GEDC | THE GERIATRIC EMERGENCY DEPARTMENT COLLABORATIVE

EDUCATE IMPLEMENT EVALUATE

SAN DIEGO COUNTY SENIOR EMERGENCY CARE INITIATIVE

GEDC BOOTCAMP

THURSDAY, JULY 23, 2020
1:00–3:00 PM PCT

SUPPORTED BY

The County of San Diego

GARY & MARY westhealth institute

WELCOME

JON ZIFFERBLATT
MD, MPH MBA
Executive Vice President, Strategy and Successful Aging

KIMBERLY GALLO
Director Aging and Adult Services, Aging & Independence Services

CARYN SUMEK
MPH
Vice President, Hospital Association of San Diego and Imperial Counties

VAISHAL TOLIA
MD, MPH, FACEP
Medical Director, Department of Emergency Medicine, UC San Diego Health and Director of the Gary and Mary West Senior Emergency Care Unit

ROBIN GOMEZ
RN, MSN
CEO, Alvarado Hospital Medical Center

San Diego County-Wide Bootcamp Resources

Welcome to your GEDC Bootcamp Resource page! Check back after your Bootcamp for meeting recordings, chat notes, slides and more.

Your Bootcamp details:
Thursday, July 23
1:00-3:00 PST

VISIT YOUR GEDC RESOURCE CENTER

https://gedcollaborative.com/san-diego-westhealth-resources/

- Agenda & goals
- Course Pack with Case Studies
- Recording of this event
- Chat notes
- Other GEDC Resources
- Follow Up events such as Boosters or Office Hours with GEDC Faculty
- Quick links to West Health Toolkits
- Quick links to ACEP GEDA guidelines and criteria

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Tips for Participation

GET THE MOST OUT OF YOUR BOOTCAMP

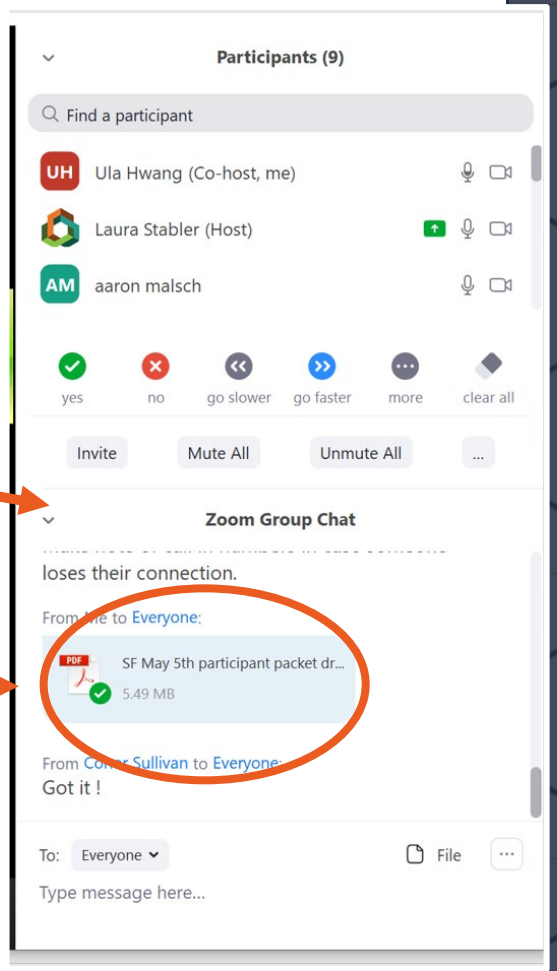
Open your zoom chat! (bottom toolbar)
We encourage dialogue in the **Zoom Group Chat**
Please write your comments, experiences at your hospital, feedback, questions.

Course Pack
Your course pack is on the GEDC Bootcamp resource page and is available for download via Zoom Chat as attachment.

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

Smile!
Turn on your cameras! 😊

If you have dialed in with separate audio, please let Lorraine know which phone number you're using so we can merge your audio and video!



What if I have Questions!?

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

Consolidate your questions and email Misti Benson after the conference
mdbenson@westhealth.org

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

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Technical difficulties

Please text:

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

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EDUCATE IMPLEMENT EVALUATE

Meet Your GEDC Faculty

Aaron Malsch
RN, MSN, GCNS-BC

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

Don Melady

MD

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

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Adam Perry

MD

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

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Ula Hwang

MD, MPH, FACEP, Co-PI

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

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Kevin Biese

MD, MAT, Co-PI

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

San Diego Senior Emergency Care Initiative

AN OPPORTUNITY TO IMPROVE CARE FOR SENIORS IN SAN DIEGO COUNTY

Kevin Biese, MD MAT

Associate Professor Emergency Medicine and Geriatrics, University of North Carolina School of Medicine;

ACEP Geriatric ED Accreditation Chair

GEDC Co- Principal Investigator

West Health Consultant

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OLDER ADULTS IN THE ED

NATIONALLY

ONE OUT OF
EVERY 10
HOSPITAL ADMISSION IS
POTENTIALLY AVOIDABLE

60%
OF THOSE ADMISSIONS ARE FOR PATIENTS
65 YEARS OR OLDER[7]

46%
OF ALL ED VISITS RESULTING IN
HOSPITALIZATION ARE SENIORS[6]

MORE THAN 130
GEDs CURRENTLY
EXIST IN THE U.S.

GROWING
NUMBER

OF EDs HAVE APPLIED
FOR OR INDICATED INTEREST
IN ACEP'S GERIATRIC ED
ACCREDITATION PROGRAM

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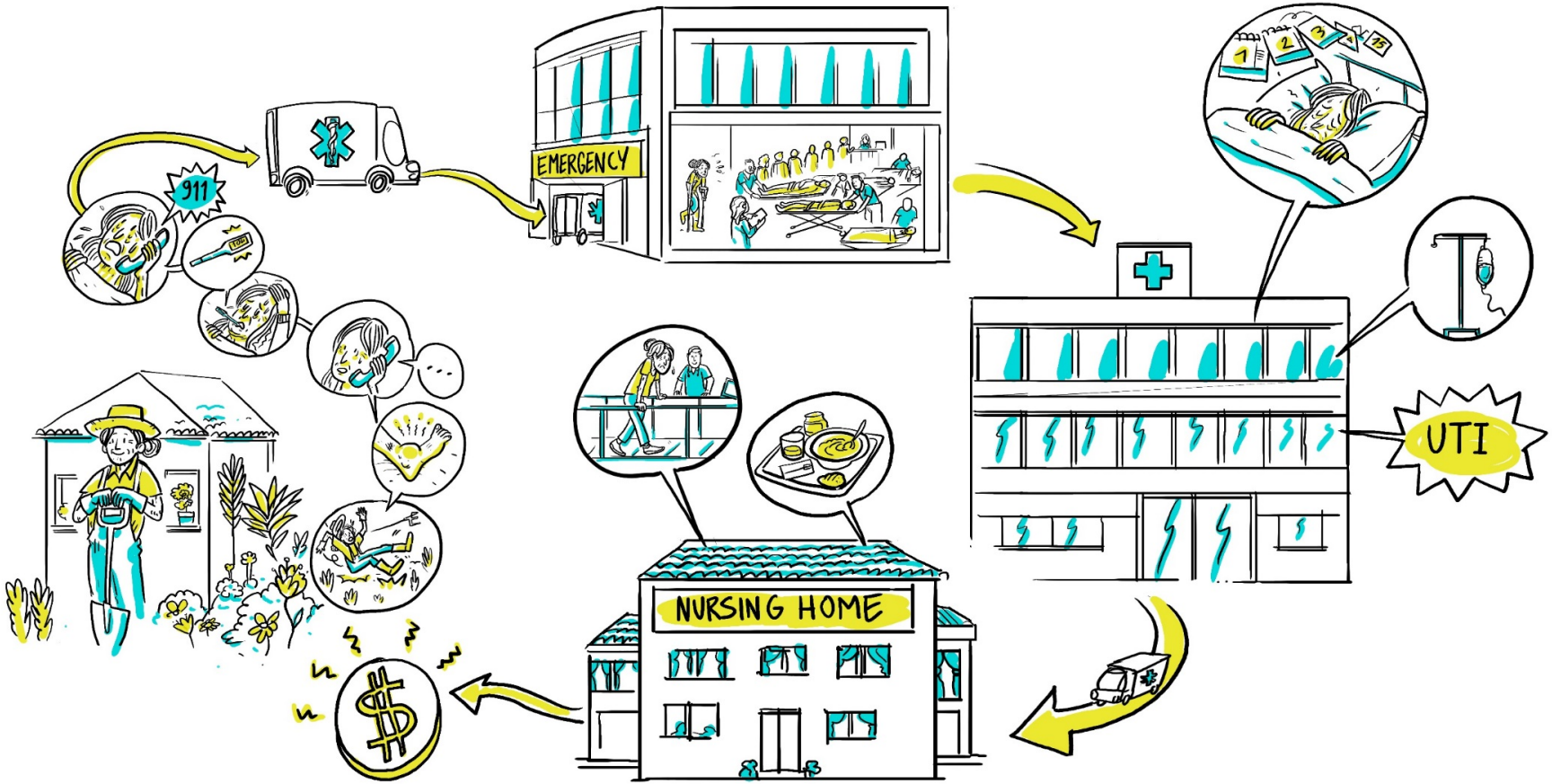
WHY SAN DIEGO?

