

Level III Geriatric ED Accreditation Bootcamp



1:30 – 3:30 PM EST



HOSTED BY



IN COLLABORATION WITH



January 29, 2024 (1:30-3:30 pm EST)	Topic	Presenter(s)
1:30 – 1:40 (10 mins)	Welcome & Introductions	GEDC / TN Sites
1:40 – 1:45 (5 mins)	Age-Friendly Package	Alycia Cleinman (CHI Memorial)
1:45 – 2:05 (20 mins)	GEDC Intro Why Geriatric EDs? The 5 M's of Geriatric Care	Kevin Biese
2:05-2:30 (25 mins)	Case Studies & Connecting them to Geriatric ED Guidelines	Don Melady (Moderator)
2:30 – 2:35 (5 mins)	Break	
2:35 – 3:05 (30 mins)	1. 3 Required Care Processes 2. Fourth Care process	GEDC & TN Sites
3:05–3:20 (15 mins)	Wrap-up & GEDC resources	GEDC
3:20-3:30 (10 mins)	GEDA Application Questions	GEDA

Bootcamp Facilitators



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



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



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



Laura Stabler
MPH
Program Director GEDC



Alex Ostberg
MPH
Program Manager GEDC



Conor Sullivan
BS
Program Manager GEDC



Heather Wojtarowicz
BS, BA
Communication Specialist GEDC

Welcome

Tennessee Geri ED Teams



CHI Memorial

Level 3



24 K

EMERGENCY DEPARTMENT

OLDER ADULTS SERVED

Annually in the ED



TEAM MEMBERS

Christopher McArdle, DO Emergency Physician

Rebecca Taylor RN ED Nursing Director

Deann Champion, MD ED Medical Director



UNIQUE ASPECT of CHI Memorial Hospital

Newly implemented stroke program with interventional capabilities

Indian Path

Level 3



4,350

EMERGENCY DEPARTMENT

OLDER ADULTS SERVED

Annually in the ED

TEAM MEMBERS



- Lauren Py, MD - Medical director/Chair ED
- Melissa Williams, RN – Nurse manager
- Rebecca Mullins, RN – Case manager
- Jordan Harrington, MHA, MS-HI – Associate administrator
- Diamond Smith – Program Manager

UNIQUE ASPECT of Indian Path Community Hospital

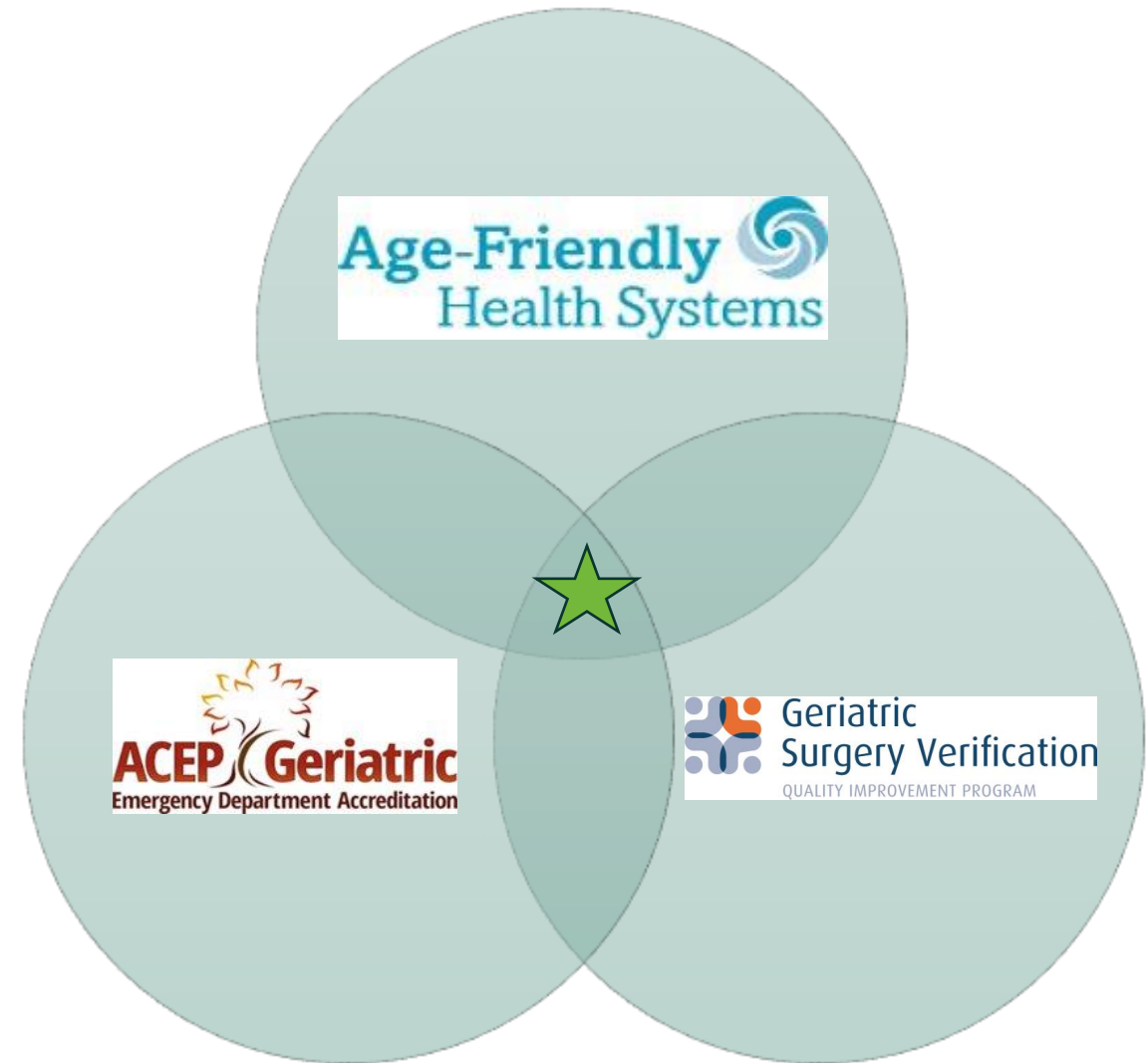
- The IPCH campus is home to several unique services in the region including a Center for Healthy Aging, Post-Covid Clinic, and a Sensory Motor Gym uniquely designed for pediatric rehab. In addition, IPCH has the largest Cancer Center in the tri-cities and across Ballad Health. IPCH is also one of three hospitals in the region with a dedicated pediatric Emergency Room.

