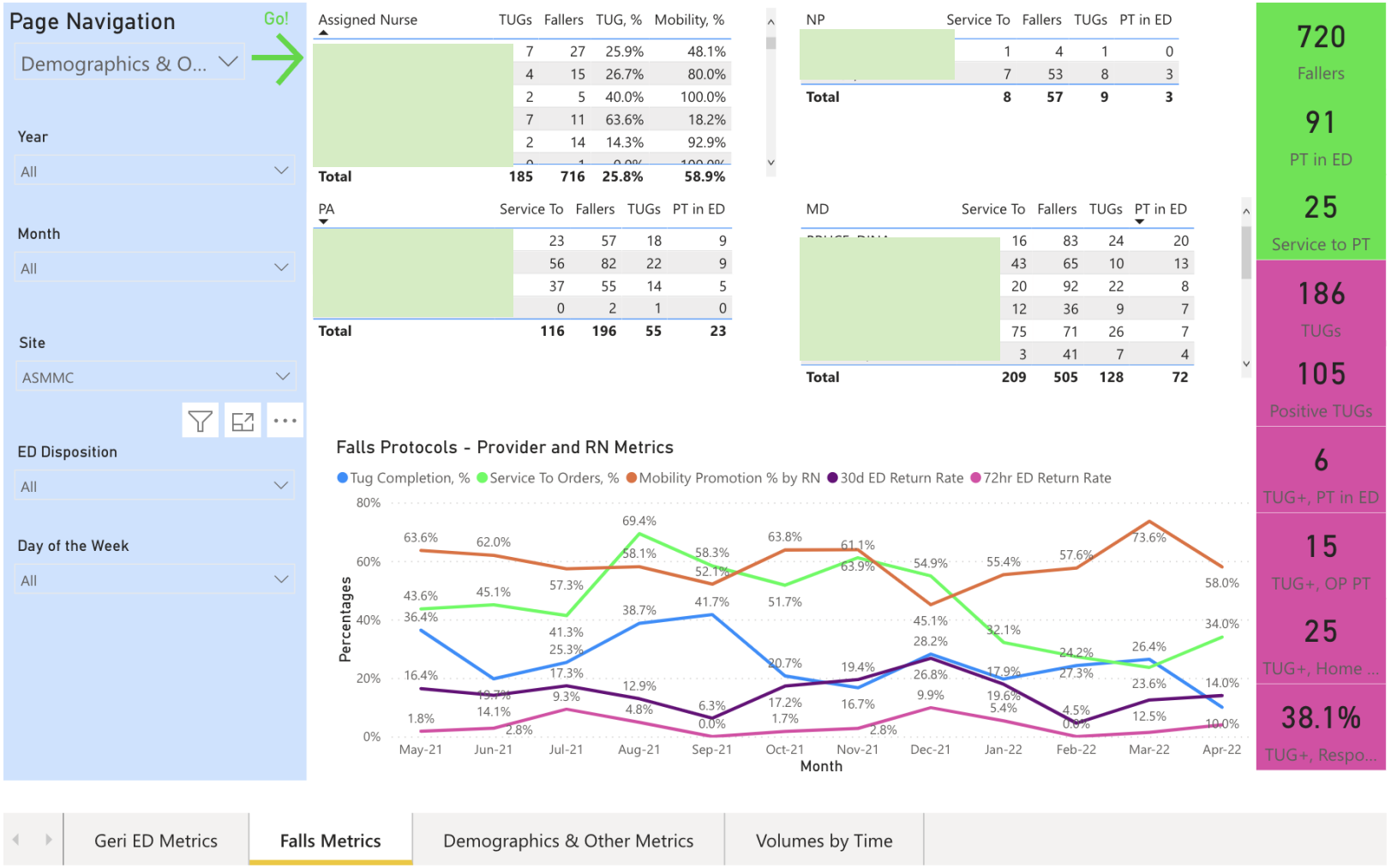
- ED Provider orders “Consult PT for training”
- (Optional site specific)RN or Tech calls and request PT assessment in the ED



Metrics & Reports

Example of AAH Falls & Mobility Dashboard (SharePoint)

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



Lessons Learned

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

THANK YOU!

