Geriatric Emergency Departments and Clinics: Pioneering Change in Healthcare Delivery and Opening Doors for Community-Based Partnerships

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Zia Agha, MD
Chief Medical Officer and Executive Vice President
It’s time to reimagine healthcare delivery

• 80% of older adults have at least one chronic disease and 77% have at least two

• Patients over the age of 75 represent the second highest group of Emergency Department users

• 40% of a patient’s health is attributed to socioeconomic factors
Escalating Cost of Healthcare

Healthcare cost as of April 10, 2019

healthcostcrisis.org
Healthcare Delivery Models for Senior Patients are Evolving
West Health

Dedicated to lowering healthcare costs to enable seniors to successfully age in place with access to high-quality, affordable health and support services that preserve and protect their dignity, quality of life and independence.

Outcomes-based philanthropy

Applied medical research

Policy, Research and Education

[Logos and names of West Health Foundation, West Health Institute, West Health Policy Center]
What We’ll Learn Today

• Transformation within different healthcare settings to deliver senior-focused care

• Screening and assessment tools utilized in Geriatric Emergency Departments and clinics

• Opportunities and challenges associated with bridging healthcare and community-based supportive services

• Opportunities for community-based organizations to engage with different healthcare settings to support seniors with complex medical and social needs
Meet our Presenters

Kelly Ko, PhD
Director, Clinical Research
West Health Institute

Brenda Schmitthenner, MPA
Senior Director, Successful Aging
West Health Institute

Jon Zifferblatt, MD, MBA
Vice President, Strategy and Successful Aging
West Health
Geriatric Emergency Departments: Why, What, and How They Work

Kelly J. Ko, PhD
Director, Clinical Research
Audience Question

How many of you are familiar with the concept of a Geriatric Emergency Department (GED)?
Why Geriatrics and the Emergency Department?

• Increasing population of older adults = increased pressure on EDs
  – >21 million seniors visited the ED in 2015, up from ~ 16 million in 2001

• ED often viewed as “front porch”
  – Clinical, social, insurance status impact how seniors access care
  – ED viewed as medical and social safety net
Why Geriatrics and the Emergency Department?

**Other Indicators**
- 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
- 46% of all ED visits resulting in hospitalization are seniors
- One out of every 10 hospital admissions is potentially avoidable
- 60% of those admissions are for patients 65 years or older

These indicators demonstrate the growing interest and need for GEDs and specially trained geriatric emergency medicine providers.
What is a Geriatric Emergency Department?

• Culture of care tailored to the specific needs of older adults in the ED with an eye toward improving healthcare outcomes and reducing unnecessary hospitalizations and readmissions.

• There is no “one-size-fits-all” approach

• Not necessarily a separate physical space
What is a Geriatric Emergency Department?

Staff
- MD with training in Geriatrics
- Social Work
- Geriatric Nurse

Processes
- Cognitive impairment
- Fall Risk

Enhanced space
- Entire GED geriatric-friendly
- Dedicated, separate space
- No physical space changes

Community
- Social Support
- Home Health
- Meals on Wheels
- Agencies on Aging

On Aging
What Does a Geriatric Emergency Department Look Like?
How Does a Geriatric Emergency Department Work?

1. **Patient Arrives**
   - Registration

2. **Triage Criteria**
   - 65+
   - ESI 3
   - ISAR+

3. **Triage Criteria to SECU**

4. **Patient Placed in Room**
   - Initial Assessment by Physician and Primary RN

5. **Lab and Imaging Orders, Consults, and/or Other Services Ordered**

6. **Patient Leaves ED**
   - Discharge, Admit to Hospital, Admit to Home, Follow Up with Community Services, Awaiting Further Services, or Transfer

7. **Long-term Services and Supports Coordination**
   - Social Worker/Navigator or GENIE Follow Up
   - Physician Disposition

8. **GENIE Consult**
   - Secondary Geriatric Screenings
   - Key Non-Clinical Needs Identified

9. **POST DISCHARGE**
   - Callback in 24-48 hours Follow Up appointment to Primary Care Physician (PCP)
   - Home Assessment
   - Discharge Home Visit Meds, Med Reconciliation