The Age-Friendly Health Care Package for Improved Care of Older Adults is an initiative of:



An Age-Friendly Health Care Package

Concurrent adoption of the three evidence-informed programs to address three places older adults are served in the hospital:
Emergency Departments;
Surgery; Inpatient Wards.





GEDDC

THE GERIATRIC
EMERGENCY DEPARTMENT
COLLABORATIVE

EDUCATE IMPLEMENT EVALUATE

gedcollaborative.com

Mission & Vision

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

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

<https://gedcollaborative.com/membership/application/>

Membership

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

- **Make your plan to become a GED**
- **Access to GEDC Community**
- **Participate in consulting services**
- **Access to education tools**
- **Implementation tools and training**
- **Evaluation resources**



**Join
the
GEDC**

**Generously
supported by**

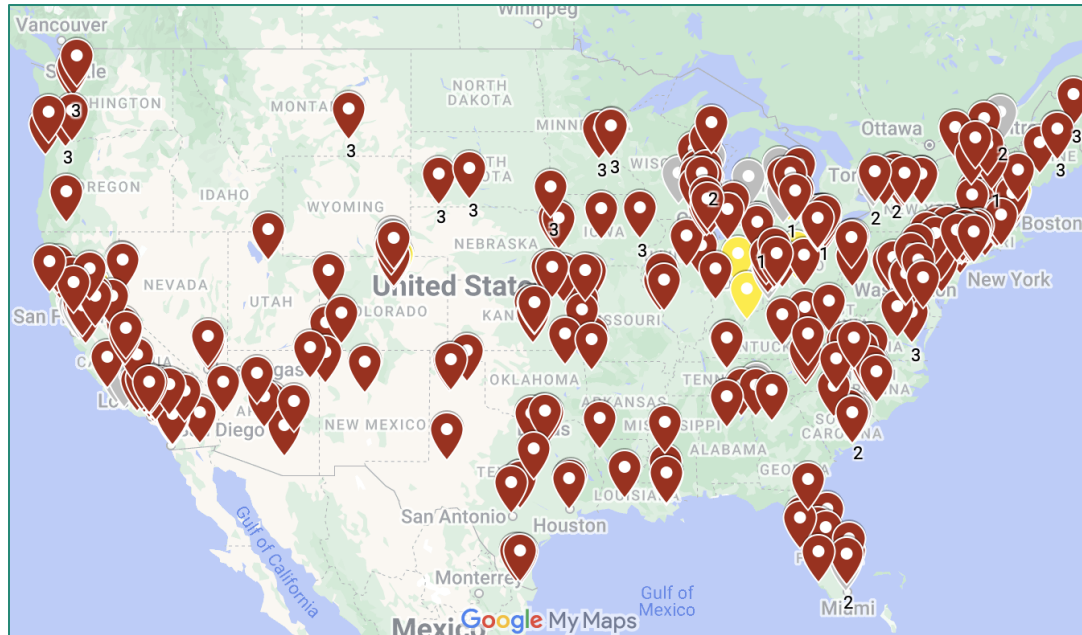


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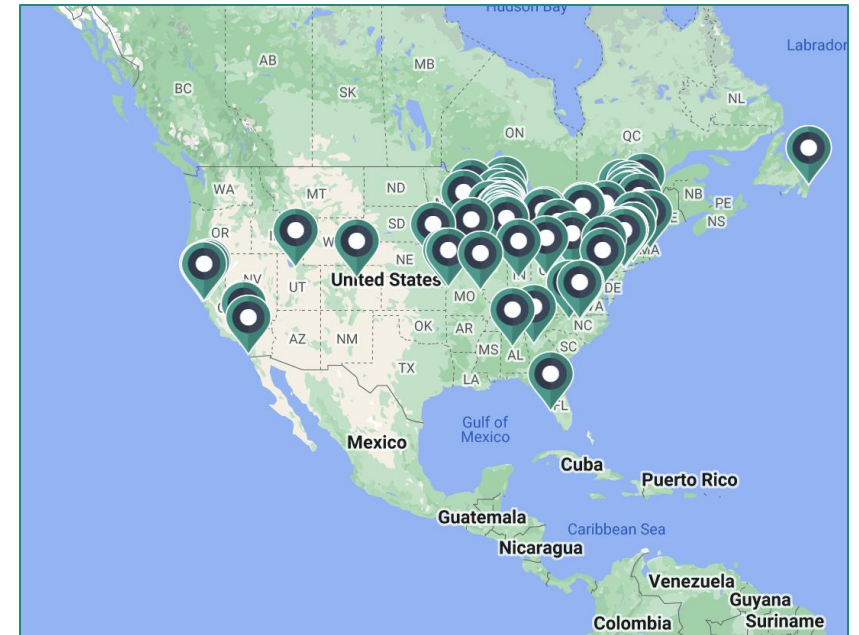