- 374,000 seniors aged 65 or older
  - 12% of County's population
- By 2030, expected to double – >720,000 seniors
- >75,000 dual-eligible for Medicaid



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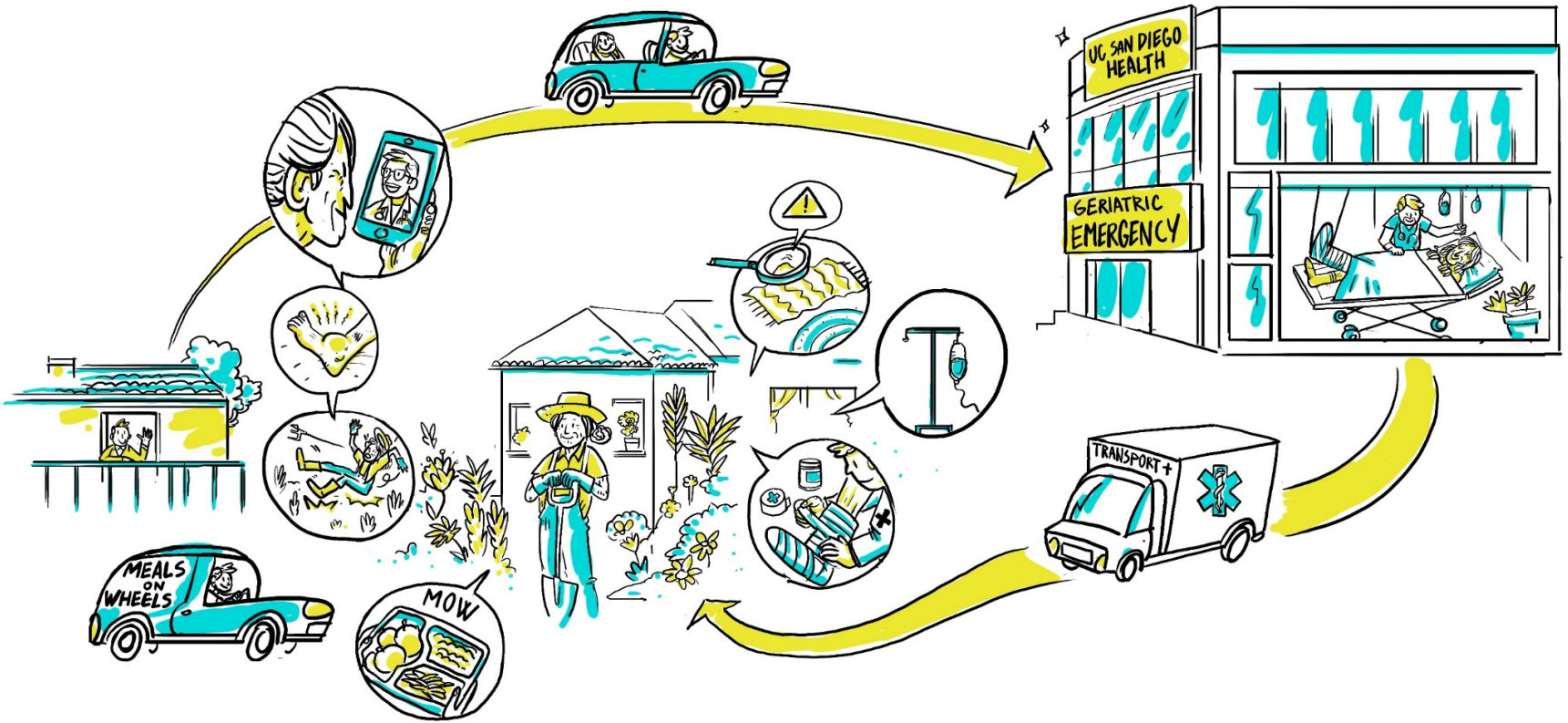

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WHY GERIATRIC EDs?

ED visits can address social and chronic care needs, and prevent hospitalizations

Up to 16% reduction in risk of hospital admission from the ED

Reduce or delay admission to skilled nursing by 70% or more

Enable seniors to *“age in place”*

Connect seniors and caregivers to community resources

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COVID-19 Brings GEDs to the Forefront

GEDA IS ADAPTING TO COVID-19

Excerpts of COVID-19 guideline updates for GEDA to highlight issues of COVID-19 relevance

Delirium	COVID-19 itself and/or ED conditions during the COVID-19 crisis (e.g., use of face-obscuring PPE, increased crowding and waiting times) may contribute to triggering delirium.
Dementia	Many EDs are allowing caregivers to remain with patients with cognitive impairment in the ED even if a no visitor policy is in place during COVID-19.
Elder Abuse	There is concern that elder abuse could increase during the COVID-19 pandemic as social isolation is a major risk factor. See the National Center on Elder Abuse recommendations.
SNF/ ALF Transfers	Improved coordination to care for SNF/ALF residents is key for patient well being and facility/ health care system functioning.
Pain Management	Protocols aimed at pain and symptom management are key for older adults with COVID 19.

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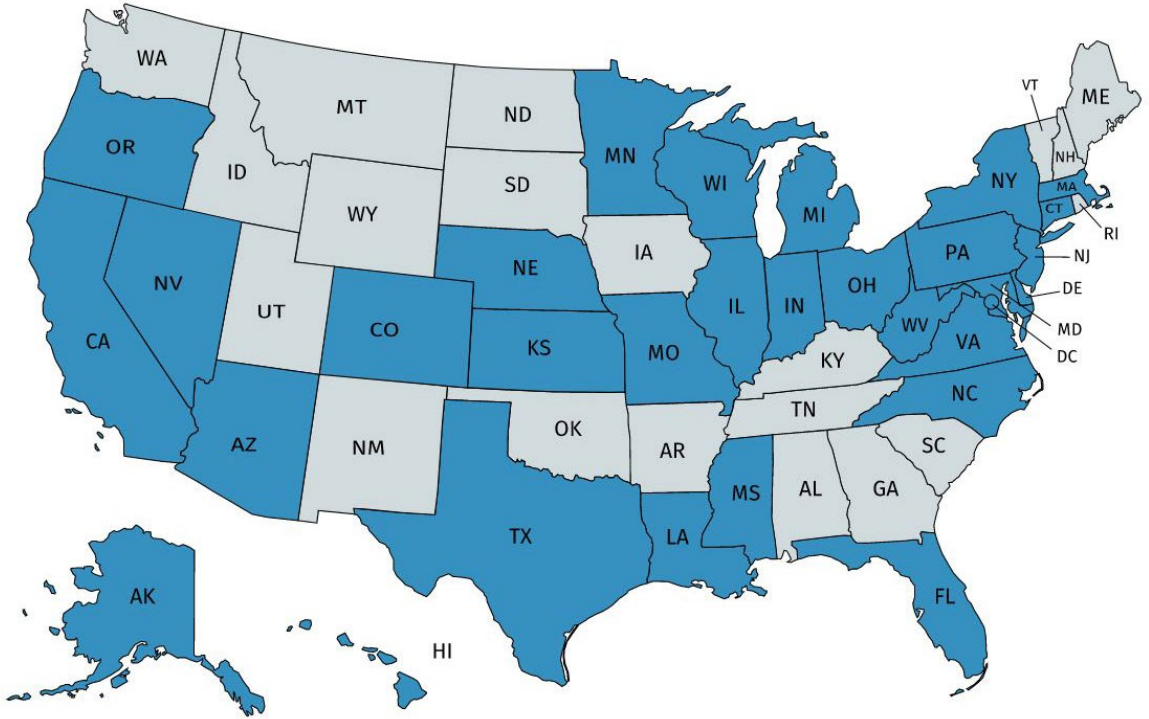
ACCREDITED STATES

166 Total Sites

Level 1	10
Level 2	13
Level 3	143

32 States Represented

18 in California



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Resources & Requirements

LEVEL 3 ACCREDITATION

01

STAFFING

1 Physician Champion with focused education for Geriatric EM

1 Nurse Champion with focused Education for Geriatric EM

02

EDUCATION

Physician education related to Geriatric EM (4 hours CME)

Nursing education related to Geriatric EM (e.g., Emergency Nurses Association)

03

POLICIES

Evidence of at least one Geriatric EM care initiative

Today's GEDC Bootcamp

04

EQUIPMENT

Access to mobility aids (canes, walkers)

05

PHYSICAL ENVIRONMENT

Easy access to food/drink

Follow Up Sessions with GEDC Faculty to support your initiatives

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Partnership

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

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

About GEDC →

gedcollaborative.com/partnership

laura_stabler@med.unc.edu

conor_sullivan@med.unc.edu

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THANK YOU

Kevin Biese

kevin.biese@med.unc.edu

Case Studies: Five Older Adults

Mrs. Cado	78-year-old woman with a broken wrist “ready for discharge”
Mr. Waranski	82-year-old man fell at home. Cannot follow discharge instructions and is readmitted to hospital.
Mrs. Perdito	79-year-old woman arrives in the ED for unclear reasons with normal vitals.
Miss Piedra	74-year-old woman, third visit in three days “failure to cope”
Mrs. Schwach	80-year-old woman, not feeling right “Mom seems a little off”

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

For a video of Mrs. Perdito:
geri-em.com/cognitive-impairment/mrs-perdito/

Case Study Breakout Rooms

25-MINUTE SMALL GROUP DISCUSSION

Mrs. Cado
Vaishal Tolia &
Kevin Beise

Mr. Waranski
Aaron Malsch

Mrs. Perdito
Adam Perry

Miss Piedra
Don Melady

Mrs. Schwach
Ula Hwang

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Joining Breakout Rooms

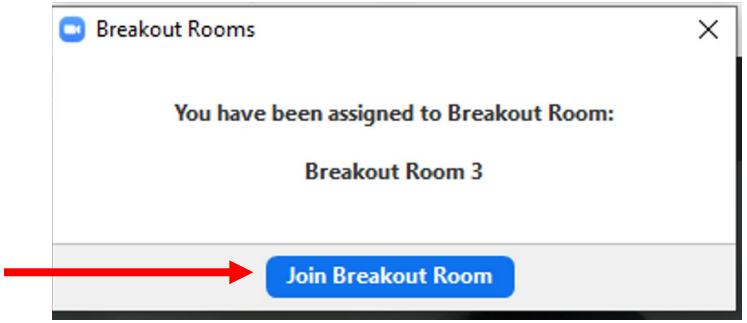
QUICK OVERVIEW

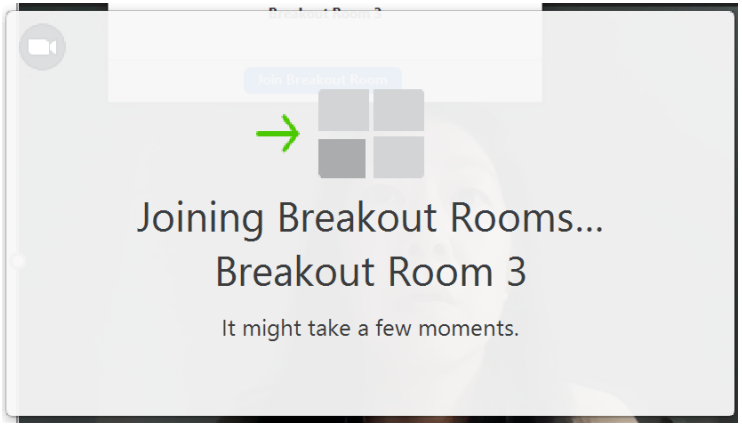
You have already been assigned to your breakout room.

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

Please be patient.

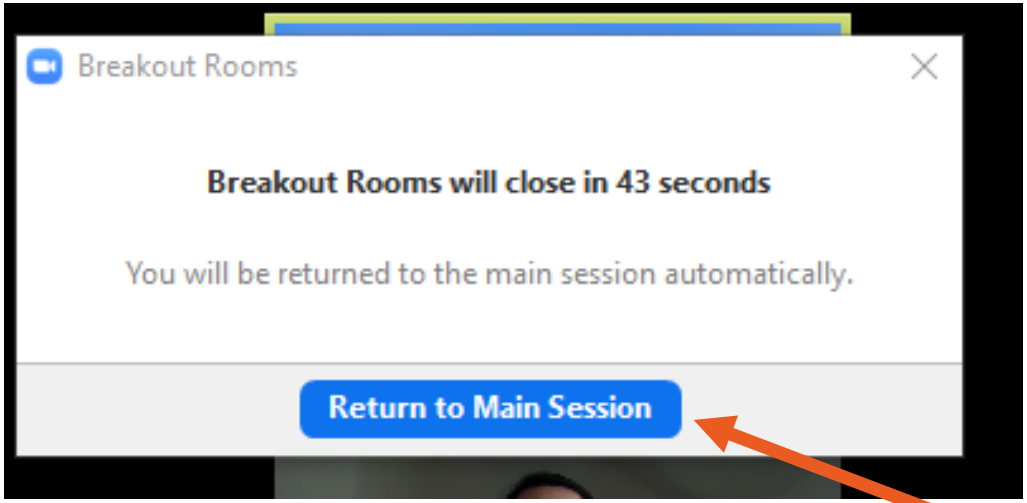
It can take a little while for all the connections to come through.





