IDENTIFYING RESTORATIVE POTENTIAL THROUGH RISK SCREENING, ASSESSMENT & EARLY INTERVENTION IN GERIATRIC SYNDROMES FOR FRAIL SENIORS IN THE EMERGENCY DEPT.

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May 1, 2015
OUR QUALITY IMPROVEMENT QUESTIONS

- What could we do differently to be more **senior-friendly** in our Emergency Department (ED)?
- How could we **optimize** our Geriatric Emergency Management (GEM) resources for frail seniors needing geriatric rehabilitative care?
- How do we identify **restorative potential** in patients in ED?
- What will it take to develop a **geriatric care path** incorporating screening, assessment and early access to rehabilitative care to **reduce risk** of admission to hospital or long term care?
METHODS

- Aug 2014 approved for project
- Learning Collaboratives
- Project Charter
- Aim and Measures
- Change ideas
- Actions
- Measurement
RESULTS

- Outcome measures
- Process improvements
- Balancing measures
RESULTS

Majority of seniors aged 75+ are Urgent and Emergent (CTAS 2,3). Opportunity for GEM RN resources to be focused on higher severity patients (AUA 4-6) and alternate resources or algorithms focused on lower severity patients (AUA 1-3)
2nd GEM RN started creating special cause variation; Increased daily activity for Jan/15; no increased trend in screening
63.0 – 81.1% of the patients 75+ years had a risk level above 3 on the AUA.
RESULTS

Nov data missing from database

Reduction in re-visit rate
NEXT STEPS

- Methods of efficient **data collection** of process (tracking stickers, if AUA score present, referrals to GEM)
- Understand results of the **screening scores** and cross-LHIN collaborative development of **care pathways**
- Developing **system capacity** to address the needs of identified high risk seniors and facilitate **access to appropriate rehabilitative care**

Adapted from Sinha, S. (2012). Living Longer, Living Well, MOHLTC, p. 94
KEY TAKE-AWAY MESSAGES

- Seniors >75 yr+ use the ED appropriately and need varying levels of assessment and treatment, e.g., GEM RN, Health Links
- AUA App easy to implement and keenly adopted; further changes to fit into work flow
- Care path creates the vision for standardized care
- Screening can striate the patients to optimize resource use and identify restorative potential
- Algorithms for AUA scores – custom build for clinical engagement local resources
THANK YOU FOR YOUR TIME

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www.ckha.on.ca
FOR MORE INFORMATION

LINKS

www.ckha.on.ca
www.eriestclairlhin.on.ca
www.ideasontario.ca

For InterRAI Assessment Urgency Algorithm app download:
(for Androids)

SPONSORS AND COACHES

Willi Kirenko & Sarah Padfield (CKHA), Gary Switzer (ESC LHIN)
Shawna Cunningham IDEAS Quality improvement specialist &
Michael Campellini IDEAS ICES advisor
GEM RN able to assess 5-6 per 7.5 hr shift; 12 hr shifts 7 days per week beginning December 2014; insufficient capacity for range of 15-37 patients per day.
Clinical Frailty Scale (introduced by GEMs 2014) scores >4 may indicate high risk for seniors and require comprehensive geriatric assessment.
Because of the high number of patients with AUA scores of 1, 2 & 3, we are studying the AUA scores by age groups, the reasons for presentation to ED and the discharge disposition after seen by GEM RN.
TOOLS OR METHODS USED TO DATE

Time of Day of Patient Presentation to ED at CKHA, age 70 yrs+, FY 2013-14
Total = 8956 patients
PROCESS MEASURES

CKHA ED Patients aged 75+ screened by GEM/total patients aged 75+

Number of patients

Date

No GEM RN available
**PROCESS MEASURES**

**Patient distribution by gender**

- Total: 339 (58% female), 249 (42% male)

**Age distribution patients aged 75+ at CKHA ED Nov 2014**

- 75 to 79: 197
- 80 to 84: 172
- 85 to 89: 118
- 90+: 101

**Triage Acuity Patients aged 75+ CKHA ED Nov 2014**

- Number of patients: N=588
- CTAS level:
  - 1: 350
  - 2: 250
  - 3: 200
  - 4: 150
  - 5: 100
  - Total: 80% CTAS 2 & 3
ADAPTIVE LEADERSHIP

Implementing a new tool in the ED is challenging
- Phased approach planned
- 2 ED RN champions identified as next step – then spread
- ED Leadership team have multiple commitments

Collaboration with other team partners
- Meeting held with CCAC Partners to discuss project
- CCAC also use the AUA from RAI contact assessment
- Ongoing meetings planned to identify opportunities to collaborate on care plans based on AUA score
- Physician partnership to be determined
## HIGHLY ADOPTABLE IMPROVEMENT (HAI)

