Dissemination of Geriatrics Guidelines in the Emergency Department: The Intersection of Geriatric Experts, National Guidelines, and Quality Improvement in 3 Midwestern Hospitals

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Dissemination of Geriatrics Guidelines in the Emergency Department:
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Objectives:

1. Describe innovative methods of disseminating Guidelines

2. Identify methods of translating Guidelines into clinical practice

3. Demonstrate positive consequences of ED staff leading innovation at an integrated health system
Background:

Geriatric Emergency Department Guidelines
- The purpose of the 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.
- Geriatric ED Boot Camp: Dissemination, Adaption, and Incorporation of Geriatric Principles into the ED.
  - [http://www.acep.org/geriEDguidelines/](http://www.acep.org/geriEDguidelines/)

American College of Emergency Physicians (ACEP),
American Geriatrics Society (AGS),
Emergency Nurses Association (ENA),
Society for Academic Emergency Medicine (SAEM)
  - Funding by the John A. Hartford Foundation (JAHF) and American Geriatrics Society (AGS).

Geri ED Boot Camp: December 2014
- Three Aurora Emergency Departments:
  - Aurora Sheboygan Memorial Medical Center
  - Aurora St. Luke’s South Shore Medical Center (NICHE Exemplar Status)
  - Aurora West Allis Medical Center (NICHE Exemplar Status)
- 5 National experts traveled to Milwaukee to provide Geri ED Boot Camp and implement a quality improvement project based on the Geri ED Guidelines; this includes monthly follow up via telephone meetings with each site.
- The teams agreed on one focused aspect of the guidelines:
  - Improving transitions from ED to the community.

Geri ED Boot Camp: December 2014
- The Aurora Geri ED Project:
  - Nurses at each site implemented an ISAR (Identification of Seniors at Risk) assessment of older patients with interventions offered to those who were identified as high risk:
    - Identify the community dwelling older patients who are transitioning home, but are vulnerable.
    - High Risk patient determined with ISAR score of 2 or greater
    - ISAR- Implement interventions and processes to support the patient
Interventions:

1) Follow up with primary care provider
   Utilize clinic Transitional Care Management (TCM) processes
2) Home care (RN, PT, OT)
   Partner with Aurora at Home
3) Referral to local Aging and Disability Resource Center (County)
4) Palliative care consultation,
5) Community Resources

ISAR: Identification of Seniors at Risk

Implementation of ISAR Tool / “Identification of Seniors at Risk”

1. Before the illness or injury that brought you to the Emergency Department, 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 6 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?

Workflow: ISAR in EHR
Description of 3 Aurora EDs: September 2015

ISAR Screened patient 65 ≥

<table>
<thead>
<tr>
<th></th>
<th>Site A</th>
<th>Site B</th>
<th>Site C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of older patients</td>
<td>220</td>
<td>144</td>
<td>145</td>
</tr>
<tr>
<td>Discharged to home:</td>
<td>85 (39%)</td>
<td>54 (38%)</td>
<td>79 (54%)</td>
</tr>
<tr>
<td>Age &gt;=85 years:</td>
<td>95 (43%)</td>
<td>50 (35%)</td>
<td>37 (26%)</td>
</tr>
<tr>
<td>72 hour readmit rate :</td>
<td>12 (5%)</td>
<td>13 (9%)</td>
<td>14 (10%)</td>
</tr>
<tr>
<td>Return to ED within 30 days any site:</td>
<td>82 visits (37%)</td>
<td>49 visits (34%)</td>
<td>60 visits (41%)</td>
</tr>
<tr>
<td>Patients with multiple return in 30 days:</td>
<td>12</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Falls as chief complaint:</td>
<td>36 (16%)</td>
<td>18 (13%)</td>
<td>19 (13%)</td>
</tr>
</tbody>
</table>

What is our population?:

- What percent of the older patients seen in the ED are sent home?
- What percent of those who are sent home are at risk?
- What is the ISAR trigger point? ≥2 or ≥3 or ≥4
- What is the best strategy to address the needs of older patients who transfer home from the ED?