Leaving Breakout Rooms

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



When your case discussion time is over (25 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 component of the West Health GEDC Toolkits that could help your emergency department.
- 3 minutes per group

CASE DEBRIEF

CONNECTING CASE STUDIES

BARRIER TO QUALITY CARE

- Challenges in ED of addressing multiple problems
- Ambulating patient while in ED (gait/ falls assessment)
- Access to meds post ED discharge, caregiver for spouse, now debilitated post ED visit
- Limited recognition of cognitive status in the ED
- Limited assessment of prescribed medications in ED
- Limited assessment of home social supports in ED
- Not fed nor ambulated during prolonged ED evaluation
- Challenges of safe discharge from ED to home
- Facilitating care transitions from ED

COMPONENT OF GED TOOLKITS THAT COULD HELP YOUR DEPARTMENT

- Use of Identification of Seniors At Risk may have triggered additional multidisciplinary resources (SW, Pharm, PT for fall) to patient. Future reimbursement for this care.
- ED discharge planning and supports (f/u appts, ambulatory assist devices, prescriptions, check lists for patient home safety)
- Cognitive assessment in ED (mini-cog, CAM). Impairment triggering additional resources (SW, prescribing safety assessment by pharmacy)
- Standardized assessment of cognitive function for older ED patients
- Training of RN and support staff in ED with assessments and discharge coordination roles for post-ED transitions
- Assessing for mobility

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The West Health GEDC Toolkits

Dementia Screening

https://gedcollaborative.com/toolkit/dementia/

Delirium Screening

https://gedcollaborative.com/toolkit/delirium/

Falls and Safe Mobility

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

For Level 3 Accreditation, you need to demonstrate proficiency in just one of these areas of focus

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Screening for Delirium in Older ED Patients: The Delirium Implementation Tool Kit & Lessons Learned

Ula Hwang, MD, MPH

Yale University
Department of Emergency Medicine

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INTERESTED IN ACCREDITATION?

Table 1. Level 2: GED policies/protocols, guidelines and procedures

1	A standardized delirium screening guideline (examples: DTS; CAM; 4AT, other) with appropriate follow-up
2	A standardized dementia screening process (Ottawa 3DY; Mini Cog; SIS; Short Blessed Test; other)
3	A guideline for standardized assessment of function and functional decline (ISAR; AUA; interRAI Screener; other) with appropriate follow-up

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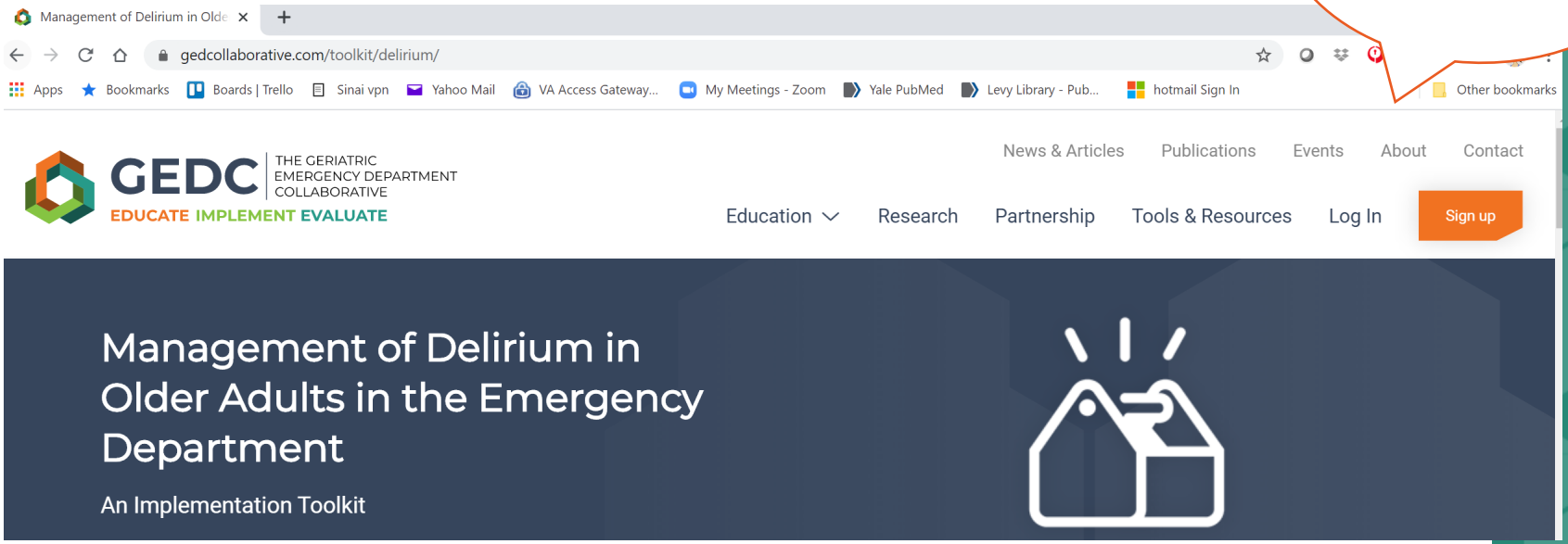
Delirium Screening Implementation Tool Kit

WEST HEALTH GEDC DELIRIUM TOOLKIT

gedcollaborative.com/toolkit/delirium/

...pssst...

It's a GEDA QI road map!



What's Inside

Delirium is a key ED symptom – like chest pain or abdominal pain. It is common among older ED patients and commonly missed in their assessment. This toolkit provides resources to help you make changes in your ED to provide better care for those patients presenting with delirium. It includes resources and tools and links to the evidence to support their implementation.

