GEDC THE GERIATRIC EMERGENCY DEPARTMENT COLLABORATIVE
EDUCATE IMPLEMENT EVALUATE

# SAN FRANCISCO GERIATRIC ED DEMENTIA CARE VIRTUAL BOOT CAMP

CONNECTING WITH INTERDISCIPLINARY COLLEAGUES FROM:

Kaiser, UCSF, ZSFG, and the GEDC

Sharing best practices and promising interventions in Geriatric Emergency Care

HIRSCH & ASSOCIATES LLC
PHILANTHROPIC ADVISORS

## OUR FACULTY

Ula Hwang, MD
Emergency Physician
Mount Sinai, NYC

Aaron Malsch, RN
Senior Services Program Coordinator
Aurora Health Care

Kevin Biese, MD
Emergency Physician
UNC

Laura Stabler, MPH
GEDC Program Director

Chris Carpenter, MD
Emergency Physician
Washington University

Conor Sullivan
GEDC Research Associate

Michael Malone, MD
Geriatrician
Aurora Health Care

A Warm Welcome To:

Allison Domicone
Associate Director, Hirsch & Associates

Elizabeth Edgerly, PhD
Executive Director, Alzheimer's Association Northern California and Northern Nevada Chapter

 

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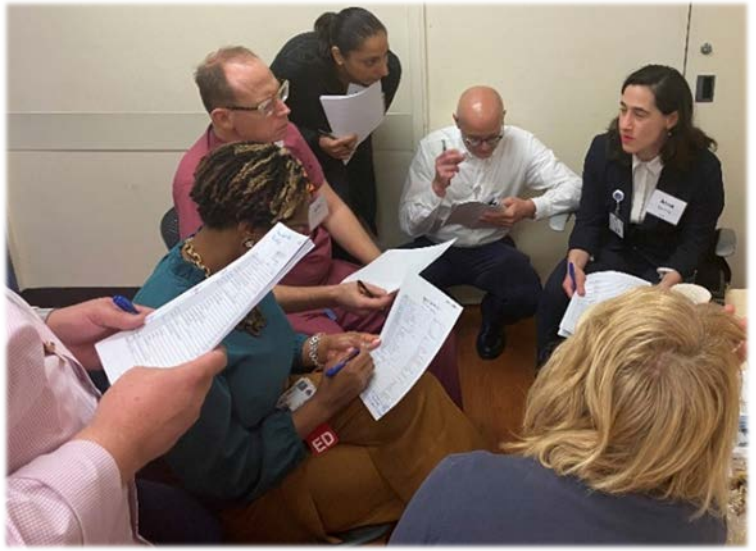
# Transforming Dementia Care in San Francisco Emergency Departments




***Phase 1: Planning and Ramp-up***

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# Who YOU are

ZOOM POLL RESULTS

## Ula Hwang

**MD, MPH, FACEP, Co-PI**

Dr. Ula Hwang is Professor of Emergency Medicine and Geriatrics and Palliative Medicine at the Icahn
School of Medicine at Mount Sinai in New York 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.



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## Chris Carpenter

**MD, MSC, FACEP, FAAEM**

Dr. Chris Carpenter is dual-board certified in Emergency Medicine and Internal Medicine and is Professor in Emergency Medicine at Washington University in St. Louis. His funded research interests include diagnostics, dementia, falls prevention, and implementation science. He is on the Society of Academic Emergency Medicine Board of Directors as well as the American College of Emergency Physicians Clinical Policy Committee. He is also Deputy Editor-in-Chief of Academic Emergency Medicine, Associate Editor of both Annals of Internal Medicine's ACP Journal Club and the Journal of the American Geriatrics Society. He co-led the collaboration to develop the American College of Emergency Physician/American Geriatrics Society Geriatric Emergency Department Guidelines As well as the international Standards for Reporting of Implementation Research (StaRI) reporting guidelines. He is also faculty for Emergency Medical Abstracts and Best Evidence in Emergency Medicine courses, as well as a contributor to Skeptics Guide to Emergency Medicine and Sketchy EBM.



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## Teresita Hogan

**MD**

Dr. Teresita Hogan is an Associate Professor of Medicine and Director of Geriatric Emergency Medicine at University of Chicago Medicine. Her clinical research interest are Geriatric EM, Quality Improvement, Emergency Pain Management, Emergency Management of Falls in Older Adults, and Models of Care. . Dr Hogan is the ACEP representative to the AGS and serves on the executive committee Section for Enhancing Geriatreic Understanding and Epertise among Duregical and Medical Specialists. She is an expert in graduate medical education and led the expert consensus process to establish The Geriatric Competencies for Emergency Medicine Residents.

She has also worked on identifying the number and characteristics of geriatric emergency departments across the United States, and is a member of the GEDA Board of Governors.



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## Michael Malone

**MD**

Dr. Michael Malone is the Medical Director of Aurora Health Care - Senior Services and the Aurora at Home. He is a Clinical Adjunct Professor of Medicine at the University of Wisconsin School of Medicine and Public Health. He also serves as the Director of the Geriatrics Fellowship Program at Aurora Health Care. Dr. Malone received his undergraduate and medical degrees from Texas Tech University in Lubbock, Texas; he completed his internal medicine residency and geriatric fellowship training at Mt. Sinai Medical Center in Milwaukee. His Aurora Health Care practice is to home bound older persons in inner city Milwaukee.



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## Aaron Malsch

**RN, MSN, GCNS-BC**

Aaron Malsch is the Senior Services Program Coordinator at Aurora Health Care in Eastern Wisconsin. He supports several geriatric models of care (NICHE, Geri ED, HELP, ACE Tracker, Geriatric Scholars) that has resulted in the expansion to multiple sites nationally. His focus is on nursing and interprofessional practice as it relates to the elder population throughout the Aurora 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 has lead the Geriatric ED implementation and achieved ACEP Geri ED accreditation at 5 Aurora EDs as of 2019. Aaron contributes nationally to the improvement of care for older adults, highlighted by being a member of the geriatric committee at the Emergency Nurses Association (ENA), co-planner of GEDC symposium at the ENA conference in 2017 & 2018, and reviewer of Geriatric ED Accreditation program at American College of Emergency Department.

## Pamela Martin

**FNP-BC, APRN GS-C**

Pamela Martin is both nurse practitioner and program director at St Mary's Hospital Senior Services Emergency Department in Richmond, VA. St Mary's has the first Senior Services Emergency Department in the Commonwealth of Virginia. Pam received her undergraduate degree from Lynchburg College and her Masters of Nursing Science from the University of Virginia. She currently serves as President for the Central Virginia Gerontological Advanced Practice Nursing Association. She is a member of the American Geriatrics Society, the American Nurses Association, the Virginia Nurses Association, the American Association of Nurse Practitioners, and the Gerontological Advanced Practice Nursing Association.



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## Laura Stabler

**Program Director**

Laura Stabler is the Program Director of The Geriatric Emergency Department Collaborative. She received her MPH in Health Policy and Management from the University of North Carolina and her BS in Health Education from North Carolina State University. Before joining the Geriatric Emergency Department Collaborative, Laura was Director of OP Services for UNC Health Care Systems in Psychiatry for seven years and Radiation Oncology for 20 years.



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## Conor Sullivan

Research Associate

Conor is a research associate and medical student working for the GEDC. He is very excited to be part of a collaborative effort endeavoring to find innovative and evidenced-based strategies to improve the delivery of healthcare to our nation's elder population. He looks forward to expanding his skill set and knowledge base as part of the GEDC team.

 

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# GEDC SF Dementia Friendly Virtual Boot Camp

SCHEDULE MAY 5, 2020

| *Time (PST)* | Topic | Speaker(s) |
|---|---|---|
| 9:00-9:15a<br>12:00-12:15p | ***Why this initiative?***<br>***Caregiver experience*** | Allison Domicone<br>Elizabeth Edgerly |
| 9:15-9:30a<br>12:15-12:30p | ***GEDC Introductions,***<br>***Mini-Boot Camp Overview***<br>***GED parallel stories*** | Ula Hwang<br>Kevin Biese |
| 9:30-9:50a<br>12:30-12:50p | ***3 Case Discussions*** | Zoom breakout rooms<br>Mrs. Piedra / Mrs. Schwach / Mr. Kikway |
| 9:50-10:05a<br>12:50-1:05p | ***Case Discussion Debrief*** | All |
| 10:05-10:50a<br>1:05-1:50p | ***Overview, 3-course Prix-fixe stations***<br>***(10-min each)*** | Care Transitions<br>Delirium Implementation<br>Dementia screening |
| 10:50-10:55a<br>1:50-1:55p | ***Preview September In-person Conference***<br>***Alternate options*** | Laura / Ula / Kevin |
| 10:55-11:00a<br>1:55-2:00p | ***Questions / Feedback*** | All |

# TIPS FOR PARTICIPATION

## Zoom CHAT

Open your zoom chat! (bottom toolbar)

We encourage dialogue in the Zoom Group Chat

Please write your comments, experiences at your hospital, feedback, questions.