Population Description: Site B

Description of ED Patients at Risk:

2,000 total ED visits
25% ≥65 ED visits (400 patients)

65% (positive risk) ISAR > 2 (260 patients)
21% (positive high risk) ISAR >4 (55 patients)

69% ISAR >4 admitted (38 patients)
31% ISAR >4 d/c to community (17 patients)
ISAR Distribution: Site A

ISAR Outcome

46% ISAR >=2

Workflow: Interventions

- Investment in an Emergency Department Case Manager / Social Worker
- Intersection of Geriatric Experts: Geriatric Boot Camp
- Establish relationships / link to community resources
- Establish a referral process
- Educate Staff on ISAR and Community Resources / Services and referral process (implementing culture change)

Workflow: Processes

Geriatric Referral Process

ISAR Screening completed

Is ISAR 2 or >?

NO
Referral need identified

YES
Stop data collection

Referral accepted?

NO
Referral process initiated

YES
No referral provided

Nurse offers referral to Primary Care, Aurora Sheboygan Palliative Care, Skilled Home Care, and or Aging and Disability Resource Center based on identified need

Primary Care Physician?

Aurora Sheboygan Palliative Care?

Skilled Home Health?

Aging and Disability Resource Center?

Service to order is placed by provider
Clinic Calls patient to set appointment
Service to order is placed by provider
Palliative care contacts patient to set appointment
Service to order is placed by provider
Skilled Home Health contacts patient for appointment.

Patient completes appointment or not

Nurse provides pamphlet or resource guide provided
Outcomes: ED Utilization Site C

Analysis of Intervention vs Standard Care
176 patients in the study (3 months - 1 site)
- 65 years or older with ISAR of 2 or greater

70 patients Intervention group.
- Appropriate referral identified and patient accepted
- 70 patients received and completed the referral
- 9 patients did not complete the referral

97 patients Standard Care group.
- Patient refusal
- ED RN did not identify a need or an appropriate referral

Outcomes: ED Utilization Site C

Intervention Group (70 patients)

- Readmissions (14)
- Non Readmissions (56)
- 20%
- 80%

Standard Care Group (97 patients)

- Readmissions (24)
- Non Readmissions (73)
- 25%
- 75%

Data shows a 5% decrease in ED readmissions with utilization of referrals.
Outcomes: 2015 72 hour Revisits Site C

Outcomes: Site C
Patient Satisfaction Pre & Post Geri ED

Top Box Trends
Emergency Department
Overall

Challenges:

• Time
• “Hardwire” Nurse / Physician process
• Establish “a single practice” culture at multiple sites.
• Case Management and Resource availability
• Patient compliance
• Takes time to change practice / culture
• Diversity among Hospitals – demographics, staff, and resources
• Collaboration with external resources
Lessons Learned

- Paradigm shift from reactionary to preventative
- ISAR Tool is limited, does not capture all at risk patients
- ISAR has good sensitivity, poor specificity
- Practice change for ED nurses (culture change) takes time
- Collateral benefit, identifies non-geriatric patients that may need similar referrals
- Creating a team approach for Geriatric Care in the Emergency Department

Next Steps:

- Improve the design and implementation of the intervention.
- Define roles of each discipline at multiple sites for continuity and future dissemination to all 14 sites in Aurora.
- Primary Care Pilot
  - Determine volumes
  - Further develop processes for stratified clinic follow-up
  - PCP vs. RN Care Coordinator
  - Collaborate with PCP leadership
  - Prevent duplication, align resources

Next Steps:

- Metrics:
  - Daily (real time), weekly, monthly reports
  - Standardization of reporting
  - Cost analysis
  - Analysis of population to focus next interventions
- Prepare for dissemination to our next EDs
  - Develop a communication plan to build consensus
  - Align with Aurora’s Medicare strategy & care at all 14 ED sites
  - Define resources
  - Define value proposition of Geri ED project
Conclusion

Providing expert geriatric care in emergency departments and offering needed referrals is effective at:

• Helping Geriatric patients obtain the resources and care to remain at home
• Enjoy a better quality of life
• Decrease Emergency Departments utilization
• Increased Patient Satisfaction

Reference


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