Staffing

Policies & Procedures

Screening & Assessment

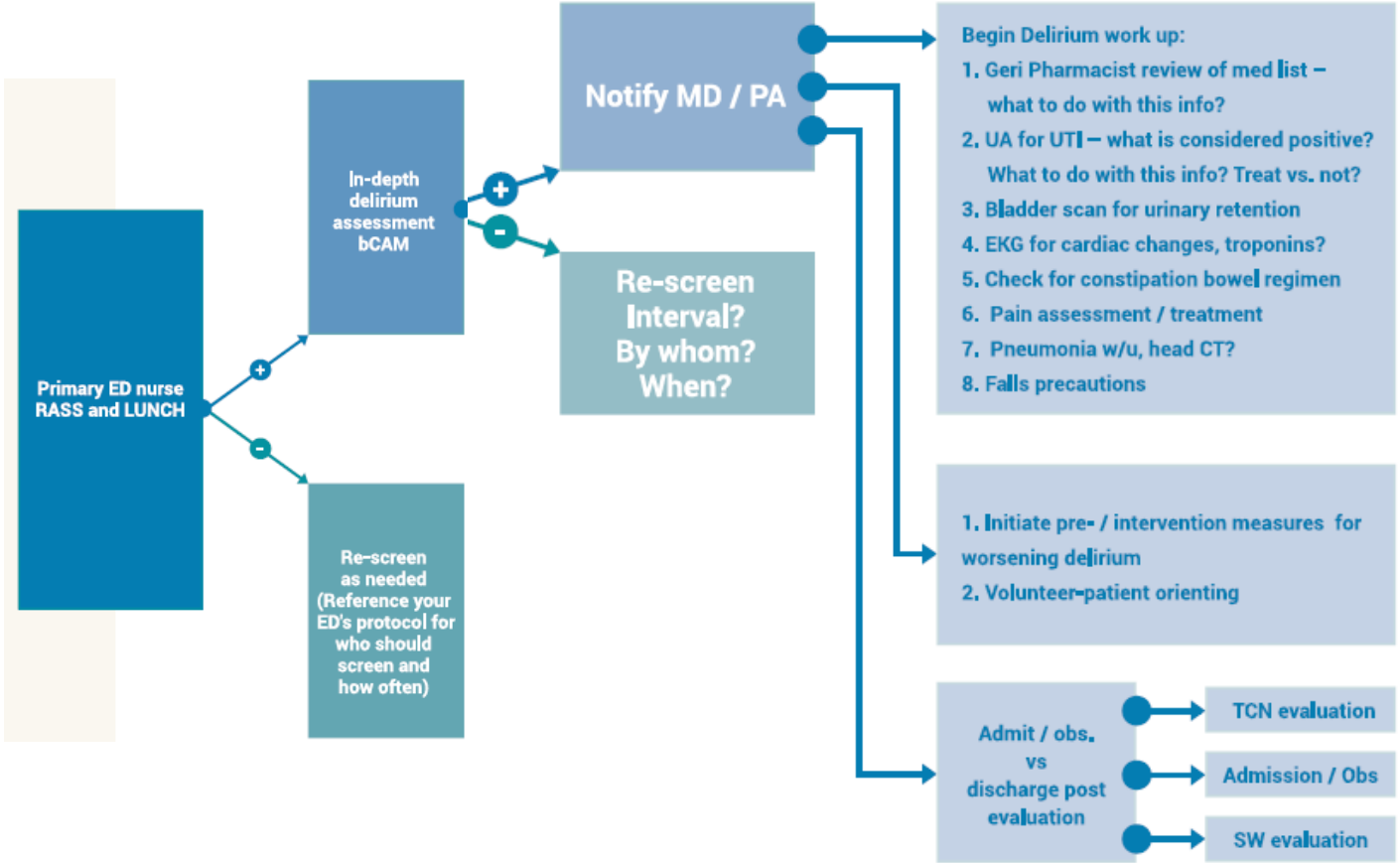
Process & Outcome Measures

Support for Patients & Caregivers

Example Delirium Workflow

INITIATING AT BEDSIDE

Note: Your workflow may differ



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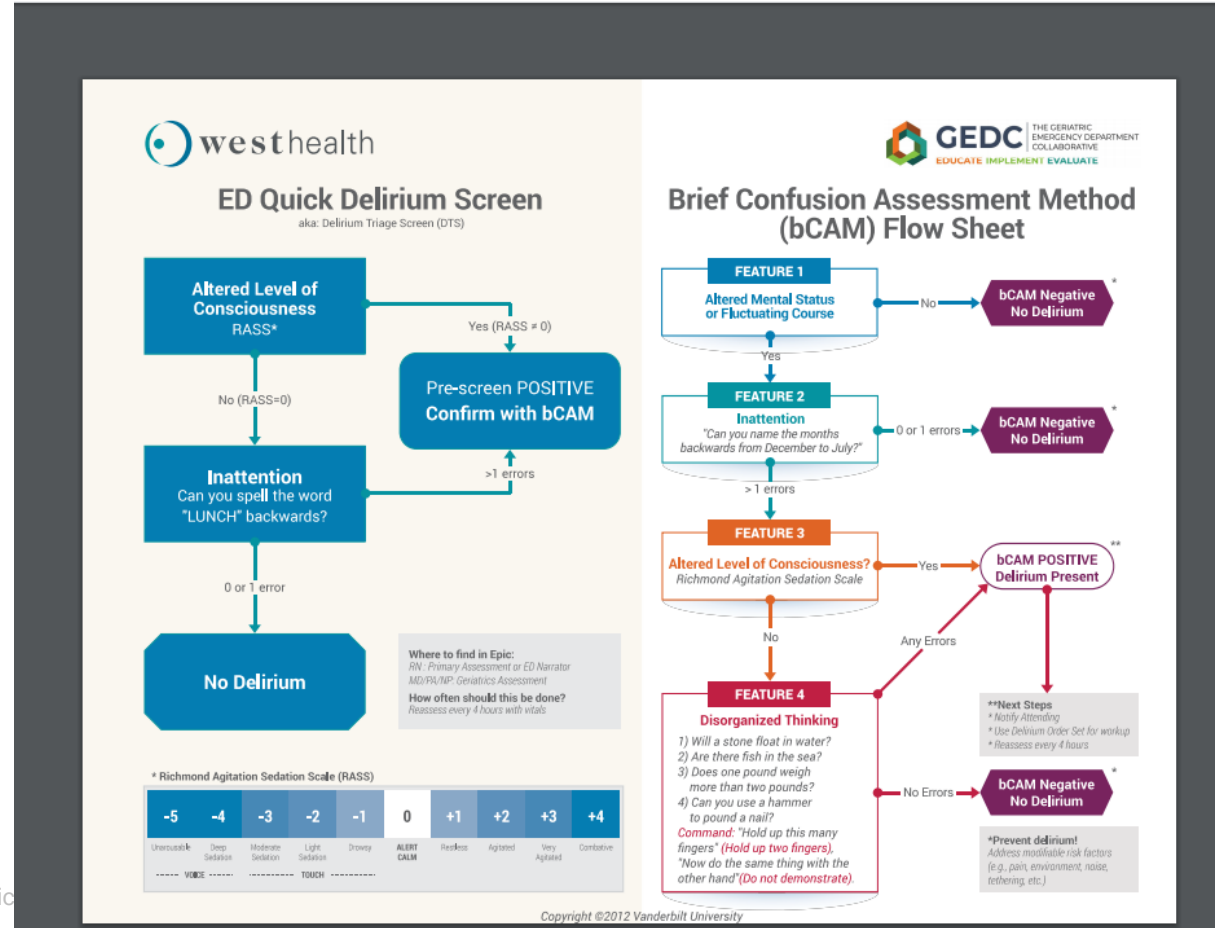
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ED Quick Delirium Screen
aka: Delirium Triage Screen (DTS)
Altered Level of Consciousness
RASS*
Yes (RASS ≠ 0)
Pre-screen POSITIVE
Confirm with bCAM
No (RASS=0)
Inattention
Can you spell the word "LUNCH" backwards?
>1 errors
0 or 1 error
No Delirium
Where to find in Epic:
RN: Primary Assessment or ED Narrator
MD/PA/NP: Geriatrics Assessment
How often should this be done?
Reassess every 4 hours with vitals
* Richmond Agitation Sedation Scale (RASS)
-5 -4 -3 -2 -1 0 +1 +2 +3 +4
Unarousable
Deep Sedation
Moderate Sedation
Light Sedation
Drowsy
ALERT CALM
Restless
Agitated
Very Agitated
Combative
VOICE
TOUCH
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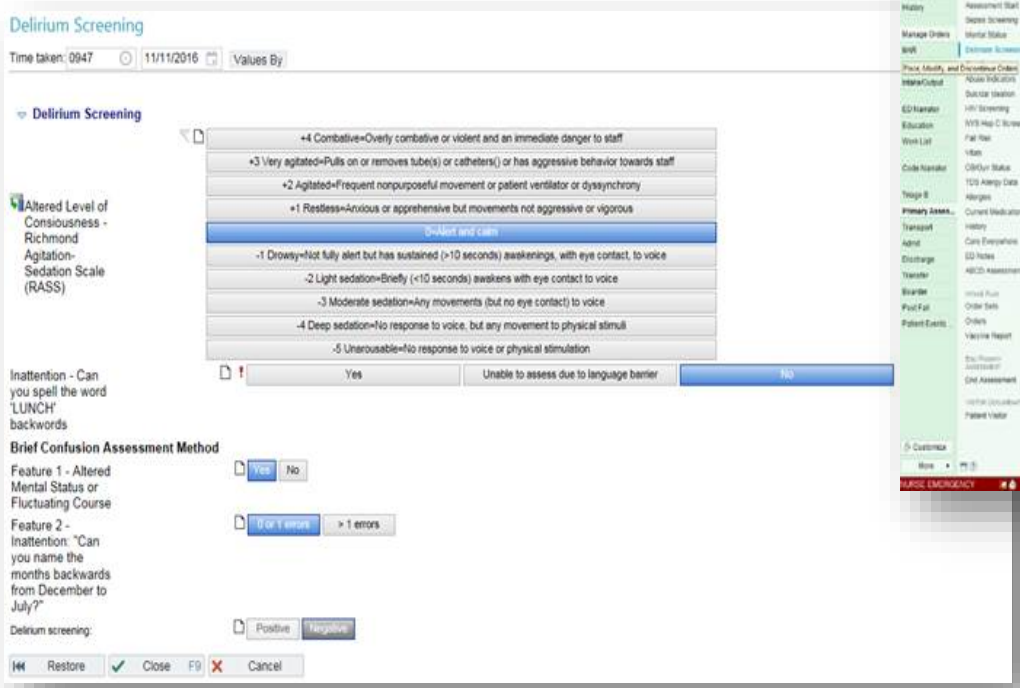
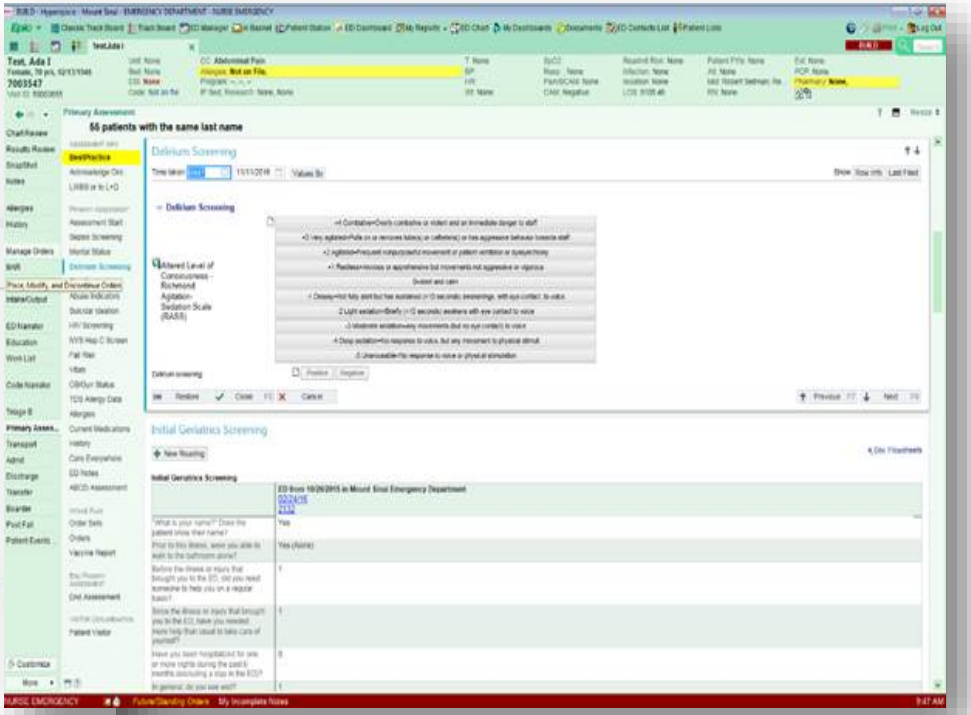
EDUCATE IMPLEMENT EVALUATE
Brief Confusion Assessment Method (bCAM) Flow Sheet
FEATURE 1
Altered Mental Status or Fluctuating Course
No
bCAM Negative No Delirium
Yes
FEATURE 2
Inattention
"Can you name the months backwards from December to July?"
0 or 1 errors
bCAM Negative No Delirium
>1 errors
FEATURE 3
Altered Level of Consciousness?
Richmond Agitation Sedation Scale
Yes
bCAM POSITIVE Delirium Present
No
Any Errors
FEATURE 4
Disorganized Thinking
1) Will a stone float in water?
2) Are there fish in the sea?
3) Does one pound weigh more than two pounds?
4) Can you use a hammer to pound a nail?
Command: "Hold up this many fingers" (Hold up two fingers). "Now do the same thing with the other hand" (Do not demonstrate).
No Errors
bCAM Negative No Delirium
**Next Steps
* Notify Attending
* Use Delirium Order Set for workup
* Reassess every 4 hours
*Prevent delirium!
Address modifiable risk factors (e.g., pain, environment, noise, tethering, etc.)
Copyright ©2012 Vanderbilt University

Lessons Learned

1. Engaged clinical stakeholders
   - Tool implementation – ED nurses selected DTS / bCAM
   - Workflow – NOT done at triage
2. Creating screening template in EHR
3. Redirect and refocus with Booster
4. Education huddles
5. Incentivize sustainability – booster refreshers, purpose

Implementing in EPIC





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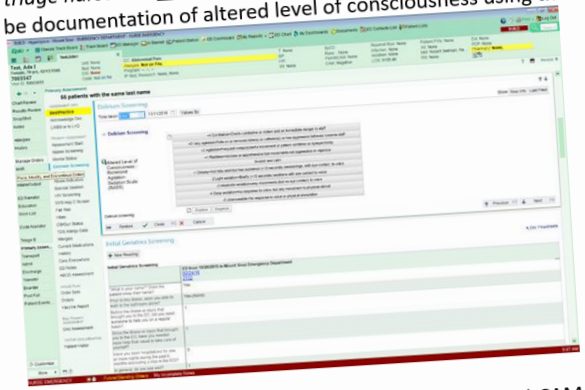
Handouts during morning and evening huddles

New Delirium Screening Workflow in the ED

Beginning December 6, 2016, the ED will begin using two evidence-based scales to improve screening for delirium, the **Richmond Agitation-Sedation Scale** (RASS) and the **Brief Confu Assessment Method** (BCAM)) in the following stepwise process:

1. The primary nurse will open the **Primary Assessment** tab in Epic and complete the deli screening along with the rest of the necessary documentation for new ED patients 65 an older. (*The triage nurse will not be completing delirium screening.*) The first step in screening will be documentation of altered level of consciousness using the RASS.