Questions?

aaron.malsch@aah.org

Geriatric EDs: Implementation Tips, & QI resources

Kevin Biese
MD, MAT

Geriatric Emergency Department Collaborative Implementation

Geriatric Emergency Department Accreditation

GEDC

Level 3 Accreditation

1

Champion Education

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

2

Mobility and Nutrition

3

Protocol

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

4

General Tips for Success Pre-Peri-Post Application

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

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Key Application Criteria: Physician & RN Champion

Job Description

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

Education

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

Key Application Criteria: Protocol

Existing Policy vs. GED Protocol

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

Transition Beyond the ED

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

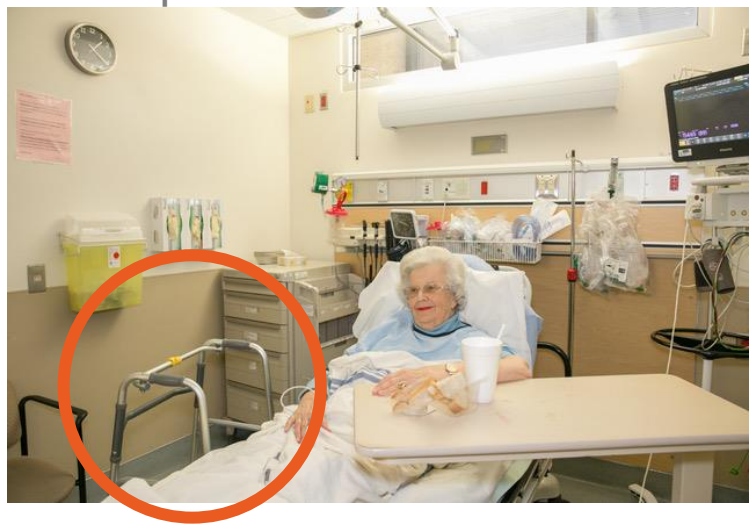
Evaluation

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

Key Application Criteria: Mobility & Nutrition

Access to Mobility Devices

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

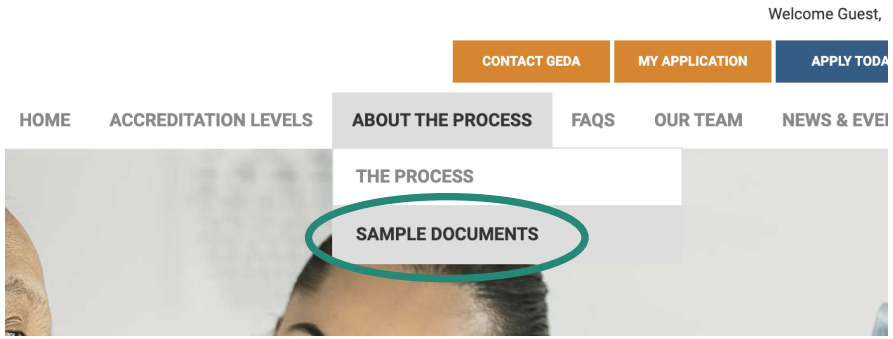


Access to Nutrition

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

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

Sample Documents



ACEP Geriatric Emergency Department Accreditation

Welcome Guest, Log In

CONTACT GEDA | MY APPLICATION | APPLY TODAY

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

Sample Documents

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

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

GEDC

General Tips for Success

It's a JOURNEY not a destination

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

Interprofessional

Empower all disciplines at all levels

Economies of Scale at Prime:

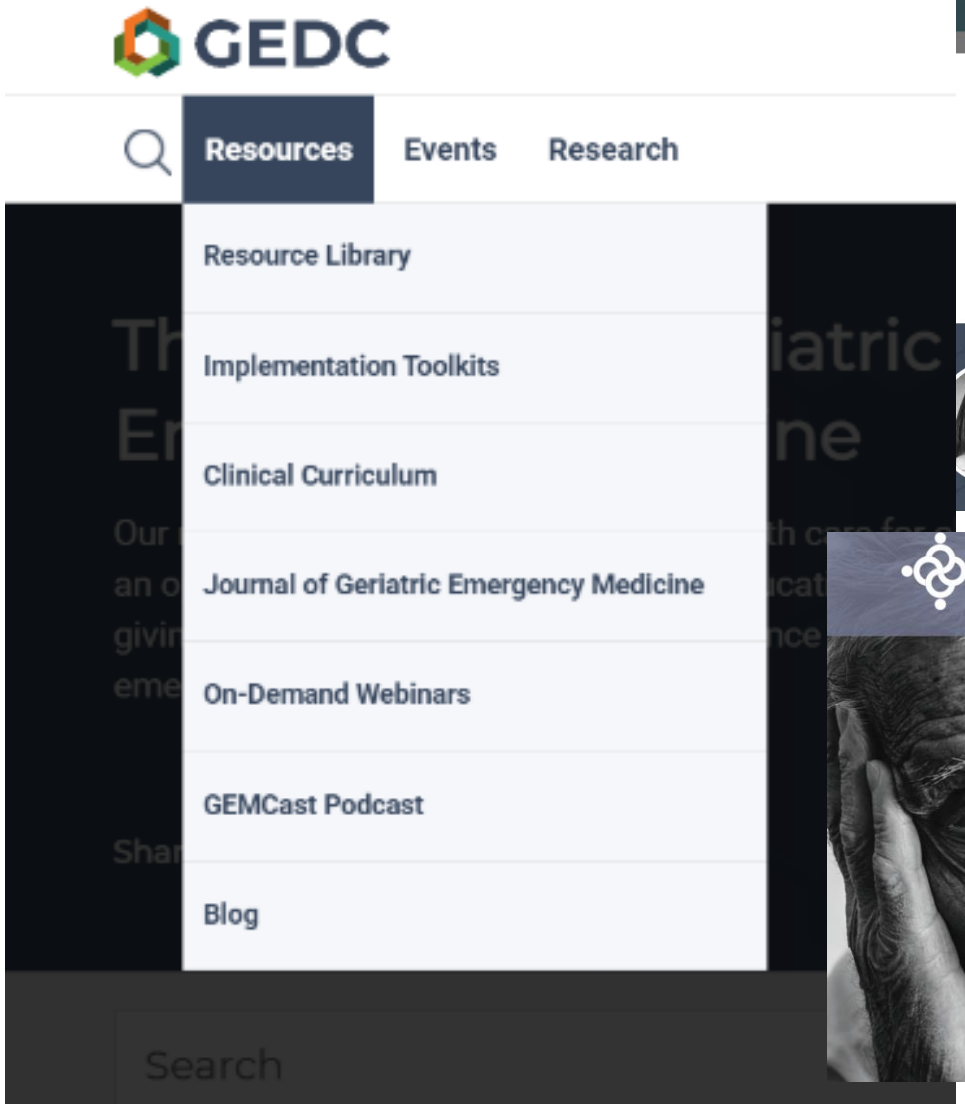
- Multiple Sites & 1 Goal
- Organize multi-site work teams
- Leverage teams for Protocol development, Metrics, Job descriptions, Charter