UC San Diego Health
Opportunistic/Proactive Care: Great Opportunities

Common Geriatric Syndromes in the ED

Falls
- ~ 3 million ED visits/year among 65+
- 3.5% revisited ED for a fall within 2 months
- Only 3.2% received PT in ED (reduced revisit rate >25%)

Dementia
- 30-day ED revisit rate 3.7x higher than 65+ w/o dementia
- Higher likelihood of admission from ED

Delirium
- Undiagnosed in up to 80% of ED cases
- Higher mortality risk post-discharge
# Senior-specific Screenings

<table>
<thead>
<tr>
<th>Domain</th>
<th>Tool used in SECU (+ estimated time to administer)</th>
<th>Referral type(s) potentially triggered by a positive result at UCSD SECU</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Risk Screening</td>
<td>ISAR (identification of Seniors at Risk) (≤ 5 minutes)</td>
<td>GENIE Consult, Home Health, Physical Therapy / Occupational Therapy</td>
</tr>
<tr>
<td>Mobility</td>
<td>GUG (Get Up and Go) (1-2 minutes)</td>
<td>GENIE consult</td>
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<tr>
<td></td>
<td>Hester Davis Fall Risk Assessment Scale (3 minutes)</td>
<td>GENIE consult</td>
</tr>
<tr>
<td>Agitation</td>
<td>RASS (Richmond Agitation and Sedation Scale) (1-2 minutes)</td>
<td>CAM-ICU Screen</td>
</tr>
<tr>
<td>Cognition / dementia</td>
<td>MoCA (Montreal Cognitive Assessment) (7-10 minutes)</td>
<td>Refer to UC San Diego Memory Aging and Resilience Clinic or Alzheimer's Disease Resource Center</td>
</tr>
<tr>
<td>Depression</td>
<td>PHQ2 (2 minutes) PHQ9 (if PHQ2 is positive) (5 minutes)</td>
<td>Inpatient psychiatry consult / outpatient psychiatry referral as appropriate</td>
</tr>
<tr>
<td>Nutrition</td>
<td>MNA (Mini Nutritional Assessment) (7 minutes)</td>
<td>UC San Diego Nutrition Consult, UC San Diego ED Social Worker Consult</td>
</tr>
<tr>
<td>Potentially Inappropriate Medications</td>
<td>UC San Diego Abbreviated Beers Criteria</td>
<td>Pharmacist consultation</td>
</tr>
<tr>
<td>Elder Abuse</td>
<td>EAI (Elder Assessment Instrument) (20 minutes)</td>
<td>Referral to UC San Diego Social Work and local authorities.</td>
</tr>
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### Staff (FTE)

- Medical Director/ Site Champion
- Geriatrician
- GED Nurse
- Triage Nurse
- RN Manager
- Case Manager
- Social Worker
- Physical/Occupational Therapist
- Pharmacist
- Pharmacist Tech
- ED Tech
- Executive Support
- Data Support / EHR Modification Programming
- Department Business/Administrative Manager
Bridging the Silos of Health and Social Care

Brenda Schmitthenner, MPA
Senior Director, Successful Aging
How many of you have a formal partnership with an emergency department or healthcare clinic?

How many have a formal partnership with a community-based organization?
Changes Across the Care Continuum

• Preference shifts to managing health at home and in community

• GEDs and community clinics emerging as epicenters for care transitions

• Integration of senior-focused screenings and assessments

• Partnerships with healthcare and community-based organizations
Case Study #1: University of California, Irvine (UCI) Senior Health Center

• Accredited patient-centered medical home

• Provides primary care through a team of senior-care experts, including:
  • Geriatricians
  • Nurses
  • Social Workers
  • Pharmacists
  • Neurologists
  • Psychiatrists
  • Psychologists
UCI: 360° Caregiving Solution

Developed technology-enabled care coordination model to identify and address social needs and facilitate communication across clinical and community settings

Model includes:

• Community-based social worker
• Screening and assessments for unmet social needs
• Comprehensive care navigation
• Connection to appropriate community supports
• Bi-directional communication across clinical and community settings