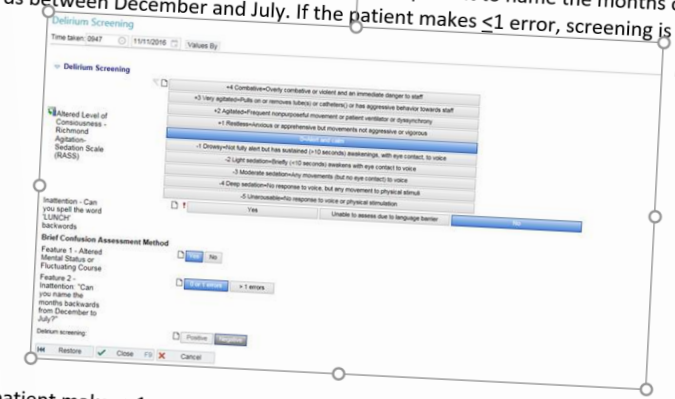


2a. If the RASS is anything but 0, you will be prompted to complete the bCAM (see 3 patient receives a RASS of 0, the next step is to ask the patient to spell the word 'LU backwards to test for inattention. (Note: This can only be done for patients who sp

2b. If the patient cannot spell lunch backwards, this is a sign of inattention. You then move on to completion of the bCAM.

3a. When completing the bCAM, first answer Feature 1: Is there altered mental status of fluctuating course?

3b. In Feature 2, you assess inattention by asking the patient to name the months of the year backwards between December and July. If the patient makes ≤1 error, screening is negative.



3c. If the patient makes ≥1 error, the nurse will be prompted to re-document the RASS score in Feature 3.

4. In Feature 4, the patient is screened for disorganized thinking using the following questions:
   - Will a stone float on water?

THANK YOU!

Any Questions?

ula.hwang@yale.edu

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

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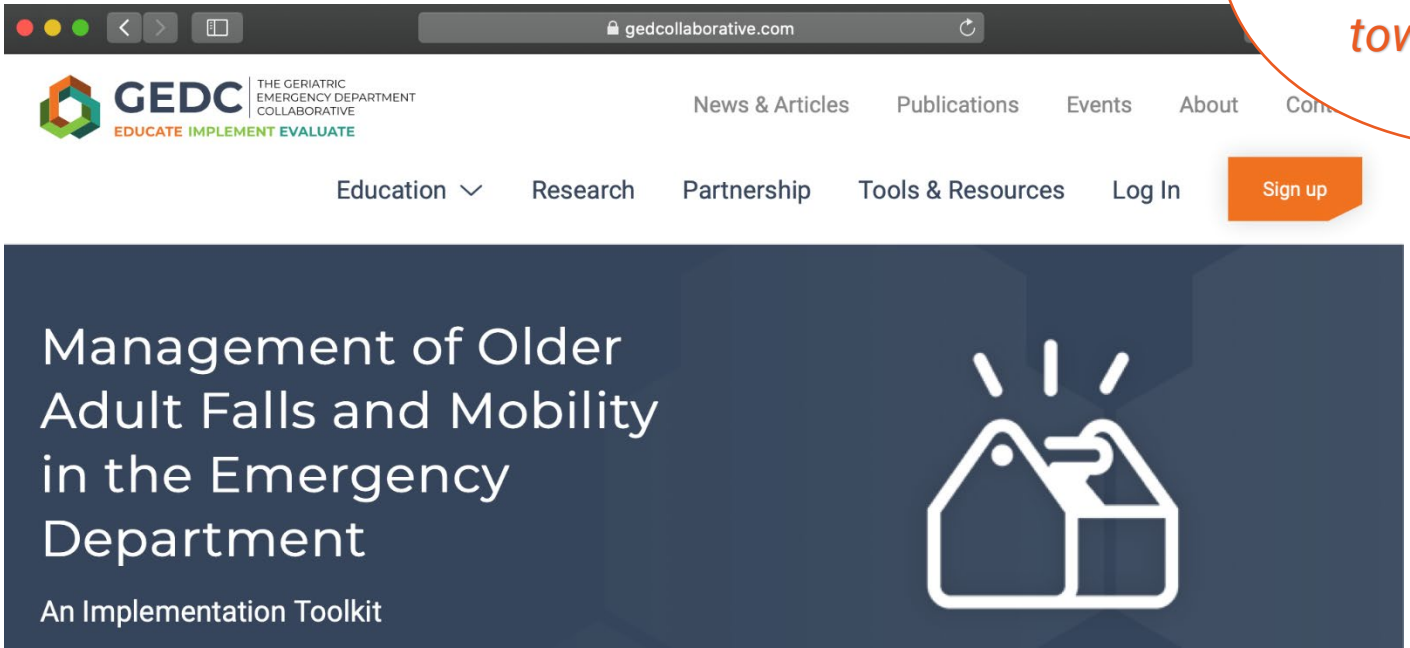
Falls & Mobility Implementation Tool Kit

WEST HEALTH GEDC FALLS & MOBILITY TOOLKIT

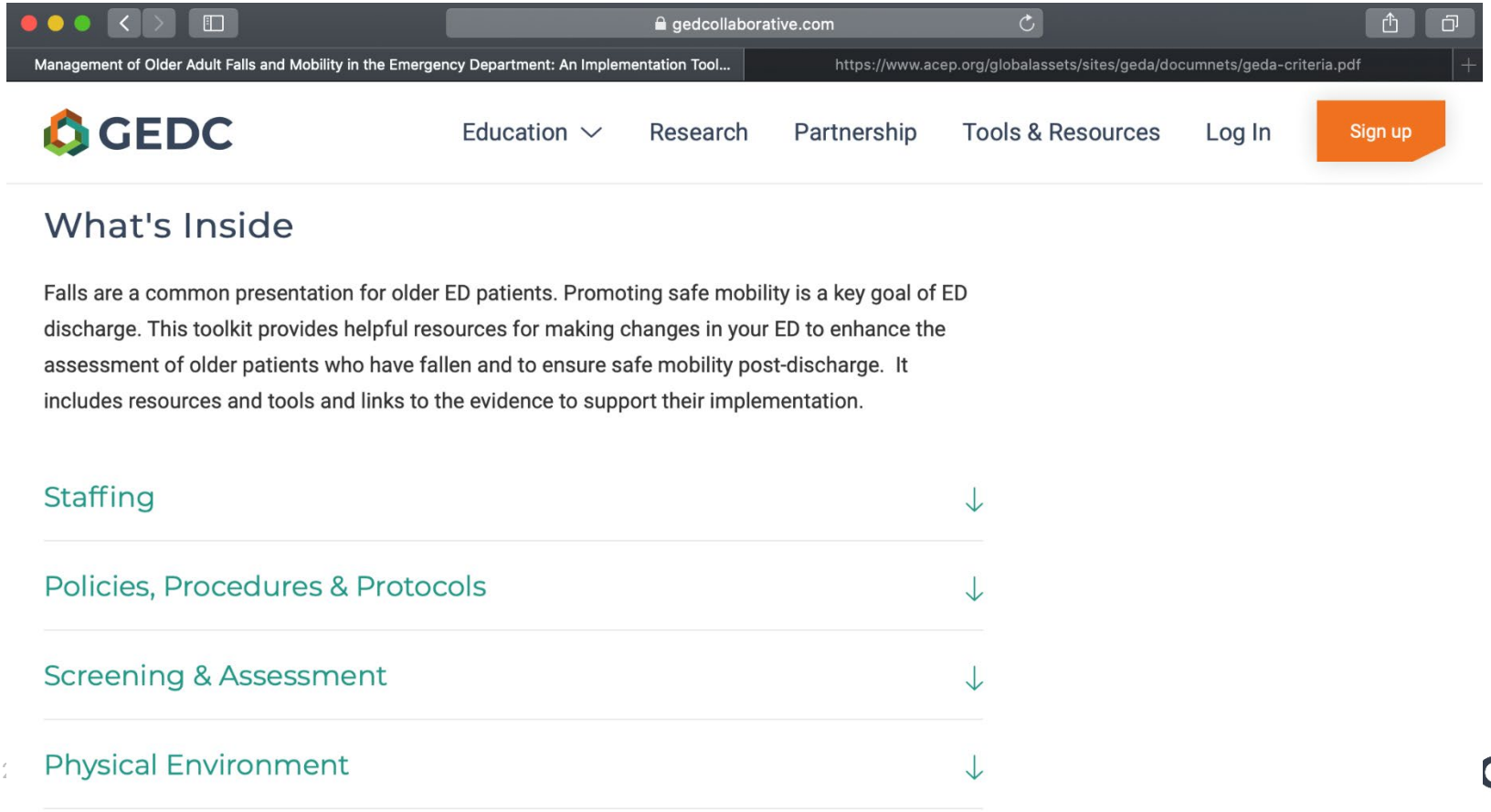
gedcollaborative.com/toolkit/falls-and-safe-mobility/

...pssst...