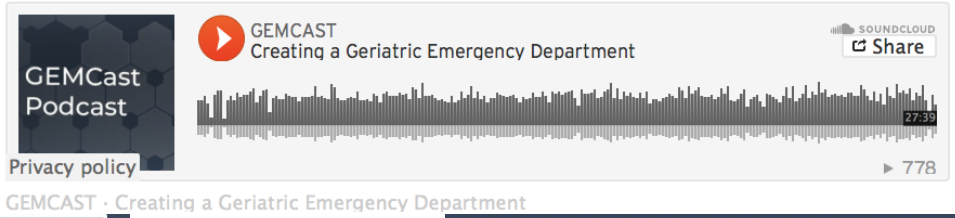
Align with Existing Resources

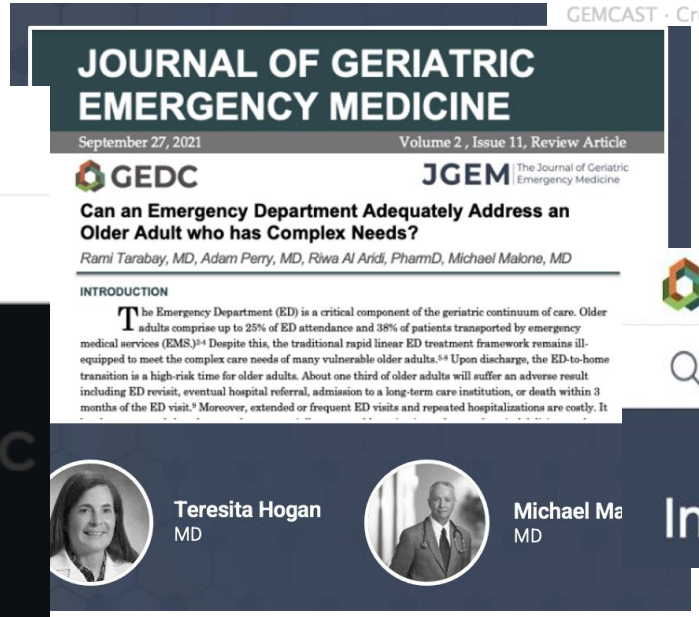
- Shared governance
- Quality
- ACO's

GEDCollaborative.com

Resources







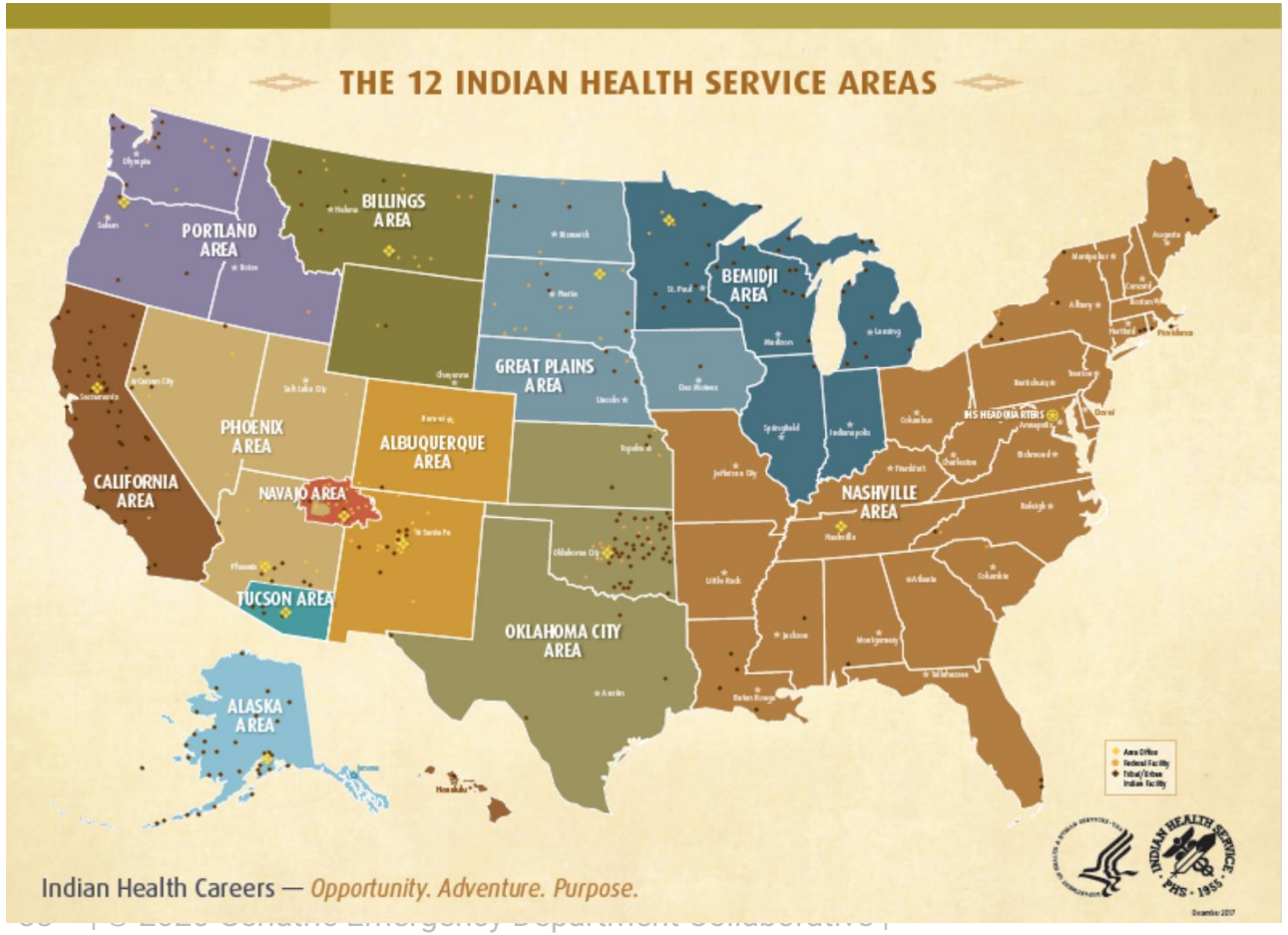
Delirium in the Older Emergency Department Patient
(ED-DEL)