westhealthTM
institute

Geriatric EDs are Expanding Along with GEDC Membership



472 GEDA EDs



100 GED Member Sites
13 Participating Health Care Systems



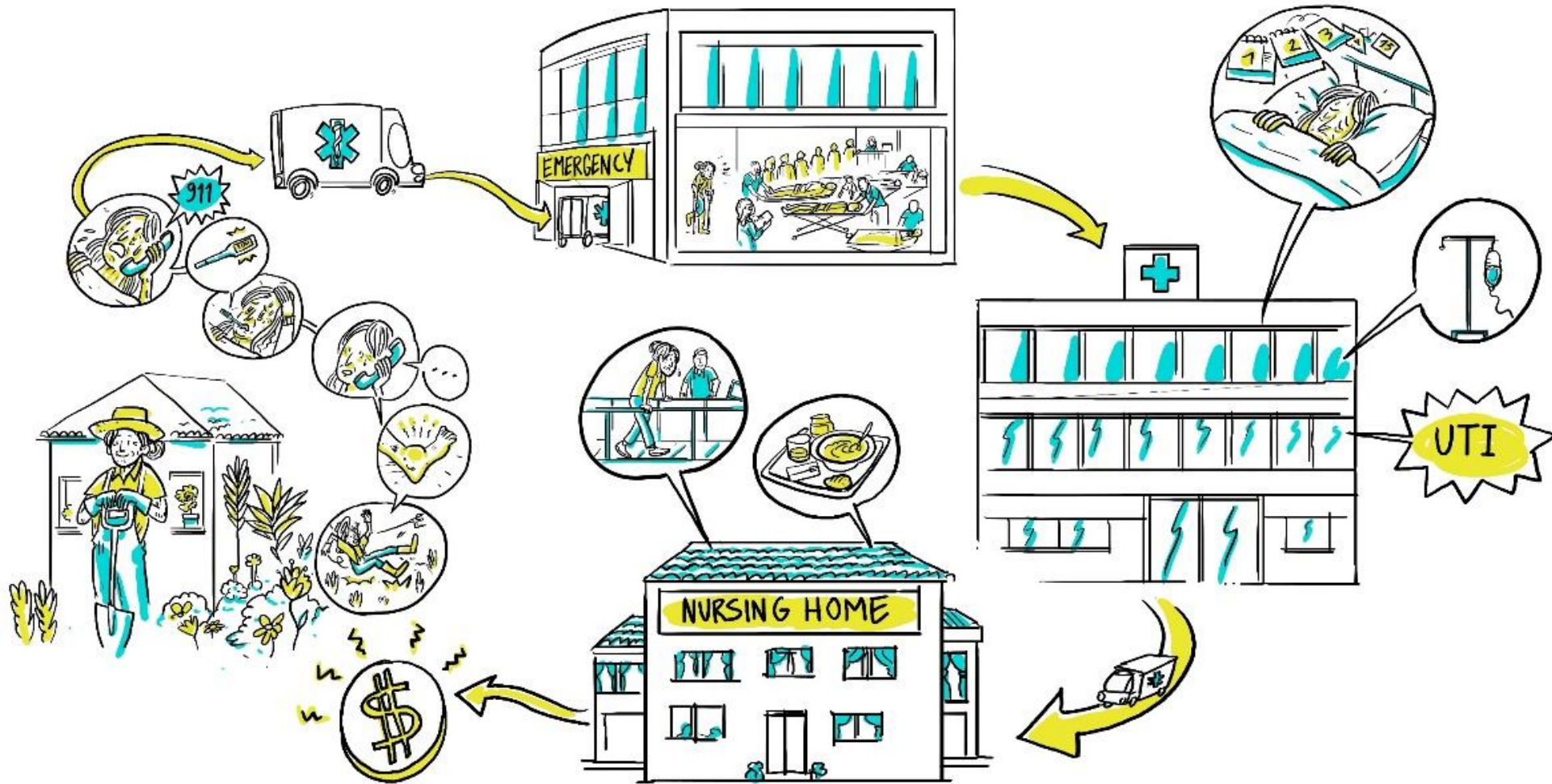
Geriatric EDs: The Why?

