westhealth

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

April 15, 2019

# Pioneering Change in Healthcare Delivery


**Zia Agha, MD**
**Chief Medical Officer and Executive Vice President**

# It’s time to reimagine healthcare delivery

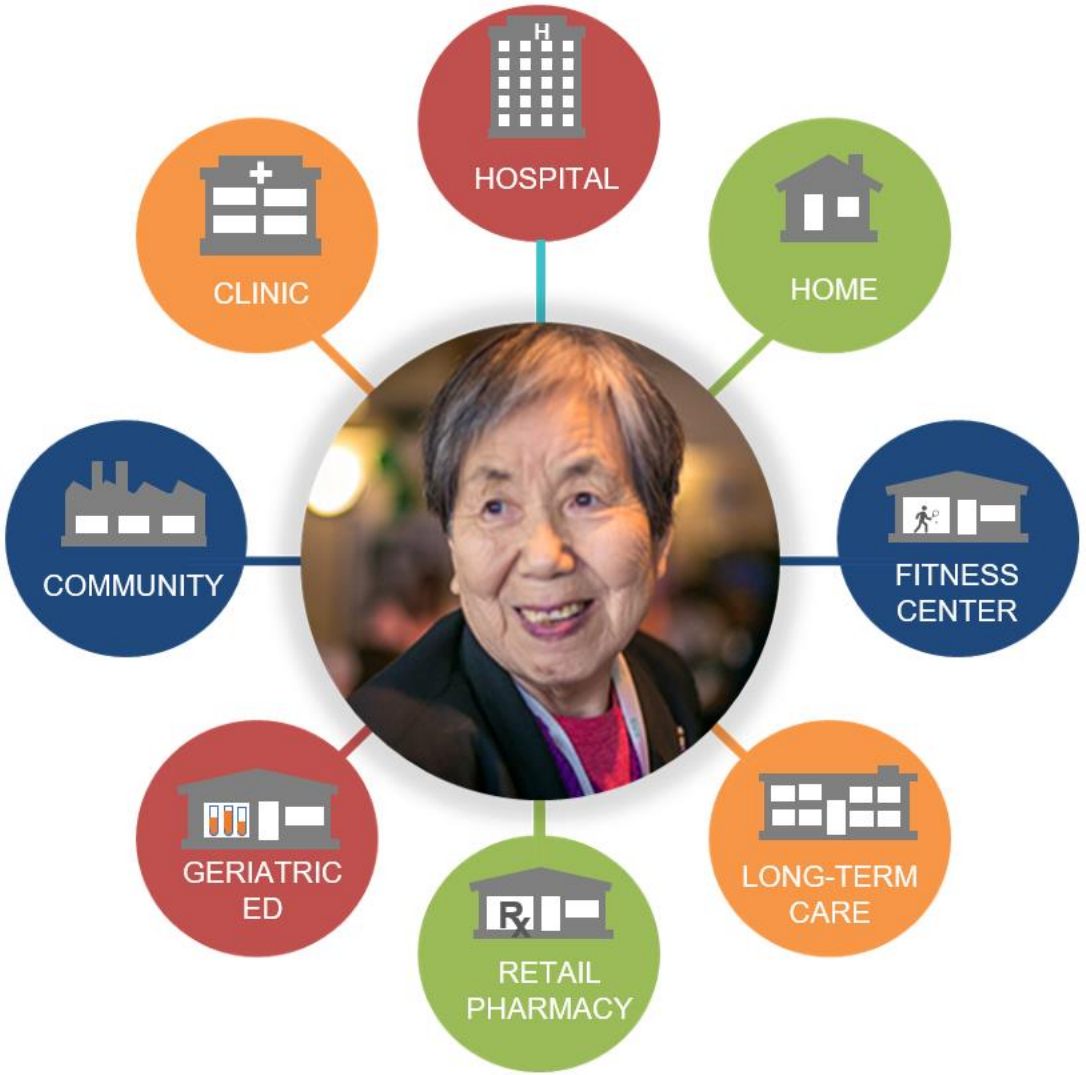
- 80% of older adults have at least one chronic disease and 77% have at least two
- Patients over the age of 75 represent the second highest group of Emergency Department users
- 40% of a patient’s health is attributed to socioeconomic factors

# 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**

GARY & MARY west foundation™ EST. 2006

**Applied medical research**

westhealth™ institute

**Policy, Research and Education**

westhealth™ 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?