Change Package and Toolkit

THANK YOU!

Questions?

Closing Remarks



Blackfeet 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

GEDC

Your Path to Process Improvements

NEXT STEPS

BOOTCAMP

YOU ARE HERE

June 6 Webinar
3:00 – 4;00p EST

"Creating an Educated Workforce for the Geriatric ED"

June 27 Office Hour
3:00p – 4:00p EST

What is your process improvement?

What are the next steps for your QI initiative?

GEDA Application

GEDA Level III

December 2022

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

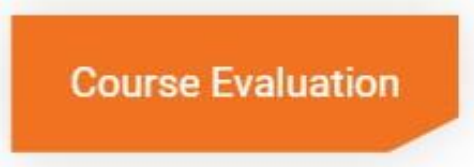
To receive credit, must complete the course evaluation.

TWO WAYS TO ACCESS THE EVALUATION:

GO TO:

gedcollaborative.com/IHS/

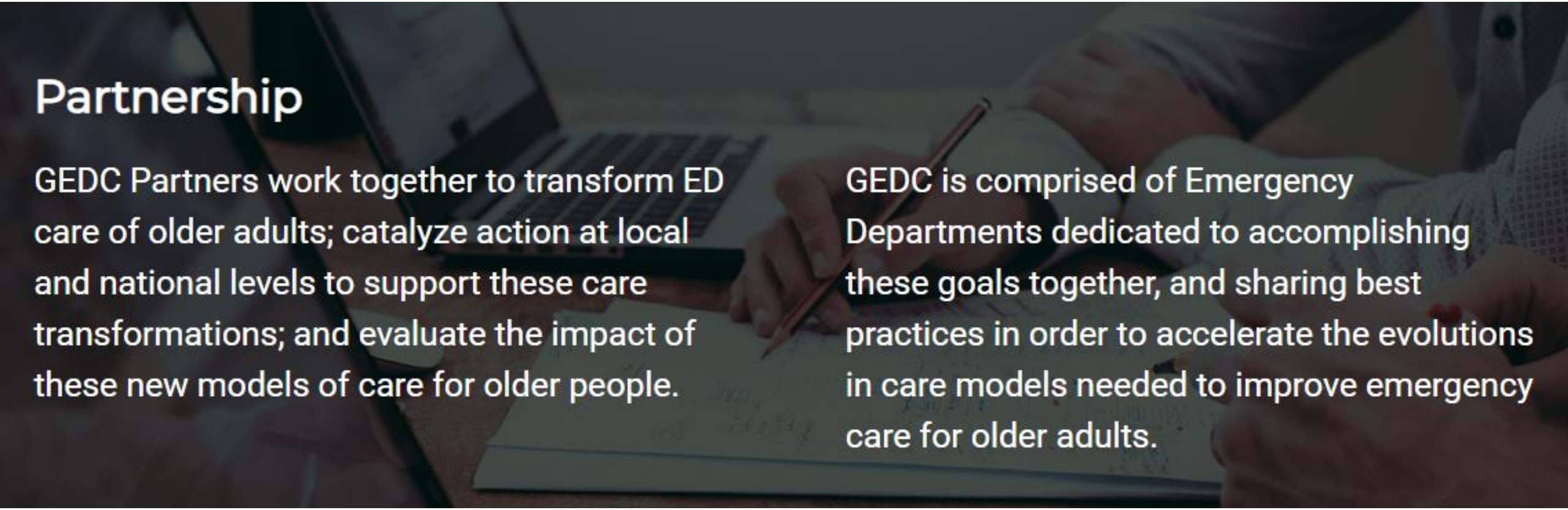
And click on the Course Evaluation button