## Webinar packet

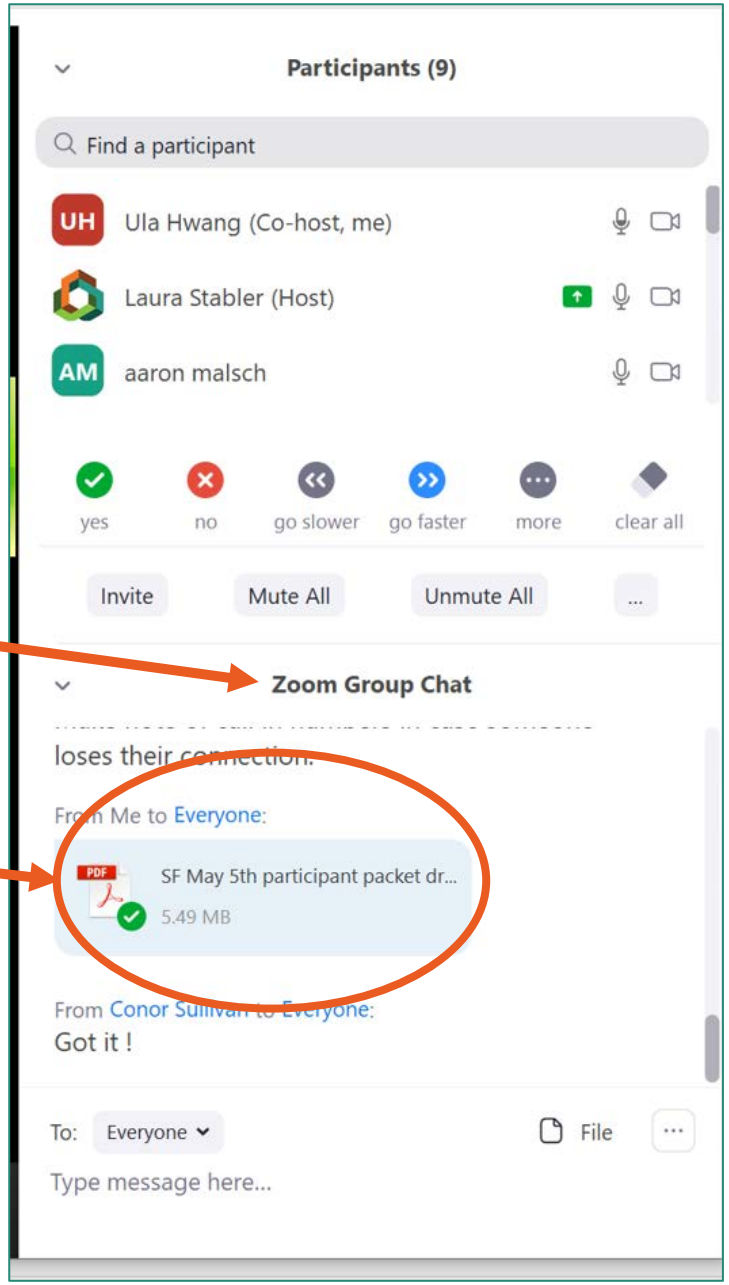
If you registered for this session, check your email for packet.

Also 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! ☺



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# SAN FRANCISCO GERIATRIC ED DEMENTIA CARE
# MINI-BOOT CAMP

**Any technical difficulties - please TEXT:**

**LAURA STABLER: 919-937-0411 (cell)**

**CONOR SULLIVAN: 910-200-1312 (cell)**

 

# Creating Geriatric Appropriate EDs


**Kevin Biese, MD MAT**

Associate Professor Emergency Medicine and Geriatrics, University of North Carolina School of Medicine; ACEP Geriatric ED Accreditation Chair


 

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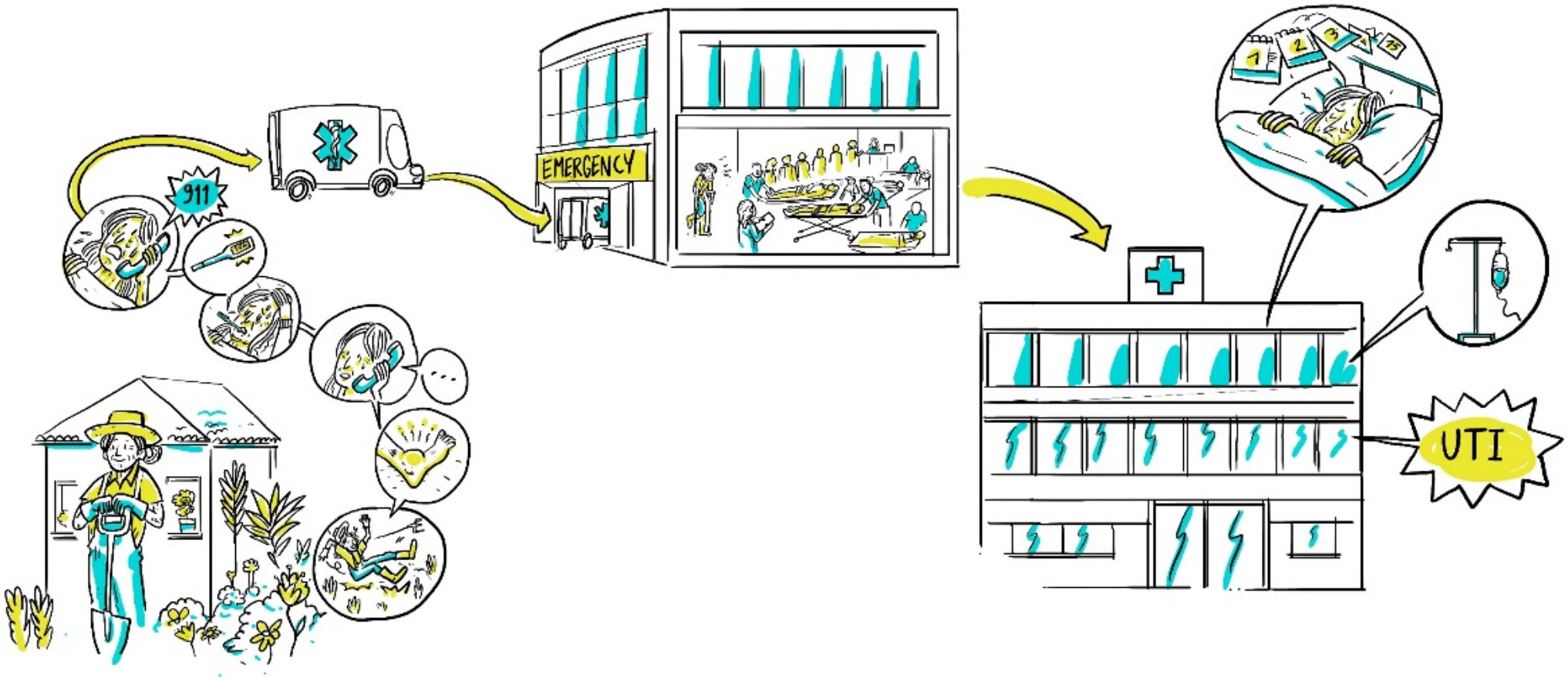


 

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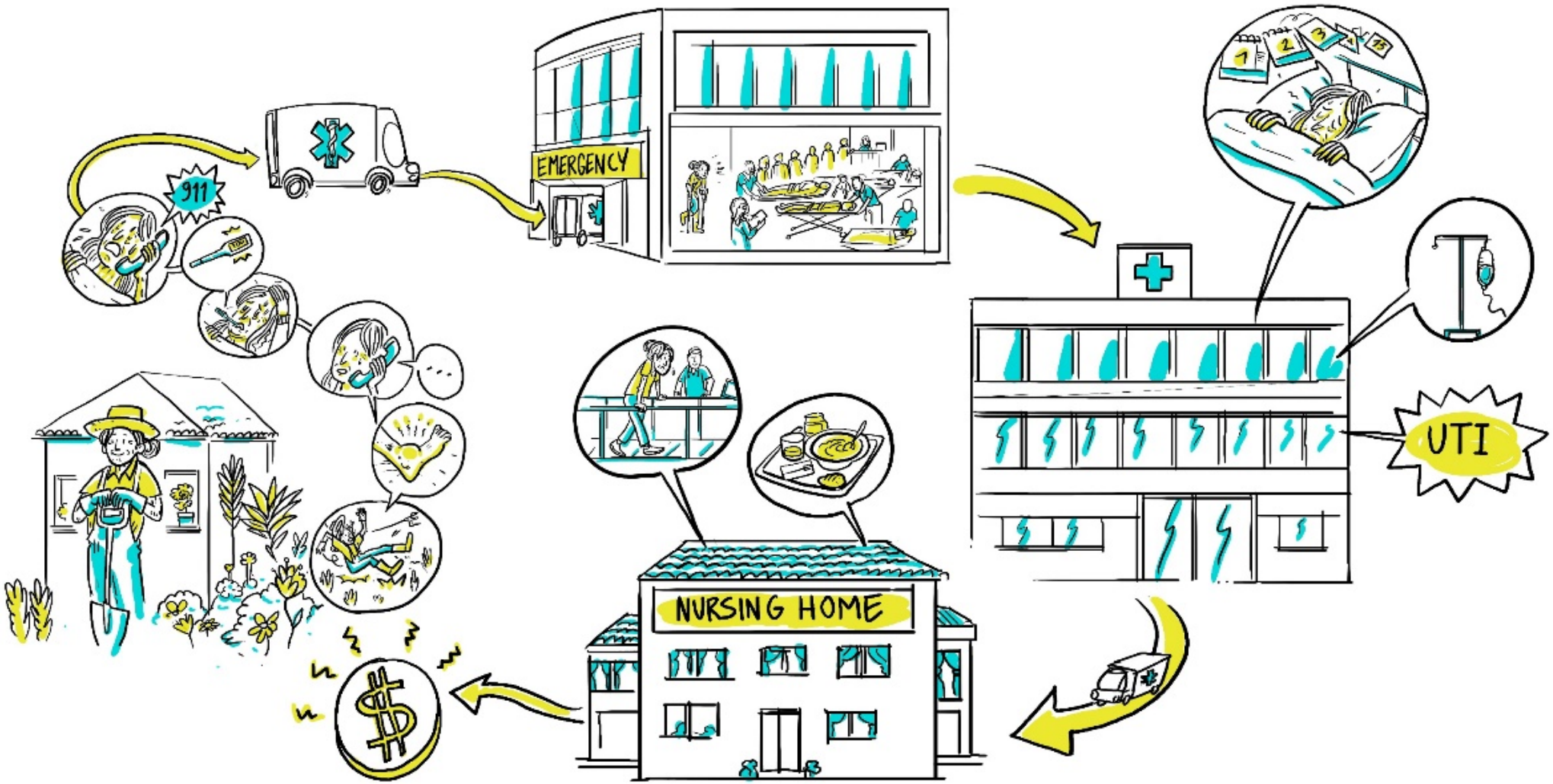


 