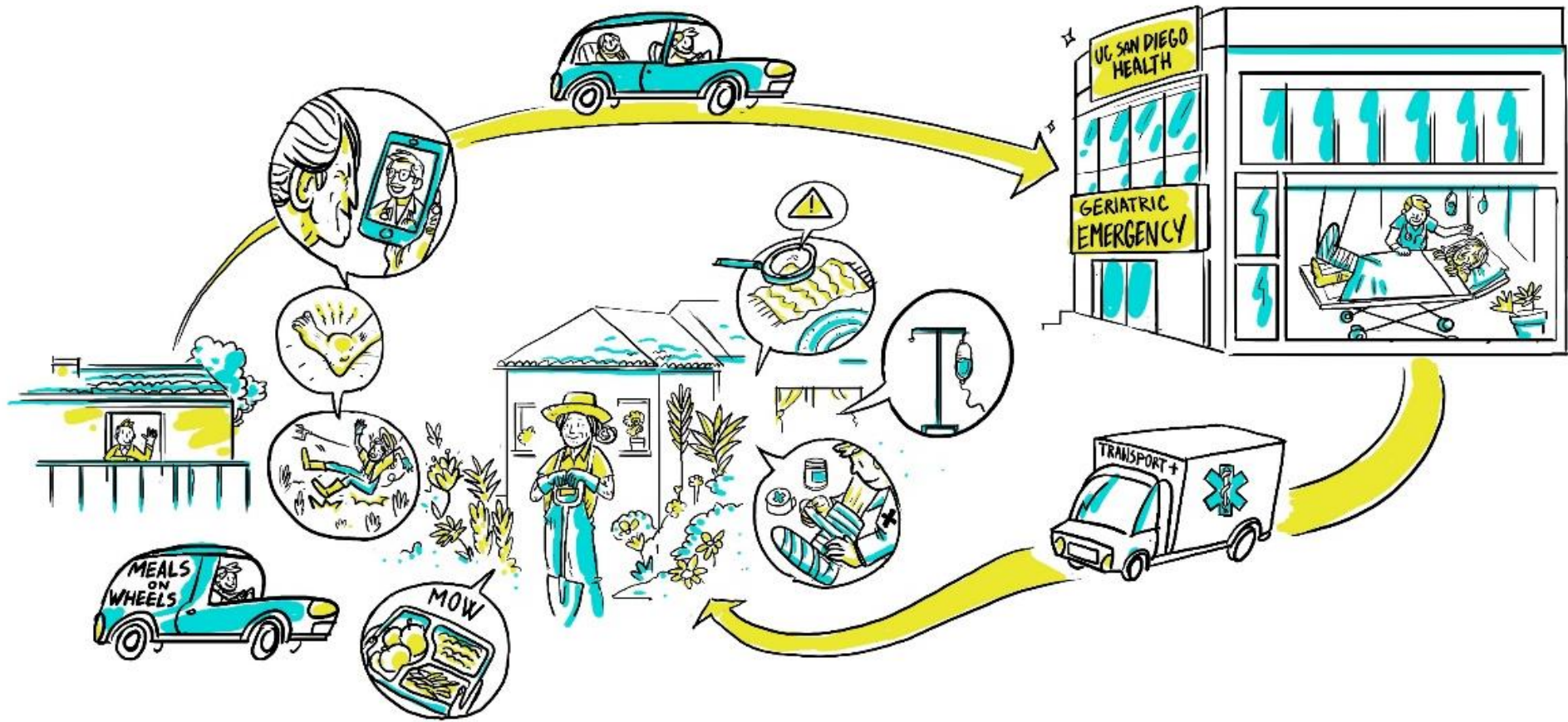
Kevin Biese
MD, MAT



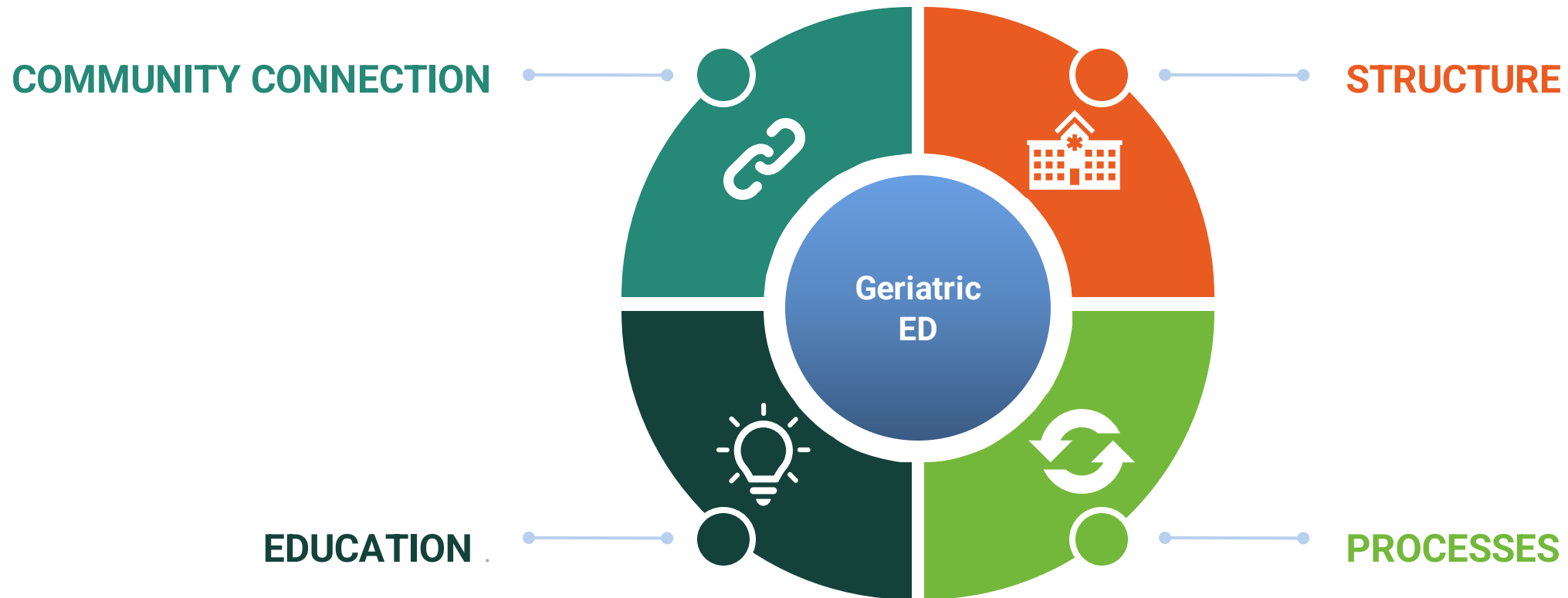
Geriatric Emergency Department
Collaborative Implementation PI

Chair, Geriatric Emergency
Department Accreditation





FOUR COMPONENTS OF GEDs



WHY GEDs?



Lower return visits

Recent data affirms that readmissions, as well as returns to the emergency department for high-risk populations are lower in communities with GEDs.



Greater market share

GEDs enable health systems demonstrate their commitment to excellent care to the community, while also allowing emergency departments to better manage existing patients to create space for patients needing a high level of care.



Improved patient experience

According to emerging research, older adult patients who receive comprehensive geriatric assessment and enhanced transition of care services report higher patient satisfaction.



Better census management

Studies demonstrate that hospitals with GEDs have up to 16% fewer hospital admissions and a decreased inpatient length-of-stay for admitted older patients.



Higher staff morale

GEDs help staff know that they are doing an excellent job caring for their patients.

A new library of literature supports Geriatric EDs as a solution

HealthAffairs TOPICS JOURNAL BLOG

HEALTH AFFAIRS BLOG DIFFUSION OF INNOVATION

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

July 10, Adriane Levant, Kevin Biese, Ula Hsiang, Christopher Carpenter

10.1371/journal.pmed.1001910

Academic Emergency Medicine

SPECIAL CONTRIBUTION

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

Teresa M. Hogan, MD, Tololope Oyejide Olade, and Christopher R. Carpenter, MD, MS

Abstract

Background: The United States faces a challenge to emergency departments (EDs). Studies show that emergency department (ED) visits, prolonged periods of observation, and response, emergency medicine (EM) bodies have implemented strategies to enhance patient, equipment, practice, and protocols. One example is the use of a snowball sample to identify geriatric emergency medicine (GEM) in the United States.

POLICY STATEMENT

Geriatric Emergency Department Guidelines

2014-15 See front matter. Copyright © 2014 by the American College of Emergency Physicians. 10.1016/j.ajem.2014.02.008

RELATED ARTICLE, P. e1.

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

Approved by the ACEP Board of Directors (October 2013) by the American Geriatrics Society (October 2013), by the Emergency Nurses Association (January 2014), and by the Society for Academic Emergency Medicine (October 2013).

INTRODUCTION

According to the 2010 Census, more than 40 million Americans were over the age of 65, which was "more people than in any previous census." In addition, between 2000 and 2010, the population 65 years and over increased at a faster rate than the total U.S. population. The census data also demonstrated that the population 85 and older is growing at a rate almost three times the general population. The subsequent increased need for health care for this burgeoning geriatric population represents an unprecedented and overwhelming challenge to the American health care system and is also to emergency departments (EDs) specifically.¹⁻³ Geriatric EDs began appearing in the United States in 2008 and have become increasingly common.⁴ The ED is uniquely positioned to play a role in improving care to the geriatric population.⁵ As an ever-increasing access point for medical care, the ED acts as a crossroads between inpatient and outpatient care (Figure 1).⁶ Specifically, the ED represents 57% of hospital admissions in the United States, of which almost 70% receive a non-surgical diagnosis.⁷ The expertise which an ED staff can bring to an encounter with a geriatric patient can meaningfully impact not only a patient's condition, but can also impact the decision to utilize relatively expensive inpatient medications, or expensive outpatient treatments.⁸⁻¹¹ Emergency medicine experts recognize similar challenges around the world.¹² Geriatric ED care principles have been described in the United Kingdom.¹³

Furthermore, as the initial site of care for both inpatient and outpatient events, the care provided in the ED has the opportunity to "set the stage" for subsequent care provided. More accurate diagnosis and improved therapeutic measures can not only expedite and improve inpatient care and outcomes, but can effectively guide the allocation of resources towards a patient population that, in general, utilizes significantly more resources per visit than younger populations.¹⁴ Geriatric ED patients

represent 43% of admissions, including 48% admitted to the intensive care unit (ICU).¹⁵ On average, the geriatric patient has an ED length of stay that is 20% longer and they use 50% more laboratory services than younger populations.¹⁶⁻¹⁸ In addition, geriatric ED patients are 40% more likely to require social services. Despite the focus on geriatric acute care in the ED manifest by disproportionate use of resources, these patients frequently leave the ED dissatisfied and optimal outcomes are not consistently attained.^{19,20}