...it counts for TWO procedures towards GEDA



Falls & Mobility Implementation Tool Kit



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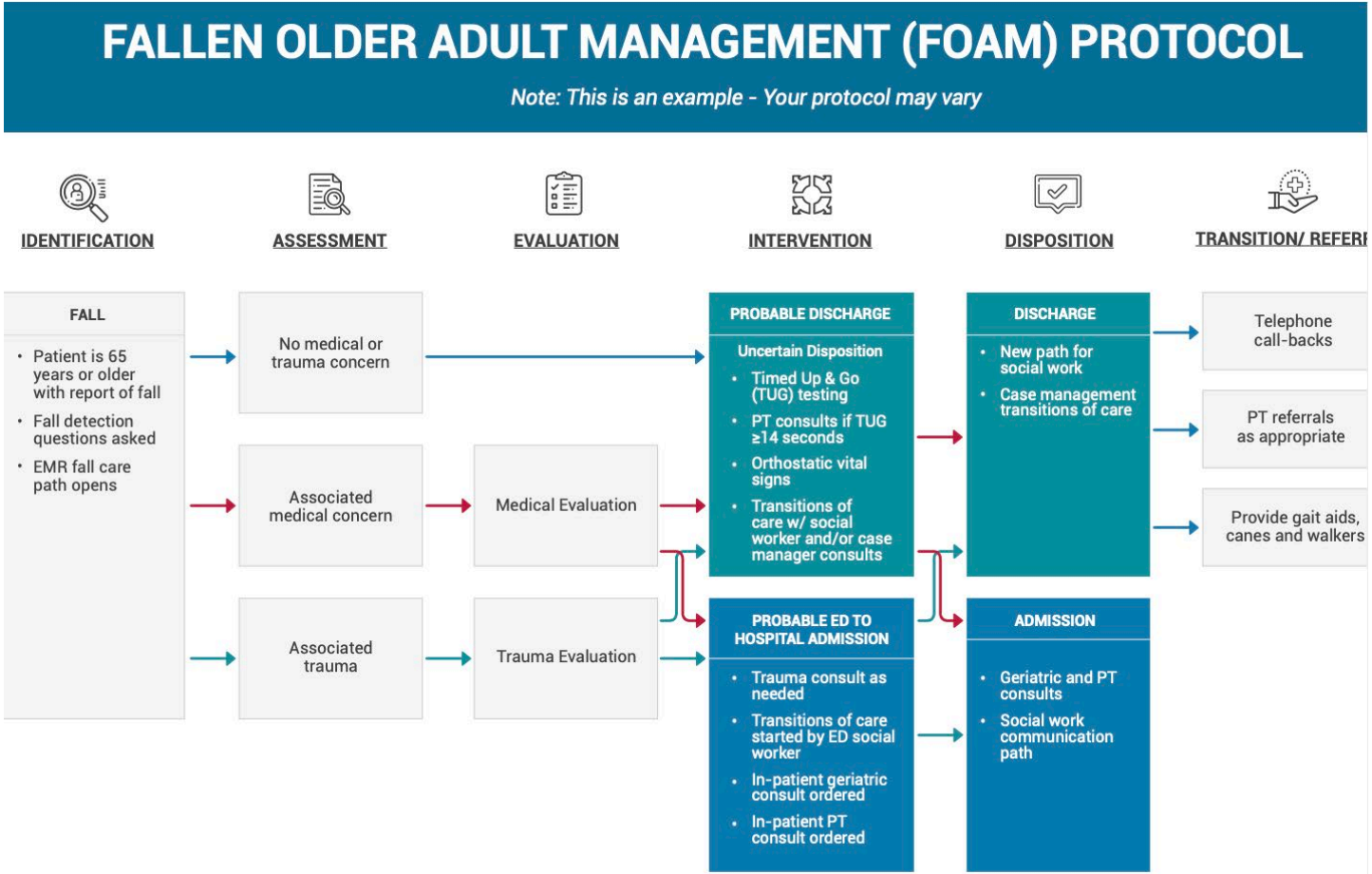
FOAM Protocol

INITIATING AT BEDSIDE

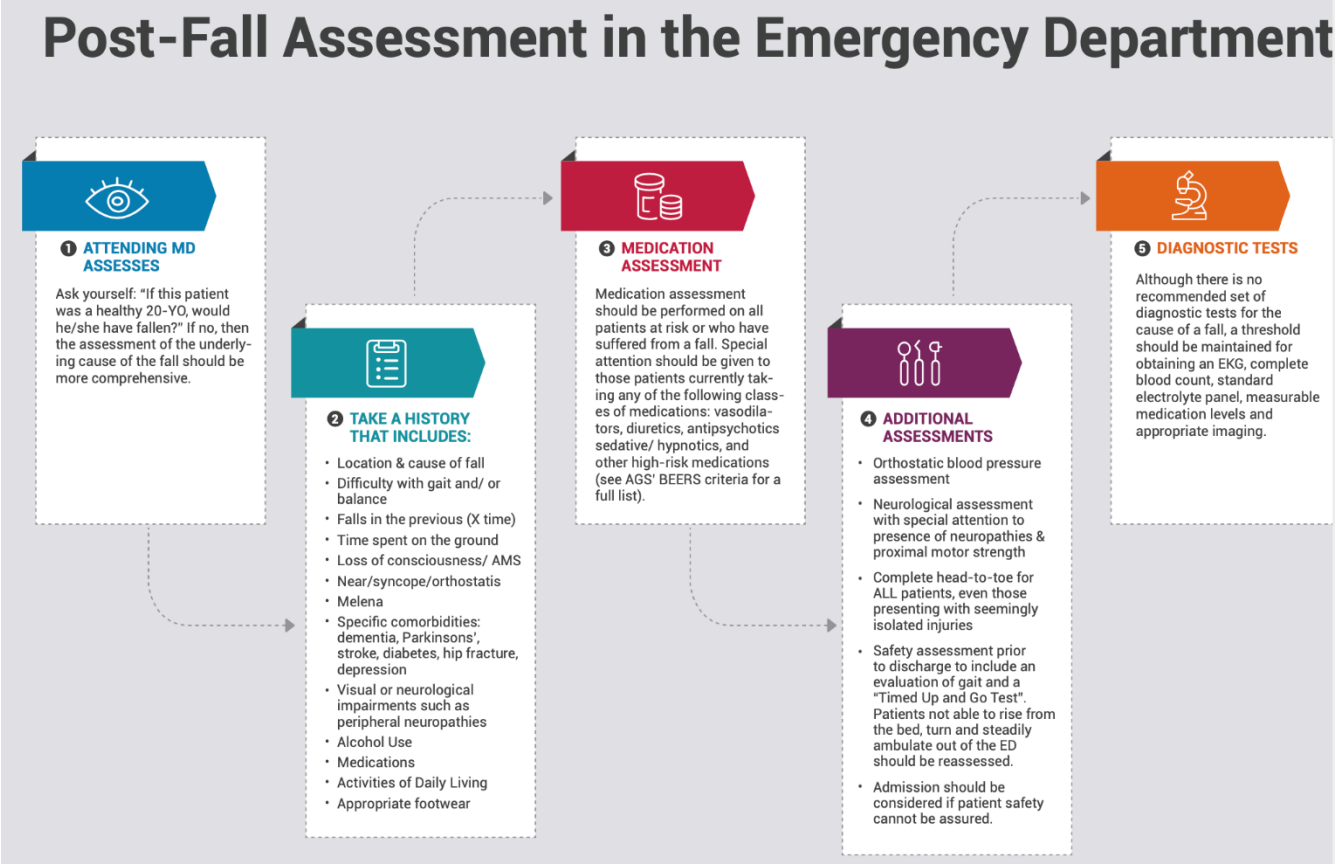
Note: Tailor to your specific needs and resources



Post-Fall Assessment

INITIATING AT BEDSIDE

Note: Example of potential assessments



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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 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

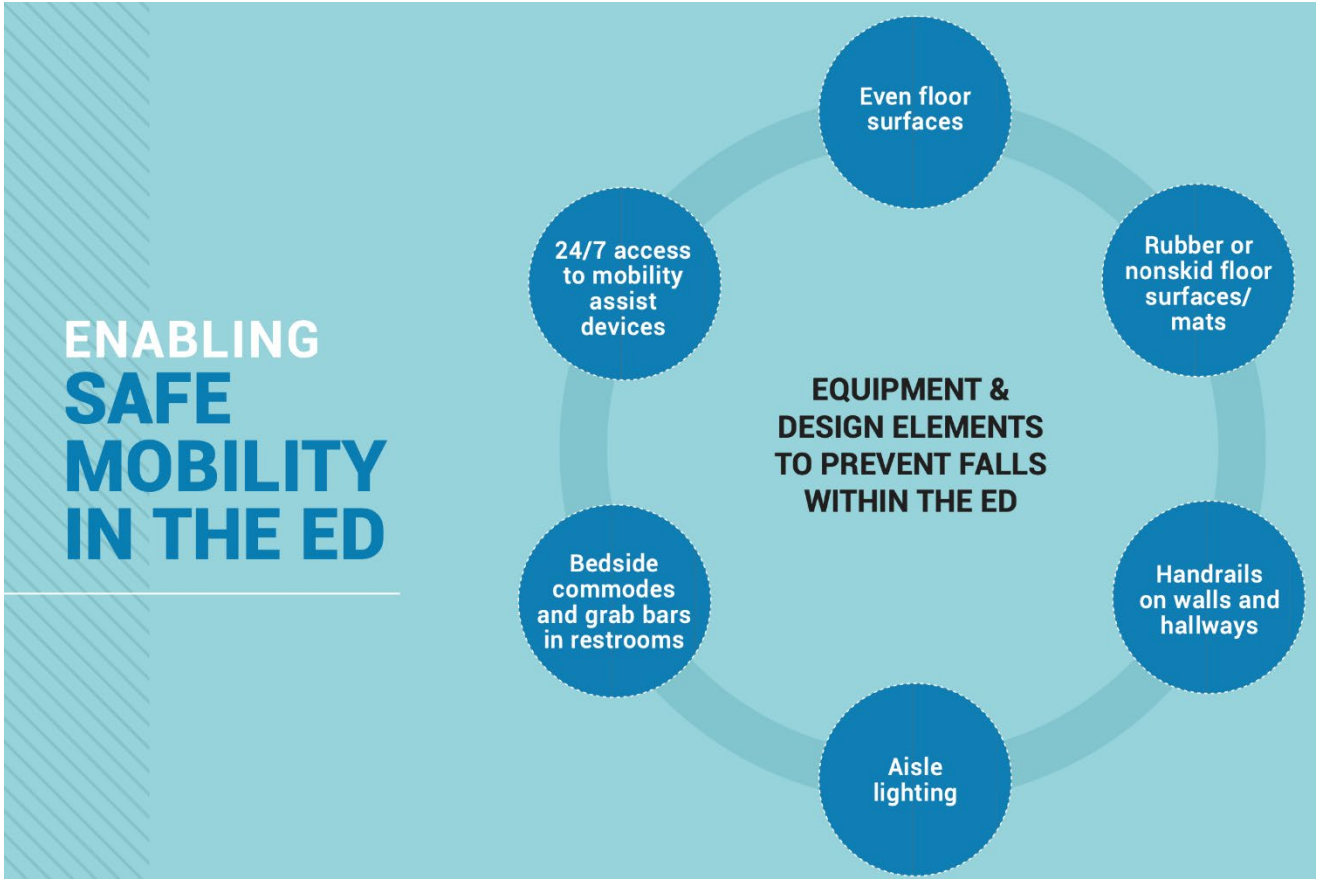
SECONDS	RATING
< 10	Normal, freely mobile
< 20	Mostly independent, can go out alone
20-29	Variable mobility, requires assistance
> 30	Mobility impaired

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.

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

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

Identification:

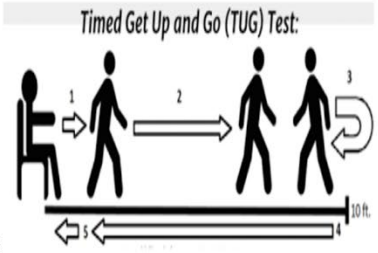
Patients aged >=65 years in the Emergency Department
Is this ED visit the result of a fall?