Image source: https://www.allianceon.org/Rx-Community-Social-Prescribing
Screening for Health-Related Social Needs

| Patient Name: ___________________ | Epic ID: ___________________
<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>SHC Social Needs Screener</strong></td>
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<tr>
<td><strong>Circle the best answer:</strong></td>
<td></td>
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<tr>
<td>1. How often do you see or talk to people that you care about and feel close to? For example, talking to friends on the phone, visiting friend or family, going to church.</td>
<td>Less than once a week [3]</td>
</tr>
<tr>
<td>2. Are you satisfied with the amount of social interactions you have every week?</td>
<td>Yes [1] No [1]</td>
</tr>
<tr>
<td>3. Do you need help from another person or service animal with any daily activities, such as bathing, dressing, eating or doing household chores?</td>
<td>Yes [1] No [1]</td>
</tr>
<tr>
<td>5. Do you have family members or other people willing and able to help you when you need it?</td>
<td>Yes [1] No [1]</td>
</tr>
<tr>
<td>6. In the last 6 months, were you able to afford to eat healthy meals?</td>
<td>Yes [1] No [1]</td>
</tr>
<tr>
<td>7. In the last 6 months, did you ever eat less than you felt you should?</td>
<td>Yes [1] No [1]</td>
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<thead>
<tr>
<th><strong>FOR STAFF USE ONLY</strong></th>
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<tr>
<td><strong>Interventions</strong></td>
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<tr>
<td><strong>Assessments</strong></td>
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<td><strong>Associated Care Plans</strong></td>
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<td><strong>Services</strong></td>
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<td><strong>Appointments</strong></td>
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<td><strong>Notes</strong></td>
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**Screening Total Score (add up all responses)**
- Negative screen, but requested intervention:
  - Administration of screening tool: [1]
  - Includes self-administered screen: [1]
  - Other screening tools available: [1]

**Interventions**
- Select [Complete]
  - Check score of “General assessment - FRESH” or administer if incomplete
  - Administration of “Follow-Up - Hunger Vital Sign” assessment
  - Administration of “Follow-Up - SCREEN-11” assessment
  - Administration of “Follow-Up - Nutrition” assessment questions and additional conversation
  - Review Resource Directory, obtain verbal consent and issue referral to address nutritional need/s
  - Review with patient if there are any additional needs for referrals and document
  - Update patient’s medical record (EPIC) with nutritional need/s identified and referral/s made, including verbal consent
  - Follow-up with CBO/service provider and/or patient to confirm nutrition need was met

**Completed**
- False
- False
- False
- False
- False
- False
- False
- False
- False
- False

**Date Completed**
- 3/27/2019
- 3/27/2019
- 3/27/2019
- 3/27/2019
- 3/27/2019
- 3/27/2019
- 3/27/2019
- 3/27/2019
- 3/27/2019
Screening and Response Workflow

SDOH Domains Included in Screener:
- Housing
- Food/Nutrition
- Transport
- Finances
- Mobility/Daily Living
- Caregiving
- Loneliness/Social Isolation

Screen Positive → Connect to Care Navigator

Determine need/s → Administer follow-up care plan/s

Referral to community → Follow-up re: need/s met
Key Learnings - UCI: 360° Caregiving Solution

- Healthcare settings not systematically screening for unmet social needs
- Need to create senior specific SDOH screener
- Integrating social worker into care team was challenging
- Configuring and integrating electronic care coordination platform harder than expected
- New screener effective in identifying unmet social needs
- Top identified needs: social isolation; daily living/mobility challenges; financial insecurity
B.R.I.D.G.E.: Building Resilience and Independence for Geriatric patients in the Emergency Department Study

- Objective of study:
  - Identify seniors at risk for malnutrition and food insecurity and link them to supportive services

- Early findings:
  - 35% at-risk for malnutrition; 18% are food insecure and 8% are both
Getting to the Root Cause and Addressing Social Risk Factors for Malnutrition

UNC GED - Identify Social Risk Factors for Malnutrition

Referral to AAA (Piedmont Triad) to uncover the root causes

Warm handoff to appropriate community-based service
Call to Action

Healthcare

CBOs
Let’s Get Real!

We know it’s challenging …

- Referral management
- Capacity
- Information Exchange
- Reimbursement

… but what’s working well?