Despite the fact that the geriatric patient population accounts for a large and ever-increasing proportion of ED visits, the contemporary emergency medicine management model may not be adequate for geriatric adults.²¹ A number of challenges face emergency medicine to effectively and safely improve post-ED geriatric adult outcomes.²² Multiple studies demonstrate emergency physicians' perceptions about inadequate geriatric emergency care model training.²³⁻²⁵ More common geriatric ED problems remain under-researched leaving uncertainty in optimal management strategies.²⁶ In addition, quality indicators for minimal standard geriatric ED care continue to evolve.²⁷ Older adults with multiple medical co-morbidities, often multiple medications, and complex physiologic changes present even greater challenges.²⁸ Programs specifically designed to address these concerns are a realistic opportunity to improve care.

Similar programs designed for other age groups (pediatric) or directed towards specific diseases (STEMI, stroke, and trauma) have improved care both in individual EDs and system-wide, resulting in better, more cost effective care and ultimately better patient outcomes.^{29,30}

GERIATRIC ED-PURPOSE

Purpose

The purpose of these Geriatric Emergency Department Guidelines is to provide a standardized set of guidelines that can effectively improve the care of the geriatric population and which is feasible to implement in the ED. These guidelines contain a template for staffing, equipment, education, policies and procedures, follow-up care, and performance improvement measures. When implemented effectively, a geriatric ED can expect to see improvements in patient care, customer service, and staff satisfaction.³¹ Improved attention to the needs of the challenging population has the opportunity to more effectively allocate health care resources, optimize admission and readmission rates, while simultaneously decreasing emergency complications and the resultant increased length of stay and decreased reimbursement.

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,* Liana Spadolini, MD,* Stefano Polonara, MD,* Giuseppe De Tommaso, MD,* Alessandro Rappelli, MD,* and Paolo Dess-Fulgheri, MD*

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

episodes model of emergency care does not adequately address the complex needs of elderly patients.³² The aim of EDs is to provide acute intervention and timely health care to all patients with emergent or urgent problems. When a medically complex or poor social support presents to the ED, the system experiences crisis, slows down, and becomes inefficient. Unfamiliarity of the ED staff with the management of elderly patients complicates the clinical

model, size, and complexity of geriatric emergency medicine (GEM) in the United States. Geriatric emergency medicine (GEM) is a specialty that focuses on the care of elderly patients in the emergency department (ED). The purpose of this study was to identify and characterize geriatric emergency departments (GEDs) in the United States. We used a snowball sample to identify GEDs and compared them to conventional emergency departments (CEDs). The study found that GEDs are more likely to have geriatric-specific staff, equipment, and protocols. GEDs also have higher rates of geriatric patients and are more likely to have geriatric-specific protocols. The study also found that GEDs are more likely to have geriatric-specific protocols and are more likely to have geriatric-specific protocols.

MODELS OF GERIATRIC CARE, QUALITY IMPROVEMENT AND PROGRAM DISSEMINATION

The Geriatric Emergency Department

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

With the aging of the population and the demographic shift of older adults in the health-care system, the emergency department (ED) will be increasingly challenged with complexities of providing care to geriatric patients. The special care needs of older adults unfortunately may not be aligned with the priorities for how ED physical design and care is rendered. Rapid triage and diagnosis may be impossible in the older patient with multiple comorbidities, polypharmacy, and functional and cognitive impairments who often presents with subtle clinical signs and symptoms of acute illness. The use of Geriatric Emergency Department Interventions (GEDI) and standardized protocols for geriatric patients addressing the special care needs of older patients, may help to address these challenges. *J Am Geriatr Soc* 55:1875-1876, 2007.

Key words: emergency medicine; geriatric health services

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

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

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MODELS OF GERIATRIC CARE, QUALITY IMPROVEMENT, AND PROGRAM DISSEMINATION

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

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

ABSTRACT OBJECTIVE: To determine whether providing physical therapy (PT) services in the emergency department (ED) was associated with lower rates of ED revisits for older adult fallers. DESIGN: We used Medicare claims data to evaluate ED revisits for older adult fallers who presented to the ED for a ground level fall and whether they received PT services in the ED. We used logistic regression models to evaluate the association between ED PT services, ED revisits, and ED length of stay. RESULTS: We analyzed national 2012 ED Medicare claims data for individuals aged 65 and older who presented to the ED for a ground level fall and who received PT services in the ED. We found that older adult fallers who received PT services in the ED were less likely to be readmitted to the ED for a ground level fall (OR 0.78, 95% CI 0.68-0.89) and less likely to be readmitted to the ED for any reason (OR 0.88, 95% CI 0.81-0.96). CONCLUSION: Providing PT services in the ED for older adult fallers was associated with lower rates of ED revisits for older adult fallers.

Geriatric Emergency Department Innovations: Transitional Care

Ula Hsiang, MD, MPH,^{1,2} Acar M. Dvorkin, MD, MS,³ Mark S. Rosenberg, MD, MPH,⁴ Alan S. Jaffe, PhD,⁵ G. George Yost, MPA, MPH, DrPH,⁶ Jeremy Scott, MD, MSc,⁷ D. Mark Courtney, MD, Raymond Kang, MD,⁸ Carolyn Yargian-Torres, MA,⁹ Conita R. Gendron, MD, MMS,¹⁰ and Lynne D. Richardson, MD, Investigator

OBJECTIVE: To describe geriatric emergency department (GED) innovations in transitional care. DESIGN: We conducted a descriptive study of GED innovations in transitional care. SETTING: We conducted a descriptive study of GED innovations in transitional care. PARTICIPANTS: We used a snowball sample to identify GEDs and compared them to conventional emergency departments (CEDs). The study found that GEDs are more likely to have geriatric-specific staff, equipment, and protocols. GEDs also have higher rates of geriatric patients and are more likely to have geriatric-specific protocols. The study also found that GEDs are more likely to have geriatric-specific protocols and are more likely to have geriatric-specific protocols.