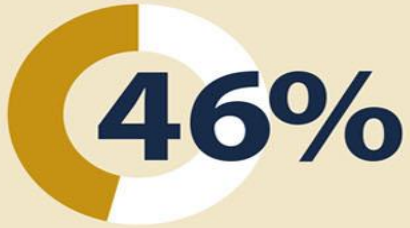
## OTHER INDICATORS

**that demonstrate the growing interest and need for GEDs and specially trained geriatric emergency medicine providers include:**


GEDs CURRENTLY EXIST IN THE U.S.

**GROWING NUMBER**

OF EDs HAVE APPLIED FOR OR INDICATED INTEREST IN ACEP'S GERIATRIC ED ACCREDITATION PROGRAM




OF ALL ED VISITS RESULTING IN HOSPITALIZATION ARE SENIORS[6]

**ONE OUT OF EVERY 10**

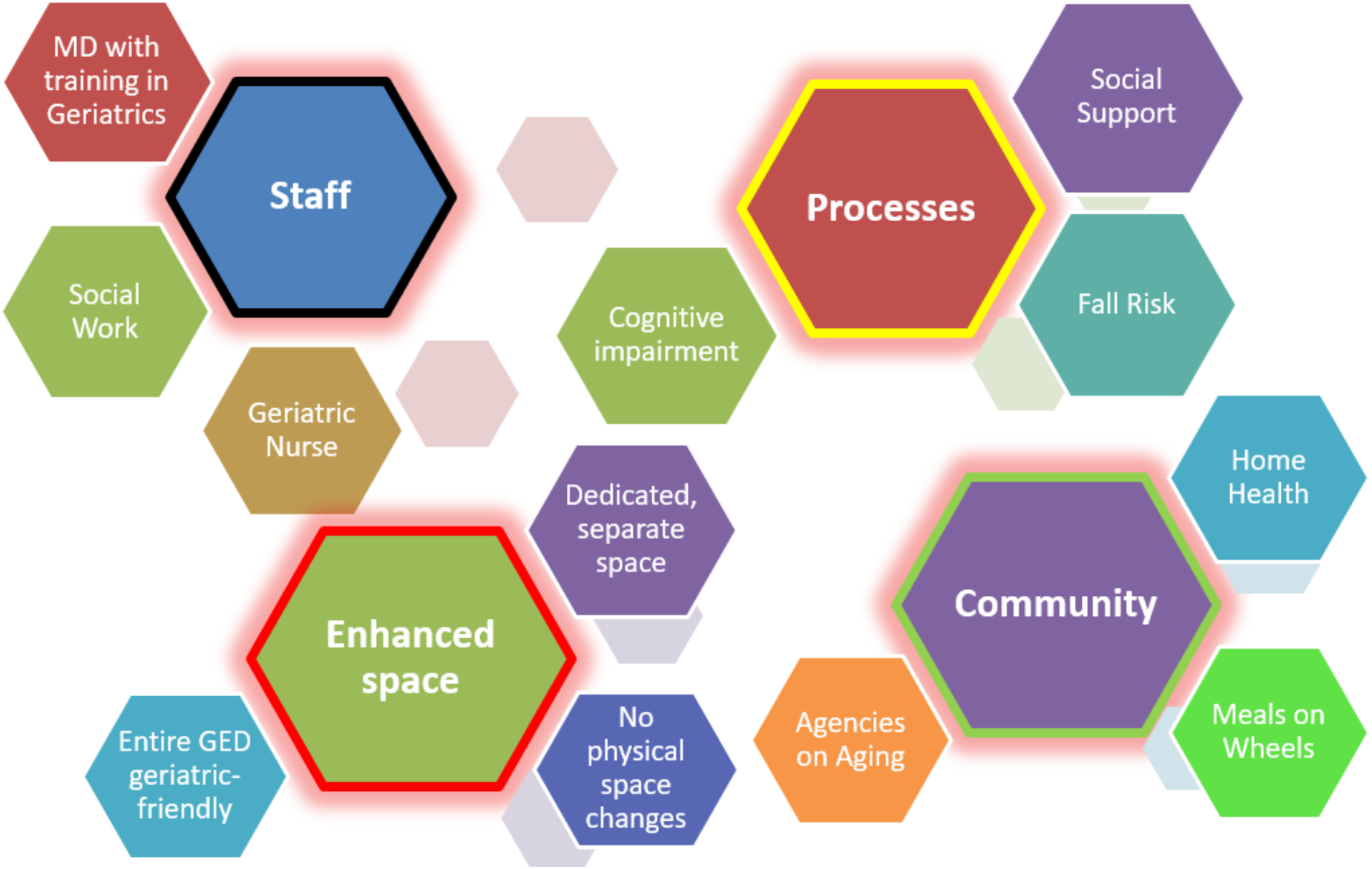
HOSPITAL ADMISSION IS POTENTIALLY AVOIDABLE