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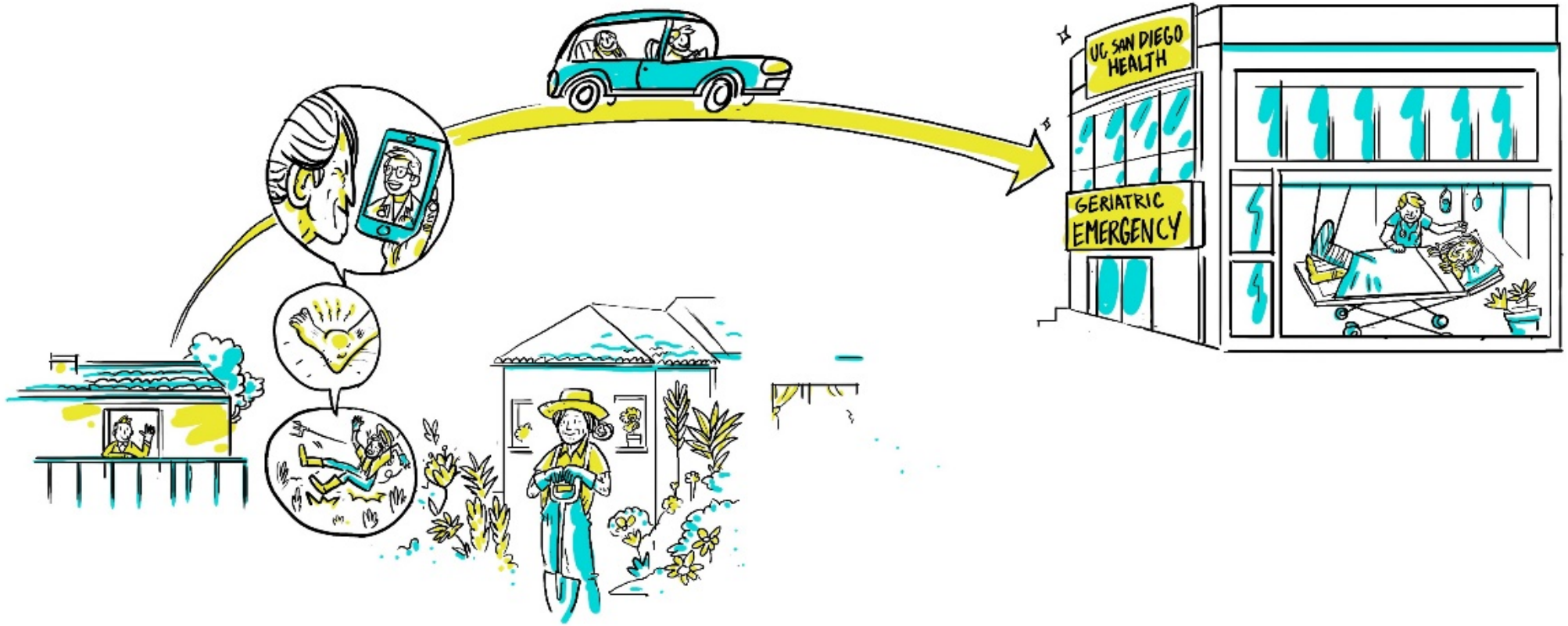


 

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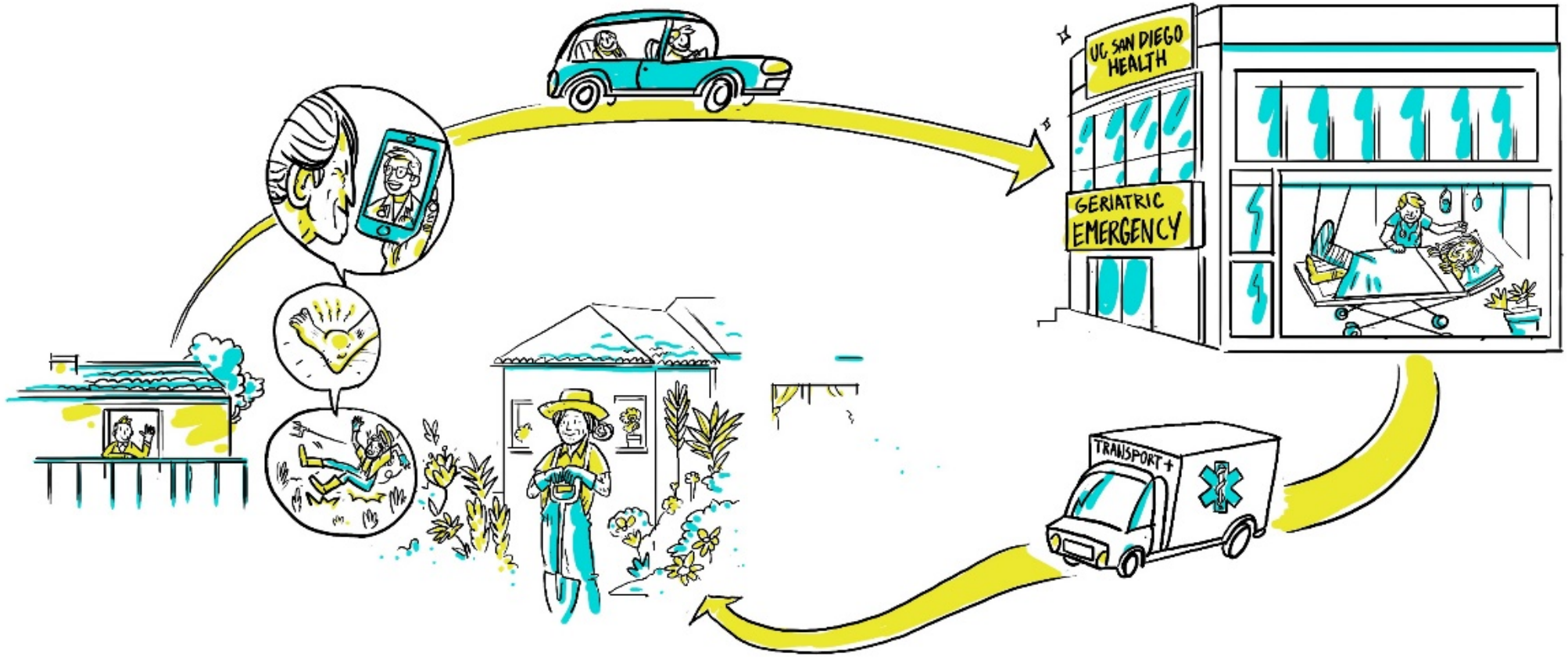


 

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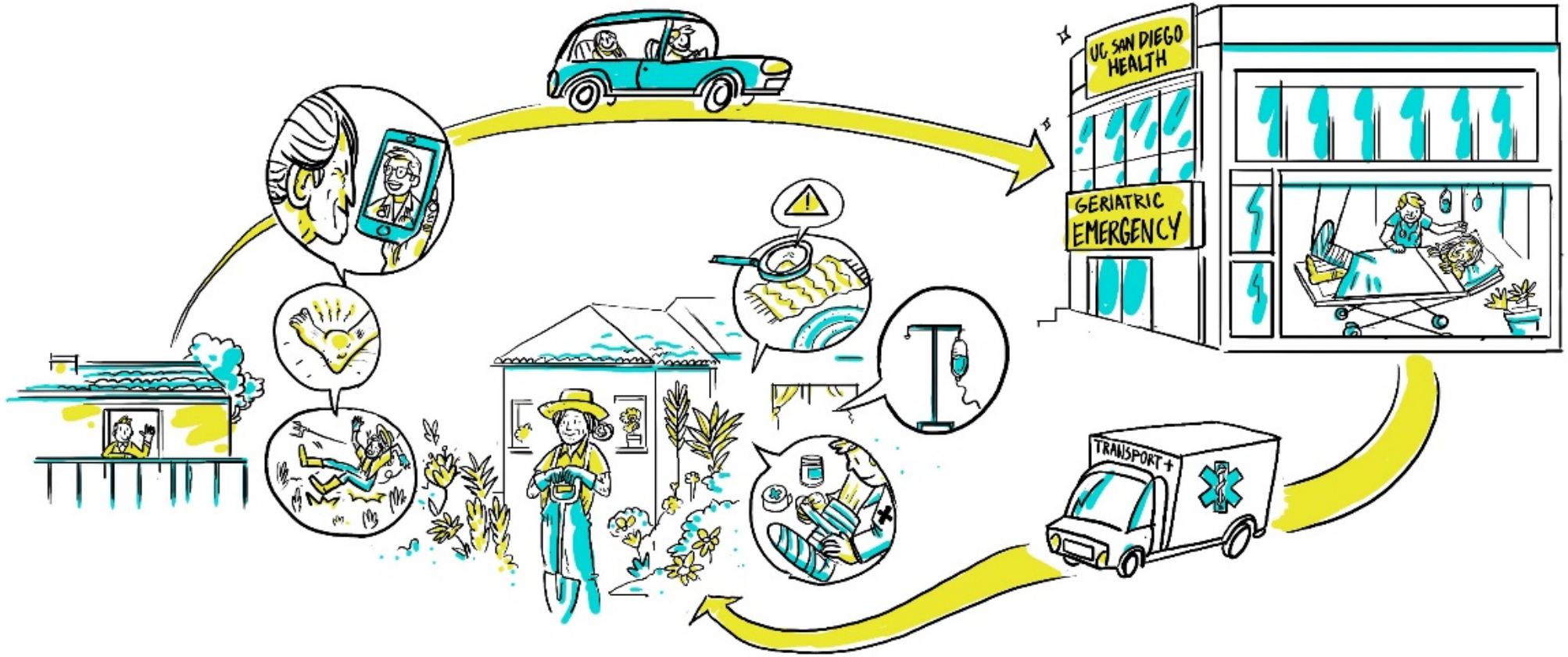


 

