TH10- An Evolution in Transitions: Improving the Skilled Nursing Facility and Emergency Department Relationship

Thursday, March 22
1:30 PM- 5:00 PM

Session Description

This session will lay the foundation for understanding, appreciating, and improving the compromised relationship that has existed between the emergency room and the skilled nursing facility. Experts from the American College of Emergency Physicians (ACEP) and AMDA – The Society for Post-Acute and Long-Term Care Medicine will describe the current state of affairs and how these two institutions can begin to work together in a meaningful and collaborative way as advocates for their mutual patients, based on enhanced communication, education, and the recognition of common goals.

Learning Objectives

Describe the challenges that exist in the transitions of care environment that act to compromise a purposeful relationship between the skilled nursing facility (SNF) and emergency department (ED).
Realize how the ED, through the work of ACEP, is understanding how it needs to re-define itself in it's care of patients and it's relationship to PA/LTC providers,
Consider how "best practices" in transitioning patients between the ED and SNF can be implemented in both locales
Appreciate how the "geriatric" emergency room can augment the care of patients and positively impact Population Health programs and the Triple Aim.

Presenter(s): Robert Burke, MD, MS; Wayne Saltsman, MD, PhD, CMD; William Jaquis, MD; Leslie Eber, MD, CMD; Marianna Karounos, DO

Presenter(s) Disclosures: All speakers have reported they have no relevant financial relationships to disclose.
An Evolution in Transitions: Improving the Skilled Nursing Facility and Emergency Department Relationship - SNF perspective – Burke, Eber

Speaker Disclosures
Dr. Burke:
- supported by a VA HSR&D Career Development Award
- Fellowship placement in the Center for Medicare and Medicaid Services (CMS)
- Opinions my own and do not necessarily reflect those of the Department of Veterans Affairs or CMS.

Dr. Eber has no financial relationship(s).

Learning Objectives
By the end of the session, participants will be able to:
- Describe important national influences on the ED-SNF relationship
- Identify promising areas for improving ED-SNF transitions
- List specific examples of new initiatives that demonstrate promise

Background
• How often are NH residents sent to the ED?
  • What happens to them while they are there?

National analysis of NH resident ED visits
- 2005-2010 National Hospital Ambulatory Care Survey
  • NH residents sent to the ED
    - Comparison of visits that did/did not lead to admission
    - Over 14 million ED visits examined
  • Overall findings:
    - 1.8 ED visits per resident per year
    - 54% do not lead to admission

Burke et al., JAMDA 2015

Testing and treatment in the ED
- More than 80% of those discharged underwent testing:
  • ~60% had laboratory testing
  • ~66% had imaging (25% were CT scans, mostly of head)
- More than 60% underwent a procedure:
  • ~10% had bladder catheterization
  • 15% had a CNS-active agent administered
  • Anxiolytic/hypnotic, narcotics, or antipsychotic
  • ~10% received a prescription for these on discharge
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Doing the math – at what cost?

- 1.8 ED visits per resident per year
- x 1.6 million NH residents
- x $1000 average reimbursement by Medicare

= $1 billion

Ouslander et al., JAMDA 2015

Influence 1 - Payment reforms

- More shared responsibility for outcomes/costs
  - Bundled payments for care improvement (BPCI)
  - Medicare Spending Per Beneficiary (part of hospital VBP)
  - SNF Value-Based Purchasing (VBP)
  - Readmission and community discharge rates in FY19

BPCI

Jubelt et al., JAMA IM 2016

Effects of payment reforms

- Intended effects:
  - Build stronger hospital-SNF linkages
  - Encourage alternative care models
- Potential adverse effects:
  - Send only the sickest to SNF
  - Disincentive to admit from ED
- Promising:
  - How can we take advantage of the intended effects?