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, MS¹; Marilyn Browne, RN, Jeffrey M. Cantorio, MD, MPH, Audrey Chiu, MD, Lowell W. Gerson, PhD, Jason Gumpert, MD, Ula Hsiang, MD, David P. Jahn, MD, William L. Levin, MD, Timothy J. Pflaum, MD, MS, MD, Barry Morrison, PhD, Laura Roggiani, MD, MPH, Mark Rosenberg, MD, MS, Scott T. Wilson, MD, MPH, for the ACEP Geriatric Emergency Medicine Section, American Geriatrics Society, Emergency Nurses Association, and Society for Academic Emergency Medicine

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CLINICS REVIEW ARTICLES

Clinics in Geriatric Medicine

CARE FOR THE OLDER ADULT IN THE EMERGENCY DEPARTMENT

EDITORS
MICHAEL L. MALONE
KEVIN BIESE

August 2018

Geriatric Emergency Department Innovations: Transitional Care

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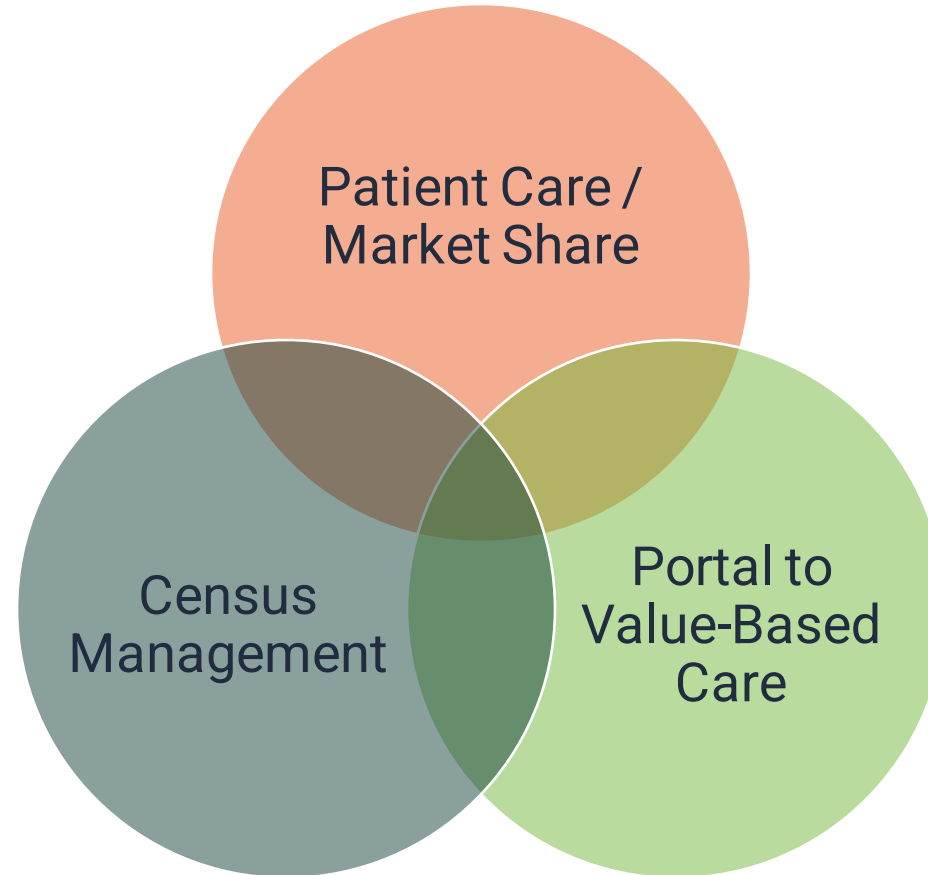
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HEALTHCARE SYSTEM GED Return on Investment



The Five Ms of Geriatric ED Care

1

Mobility

2

Mentation

3

Medication

4

Elder Mistreatment

5

What Matters

https://www.healthinaging.org/sites/default/files/media/pdf/HIA-TipSheet%20Geriatric%205Ms.July20_0.pdf

Mobility

Clinical Pearl

How many falls have you had in the last three months?

- Falls are not an event, they are a syndrome
- How do we help you keep from falling after you leave the ED (and hospital)?
 - Medication reconciliation
 - Community Paramedicine
 - Physical therapy consults
- Screening Test: Timed Get Up and Go Test

Mobility Part Two: Geriatric Trauma

Clinical Pearl

Older adults break easily.

- Falls are the number one reason for trauma admissions in the US
- Shock index; retrospective study National Trauma Data Bank (NTDB)
 - $HR/ SBP \geq 1 = OR 3.1$ death
 - Increased blood products, ex lap
- Age adjusted hypotension definition
 - Retrospective from NTDB if $SBP < 110$ better than $SBP < 90$ for needing trauma center care
 - Sensitivity 5 to 13%
 - Specificity 99 to 93%
- **Screening Tool:** Silver alert

Mentation



Delirium

Clinical Pearl

Delirium is the vital sign of older adults.

- Delirium is a change from baseline with inattention
- Picture of sleeping older adult
- **Screening Tool:** BCAM or 4 AT

Dementia

Clinical Pearl

Family and caregivers are your friends.

- Don't make them delirious
- Care transitions are key
- Referral for definitive diagnosis
- **Screening tool:** Mini Cog

Medication

Clinical Pearl

First think drugs. Are you taking any new medications?



Elder Mistreatment

Clinical Pearl

We miss it all the time.



what Matters



Case Studies



Don Melady
Moderator



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

With your GEDC Expert
Kevin Biese



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

With your GEDC Expert
Aaron Malsch

Case Studies

- What challenges would you have when managing this patient in your ED?
- Name 3 care processes you could implement in your ED to improve the care of this person.

Mrs. Cado

Challenges

- **Fall risk assessment / prevention at home**
- **Evaluating the home environment**
- **Integrating case manager can be difficult**
- **Unclear medications**
- **Possible Dementia**

Care processes

- **Timed Up and Go Test**
- **Involve an at home assessment**
- **Improve communication with PCP**
- **Pharmacy consult / medication reconciliation**
- **Standardized clinical screening for dementia identification**

Mrs. Schwach

Challenges

- **Understanding baseline is difficult**
- **Unclear medications, cognition, PMH**
- **Is the catheter necessary? Is there retention?**
- **Has not eaten for hours**
- **Incomplete communication between providers and daughter**
- **Missing keys and light headed at discharge**

Care processes

- **Catheter placement**
- **Minimize NPO status**
- **Medication review**
- **Streamline & Document communication**
- **Delirium screening**
- **Safe mobilization strategies**