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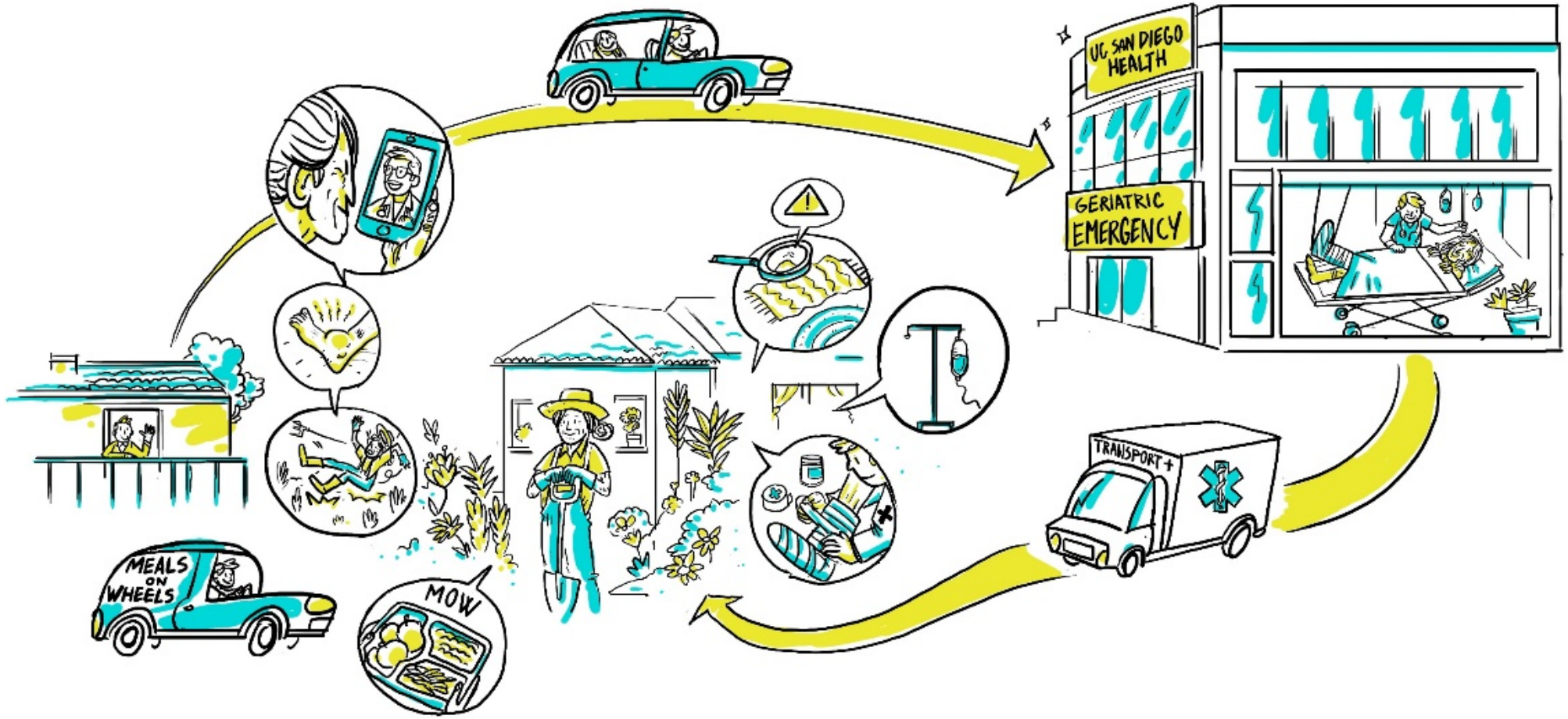


 

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# CASE DISCUSSION

## YOUR BREAKOUT ROOM HOSTS

BREAKOUT ROOM 1

**Michael Malone**
MD

Case: Mr. Kikway

BREAKOUT ROOM 2

**Aaron Malsch**
MS, RN, GC-BA

Case: Mrs. Schwach

BREAKOUT ROOM 3

**Kevin Biese**
MD, MAT

Case: Mrs. Piedra

 

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# Please look for case discussion handouts in your Boot Camp Packet

Session hosts will also upload a copy to the chat for download.



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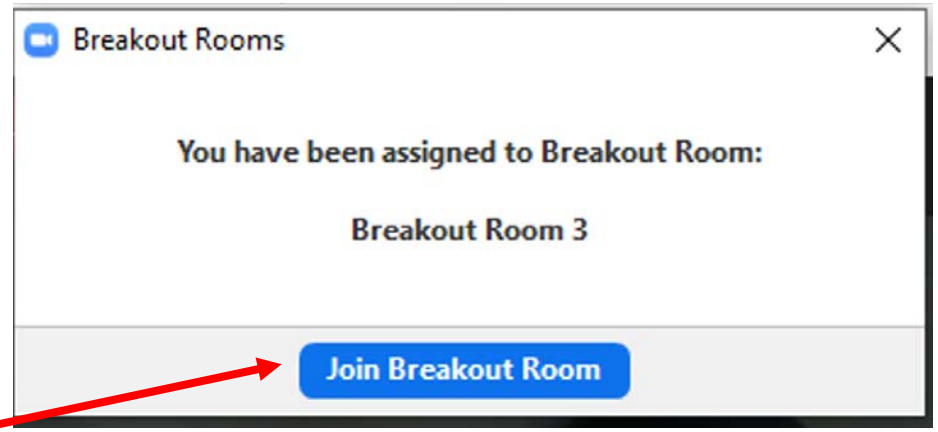
# Joining Breakout Rooms

## QUICK OVERVIEW

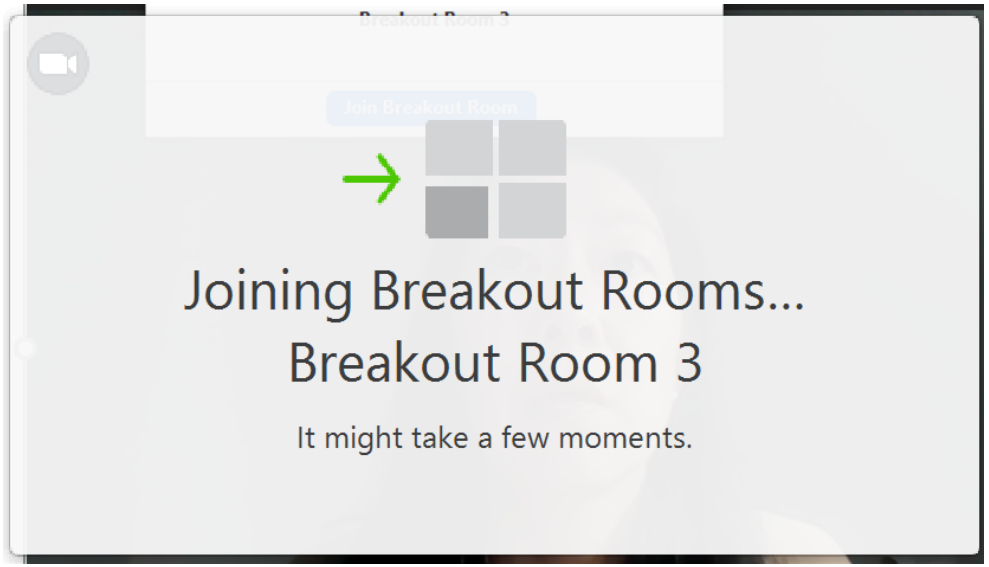
You have already been assigned to your breakout room.

A pop up will appear. Click “join breakout room”.

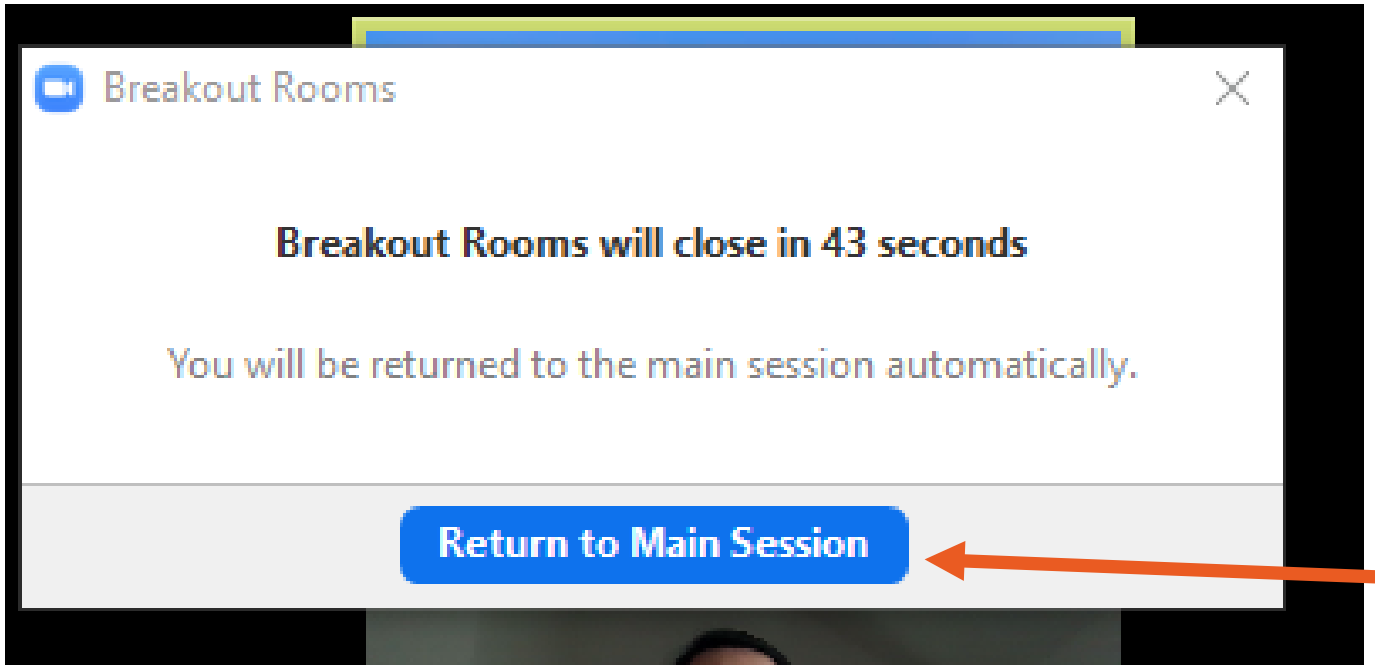



Please be patient.

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






When your case discussion time is over (~20 minutes), your Breakout room will receive a 2 minutes countdown warning and be automatically returned to the Main Session.

Click “Return to Main Session” (instead of Exiting the zoom meeting)

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# Debrief & Key Concepts from Case Discussions (9a session)

Mrs. Piedra: Case of a 74-yo woman with multiple ED visits for renal colic, and subsequent admission after 3rd visit for "failure to cope." Medicine inpatient evaluation of patient with modest dementia.

1. Converting barriers to opportunities. Assessing baseline cognitive impairment while in ED.
2. EMR to give alerts (flagging potentially inappropriate medications)
3. Coordination with discharge – instructions (signs to return, medications), home safety and environment
4. Having Geriatric Emergency Nurse Intervention (GENI)

 

# Debrief & Key Concepts from Case Discussions (12p session)

#3 Mrs. Piedra: Case of a 74-yo woman with multiple ED visits for renal colic, and subsequent admission after 3rd visit for "failure to cope." Medicine inpatient evaluation of patient with modest dementia.

1. Medication reconciliation and if potentially inappropriate.
2. Evaluation of patient function (cognitive evaluation in the ED?), patient supports at home (or lack there of?).
3. Improvement of ED processes, flow, and evaluation. Via education, EMR decision supports, flagging of patients at risk.
4. Communication and coordination of care with PCP, SW as transitions from ED
5. Geriatric syndromes (falls, delirium, polypharmacy) appear in the ED. Older age and functional status that change vs. younger patients.