OF THOSE ADMISSIONS ARE FOR PATIENTS **65 YEARS OR OLDER**[7]

# What is a Geriatric Emergency Department?

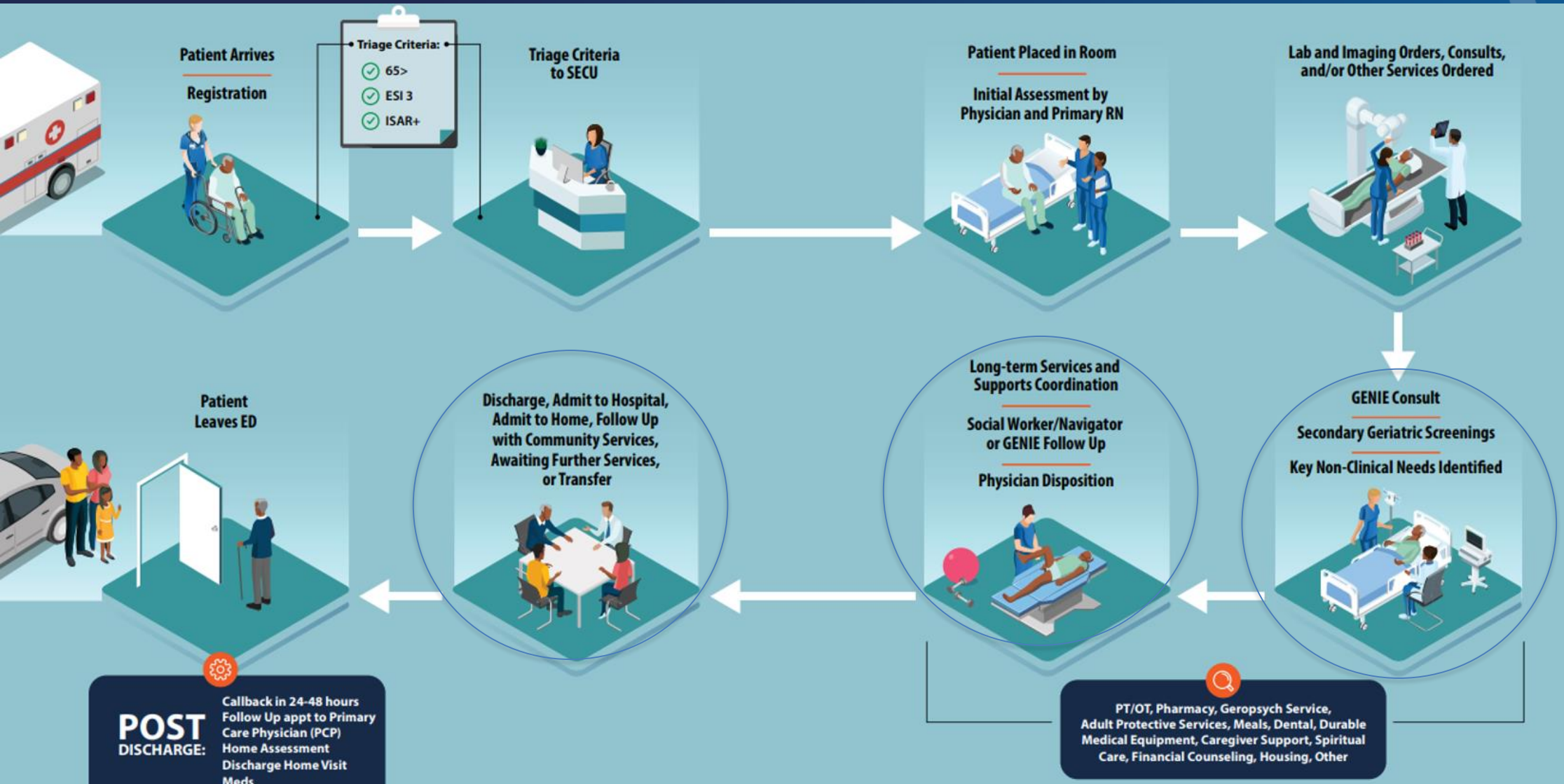
- Culture of care tailored to the specific needs of older adults in the ED with an eye toward improving healthcare outcomes and reducing unnecessary hospitalizations and readmissions.
- There is no “one-size-fits-all” approach
- Not necessarily a separate physical space