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



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

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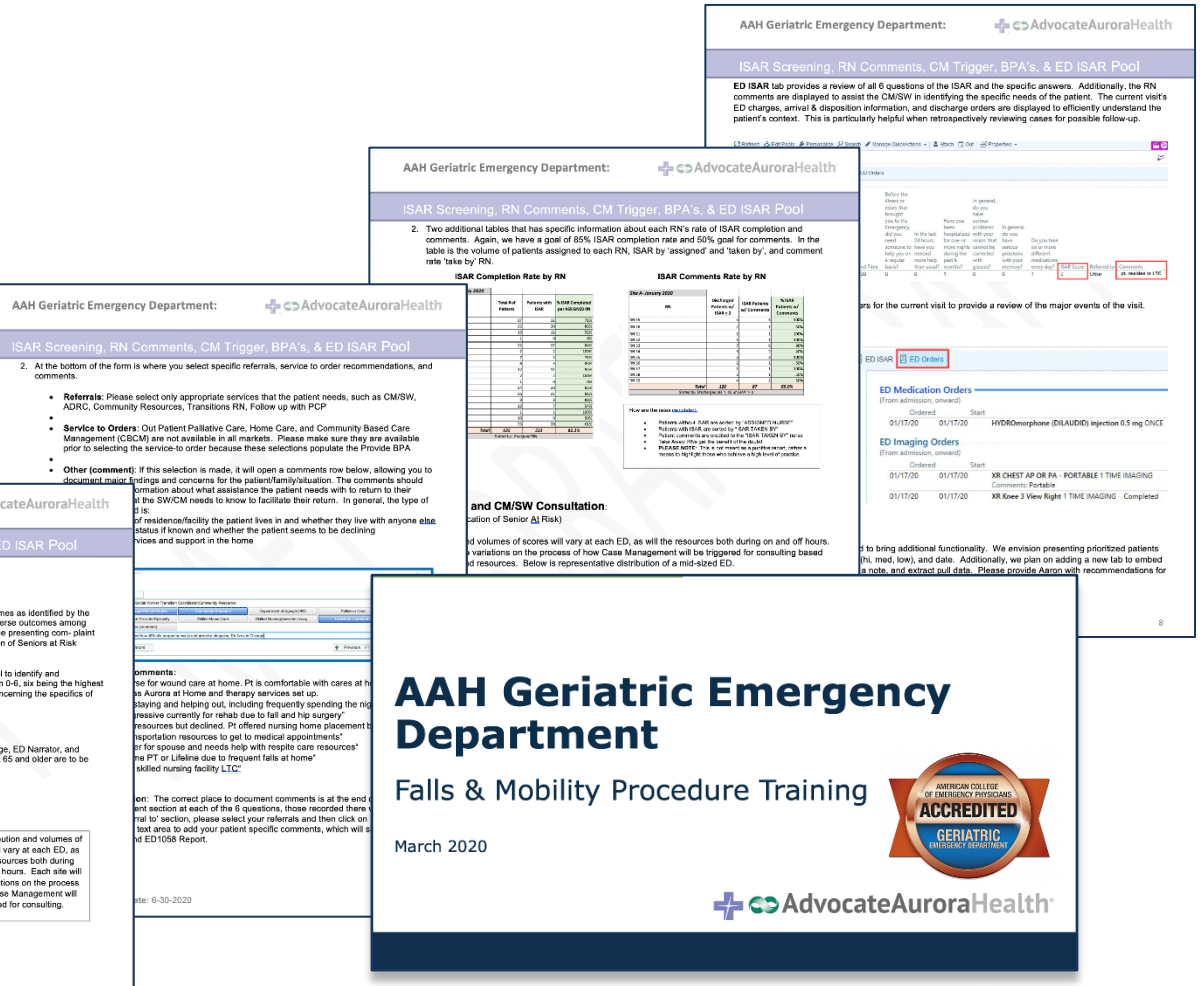
Key Points in Implementation

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

Education

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



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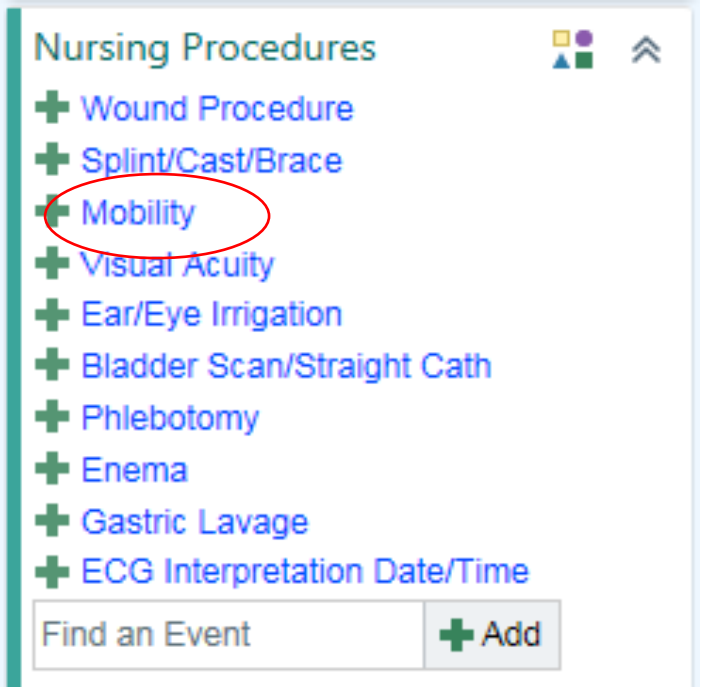
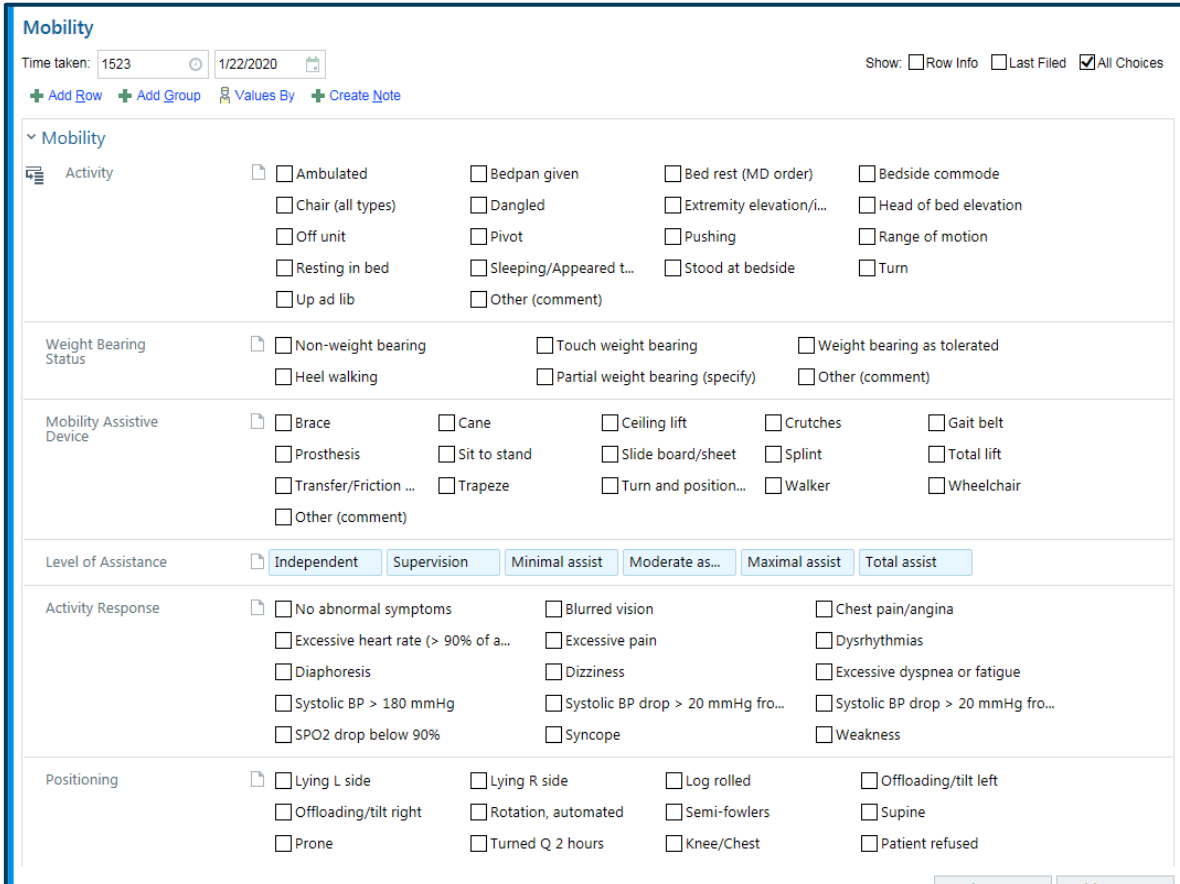
Mobility Documentation

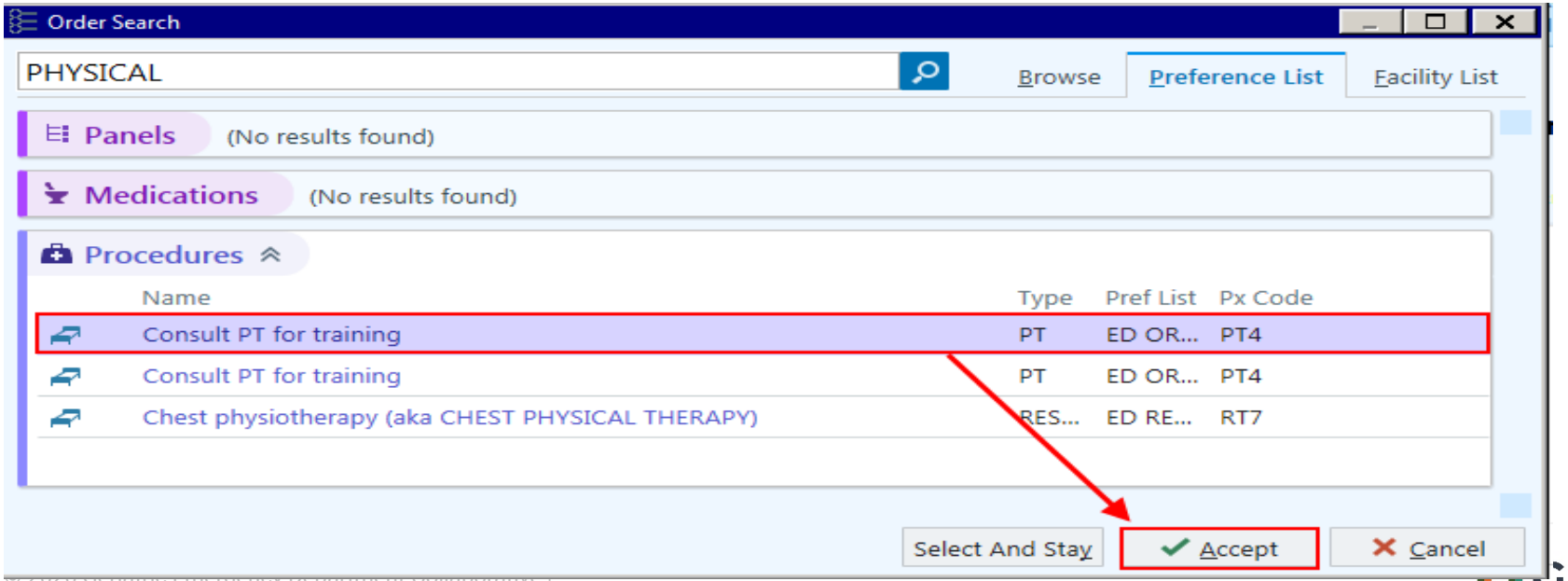
- Go to the nursing procedures toolbox





How To Order EMERGENCY DEPARTMENT PHYSICAL THERAPY Consult?