Influence 2 – shifts in need/availability

- One thing we wont test is your patience. 4 Mins
- 24 HOUR EMERGENCY CARE

HCUP Statistical Brief 6277, 2017

Hsia et al., JAMA 2011
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Influence 2 – effects and promise

- **Effects:**
  - Increased ED crowding and diversion
  - Providers with less time for thorough evaluation

- **Promise:**
  - Care models that obviate need to travel to ED
  - Treating in place
  - “Win-wins” that reduce ED evaluation time
  - Development or promotion of improved care guidelines

Influence 3 – growth of technology

- **Effects:**
  - More “third-party” solutions
  - Widening gap in investment in IT

- **Promise:**
  - Easier-to-use technology for information exchange
  - Linking nursing homes with central providers

Influence 4 – changes in workforce

- **Effects:**
  - Larger number of dedicated NH supervisory staff
  - Increased costs to NHs or payors

- **Promise:**
  - More on-site staff for emergent evaluation/treatment
  - Communication with ED
  - Building relationships with hospitals

Promising Areas and Examples
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### Barriers to treating in place: why patients come to ED

- Injuries
- Infections
- Change in mental status
- Respiratory / dyspnea / CHF
- Fluid / electrolyte disorder
- GI / GIB
- Syncope

**Burke RE et al. J Am Med Dir Assoc. 2015; May 1;16(5): 395-399**

### Decision to send to the ER

- After hours
- Need for immediate care (injury, change in mental status)
- Need for immediate imaging
- Primary care follow up availability
- Acute distress
- Patient / family request
- Psychiatric issues / Change in behavior that endangers patient or others

### Promising area 1: New Options to Treat in Place

**Dispatch Health**

- ED-trained APP with support of on-call ED MD comes to SNF
- Provides care in place, including:
  - IVF, labs, EKG, suturing, nasal packing / cautery, G-tube

**High-Intensity Telemedicine**

- Immediate treatment of ambulatory care sensitive conditions (ACSCs)
- Decreased the rate of ED utilization by 34% over one year


**Promising area 1: New Options to Treat in Place**

- **Novel paramedic programs**
  - Broadened scope of practice to treat in place
  - Unexpected benefit – palliative care (IVF and pain control)
  - “Facilitated” ER visit if needed
- Less time, less work up, less waiting for the patient
- More input from patients and families
- Reduced ER congestion

- **Whitehall Community Paramedic Program**
  - Emergency Prevention

**Moulton D. CMAJ 2011 183(10)E631-E632**

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Promising area 2: improved communication

- Technology solutions
  - Echo-CT concept
  - CORHIO and other state health information exchanges
  - Pilot VA videoconferencing in State Veteran Homes
  - Develop infrastructure with easy accessibility
    - Dedicated phone line
    - Password protected Email / Text
    - Note previous trials / assess usability

- Emergency Department Innovations: Transitional Care Nurse
  - Study completed in 3 states (NY, IL, NJ)
  - Patient aged 65 and older
  - Decreased rate of admission on day zero and the following 30 days
  - Increased risk of 72 hour ED revisit

Structured Communication from the ED the "Reverse SBAR"

- Discharge Diagnosis
- Results / Tests
- Actions/ Medications
- Plan / Follow up
  - Seen by_____ in the ED

Challenges related to geriatric syndromes

- Geriatric issues
  - Frailty
  - Medication management and polypharmacy
  - Psychotropic medication use
  - Aseptic bacteriuria
- LTC/SNF federal regulations re: medications
  - Sleepers, antipsychotics, anxiolytics

Promising area 3: finding the win-wins in geriatric syndromes

**Aseptic Bacteriuria**

- Study: Impact of 2-step urine culture ordering in the ED
  - Saves the ER time and expense
    - No need to do a UA unless the patient meets McGeer Criteria
  - Benefits the SNF
    - Antibiotic stewardship program – no true UTI, no need for antibiotics,
    - Better for patient - fewer side effects, C.Diff, mortality and morbidity
  - Study: Impact of modifying the order set in the ER on Urine Culturing practices
    - 47% decrease in urine cultures, decrease antibiotic use and call backs

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Promising area 3: finding the win-wins in geriatric syndromes

**Communicating Goals of Care**

- Often established in SNF and GOC may not include hospital admission or workup
  - Saves ER time
  - Saves SNF – just need workup of single issue and patient-centered

**Communicating what has already been done**

- Wound culture and now on antibiotics, already has specialist input/sharing information
  - Decreased Bounce Backs and Readmissions

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Promising area 4: focus on ER-SNF provider relationships

- Providers have different agendas
- **Interventions include:**
  - Promote relationship building
  - Sharing education, research and Grand Rounds
  - Combining goals / being on the same page
  - The soft handoff