### Domain

<table>
<thead>
<tr>
<th>Domain</th>
<th>Degree of Adoptability</th>
<th>Findings</th>
<th>Next steps</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High risk</td>
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<tr>
<td></td>
<td>Mod risk</td>
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<tr>
<td></td>
<td>Some risk</td>
<td></td>
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<tr>
<td></td>
<td>Highly adoptable</td>
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</tbody>
</table>

### Implementation Strategy

<table>
<thead>
<tr>
<th>End user participation</th>
<th>√</th>
<th>ED RN’s are end user</th>
<th>Phased approach planned 2 ED RN’s identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alignment and planning</td>
<td>√</td>
<td>Highly adoptable but competing priorities</td>
<td>Identify Management Team priorities</td>
</tr>
<tr>
<td>Resource availability</td>
<td>√</td>
<td>Electronic application not feasible at first</td>
<td>Tablets have been made available for trial</td>
</tr>
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</table>

### Intervention design

<table>
<thead>
<tr>
<th>Workload</th>
<th>√</th>
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<tbody>
<tr>
<td>Complexity</td>
<td>√</td>
<td>Actions based on results are complex</td>
</tr>
<tr>
<td>Efficacy</td>
<td></td>
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</tbody>
</table>
Some of our assumptions are plotted below. We used PDSA to test using a **prototype**.
## INTEGRATION AND CARE TRANSITIONS

<table>
<thead>
<tr>
<th>ED</th>
<th>LINKAGES</th>
<th>COMMUNITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMS forms</td>
<td><strong>Informational Continuity</strong> GEM RN communication with patient primary care providers</td>
<td>Develop a letter Outline reason for visit, diagnostics and outcome</td>
</tr>
<tr>
<td>LTC, RH transfer forms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information provided by PCP’s if sending patient to ED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solcom prior patient records</td>
<td><strong>Management Continuity</strong> Referrals made and information provided with referral</td>
<td>Written materials provided to patients</td>
</tr>
<tr>
<td>CCAC CHRIS system</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CKHA Care of the Elderly Strategy</td>
<td><strong>Relational Continuity</strong> Future outpatient geriatric clinic for follow up</td>
<td>Provide follow up appointments for ongoing management for complex patients</td>
</tr>
</tbody>
</table>

- **EM:** Emergency Medicine
- **LTC:** Long-Term Care
- **RH:** Rehabilitation
- **CCAC:** Continuing Care Access & Coordination
- **CHRIS:** Continuity Health Record Information System
- **CKHA:** Cornwall & District Health Association
Geriatric Syndromes Predict Postdischarge Outcomes Among Older Emergency Department Patients: Findings From the interRAI Multinational Emergency Department Study

Andrew P. Costa, PhD, John P. Hirdes, PhD, George A. Heckman, MD, MSc, Aparajit B. Dey, MD, Palmi V. Jonsson, MD, Prabha Lakhan, RN, PhD, Gunnar Ljunggren, MD, PhD, Katrin Singler, MD, MME, Fredrik Sjostrand, MD, PhD, Walter Swoboda, MD, Nathalie I.H. Wellens, PhD, and Leonard C. Gray, MD, PhD

Abstract

Objectives: Identifying older emergency department (ED) patients with clinical features associated with adverse postdischarge outcomes may lead to improved clinical reasoning and better targeting for preventative interventions. Previous studies have used single-country samples to identify limited sets of determinants for a limited number of proxy outcomes. The objective of this study was to identify and compare geriatric syndromes that influence the probability of postdischarge outcomes among older ED patients from a multinational context.

Methods: A multinational prospective cohort study of ED patients aged 75 years or older was conducted. A total of 13 ED sites from Australia, Belgium, Canada, Germany, Iceland, India, and Sweden participated. Patients who were expected to die within 24 hours or did not speak the native language were excluded. Of the 2,475 patients approached for inclusion, 2,282 (92.2%) were enrolled. Patients were assessed at ED admission with the interRAI ED Contact Assessment, a geriatric ED assessment. Outcomes were examined for patients admitted to a hospital ward (62.9%, n = 1,436) or discharged to a
Author:
Dr. George Heckman,
Geriatrician,
Professor (Schlegel Research Chair in Geriatric Medicine)
McMaster University

Pilot study in WW LHIN 2014:
Emergency Departments at St Mary’s General Hospital and Grand River Hospital.
## PATIENT SAFETY AND RELIABILITY

<table>
<thead>
<tr>
<th>Hazard</th>
<th>Risk: consequence</th>
<th>Likelihood</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not all patients aged ≤ 75 will be screened</td>
<td>Missing a high risk patient</td>
<td>Moderate</td>
<td>Maintain high index of suspicion, keen observation skills and corroborate history with family/caregivers</td>
</tr>
<tr>
<td>Assuming that the answers to the screener are accurate (e.g. presence of dementia)</td>
<td></td>
<td></td>
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<tr>
<td>GEM RN not available for all patients who might need it</td>
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<td></td>
</tr>
<tr>
<td>Attitudes toward seniors – dismissing symptoms as normal for aging</td>
<td>Other missed geriatric syndromes inadequate care plans ED revisits</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>Missed diagnoses of delirium</td>
<td>Worsening of patient condition →→ up to DEATH Prolonged LOS</td>
<td>High</td>
<td>Education, build capacity of whole team to recognize atypical presentation of illness / delirium</td>
</tr>
</tbody>
</table>
# AUA Referral Pathway Summary