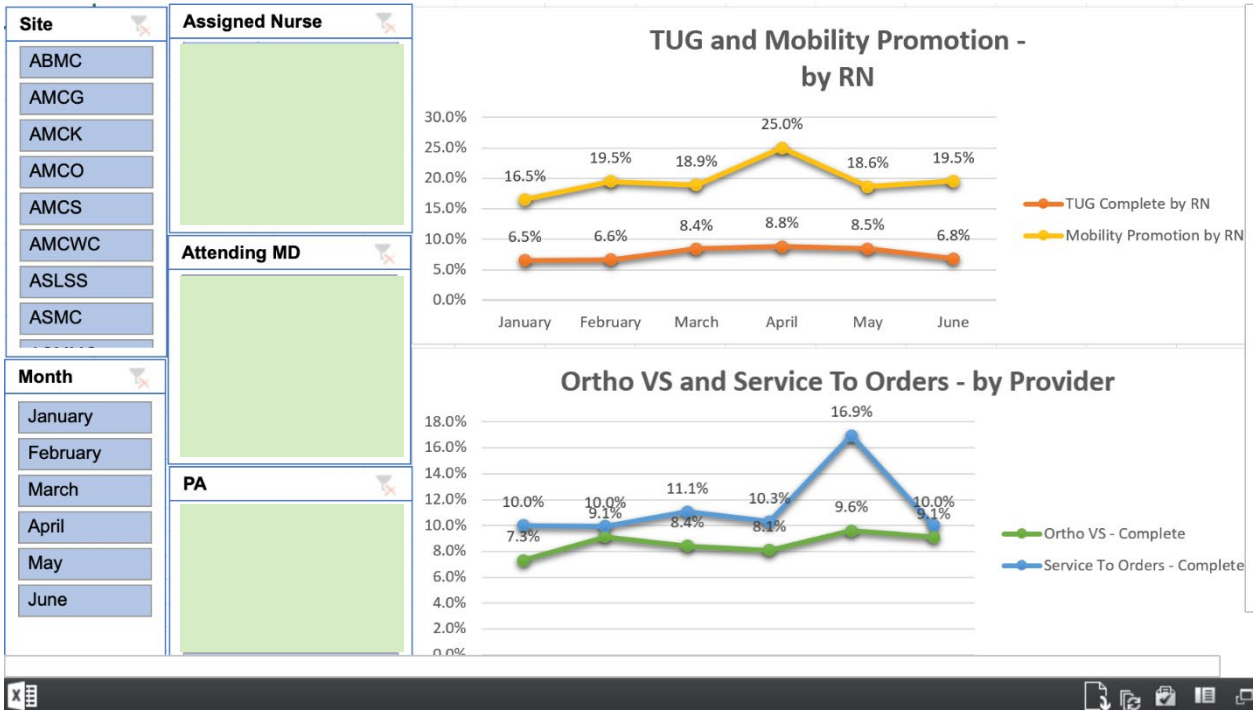
- ED Provider orders “Consult PT for training”
- (Optional site specific)RN or Tech calls and request PT assessment in the ED



Metrics & Reports

Example of AAH Falls & Mobility Dashboard (SharePoint)

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



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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

Screening for Dementia in Older ED Patients: The Dementia Implementation Toolkit

Don Melady MD, MSc(Ed), CCFP(EM), FCFP

Associate Professor of Emergency Medicine
Schwartz/Reisman Emergency Medicine Institute

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DEMENTIA IN THE ED? REALLY?

WHY IS IT IMPORTANT?

- Ability to gather history
- Ability to give informed consent
- Ability to participate in CARE
- Ability to follow up discharge instructions

The West Health Toolkit

gedcollaborative.com/toolkit/dementia/

If you go to the Toolkit online (access via your resource page, or search the Tools & Resources of our website) this is what you'll see:

What's Inside

Many older patients are in the ED not because of dementia but *with* dementia. This Implementation Toolkit contains resources that can help you make changes in your ED to provide better care for those patients. It includes resources and tools and links to the evidence to support their implementation.

- Education ↓
- Policies & Procedures ↓
- Screening & Assessment ↓
- Physical Environment ↓
- Support Programs ↓

EDUCATIONAL POSTERS

DEMENTIA IN THE EMERGENCY DEPARTMENT: BACKGROUND

Signs and symptoms of dementia[1]

- Gradually increasing memory loss
- Confusion
- Unclear thinking, including losing problem-solving skills
- Agitated behavior or delusions
- Becoming lost in formerly familiar circumstances
- Loss of interest in daily or usual activities

Challenges of Dementia Patients in the ED:[3]

- Fast-paced environment may be stressful or disorienting for those with cognitive impairment
- Persons living with dementia may provide an incomplete medical history
- Increased potential for adverse events: delirium, incontinence, dehydration, wandering, elopement

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EDUCATIONAL RESOURCES

TREATING PATIENTS WITH DEMENTIA IN THE EMERGENCY DEPARTMENT

Assessment:

- Early recognition is key - Use a standard screening tool (such as the Brief Alzheimer Screen or Mini-Cog™©)
- Consider the **CURVES** mnemonic to assess medical decision-making capacity[1]:

Choose and Communicate – can the patient communicate a choice?

Understand- Does the patient understand the risks, benefits, alternatives, and consequences?

Reason- Is the patient able to provide a logical explanation for the choice?

Value- Is the choice consistent with their value system?

Emergency- Is there an imminent, serious risk?

Surrogate- Is there a surrogate decision maker available?

Clinician Education:

- Consider training initiatives for staff, such as the Dementia-Friendly Hospital Initiative (see https://www.hcinteractive.com). the GeriEM.com education model, the GENE course (for nurses), and the GEMS course (for EMTs)
- Know atypical presentations of dementia
- Adverse medication events are common in patients with dementia. Know high-risk and potentially inappropriate medications for older adults (e.g., reference AGS' BEERS List)

Roaming /wandering

Imminent danger — falls or fire-setting

Suicidal ideation

Kinship and relationships (elder abuse, adequate social support)

Safe driving Substance misuse, Self neglect

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QI OPPORTUNITIES

Know (or create) your ED's policies and protocols around :

- Management of older people with cognitive impairment during the episode of care
- Caregiver involvement in the patient's care, including obtaining a Caregiver History and considering the ED visit as an opportunity to make a plan for unmet or evolving care needs after discharge
- Assessment and management of behavioral symptoms of older adults with cognitive impairment, including appropriate policies on chemical and physical restraints.
- Assessment and management of pain in older adults with cognitive impairment

References

For additional guidance on policies and protocols for managing dementia in the ED, reference:

- **The Geriatric Emergency Department Guidelines**
- **Geriatricfastfacts.com**
  - **Fact Fact Sheet #71:** Creating a Dementia-Friendly Emergency Department
  - **Fast Fact Sheet #72:** Assessment of Dementia Patients in the Emergency Department

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DOWNLOADABLE TOOLS: MINI-COG

For a video of the Mini-Cog:
https://geri-em.com/cognitive-impairment/mrs-perdito/

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: _____

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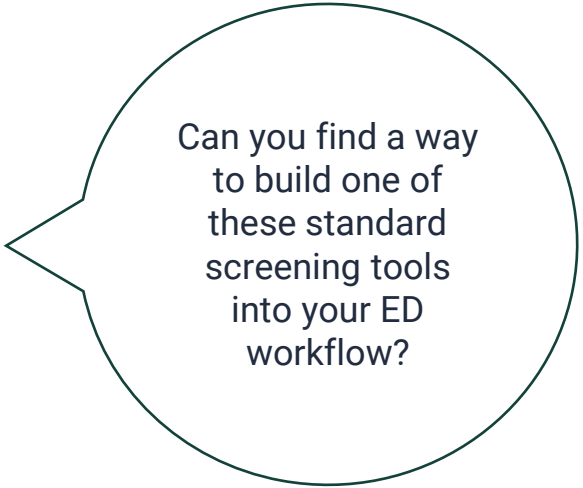
OPPORTUNITIES FOR QI IN THE GERIATRIC ED

Carpenter et al. ACADEMIC EMERGENCY MEDICINE 2011; 18:374–384

- Mini-Cog
- Ottawa 3DY
- AD8
- 4AT



INTERESTED IN ACCREDITATION?

Level Three accreditation signifies excellence in older adult care as represented by one or more geriatric-specific initiatives that are reasonably expected to elevate the level of elder care in one or more specific areas. Additionally, personnel to implement these efforts are identified and trained.

Table 1. Level 2: GED policies/protocols, guidelines and procedures

1	A standardized delirium screening guideline (examples: DTS; CAM; 4AT, other) with appropriate follow-up
2	A standardized dementia screening process (Ottawa 3DY; Mini Cog; SIS; Short Blessed Test; other)
3	A guideline for standardized assessment of function and functional decline (ISAR; AUA; interRAI Screener; other) with appropriate follow-up

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Implementing a process for screening all older patients for cognitive impairment will satisfy the criteria for Level 3 accreditation

THANK YOU!

Questions?

don.melady@utoronto.ca

QUESTIONS?

Thank you for your dedication to improving ED care for older adults

Check your GEDC Bootcamp Resource Page for resources to support your ED's QI project:

gedcollaborative.com/san-diego-westhealth-resources/

NEXT STEPS

gedcollaborative.com/san-diego-westhealth-resources/

West Health and GEDC will disseminate post-training materials and schedule webinars focused on quality improvement topics (Delirium, Falls/Mobility, Dementia)

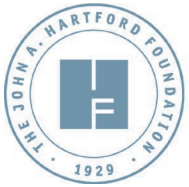
San Diego County EDs

- Complete remaining Level 3 GED accreditation requirements (e.g., training, supplies)
- Finalize geriatric quality improvement initiative
- Submit reimbursements for applicable expenses
- Apply for Level 3 GED accreditation by the end of 2020

Questions?

Misti Benson: mdbenson@westhealth.org
Caryn Sumek: csumek@hasdic.org

GEDC is Generously Supported by



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