Use your phone to scan this QR code:

GEDC Partner Sites

gedcollaborative.com/partnership



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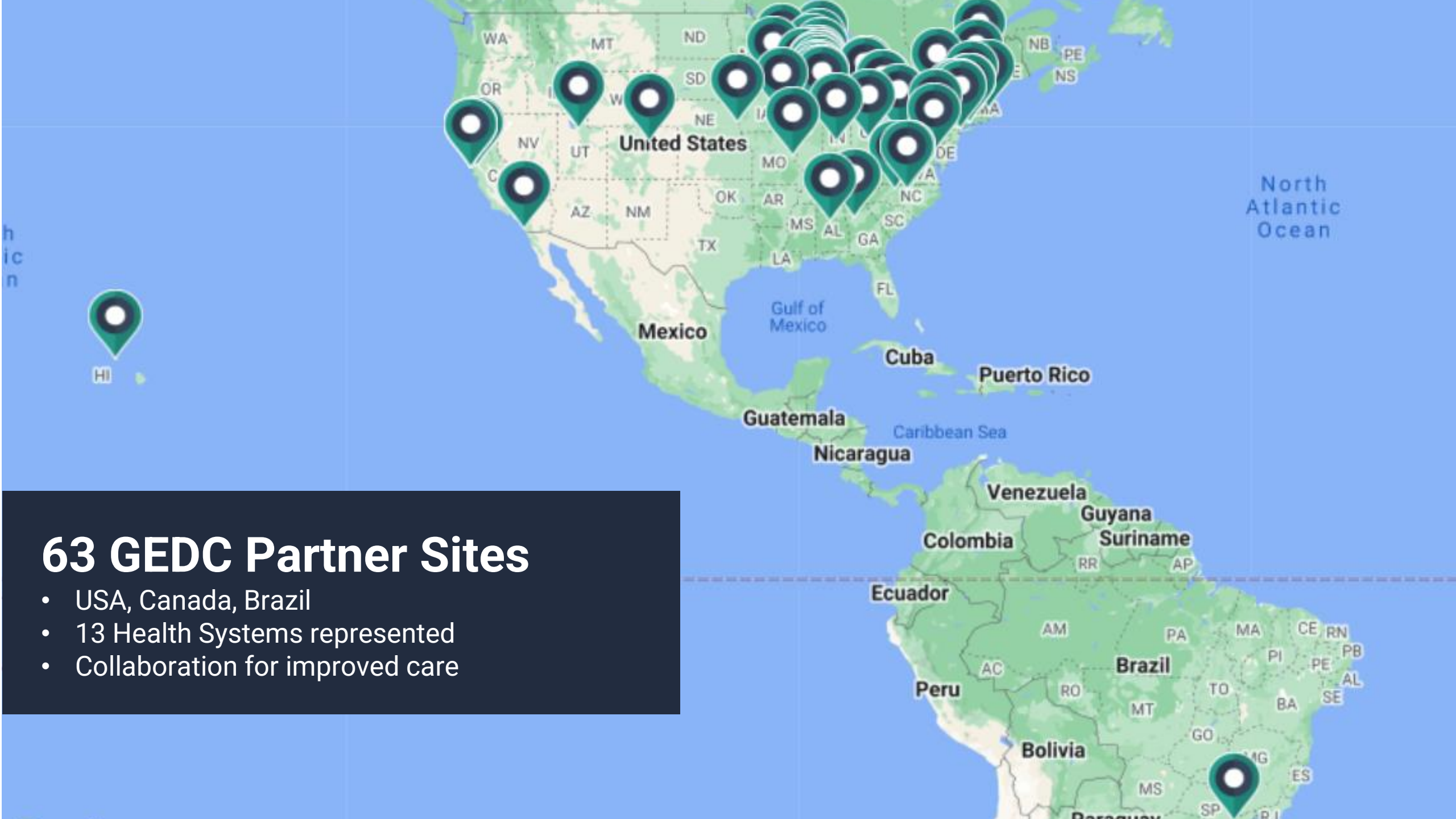

63 GEDC Partner Sites

- 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

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