# Debrief & Key Concepts from Case Discussions (9a session)

Mrs. Schwach: 80 yo woman who called ambulance because she did "not feel right" but is a poor historian with poor memory. Spends 10 hours in the ED having an unremarkable work-up, but family (out of town) reports "Mom seems off." ED is prepared to discharge patient home alone.

1. Many flags for this patient who required admission despite the negative workup. Flags including functional baseline, medication management ability, cognitive function. Need to assess change from baseline.
2. Admit vs. observation
3. ED clinicians, especially nurses, and having to switch screening priorities

 

# Debrief & Key Concepts from Case Discussions (12p session)

#2 Mrs. Schwach: 80 yo woman who called ambulance because she did "not feel right" but is a poor historian with poor memory. Spends 10 hours in the ED having an unremarkable work-up, but family (out of town) reports "Mom seems off." ED is prepared to discharge patient home alone.

1. ESI 4 (low acuity) may have impacted care in ED. Accuracy in older ED patients of ESI?
2. Having caregiver/family present at bedside would have helped guide history. Advocate at bedside important.
3. Early involvement of psychosocial supports to assist with work up and disposition. Services availability variable by time of day.
4. Geriatric ED observation units (Southerland)

 

# Debrief & Key Concepts from Case Discussions (9a session)

Mr. Kikway: 82 yo man with cough and fever who lives with family. He has modest cognitive and ADL function but has needed increased support over recent days. CXR indicates small RML pneumonia. Only beds for admission on floor with flu and enteric outbreak.

1. Disposition – risk and benefit for admission? Tools to help with this decision – CURB65 as a possible tool for mortality
2. Home care? Assessing family supports and readiness to care for patient. Home safety.
3. Hospital environment – safety on inpatient and even in ED environment
4. Care transitions support – SW support in evening is challenging

 

# Debrief & Key Concepts from Case Discussions (12p session)

#1 Mr. Kikway: 82 yo man with cough and fever who lives with family. He has modest cognitive and ADL function but has needed increased support over recent days. CXR indicates small RML pneumonia. Only beds for admission on floor with flu and enteric outbreak.

1. Disposition and options.
2. Cognitive assessment (delirium &/or dementia) vs. family/patient report of dementia history
3. Medication history, changes, how the meds are being taken

 

We want this to be **INTERACTIVE,** **use CHAT** for questions and comments!!

# PRIX-FIXE SESSION

## 10-MINUTE DEMO AND DISCUSSIONS

**Aaron Malsch**
MS, RN, GCNS-BC

Care Transitions

**Michael Malone**
MD

Delirium Implementation Toolkit

**Ula Hwang**
MD, MPH

Dementia Screening

 

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# GERI ED CARE TRANSITIONS

## Prix-Fixe Stations

GEDC SF Dementia Friendly Mini-Boot Camp

May 5th, 2020

**Aaron Malsch** MS, RN, GCNS-BC

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# Unique needs of an older population

## Receiving care in the emergency department

**The presentation illness may be atypical:**

- Falls
- Generalized weakness
- Confusion

**High rate of multiple co-morbid conditions.**

**High rate of taking multiple medications.**

**Common hearing and vision problems.**

**They often present with concurrent social needs.**

**Their ED visit may represent a transition from another health care setting.**

**Common vulnerabilities which may be disrupted by an acute illness:**

- Cognition
- Frailty
- Function

Soryal S, Boltz M, Wilber S, Malone M. How to improve care for seniors in the emergency department, In ML Malone et al. (eds.) Acute Care for Elders: A Model for Interdisciplinary Care, Aging Medicine, Springer Science + Business Media New York 2014



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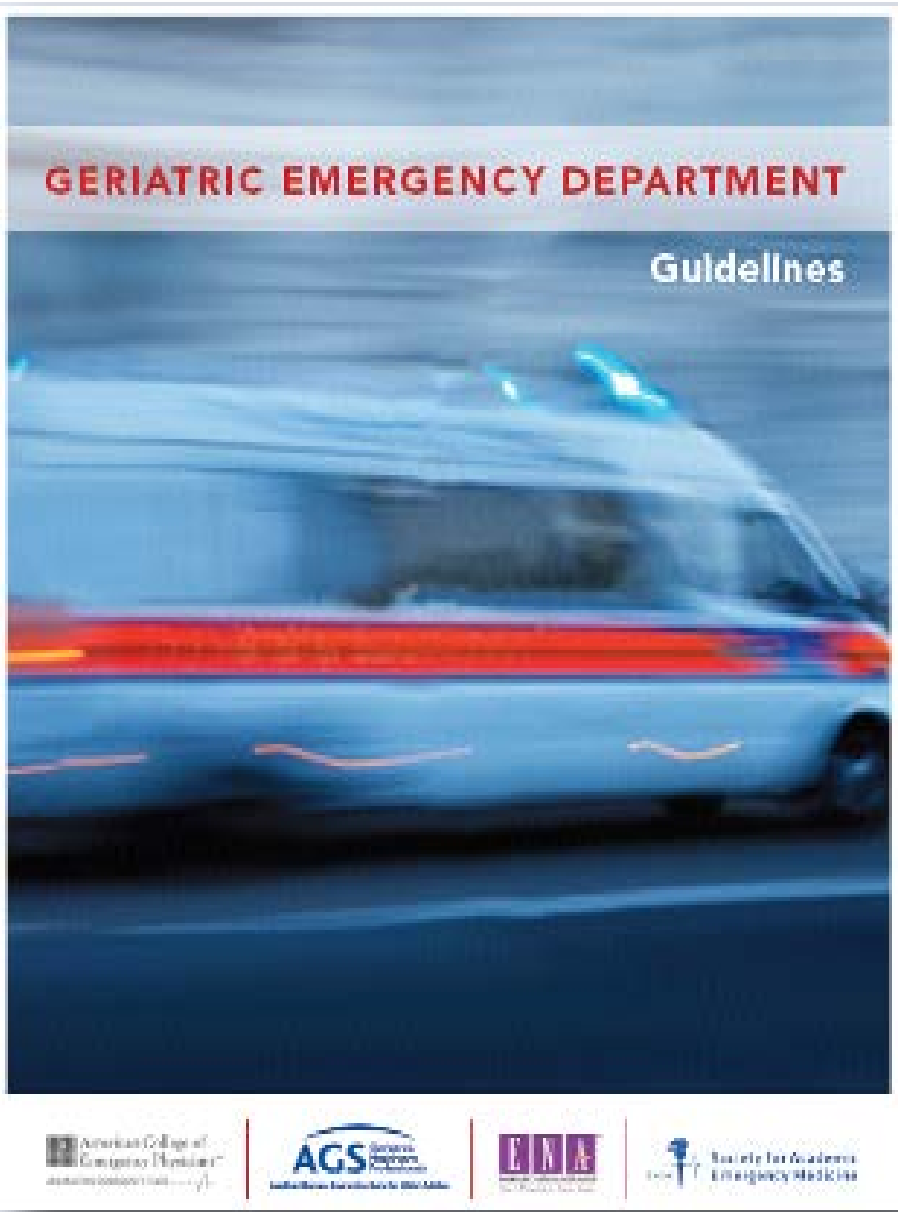


# SIX ELEMENTS OF THE GERIATRIC ED GUIDELINES

- ✓ Staffing and administration
- ✓ Education of the workforce
- ✓ Transitions in care to and from the ED
- ✓ Protocols for screening, assessment, and care of older adults
- ✓ Quality Improvement and Program Implementation
- ✓ Equipment and Supplies

 

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# Geriatric ED Discharge Elements

## DISCHARGE SHOULD INCLUDE THE FOLLOWING DATA ELEMENTS:

- Presenting complaints
- Test results and interpretation
- ED therapy and clinical response
- Consultation Notes
- Working discharge diagnosis
- ED physician note
- New prescriptions and alterations with long-term medications
- Follow-up plan
- Large Font
- Simple language
- Utilize “Teach Back”

 

# Core Elements of Geriatric ED Quality Improvement

1. Screening & Communication
2. Assessment, Evaluation, Collaboration, Intervention
3. Link to Post ED resources aka Transitions
4. Support and Improvement
5. Review of Outcomes

 

# Core Elements of Geriatric ED Quality Improvement

## 1. Screening & Communication

**Example:** ISAR screening of all patients age >= 65 in ED

- ISAR Questionnaire:
  1. Before the illness or injury that brought you to the ED, did you need someone to help you on a regular basis?
  2. In the last 24 hours, have you needed more help than usual?
  3. Have you been hospitalized for one or more nights during the past six months?
  4. In general, do you have serious problems with your vision, that cannot be corrected with glasses?
  5. In general, do you have serious problems with your memory?
  6. Do you take six or more different medications every day?

 

# Core Elements of Geriatric ED Quality Improvement

## 1. Screening & Communication

Teaching Points:

1. The task of completing a screening or assessment  is important but hinges on what you do with that information.
2. Critical thinking and Communication are essential

**Delirium Case:**

“Is the patient typically confused?”

“When did it start?”

“What were some of precipitating factors?”

 

# Core Elements of Geriatric ED Quality Improvement

2. Assessment, Evaluation, Intervention

- **ED RN** Assessment
  - TUG (Timed Up and Go) test for falls risk
  - CAM (Confusion Assessment Method) for delirium

- **ED Physician** Assessment for Service-To orders:
  - Home Care (RN, Med Mngt, PT, DME, Case Mngt, PCP)
  - **Physical Therapy** evaluation
  - **Pharmacist** Medication Review

 

# Core Elements of Geriatric ED Quality Improvement

2. Assessment, Evaluation, Intervention

Teaching Points:

1. Critical thinking and pursuit of ‘clues’ to achieve a broader clinical & psycho-social understanding of patient situation.
2. Tailor interventions to the patient’s particular set of circumstances.
3. Communicate your findings with the team

**Delirium Case:**

**“**Dr. Jones, I am concerned that Mrs. Smith may have delirium. I talked with the daughter and she wasn’t confused prior to the onset of her fever 2 days ago. The Daughter states that she goes in and out of being confused. I performed the CAM assessment and she is positive because of 1) Acute onset 2) Fluctuating course and 3) she can’t maintain attention.”