Promising area 4: focus on ER-SNF provider relationships

- Strategies to Improve Care Transitions between NH and ED
  - Prospective qualitative study
  - Additional infrastructure to support care transitions
  - Viewed as a Hospital to Hospital Transfer
  - Bidirectional checklist, 2-way statewide transfer form
  - Accountability
  - Verbal communication
  - "Relationship-Building effort has helped them overcome many of the challenges of care transitions"

Promising area 4: focus on ER-SNF provider relationships

- **Examples of relationships:**
  - The Sutter Health Collaboration and Success
  - Monthly meeting between SNF partners and Sutter Health Hospital
  - Share contact lists for SNF leadership and Hospital liaisons
  - SNF partners have access to Hospital EMRs and ePOLST
  - Tool Development used for SNF patients that return to the Hospital
  - Added Palliative care consult to the patient problem list

Sutter Health Re-admission Form for transfers from the SNF to the Hospital

Pathway Forward

- **Come to the table** – a lot to gain
  - Improve patient care / patient wishes
  - Improve provider satisfaction
  - Improve efficiency and decreased costs
- **Improve Communication**
  - Matrix development
  - Research opportunity for effective collaboration
- **Share Education / Standards of Care**
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Speaker Disclosures

Dr. Jaquis is employed by Envision Health.

Learning Objectives

By the end of the session, participants will be able to:

- Understand the current demographics of emergency department (ED)
- Review external forces that impact ED performance
- Discuss opportunities between the ED and a skilled nursing facility (SNF)
- Consider evolving approaches of the ED team to population health

The EDBA

- A 501c6 Not-for-Profit group to support professionals who manage ED’s
- A safe environment
- Low expense, no stress, consensus group
- Enable networking and data sharing
- Promote operations research and best practice identification and learning

Executive Summary 2016 EDBA Survey

- 1,521 EDs serving over 63 million patients, plus 135 Freestanding ED’s and Urgent Care Centers
- Volume increases from 2015 to 2016
  - Despite ‘surprise insurance coverage’
- Decrease percentage of children
- Flow is stable
- ED patient intake continues to improve, door to provider (physician or APP) 27 minutes

Executive Summary 2016 EDBA Survey

- Decreasing use of CT images, more ultrasound
- Mental Health patients are a burden on EDs
- ED’s the front door to inpatients, now at 69%
- Boarding is big driver of flow problems for ED’s
- Accounts for 40% of the admitted patient’s time in the ED
The Evolution of Emergency Medicine

<table>
<thead>
<tr>
<th>Your Likes</th>
<th>Your Practice</th>
<th>Your Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you like Trauma</td>
<td>You should have practiced in the</td>
<td>1970s</td>
</tr>
<tr>
<td>If you like Getting Blood and Acute Injuries</td>
<td>You should have practiced in the</td>
<td>1980s</td>
</tr>
<tr>
<td>If you like Airway and Intubating Patients</td>
<td>You should have practiced in the</td>
<td>1990s</td>
</tr>
<tr>
<td>If you like Reading x-rays and Admitting Patients</td>
<td>You are practicing in the</td>
<td>2000s</td>
</tr>
<tr>
<td>If you like Community Unscheduled Care, and out of hospital medicine, and more geriatrics</td>
<td>Wait till you practice in the</td>
<td>2020s</td>
</tr>
</tbody>
</table>

Trending and Planning for Flow Ahead: NHAMCS Says

- Latest data tables 2014
- Their 22nd year of analysis
- 2% more patients per year
- Injury is shrinking at 29.5% of ED patient load
  - Highest injury rates are over age 75
- The ED is seeing older, complex, high acuity medical patients
- Similar data from another Federal source: AHRQ Healthcare Cost and Utilization Project Statistical Brief #227, September 2017


Boarding - Traction Lacking

The ED Preparedness Burden

- Ebola
- Active shooter
- Weather

External Forces
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EMTALA
- Emergency Medical Treatment and Active Labor Act
- Passed in 1986 as part of COBRA
- This is the law the requires are EDs to see all patients who “present” to the ED regardless of ability to pay.
- Enacted as a result of patients being rejected by Eds
- Significant penalties for violation
- CORE of what we do – both legally and morally

Prudent Layperson Standard
- As soon as EMTALA enacted, insurer behavior changed
- Pre authorization required
- Post visit denials if diagnosis was “non-emergent”
- 1993 – Maryland first state to enact PL
- 1997 – Federal standard passed as part of Balanced Budget Act
- 1998 – Extended to all federal health plans
- 2010 – Extended to ERISA plans

Payment
- Under the Emergency Medical Treatment and Active Labor Act (EMTALA), all patients who “present” to the ED must be seen by a provider, regardless of ability to pay. Patients who present to the ED may be financially unable or unable to pay for services. Patients whose presentation is deemed non-emergent may be denied ED services. The definition of emergent condition is based on the criteria established by the Prudent Layperson Standard.