# What is a Geriatric Emergency Department?



# What Does a Geriatric Emergency Department Look Like?


# How Does a Geriatric Emergency Department Work?




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

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

| Category | Line Item |
|---|---|
| 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**

# Audience Question

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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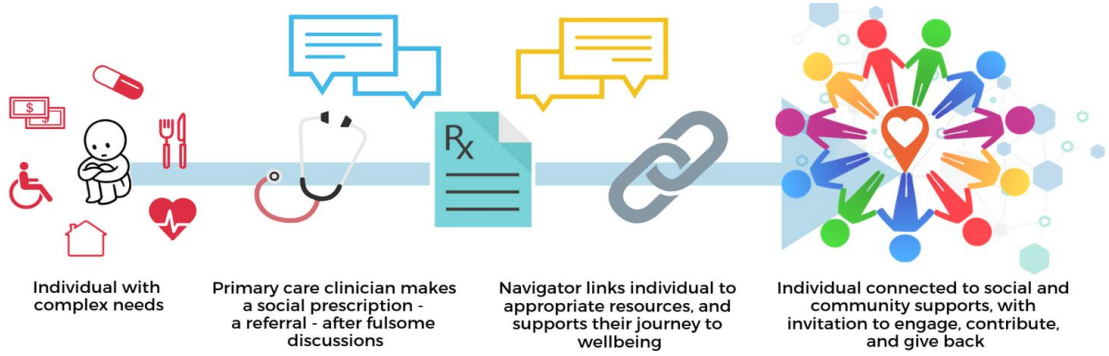
Nourishing Home, Health & Heart