 

# Core Elements of Geriatric ED Quality Improvement

3. Link to Post ED resources

- **ED Case Manager/Social Worker** Coordination
  - Coordinates post- ED services.
    - PCP & Specialist visits
    - Service To orders
  - Community Resources.
    - ADRC
    - **Community Paramedic Program**
    - Evidence Based Prevention Programs
      - **Stepping On** falls prevention program
  - Post d/c Follow-up
    - Telephonic
    - Home visits

 

# Core Elements of Geriatric ED Quality Improvement

3. Link to Post ED resources

   Teaching Points:

   1. Not everything is going to be ‘fixed’ in the ED
   2. Interventions in the ED are a start, not an end point.
   3. Does the patient understand?

 

# SUMMARY

- Effective transitions enhance the health and recovery of the vulnerable older patient population seen in the ED

  Prevent a revisits, medication errors, & worsening medical conditions

- Key aspects of effectives transitions is your work to:

  Screen, Assess, Collaborate, Communicate and Intervene

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# DELIRIUM SCREENING

## Prix-Fixe Station

Michael L. Malone,MD

Advocate Aurora Health

May 5, 2020

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# Delirium Screening Prix Fixe Station

Describe the West Health GEDC delirium toolkit.

Show the workflow (pg.14), the RASS tool (pg.16), and the bCAM (pg.11).

Discuss what is in place in San Francisco Emergency Departments.

| Name | Type | Compressed size | Password ... | Size | Ratio | Date modified |
|---|---|---|---|---|---|---|
| 01 Delirium_Pocket Cards | Adobe Acrobat Document | 307 KB | No | 314 KB | 3% | 2/21/2020 9:07 AM |
| 02 Delirium_BCAM Flowsheet | Adobe Acrobat Document | 249 KB | No | 249 KB | 1% | 2/21/2020 9:49 AM |
| 03 Delirium_BCAM Workflow | Adobe Acrobat Document | 67 KB | No | 67 KB | 1% | 2/21/2020 9:43 AM |
| 04 Delirium Process & Outcome M... | Adobe Acrobat Document | 506 KB | No | 506 KB | 1% | 2/21/2020 9:53 AM |
| 06 Delirium Workflow (2) | Adobe Acrobat Document | 182 KB | No | 182 KB | 1% | 2/21/2020 1:48 PM |
| 07 Delirium Workflow Screening in ... | Adobe Acrobat Document | 322 KB | No | 322 KB | 1% | 2/21/2020 1:52 PM |
| 08 Delirium_RASS | Adobe Acrobat Document | 135 KB | No | 145 KB | 7% | 8/29/2019 4:01 PM |
| 09 Delirium Roles and Responsibilit... | Adobe Acrobat Document | 274 KB | No | 274 KB | 1% | 2/21/2020 2:53 PM |
| 10 The Role of the Delirium Champ... | Adobe Acrobat Document | 777 KB | No | 784 KB | 1% | 2/21/2020 2:54 PM |
| 11_Things to remember | Adobe Acrobat Document | 178 KB | No | 183 KB | 3% | 2/21/2020 2:42 PM |
| 12_Post Discharge Family Educatio... | Adobe Acrobat Document | 323 KB | No | 331 KB | 3% | 2/21/2020 2:49 PM |

 

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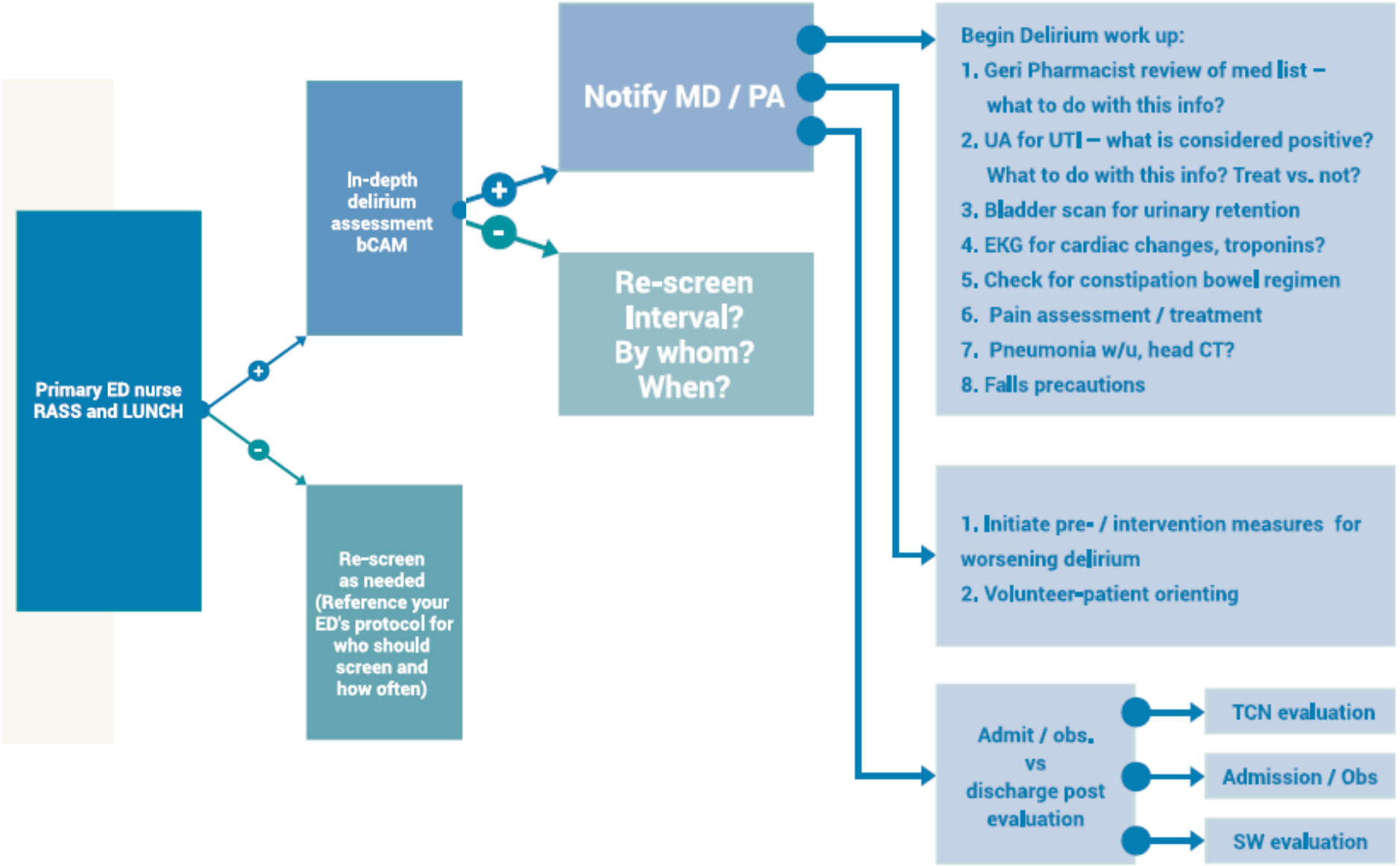
# Example Delirium Workflow

## INITIATING AT BEDSIDE

*Note: Your workflow may differ*



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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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# DELIRIUM SCREENING TOOL: RASS

## Richmond Agitation-Sedation Scale



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## RICHMOND AGITATION-SEDATION SCALE (RASS)

| Scale | Label | Description | |
|---|---|---|---|
| +4 | COMBATIVE | Combative, violent, immediate danger to staff | |
| +3 | VERY AGITATED | Pulls to remove tubes or catherers; aggressive | |
| +2 | AGITATED | Frequent non-purposeful movement, fights ventilator | |
| +1 | RESTLESS | Anxious, apprehensive, movements not aggressive | |
| 0 | ALERT & CALM | Spontaneously pays attention to caregiver | |
| -1 | DROWSY | Not fully alert, but has sustained awakening to voice (eye opening & contact >10sec) | VOICE |
| -2 | LIGHT SEDATION | Briefly awakens to voice (eyes open & contact <10sec) | VOICE |
| -3 | MODERATE SEDATION | Movement or eye opening to voice (no eye contact) | VOICE |
| -4 | DEEP SEDATION | No response to voice, but movement or eye opening to physical stimulation | TOUCH |
| -5 | UNAROUSABLE | No response to voice or physical stimulation | TOUCH |

*RASS, Richmond Agitation-Sedation Scale*
*Copyright © 2012. Vanderbilt University.*
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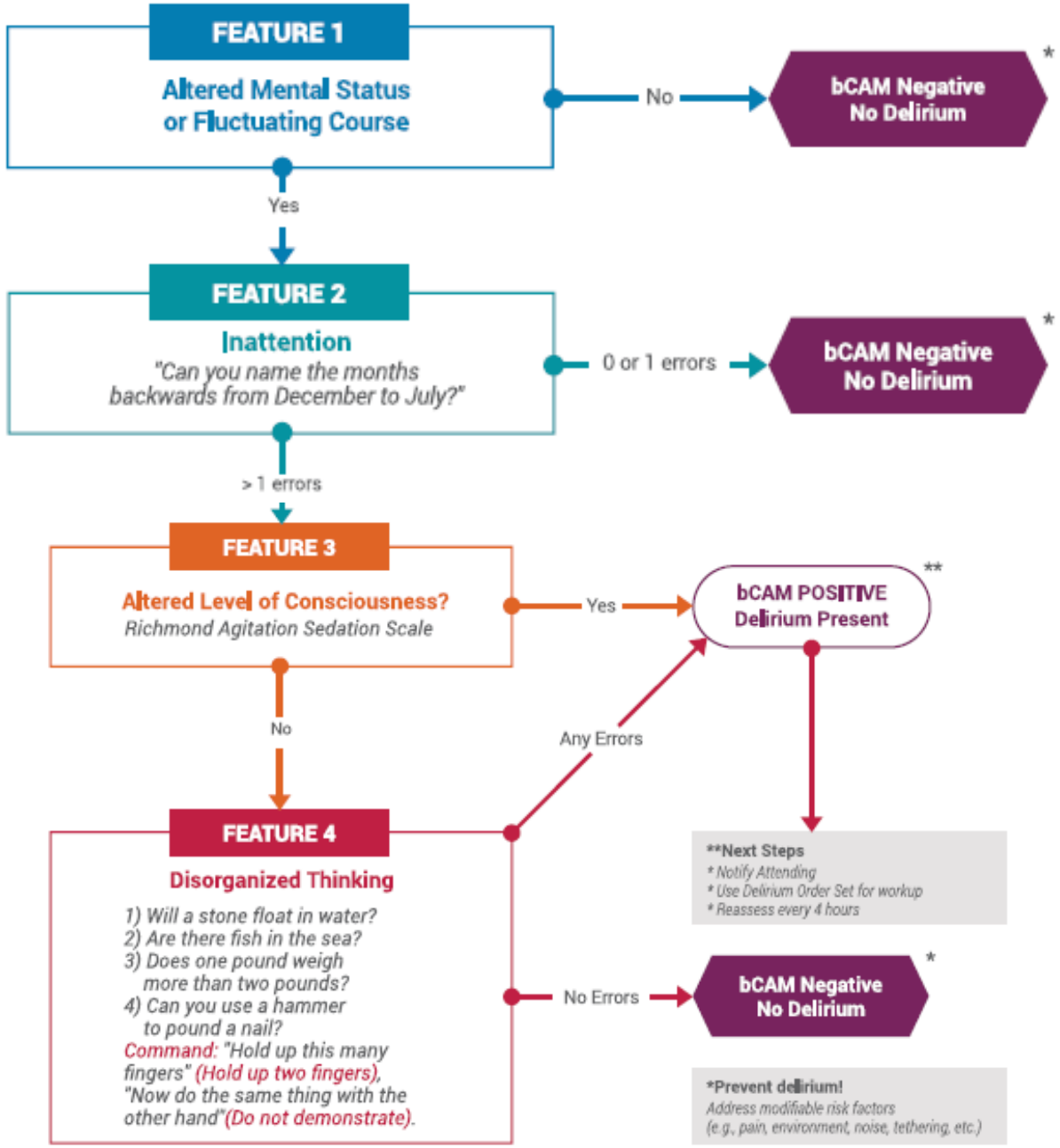
# EXAMPLE OF A bCAM FLOW SHEET