Prudent Layperson Standard
- Emergency Medical Condition
A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
- placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- serious impairment to bodily functions, or
- serious dysfunction of any bodily organ or part.

Anthem (BCBS) and Prudent Layperson
- News: Insurers Test the Limits of Prudent Layperson Standard
- Anthem (BCBS) and Prudent Layperson

Consolidation
- Hospital mega-mergers hit fast and furious in Q1
- Jeff Ravitz, Warren Buffett and Jamie Dimon want to fix health care

Aetna
- Automatic Downcodes

After Another Merger Monday In Health Care, CMS Is Still The Company To Watch In 2018
- Medical News Today - March 2017
- Hospital mergers and acquisitions are common and can increase costs for patients. However, it is not clear that these mergers result in better quality or lower costs.

Health Systems Getting Bigger, More Diverse, Insurers and Merging
- Jeff Ravitz, Warren Buffett and Jamie Dimon want to fix health care
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- Jaquis

Consolidation in EM

EMI Health closes merger with Vibra Acute Care Stakeholders

Envision Healthcare Acquires Phoenix-Area Emergency Medicine Group

Public Health

“Surprise” billing

The Upshot

Surprise! Insurance Paid the E.R., but Not the Doctor

New York Times

Why Not Medicare

Why Not Medicare

ACEP Efforts on Balance Billing

- Over 127 bills have been introduced related to this
- Focus of state chapters – Reimbursement and State Legislative Committees
- Task Force with ED Practice Management Associations for 4 year
- Expanded scope – Physicians for Fair Coverage formed from 9 ED groups

Coalition Building

- Resolution to the AMA – led to model legislation
- Outcome of relationships with the “Monday Group” – ACEP, EDPMA, ASA, ACR, AAOS, CAP, AMA

Emergency Departments circa 2018

- Despite the proliferation of alternative sites of care, volume continues to increase
- Because lower acuity is moving to alternative sites, the acuity in the ED is increasing, as well as boarding
- Patients in the ED are aging, more complex, and more likely to have medical conditions
Emergency Departments circa 2018 – cont..

- ED providers more likely to be in larger groups working for larger systems and consolidated payers
- Access to the ED continues to be threatened by regulatory and payer behavior

Solutions?

Triple Aim (or Quadruple Aim)

- Triple Aim (IHI) has been the measure of success for change
- Quadruple Aim (not IHI) has been suggested by many to incorporate physician wellness

Population Health

The health outcomes of a group of individuals, including the distribution of such outcomes within the group

Population Health - Maryland

- Long standing Total Patient Revenue Models
- State went to Global Budget Revenue in 2014
- Shift in thought from admission based to care in community
- Initial focus – high utilizers (2 tiers)
  - Avoidable hospital utilization
  - Improved quality
- Provider collaboration increased (HIE)

Geriatric EDs

As previously discussed, the ED is quickly becoming an acute, unscheduled evaluation facility for high acuity and older populations.
Coordination of Care

- Information exchange
  - SNF to ED
- Reason for transfer
- Baseline health and mental status
- Process for transfer and documentation
- Capability of SNF?
- Warm handoffs

Coordination of Care

- Information exchange
  - ED to SNF
- Treatment plan in ED and change in treatment
- Process for transfer and documentation
- Capability of SNF – admit vs observation – new unit in SNF
- Warm handoffs

Alternative Payment Models

APMs – work group 3

- Working on APM which would involve the expertise of the ED in acute evaluations – outside the ED
- “The work group believes that a model of care with shared risk between emergency physicians, SNF medical directors, and SNF operators can be implemented that would provide improved quality of care (including improved patient experience) while creating a more cost-effective system for delivery of care.”