# 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



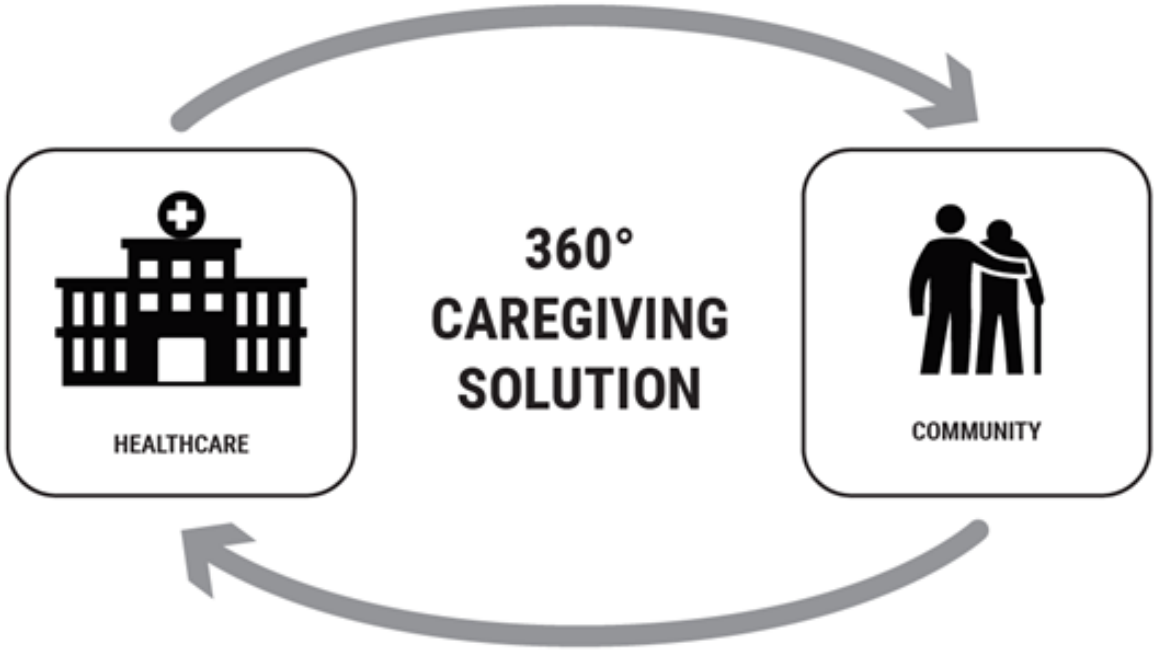




Image source: https://www.allianceon.org/Rx-Community-Social-Prescribing

# Screening for Health-Related Social Needs

UC Irvine Health

## SHC Social Needs Screener

Patient Name: _____ Epic ID: _____

| | | Circle the best answer |
|---|---|---|
| | 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. | Less than once a week [1]<br>1-2 times/week[1]<br>3-5 times/week[0]<br>More than 5 times/week[0] |
| | 2. Are you **satisfied with the amount of social interactions** you have every week? | Yes[0] No[1] |
| | 3. **Do you need help from another person or service animal** with any daily activities, such as bathing, dressing, eating or doing household chores? | Yes[1] No[0] |
| | 4. Can you **easily and safely move around** your home? | Yes[0] No[1] |
| | 5. Do you have family members or other **people willing and able to help you** when you need it? | Yes[0] No[1] |
| | 6. In the last 6 months, were you **able to afford to eat healthy** meals? | Yes[0] No[1] |
| | 7. In the last 6 months, did you ever **eat less than you felt** you should? | Yes[1] No[0] |
| | 8. Are you worried about **losing your housing**? | Yes[1] No[0] |

UC Irvine Health

| | | | |
|---|---|---|---|
| | 9. In the past 6 months, **has lack of transportation** kept you from medical appointments? | Yes[1] | No[0] |
| | 10. In the past 6 months, **has a lack of transportation** kept you from attending social events (e.g., church, senior center) or getting things needed for daily living (e.g., groceries, clothes)? | Yes[1] | No[0] |
| | 11. Do you ever **have problems making ends meet** or being able to afford everything you need? | Yes[1] | No[0] |
| | 12. In the last 6 months, has your utility company, (e.g., electric, gas, or water company) **shut off or threatened to shut off your service** for not paying your bills? | Yes[1] | No[0] |

**FOR STAFF USE ONLY**

Staff Name: _____ Date Administered: _____

Is this a new SHC patient? (circle respons

How was the screener administered? (cir

Self-Administered

Screener Total Score (add up all response

Negative screen, but requested informati

Interventions | Assessments | Associated Care Plans | Services | Appointments | Notes