5-minute Break

Level III

Good geriatric ED care

- At least one MD and one RN champion
- Evidence of geriatric-focused education (4 hours)
- Evidence of **four** geriatric focused care initiatives and adherence plan
 - Three Baseline Processes
 - One care process of your choice from pick list
- Mobility Aids
- Free food & drink 24/7



Overview of GEDA Baseline Care Processes

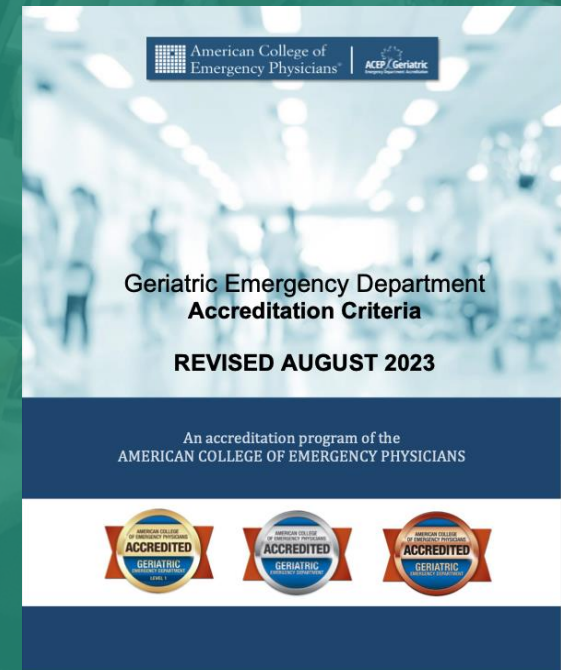
3 GED Care Processes Required for all Programs

Basic processes for all geriatric EDs

A1: Minimize Urinary Catheters

A2: Minimize NPO status

A3: Minimize Physical Restraints



Care Process A1: Minimize Urinary Catheters

Key Components

- Only for clear indications
- Method of ensuring/verifying indications
- Chart review of subset of catheters monthly

Best Practices

- EHR order with a menu of indications
- Nurse confirmation that meets pre-specified indication (of course, exceptions exist)
- 10 Foley placements are reviewed per month to ensure indication is recorded



Care Process A2: Minimize NPO status

Key Components

- Older patients can starve in our departments!
- Food is essential to patients and their caregivers
- Do *something proactive* to ensure your department can follow this care process.

Best Practices

- Change policy: consider a default “feed older people unless specifically indicated”
- Make sure appropriate food is easily available.
- Make food available to essential care partners
- Add education about feeding older people



Care Process: A3: Minimize Physical Restraints

Key Components

- Geriatric Specific, not stock policy!
- Describe alternatives
 - De-escalation, Distraction, Non-pharm
 - Promote Sitters
- Describe roles RN, MD, CM
 - Who, what, when, and then what

Best Practices

- Build upon existing policy with Geriatric ED Specific focus
- Assess staff needs for implementation
- Metrics with process & outcome metrics.

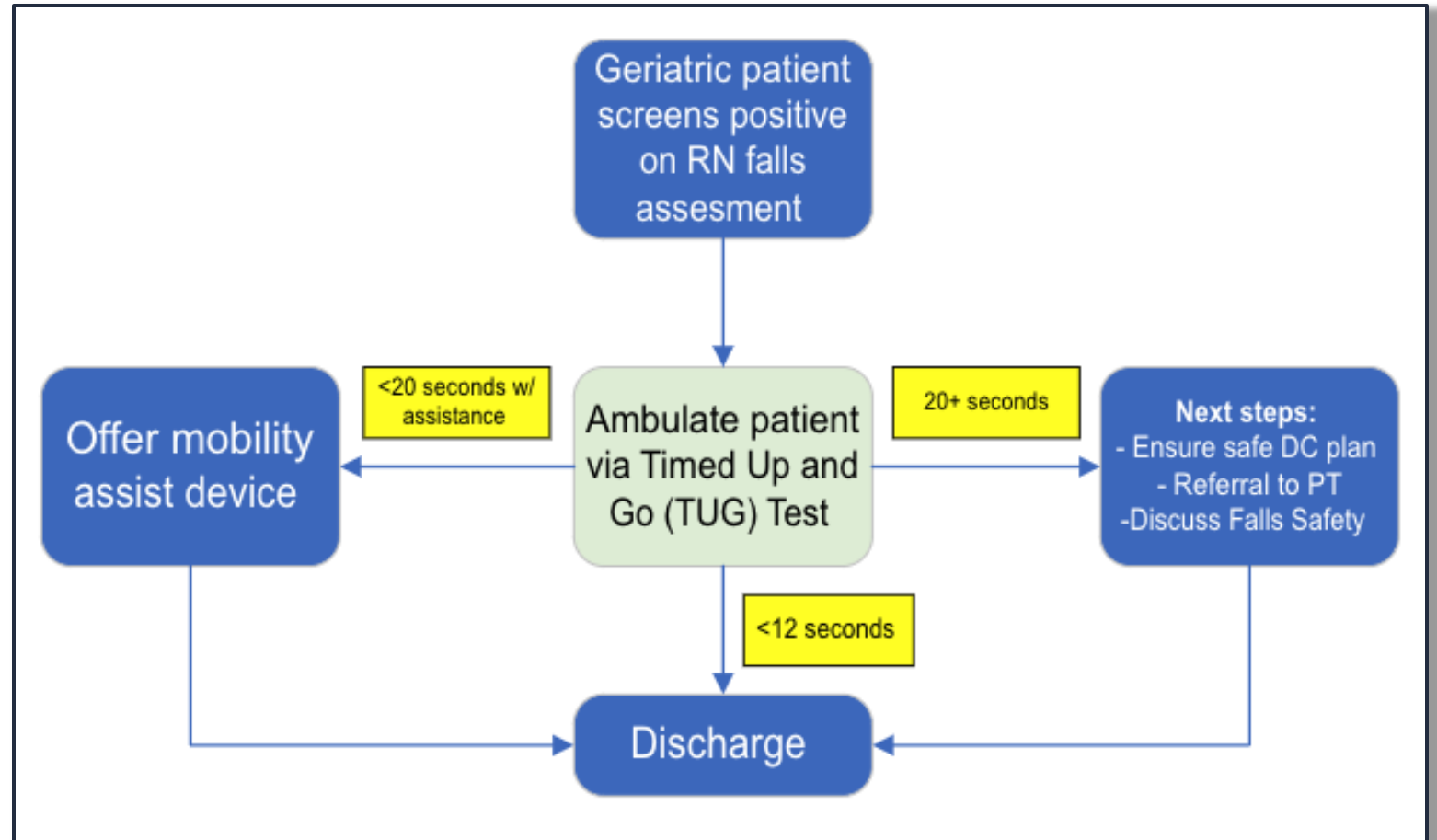


CHI Memorial: Fall Prevention

Objective: Identify and intervene with older adults at risk for falls.