Adapted from: Assessment Urgency Algorithm (AUA): Phase 1 Report: Exploring the use of the AUA screener in the ED to identify seniors at risk of frailty (April 8, 2014)

<table>
<thead>
<tr>
<th>AUA Score and Features</th>
<th>Focus of Interventions</th>
<th>Potential LHIN Specific Referral Options /Considerations</th>
</tr>
</thead>
</table>
| **Level 1** Self-reliant in ADLs / IADLs Health is excellent or good No unstable health conditions | • Enhance capacity for self management  
• Prevention and sustaining tactics  
• Social determinants  
• Ensuring proper medical care  
• Staying active  
• Linking with primary care provider(s) | • Community Support Services  
• Meals on Wheels  
• Transportation Support  
• Social Programs  
• Senior Centres  
• CCAC  
• Physiotherapy  
• Occupational therapy  
• Social Work |
| **Level 2** Self-reliant in ADLs/IADLs Health is fair or poor No unstable health conditions | • Enhance capacity for self management, no referral required UNLESS, concern expressed with ability to manage at home – then refer to Community Support Services | |

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# Referral Pathway Summary

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</thead>
<tbody>
<tr>
<td><strong>Level 3</strong> Self-reliant in ADLs/IADLs Health is excellent or good OR fair or poor Has unstable health condition(s)</td>
<td>• Intervention and Management of Medical/Mental Health Complexities • Assess the Need for Services • Follow up with Primary Care Provider(s) • Work with primary care to build capacity to care for these persons to lessen the need for geriatrician consultation • Medication adherence/ poly-pharmacy • Enhance capacity for self management (If health reported “Excellent” of “Good”). • Refer to Geriatric Emergency Management or CCAC if health reported as “Poor” or “Fair”:</td>
<td>• CCAC • Geriatric Emergency Management • Memory clinic • Mental Health • Specialized Geriatric Services (SGS) / Mental health SGS • Geriatric Psychiatry • Follow up w Primary Care • Adult Day Program • Physiotherapy • Social work • Occupational therapy • Integrated Geriatric Services Worker (IGSW) • Community Day Programs (Meals on Wheels, Friendly Visitor) • Dietician • Community Pharmacist • Geriatrician or primary care has access to geriatrician for consults</td>
</tr>
<tr>
<td><strong>Level 4</strong> Unable to complete ADLs/IADLs Family reports not overwhelmed Reports mood as not sad, depressed, or hopeless No support required in hygiene ADLs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Referral Pathway Summary – HIGH RISK
Adapted from: Assessment Urgency Algorithm (AUA): Phase 1 Report: Exploring the use of the AUA screener in the ED to identify seniors at risk of frailty (April 8, 2014)

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<tr>
<td><strong>Level 5</strong> Unable to complete ADLs / IADLs</td>
<td>• Intervention and Management of Medical/Mental Health Complexities</td>
<td>• Geriatric Emergency Medicine</td>
</tr>
<tr>
<td>Family reports not overwhelmed</td>
<td>• Wrapping care</td>
<td>• <strong>Bedded Level of Rehabilitative Care</strong></td>
</tr>
<tr>
<td>Reports mood as not sad, depressed, or hopeless</td>
<td>• Supportive discharge</td>
<td>• CCAC</td>
</tr>
<tr>
<td>Support required in hygiene ADLs</td>
<td>• Follow up with Family Doctor</td>
<td>• Geriatrician</td>
</tr>
<tr>
<td><strong>Level 6</strong> Unable to complete ADLs or IADLs</td>
<td>• More hands-on</td>
<td>• Community day programs</td>
</tr>
<tr>
<td>Family reports not overwhelmed</td>
<td>• Putting in referrals immediately</td>
<td>• Adult day program</td>
</tr>
<tr>
<td>Reports mood is sad, depressed, or hopeless</td>
<td>• Immediate medical attention</td>
<td>• Outreach programs</td>
</tr>
<tr>
<td>No support required in hygiene ADLs</td>
<td>• Assessment of frailty/geriatric syndromes</td>
<td>• SGS programs (Mental health SGS)</td>
</tr>
<tr>
<td><strong>OR</strong></td>
<td>• Linking with family</td>
<td>• Physiotherapy</td>
</tr>
<tr>
<td>Unable to complete ADLs or IADLs</td>
<td>• Long Term Care discussion</td>
<td>• Social Work</td>
</tr>
<tr>
<td>Family reports being overwhelmed</td>
<td></td>
<td>• Clinical Pharmacist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Integrated Geriatric Services Worker (IGSW)</td>
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</table>