Insert

| | | Intervention | Completed | Date Completed | Note | Last Updated |
|---|---|---|---|---|---|---|
| Select | Complete | Check score of "General assessment - FRESH" or administer if incomplete | False | | | 3/27/2019 |
| Select | Complete | Administer "Follow-Up - Hunger Vital Sign" assessment | False | | | 3/27/2019 |
| Select | Complete | Administer "Follow-Up - SCREEN-II" assessment | False | | | 3/27/2019 |
| Select | Complete | If at-risk for malnutrition based on"Follow-Up - SCREEN-II" assessment , refer to SHC LCSW | False | | | 3/27/2019 |
| Select | Complete | Administer "Follow-Up – Nutrition" assessment questions and additional conversation | False | | | 3/27/2019 |
| Select | Complete | Select CBO based on nutritional need/s and eligibility | False | | | 3/27/2019 |
| Select | Complete | Review Resource Directory, obtain verbal consent and issue referral to address nutritional need/s | False | | | 3/27/2019 |
| Select | Complete | Review with patient if there are any additional needs for referrals and document | False | | | 3/27/2019 |
| Select | Complete | Update patient's medical record (EPIC) with nutritional need/s identified and referral/s made, including verbal consent | False | | | 3/27/2019 |
| Select | Complete | Follow-up with CBO/service provider and/or patient to confirm nutrition need was met | False | | | 3/27/2019 |

# Screening and Response Workflow

SDOH Domains Included in Screener:


*Housing*


*Food/ Nutrition*

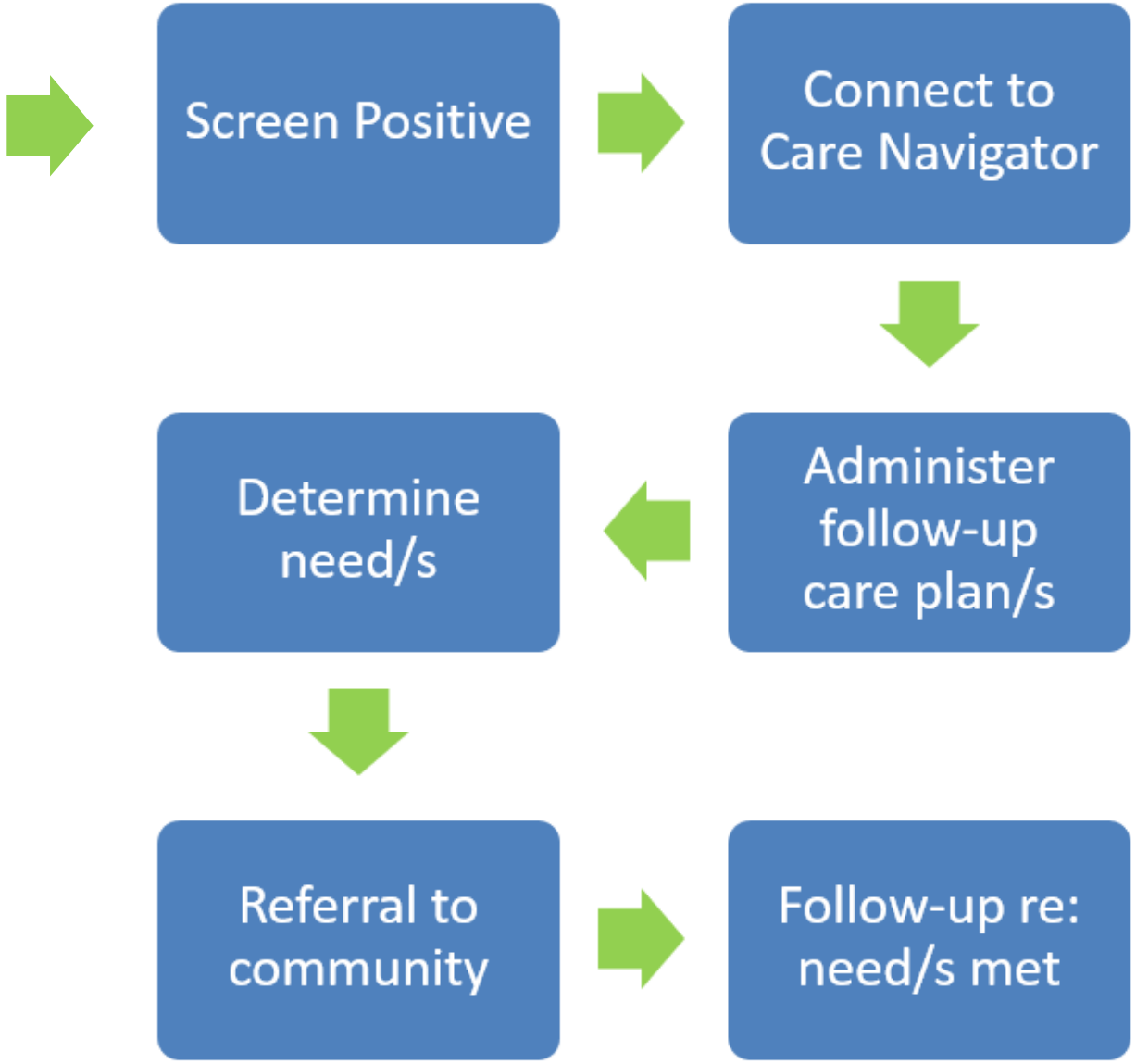

*Transport*


*Finances*


*Mobility/ Daily Living*


*Caregiving*


*Loneliness/ Social Isolation*



# 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

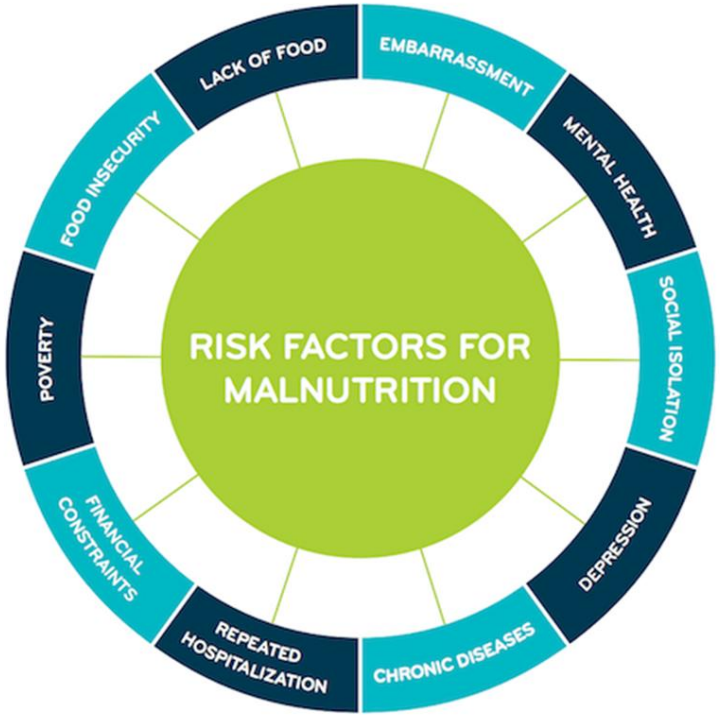
# Case Study #2: University of North Carolina Hospitals Emergency Department

**B.R.I.D.G.E.**: **B**uilding **R**esilience and **I**n**D**ependence for **G**eriatric patients in the **E**mergency 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