When: The Timed Up and Go Test will occur prior to discharge.

ED Staff Involved:
Bedside RN and clinician.

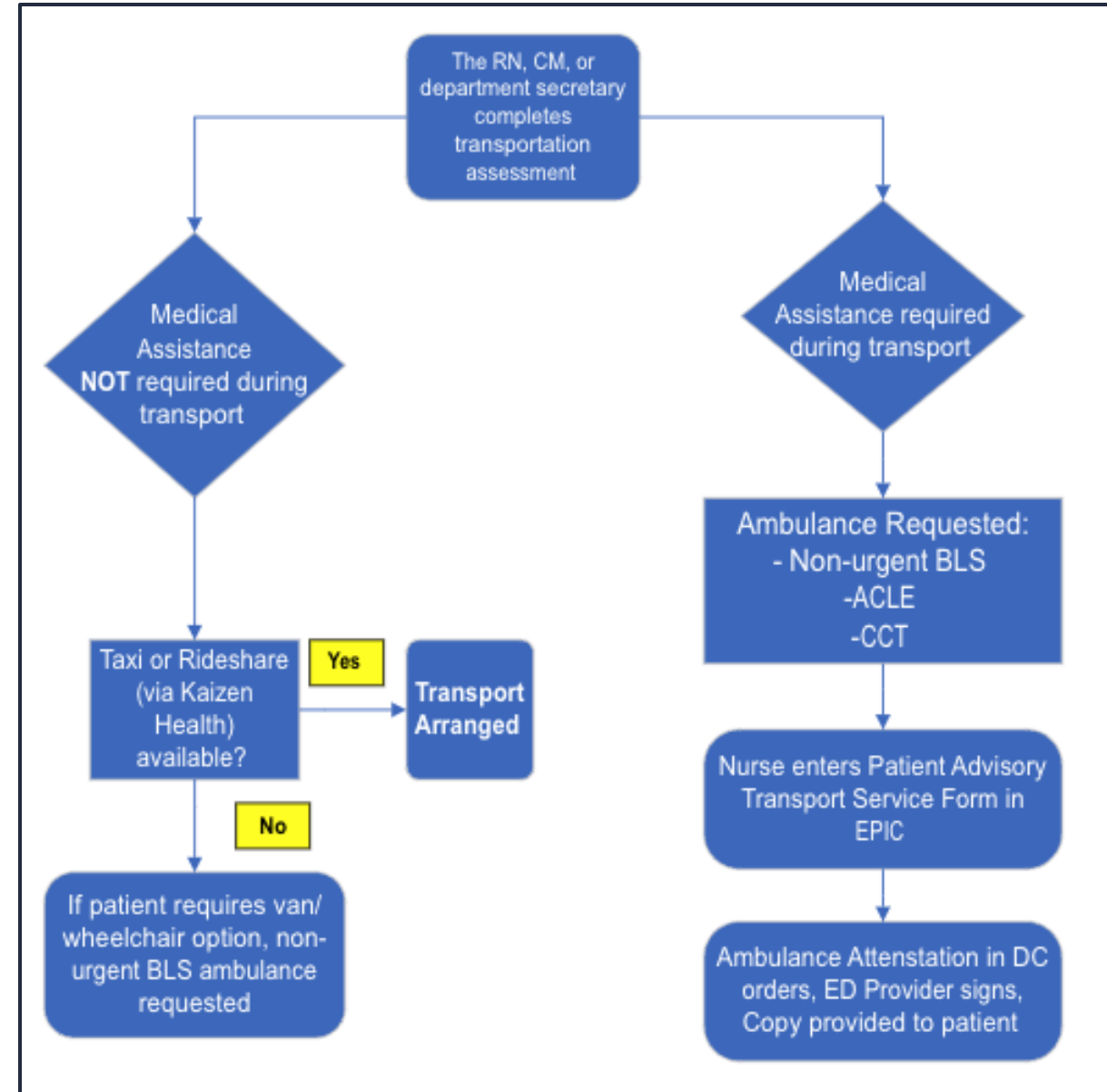


Indian Path: Transportation Protocol

Objective: Provide safe transportation options for all geriatric patients.

When: Applicable at the time of discharge. Implemented and available 24/7.

ED Staff Involved: RN, Case Manager, Department Secretary, Nurse, and Physician





Geriatric EDs: Implementation Pearls



Aaron's Tips

2 Way Feedback

Align GED with ED goals

Geriatric Focus both in the ED and beyond (transitions)

Continuous Improvement



Don's Tips

Enhance your hospital's reputation in the community, including increased philanthropic interest.

Geriatric EDs impact recruitment and retention.



Kevin's Tips

Share at least one positive outcome or patient story per month.

Use tools that the front-line staff chooses.

OUR RESOURCES



Scan to view GEDC website

Coming Soon: TN Landing Page
www.gedcollaborative.com/TN/

01

Implementation Toolkits

Topics: Falls & Mobility, Dementia Implementation, Delirium Management, Elder Mistreatment

02

Geri-EM.com online learning

Free courses which offer CPD, CME, and CNE credits

03

GEMCAST Podcast

Conversations with leading experts and researchers on clinical topics relevant to geriatric care

04

On-Demand Webinars

Immediate access to recorded webinars with related resources and key learning points attached

05

Resource Library & JGEM Articles

Categorized resources which includes access to peer reviewed, open access Journal of Geriatric Emergency Medicine articles

GEDA Application questions?

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Important Application Information

All three Levels of GEDA are operating under the revised criteria that went into effect on June 30, 2023.

Please note Level 1 and Level 2 will undertake boarding care metric requirements on January 1, 2024.

[GEDA Care Process New Requirements as of July 1 2023 \(PDF\)](#)

[Emergency Department Boarding Care Processes and Outcomes \(PDF\)](#)

Application due dates (cut-off) cycles:

August 7, 2023	October 2, 2023
December 4, 2023	February 5, 2024
April 8, 2024	

[HIDE APPLICATION INFO & DUE DATES](#)



GEDDC

THE GERIATRIC
EMERGENCY DEPARTMENT
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for Geriatric Emergency Medicine Education



Geri ED Bootcamp (2.0 hrs.)

Event

January 29, 2024

Date

THANK YOU!