Summary

- ED of 2018 and beyond is changing into a higher acuity, medical population with and increasing age
- Newer and changing payment models are not decreasing utilization but are threatening access
- EDs are evolving from simpler admit-discharge models to more complicated centers for population health and acute unscheduled care
- Broader coalitions are needed to further the triple (quadruple AIM)
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- Saltsman

An Evolution in Transitions
Improving the Skilled Nursing Facility and Emergency Department Relationships

A Symposium sponsored by:
The Subcommittee on Transitions of Care
Chair: Wayne S. Saltsman, MD, PhD, CMD
Vice Chair: Manisha Parulekar, MD, CMD

Learning Objectives for Leading Practices
By the end of the session, participants will be able to:
• Appreciate the complexity of trans-disciplinary care of patients transitioning between the ER and SNF
• Understand the multi-Society efforts to establish mutual understanding and respect in evolving to a better ER and SNF patient transition of care

A (true) Case
An 84 year old gentleman, with known early dementia, was admitted to the SNF earlier in the week after a recent fall, slp hip fracture repair. A unit nurse calls a SNF covering provider regarding the patient’s nausea and vomiting over the course of the day. No abdominal assessment recorded in the chart. A ‘small BM’ was noted the day before. On opiate. No fever. Mild abdominal pain. Covering is concerned about a potential ileus or obstruction, discusses rationale with the nurse, and orders that the patient be sent to the ER. Hours later, a noticeably upset ER provider pages the SNF covering to inquire as to why the patient was sent for concerns about a rash. The ER provider sees no rash. A discussion ensues…

What are the transition issues here?

Multiple Players = Multiple Layers of Complexity
Getting ‘lost’ in transition
• The covering provider?
• The SNF nurse?
• The ER nurse?
• The ER provider?
• ER case management?
• Emergency medical technician?
• Family? Others?
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Two Separate Realms of the Continuum
Current state

Motivation for a Solution
A unique transition
- Unread or missing paperwork
- Non-conveyed, or erroneous, communication
- An unclear source of truth
- Lack of accountability
- Getting lost in 'the trenches'
- The need for a 30-thousand foot view

Getting Society Buy-in
Working on a 'trickle-down' approach
Looking at ER/SNF patient flow for key stakeholders—the simplest view:

A Work Group is Formed
American College of Emergency Physicians (ACEP)
- Mark Rosenberg, DO, MBA
- William Jaquis, MD
Emergency Nurses Association (ENA)
- Lisa Wolf, RN, PhD
National Association of Directors of Nursing Administration (NADONA)
- Shari Carson, RN, BSN, NHA
American Case Managers Association (ACMA)
- Richard Lasota, RN, CCM
American Medical Director's Association (AMDA-PALTC)
- Thomas Lawrence, MD
- Wayne S Saltsman, MD, PhD

Two (really) Separate Realms of the Continuum
The work group agrees, and its even more of a challenge...

Work Group Basic Conceptual Framework
ACEP
- Time
- Resuscitation
- Workflow (admit?)
ENA
- Communication
- Data
- Agility
ACMA
- Education
- Disposition
NADONA
- Communication
- Data
- Accountability
AMDA-PALTC
- Plan of Care
- Accountability
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30 Thousand Foot Potentials
Case management is central
- Dual role as a navigator
- Organizes communications
- Educates patients and families
- Promotes preferred networks
- Discusses quality care
- Coordinates information and reports to the ER physician
  - Understands capabilities of a SNF
  - Advocates when appropriate for a return to the SNF setting
  - Decompresses the system

30 Thousand Foot Potentials
Nursing is the “front-line” on both sides of the wall
- Promote consistent, reliable, standardized communication
- Ongoing education on patient assessment and status in the SNF
- Understand how to convey viable and useful data
- Reinforce accountability for patient stability and wellness.
- Appreciate the concept of ‘same patient/same team’

30 Thousand Foot Potentials
Let the ER physician be an ER physician, and…
- Appreciate the (unique) ER physician role
- Educate the SNF/SNF providers on ER models of care
- Promote an ER understanding of/connexion to local/feeder SNFs
- Welcome ER resident training to include the SNF setting

30 Thousand Foot Potentials
What is the SNF provider role?
- Better understanding of the ‘order to transfer’ process
- Collaboration/teamwork with the SNF nurse
- Promoting accountability or ‘follow through’
- Educating on limitations in SNF care/needs for transition
- The concept of an “after hours plan of care”