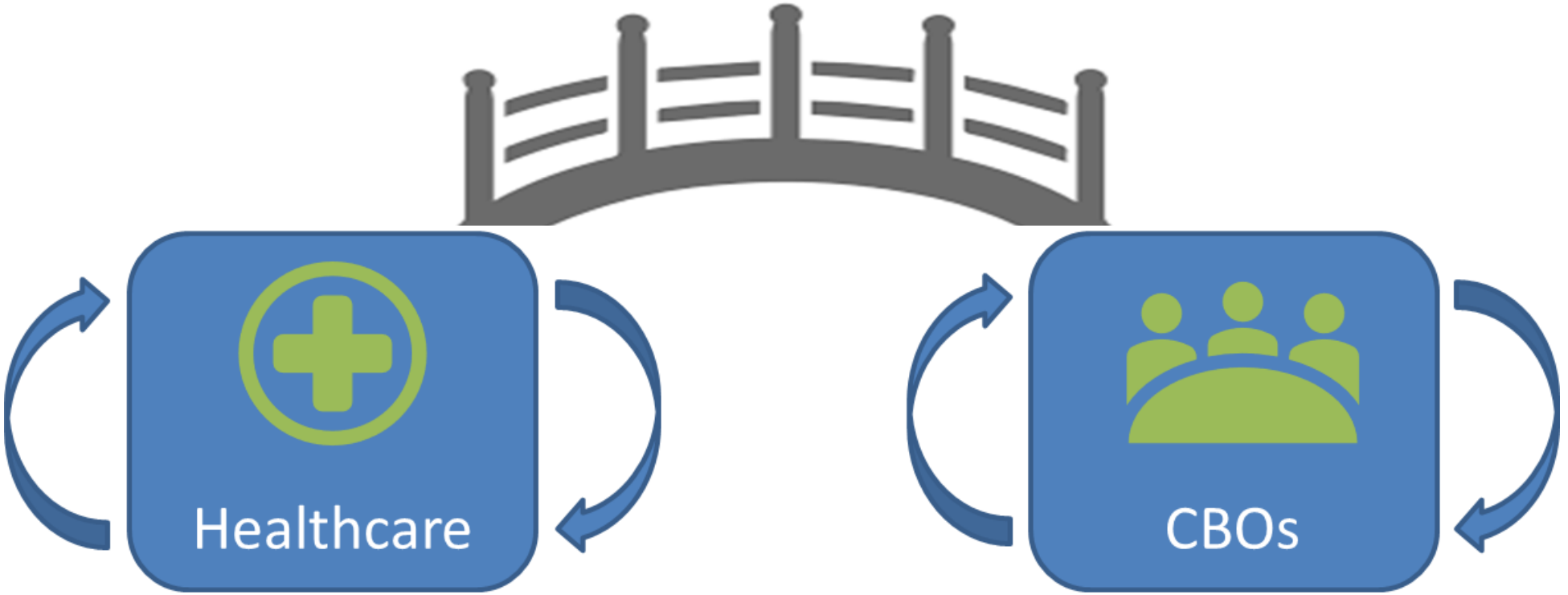
UNC GED - Identify Social Risk Factors for Malnutrition




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

Warm handoff to appropriate community-based service

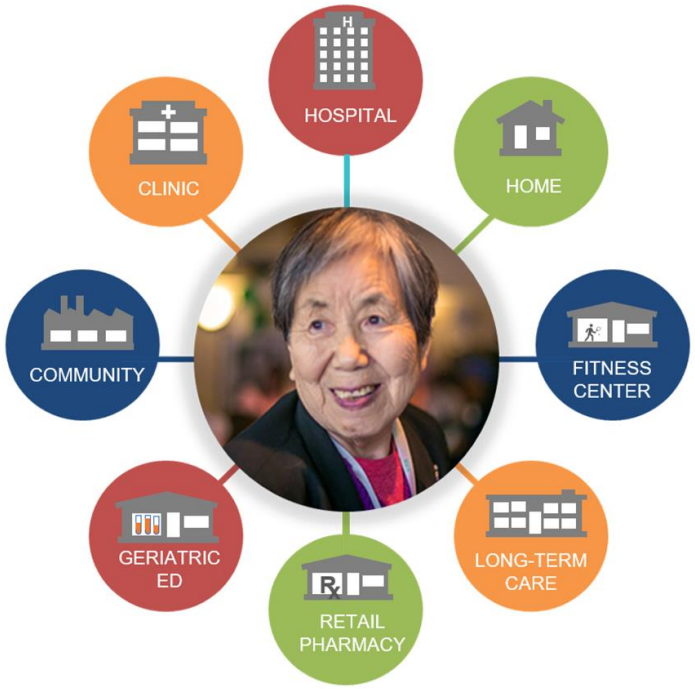
# Call to Action



# Let’s Get Real!

**We know it’s challenging …**

- ❑Referral management
- ❑Capacity
- ❑Information Exchange
- ❑Reimbursement




**… but what’s working well?**

# Thank you!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