## Brief Confusion Assessment Method (bCAM)

*Note: Your workflow may differ*

westhealth



# Accessing the Modules

**Access the cases at GeriatricsCareOnline.org**



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# KEY POINTS

Delirium screening should be integrated into the workflow of emergency department care of older adults.

A delirium toolkit developed by West Health and Geriatric Emergency Department Collaborative provides an implementation strategy.

The American Geriatrics Society website has Virtual Patient Cases with interactive video examples of vulnerable older patients.

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# ED DEMENTIA SCREENING

## Prix-Fixe Station

Christopher R. Carpenter, MD, MSc
Ula Hwang, MD, MPH

May 5, 2020

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# OBJECTIVES

Review validated instruments for emergency department dementia screening (and rationale)

# IS DEMENTIA RELEVANT IN THE ED?

## When not identified:

Time and resources wasted

Poor care, misdiagnosis & malpractice risk

Patient & caregiver experience

Lost opportunity to prevent (some) ED returns and functional decline

**Present in 30% of ED older adults but ~90% of cases are missed.**



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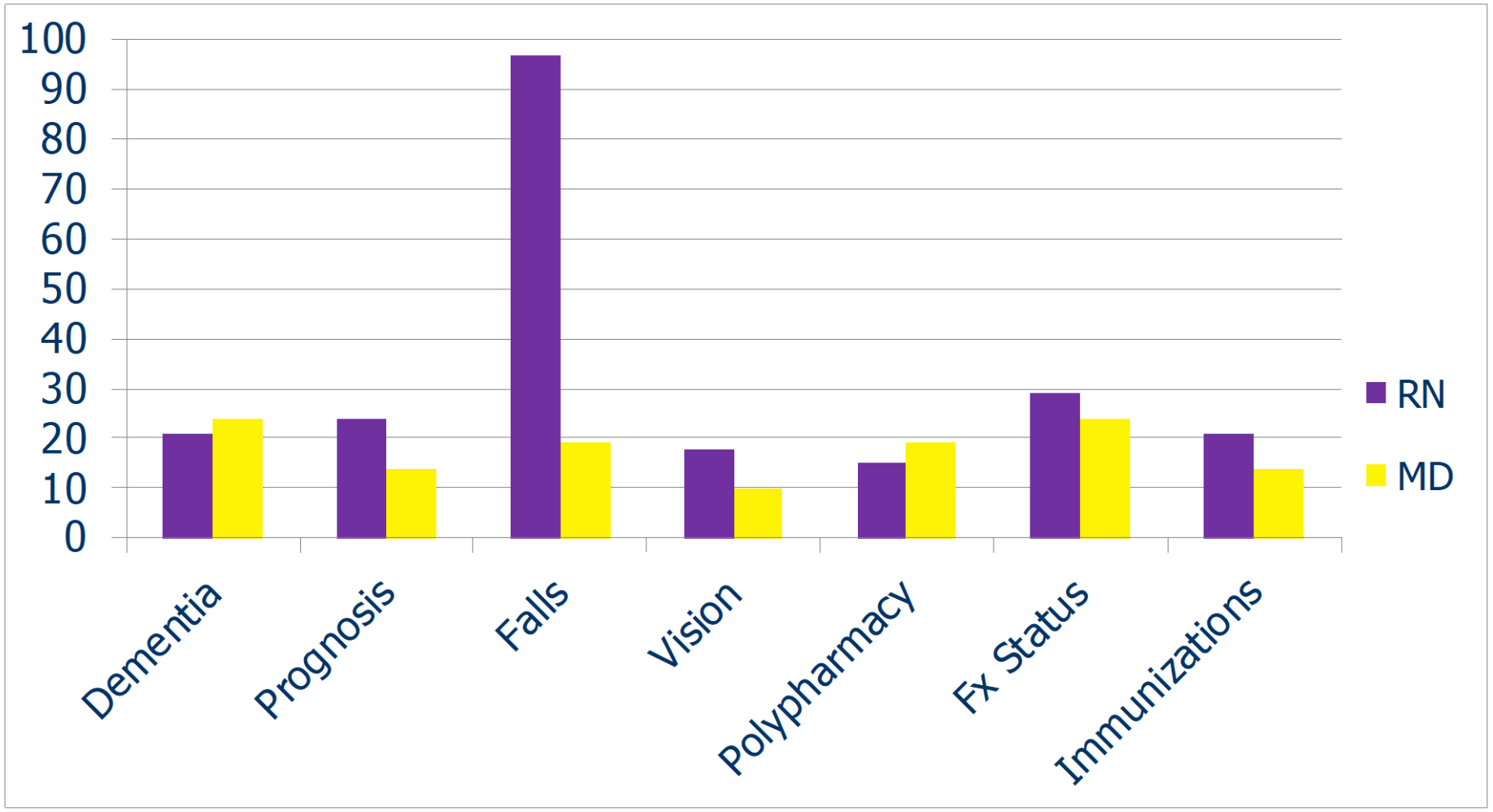
# Current ED Screening Practice




Western J Emerg Med 2011; 12: 489-495

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# Delirium Risk Factors

## PREDISPOSING

- **Cognitive impairment / Dementia**
- Sleep deprivation
- Oligoanalgesia
- Polypharmacy
- Immobility
- Visual impairment
- Hearing impairment
- Dehydration

## PRECIPITATING

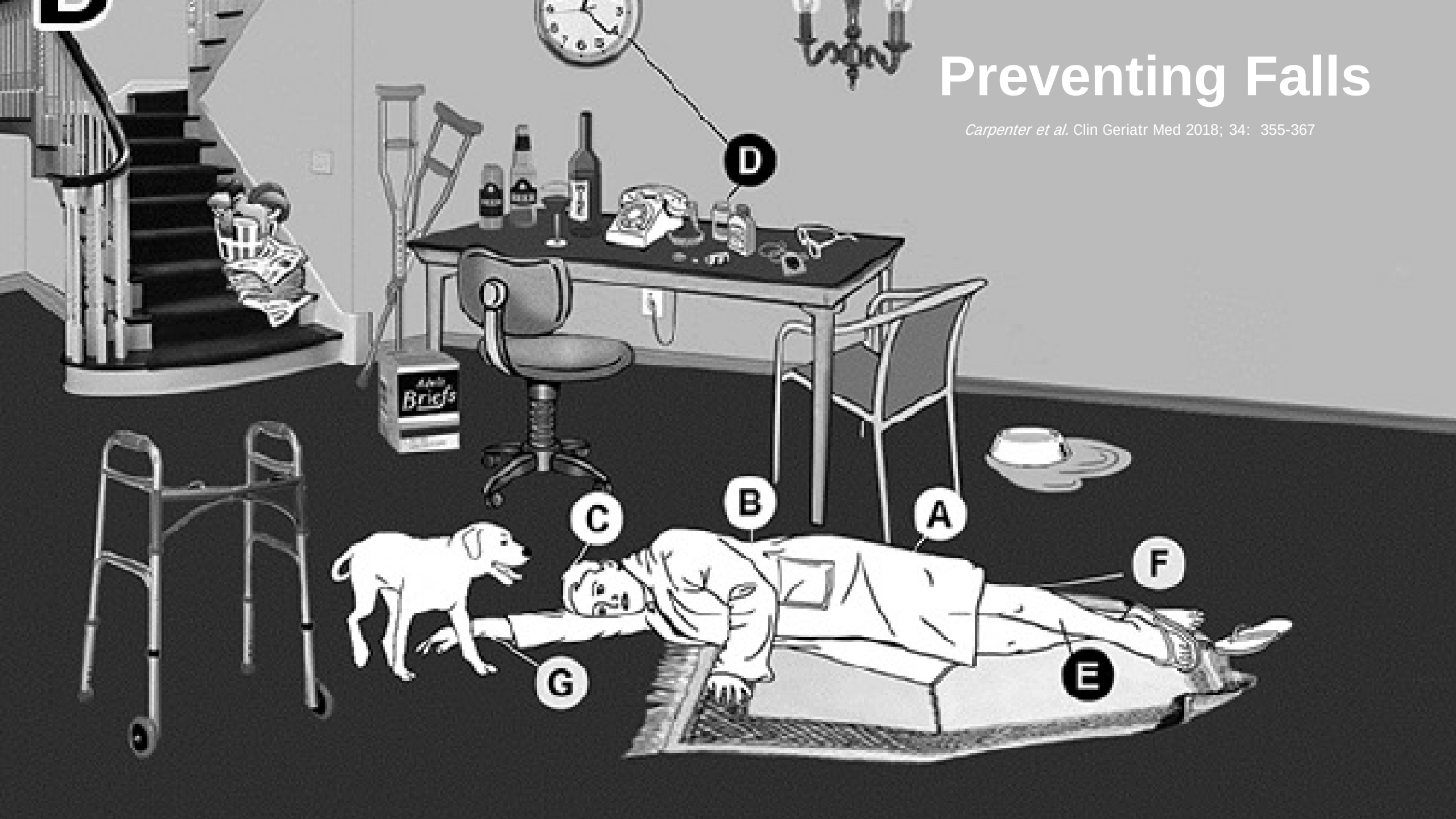
- Restraints
- Malnutrition
- Foley catheter