Evolving to (Society-based) Leading Practices
- AMDA-PALTC creates training modules for ACMA members re SNF capabilities
- encourages local chapters support
- ACEP and AMDA-PALTC develop workshops to guide and educate on respective work flows and plans of care
- ACEP and AMDA-PALTC work to creating a curriculum for the ER resident in the SNF setting
- ENA and NADONA establish an ‘in-service’ curriculum to support ‘team efforts’ in ER transitions and patient care
- NADONA supports local programs in promoting and maintaining nursing assessment and written/verbal communication skills
- AMDA-PALTC continues to promote advance care planning for respecting patient goals and wishes (limiting transitions through ‘off-hours’/coverage plans of care)

Uniting Two Realms of the Continuum
An Evolving State
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What about the 'patient'? coming to Version 2.0
(Maybe EMS too....?)

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An Evolution in Transitions: Improving the Skilled Nursing Facility and Emergency Department Relationship
The Geriatric Emergency Department - Karounos

The Geriatric Emergency Department
Marianna Karounos, DO, MS, FACEP
Chief of Emergency Medicine
St. Joseph’s University Medical Center
Paterson, NJ

Disclosures
No financial relationship(s).

Learning Objectives
1. WHY?
   • Understand the growing care needs of seniors in the ED
2. WHAT?
   • Discuss the 10 facets of the Geriatric ED (GED)
3. HOW?
   • The business case

Why?
• 79 million Baby Boomers become 65
• Age 65 and over have increase healthcare needs
• ED utilization of seniors
• Contributing factors
• Outcomes
• Paradigm shift
• More likely to fill out patient satisfaction surveys
• More likely to be dissatisfied
• VALUE-BASED PURCHASING

Why?
• 7x more usage of ED services43% of all admissions
• 48% of all Critical Care admissions
• 20% longer length of stay
• 50% more lab
• 50% more radiology
• 400% more social service interventions
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The Geriatric Emergency Department - Karounos

Why?

1. Shrinking primary care pool
   - Deficit of 25,000 Gerontologists by 2030
   - FP Residents Decreased by 50%
   - IM Residents Into Primary Care Dropped from 54% to 22%

2. Lack of financial incentives
   - Medicare is primary insurance of the elderly
   - Medicare pays 25-31% less than private insurers

3. Complexity of care
   - Multiple chronic diseases complicated by social issues

   - Outpatient management issues
     - Cognitive
     - Mobility
     - Transportation
     - Subspecialist availability

Why?

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Could the ED be an answer? YES!

Why?

1. Delay in diagnosis & treatment
   - Acute MI
   - Sepsis
   - Appendicitis
   - Ischemic bowel

2. Unsuspected diagnosis
   - Delirium
   - Depression
   - Cognitive impairment
   - Drugs & alcohol
   - Elder abuse
   - Polypharmacy

3. Under-treatment
   - PCI in MI
   - TSIs in stroke
   - Surgical interventions
   - Pain management

4. Over-treatment
   - Foley insertion
   - Adverse drug effects
   - Overuse of sedation

Why?

Potential Roadblocks

Why?

- Geriatrics isn’t sexy
- Reimbursement
  - “But we already see large number of seniors”
  - Bed pan unit
  - Little research on outcomes
  - When is the patient old?
    - 65 to 74 = Young Old
    - 75 to 84 = Old
    - 85+ = Old Old
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The Geriatric Emergency Department - Karounos

2007 AGS Dr. Ula Hwang

2010 The GED

2013 The GED Guidelines

What?
The 10 facets of the GED:
1. Physical plant
2. Quality initiatives
3. Staff and provider education
4. Operational enhancements
5. Coordination of hospital resources
6. Coordination of community resources
7. Staffing enhancements
8. Patient satisfaction extras
9. Observation and extended home observation
10. Palliative care

What? → Physical Plant
- Separate unit? Process? Universal Design?
- Thick mattresses or hospital beds
- Quieter, less chaotic environment
- Non-slip floors
- Non-glare floors
- Limiting tethers
- Handrails
- Corridors safe for walking
- Lighting
- Sound proofing
- Family friendly
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The Geriatric Emergency Department - Karounos

What? → Physical Plant

- If you don’t have space for a Geriatric ED.... make your entire ED a Geriatric ED

- If the ED is designed for the most frail and vulnerable…it will work for the strongest.