Nagaraj et al Emerg Med Australas 2016; 28: 456-458

# Preventing Falls

*Carpenter et al.* Clin Geriatr Med 2018; 34: 355-367



# ED Returns Increased

22% ED revisit (vs. 14%)

More ED and PCP visits in prior year

Kent et al J Am Geriatr Soc 2019; 67: 2254-2259

Table 2. 30-Day Emergency Department Revisits: Unadjusted Results

| Characteristics | No dementia | Dementia |
|---|---|---|
| Total | 240 249 (100) | 54 622 (100) |
| All-cause ED revisits | | |
| 30 d | 33 290 (13.9) | 9877 (22.0) |
| Mean count of revisits among those with at least one | 1.31 | 1.32 |
| Age, y | | |
| 65-74 | 123 014 (51.2) | 11 478 (21.0) |
| 75-84 | 83 258 (34.7) | 21 446 (39.3) |
| ≥85 | 33 977 (14.1) | 21 698 (39.7) |
| Mean age, y | 75.6 | 81.7 |
| Sex | | |
| Female | 140 603 (58.5) | 34 983 (64.0) |
| Male | 99 646 (41.5) | 19 639 (36.0) |
| Race | | |
| White | 207 593 (86.4) | 46 648 (85.4) |
| Asian | 2918 (1.2) | 678 (1.2) |
| Black | 19 969 (8.3) | 5304 (9.7) |
| Hispanic | 3278 (1.4) | 985 (1.8) |
| North American Native | 1244 (.5) | 246 (.5) |
| Other | 2937 (1.2) | 572 (1.1) |
| Unknown | 2310 (1.0) | 189 (.4) |
| Modified CCI scores (no dementia) | | |
| None (0) | 53 763 (22.4) | 6685 (12.2) |
| 1 | 47 977 (20.0) | 8743 (16.0) |
| 2 | 38 708 (16.1) | 8375 (15.3) |
| 3 | 30 635 (12.8) | 7513 (13.8) |
| 4 | 20 576 (8.6) | 6185 (11.3) |
| ≥5 | 48 590 (20.2) | 17 121 (31.3) |
| Mean CCI score | 2.66 | 3.52 |
| Dual enrollment status | | |
| Medicaid | 32 754 (13.6) | 13 625 (24.9) |
| Utilization during 12 mo before index encounter | | |
| Mean ED visits | 1.09 | 2.26 |
| Mean PCP visits | 9.48 | 15.33 |
| Post ED utilization | | |
| Discharged to SNF from index ED visit | 1072 (.5) | 2969 (5.4) |

Abbreviations: CCI, Charlson Comorbidity Index; ED, emergency department; PCP, primary care physician; SNF, skilled nursing facility.

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# Inpatient Services Miss Dementia

Dementia patients with **LESS**
- Accurate medication history
- Pt. or caregiver understanding about
  - Diagnoses
  - Meds, regimen, side effects
  - Whom to contact and Follow-up
  - Post-discharge symptoms

Prusaczyk et al J Gerontol Nurse 2019; 45: 15-22

**TABLE 2**

**TRANSITIONAL CARE PROVIDED TO PATIENTS WITH AND WITHOUT DEMENTIA**

| Variable | *n* (%) | | *p* Value[a] |
|---|---|---|---|
| | Patients With Dementia (*n* = 126) | Patients Without Dementia (*n* = 84) | |
| Discharge planning | 125 (99.2) | 84 (100) | 1 |
| Discharge summary included | | | |
| Diagnoses | 125 (99.2) | 84 (100) | 1 |
| Discharge medications | 126 (100) | 84 (100) | 1 |
| Procedure results | 124 (98.4) | 84 (100) | 0.518 |
| Follow-up needs | 122 (96.8) | 84 (100) | 0.152 |
| Pending test results | 7 (5.6) | 0 | 0.071 |
| Discharge summary was available to primary care physician | 26 (20.6) | 23 (27.4) | 0.35 |
| Accurate medication history taken | 76 (60.3) | 72 (85.7) | 0.0001 |
| Medications were reconciled throughout hospitalization | 121 (96) | 82 (97.6) | 0.705 |
| Medication changes were discussed with patient or caregiver | 124 (98.4) | 83 (98.8) | 1 |
| Number who understood education | 55 (43.7) | 67 (79.8) | <0.0001 |
| Patient or caregiver educated about | | | |
| In-hospital medications | 97 (77) | 84 (100) | <0.0001 |
| Diagnoses | 57 (45.2) | 70 (83.3) | <0.0001 |
| Follow-up needs | 53 (42.1) | 68 (81) | <0.0001 |
| Whom to contact after discharge | 51 (40.5) | 67 (79.8) | <0.0001 |
| Post-discharge medication regimen | 59 (46.8) | 67 (79.8) | <0.0001 |
| Post-discharge medication side effects | 3 (2.4) | 3 (3.6) | 0.684 |
| Post-discharge symptoms | 52 (41.3) | 67 (80) | <0.0001 |
| Post-discharge adverse events | 9 (7.1) | 2 (2.4) | 0.206 |
| Patient or caregiver asked about any post-discharge management challenges | 7 (5.6) | 3 (3.6) | 0.743 |
| Teach-back used during education | 122 (96.8) | 83 (98.8) | 0.650 |
| Printed educational materials used | 66 (52.4) | 54 (64.3) | 0.118 |
| Patient assessed for delirium or dementia | 126 (100) | 83 (98.8) | 0.4 |
| Arranged social or community support post-discharge | 3 (2.4) | 3 (3.6) | 1 |
| Advanced care planning | 35 (27.8) | 18 (21.4) | 0.381 |
| Coordinated with providers outside of the hospital | 113 (89.7) | 69 (82.1) | 0.172 |
| Outpatient follow up scheduled with specialty provider | 44 (34.9) | 36 (42.9) | 0.695 |
| Outpatient follow up scheduled with primary care physician | 30 (23.8) | 38 (45.2) | 0.056 |

[a] *Bonferroni corrected alpha of 0.002.*



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# Dementia Screen Accuracy

| Tool (#ED studies) | Positive LR (95% CI) | Negative LR (95% CI) |
|---|---|---|
| **Abbreviated Mental Test 4 (2)** | **7** (3-17) | **0.31** (0.10-0.90) |
| **AD8 (2)** | **2.5** (2-3.5) | **0.39** (0.26 to 0.59) |
| **Ottawa 3DY (3)** | **2.3** (1.5-3.5) | **0.17** (0.05 to 0.66) |
| **Short Blessed Test (3)** | **2.7** (2-3.6) | **0.18** (0.09-0.39) |
| **Six Item Screener (4)** | **3.2** (2.4-4.3) | **0.46** (0.36-0.59) |

Carpenter et al Acad Emerg Med 2019; 26: 226-245

 

# AD8

If the patient has an accompanying reliable informant, they are asked the following questions.


Has this patient displayed any of the following issues? Remember a "Yes" response indicates that you think there has been **a change in the last several years** caused by thinking and memory (cognitive) problems.

1) Problems with judgment (example, falls for scams, bad financial decisions, buys gifts inappropriate for recipients)?
2) Reduced interest in hobbies/activities?
3) Repeats questions, stories, or statements?
4) Trouble learning how to use a tool, appliance, or gadget (VCR, computer, microwave, remote control)?
5) Forgets correct month or year?
6) Difficulty handling complicated financial affairs (for example, balancing checkbook, income taxes, paying bills)?
7) Difficulty remembering appointments?
8) Consistent problems with thinking and/or memory?

Each affirmative response is one-point. A score of ≥ 2 is considered high-risk for dementia.



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## Abbreviated Mental Test-4

1) How old are you?
2) What is your birthday?
3) What is the name of this place?
4) What year is this?

Any error is considered high-risk for dementia.

## Ottawa 3DY

1) What day is today? **Correct** **Incorrect**
2) What is the date? **Correct** **Incorrect**
3) Spell “world” backwards

Number correct

**0** **1** **2** **3** **4** **5**

4) What year is this? **Correct** **Incorrect**

A single incorrect response on any of these four items is consistent with dementia.

Carpenter et al Acad Emerg Med 2019; 26: 226-245

 

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# RECAP/CONCLUSIONS

Dementia among older ED patients is associated with delirium, falls, and return visits

Dementia is widely under-recognized

Feasible ED dementia screening instruments exist, but only identify low risk subsets

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# Questions?

## Contact Information

**Christopher Carpenter**
carpenterc@wustl.edu
http://tinyurl.com/Carpenter2017
**Twitter1 @GeriatricEDNews**
**Twitter2 @SAEMEBM**

**Ula Hwang**
Ula.hwang@mountsinai.org

 

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# FALL IN-PERSON BOOT CAMP

OPTIONS:

**In-person schedule - September 2 or 18, 2020 (email poll)**

 

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# Sample GEDC In-person Boot Camp / Booster

September 2020?  8:00a – 3:00p

| *Time (PST)* | Topic |
|---|---|
| 8:00a – 8:30a | ***Openings, Intros*** |
| 8:30a – 9:00a | ***GEDs, Dementia,  and Accreditation*** |
| 9:00a – 10:00a | ***Case Discussions and Debrief*** |
| 10:00a – 11:00a | ***6 rotations of 10+ Buffet stations*** |
| 11:00 – 12:00p | ***Working Lunch with site ED GED checklist*** |
| 12:00 – 12:30p | ***QI primer and Implementation*** |
| 12:30 – 1:30p | ***Site teams QI prep of dementia proposal, Break*** |
| 1:30 – 2:30p | ***GEDC Shark tank (20 min / site)*** |
| 2:30 – 3:00p | ***Next Steps, Closing*** |



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# FALL IN-PERSON BOOT CAMP

OPTIONS:

**In-person schedule - September 2 or 18, 2020 (email poll)**

**Monthly single-site webinars (June/July/August)**

**Post-boot camp email with survey and feedback and copy of slides**

 

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