What? → Quality Initiatives

- Drug interactions
  - 5 Meds = 70% chance of drug interactions
  - 7 Meds = 100% chance of drug interaction

- Falls risk assessment
  - Get-up-and-go testing
  - STEADI CDC

- Beers criteria
  - Potentially inappropriate medication use in older adults

- ESI criteria

- Liberal EKG policy

- Abdominal pain awareness

- Screening Tools

What? → Quality Initiatives

Triage:

- Be aware of vague complaints
- A fractured wrist is a fall – not just a fracture
- Normal vitals
- Normal BP in a hypertensive
- Presentation of ischemic heart disease
- CP isn’t the most common complaint
- Abdominal Pain
- Be Alert
- Patient is a pending disaster until proven otherwise
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The Geriatric Emergency Department - Karounos

**What? → Quality Initiatives**

**Screenings:**
- ISAR
- CAM-ICU
- CSI
- PHQ-2 and 9
- Mini-cog
- Katz ADL
- Get Up and Go Testing

**What? → Staff & Provider Education**

- All staff
- Needs assessment through a quality program
  - Geriatric curriculum (ACEP, SAEM, ENA)
    1. Physiology of aging
    2. Abdominal pain
    3. Falls and trauma
    4. Infectious disease
    5. The dizzy patient
    6. Pharmacology
    7. Chest pain and dyspnea
    8. End of life
    9. Delirium
   10. General assessment

**What? → Operations**

- Geriatric triage screening
- Geriatric palliative care program
- Medication reconciliation and interaction screening
- Two-step call back program
  - Step One – ED Visit
  - Step Two – Follow-up Program

**What? → Operations**

- Prevent functional decline within 30 days of ED discharge
- Called by Geriatric Team within 24 hours of ED Discharge
- Risk screening tools used
- Need assessment
- Medication Review
- Hospital and community resources coordinated
- Primary care doctor notified

**What? → Operations**

Role of patient call backs
- Five concerns:
  - Status
  - Medications
  - PMD follow-up
  - ADL assessment
  - Support system
An Evolution in Transitions: Improving the Skilled Nursing Facility and Emergency Department Relationship
The Geriatric Emergency Department - Karounos

What? → Coordination of Hospital Resources
- Social workers
- Case managers
- Physical therapy
- Pharmacist
- Toxicologist
- Telemed

What? → Coordination of Community Resources

What? → Staffing Enhancements
- Program coordinator
- RN Champion
- Nurse Coordinator
- Geriatric Nurse Practitioner
- Physician Champion
- Medical Director
- ED/IM
- Fellowship Trained
- Social worker
- Case manager
- Pharmacist
- Toxicologist
- Physical therapist

What? → Patient Satisfaction
Value Based Purchasing
- Addressing by preferred name
- Patient liaison
- Blankets
- Nutrition
- Space for Family
- Internal waiting room
- Reading glasses
- Hearing assist devices
- Holistic Medicine

What? → Patient Satisfaction
- Reiki Energy
- Pranic Healing Energy
- Aroma Therapy
- Acupressure
- Music Therapy
- OMT
- Light Therapy
- Medical Harp Therapy

What? → ED & Home Observation
- Observation care in the Geriatric ED
  - Decreases need for admission
  - Admitted patient are better packaged
- Extended home observation
  - Visiting nurse
  - Paramedics
  - Return ED visit
An Evolution in Transitions: Improving the Skilled Nursing Facility and Emergency Department Relationship
The Geriatric Emergency Department - Karounos

What? → Palliative Care

Heart attack
Stroke
Heart Failure
Kidney Failure
Lung Cancer
Brain Cancer
Dementia
Parkinson's disease

What → Palliative Care

• >70% Die In Health Care Facility
• 17% Die At Home
• ~100% Want to Die at Home
• Admission Through the ED

How? → Business Case

Healthcare CEO’s Top 10 Concerns 2015

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<th>ISSUE</th>
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<td>2</td>
<td>Patient safety and quality</td>
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How → Business Case

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What is next?
• Define your goal
• Outline your needs
• Identify your barriers
• Make your case
• Make it happen!