12 July 2022

A Tale of Two Specialties: The Geriatrician and the ED Physician

Older People and Emergency Care Clinical Networks Clinical Conversation Webinar

Hosted by A/Prof Gerard O'Reilly, Emergency Care Clinical Lead, Safer Care Victoria

Acknowledgment of Country

I begin by acknowledging the Traditional Custodians who have lived and loved this country through the vastness of time.

I honour the Wurundjeri people of the Kulin nation, whose country I stand on today. I pay my respects to the old people, the Elders and Ancestors who are the safekeepers and caretakers of the oldest living culture on the planet.

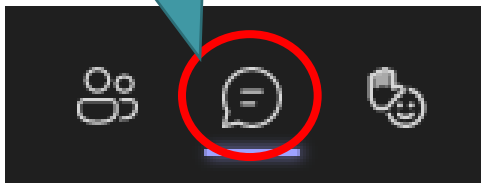
For this is the very bedrock of this place, our shared home and our special identity in the world and the source of shared pride as Australians.

For this land always was, and always will be, Aboriginal Land.

Artwork by Anmatyerr woman, Tradara Briscoe

Before we begin

Please use the **Chat** function to contribute questions and comments throughout todays session



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This session will be recorded and made available on the SCV website and sent to Network members

A Tale of Two Specialties : The Geriatrician and the ED Physician

Dr Helen Psihogios (ED Physician), Dr Jon Cheah (ED Physician), Dr Alisha Spiteri (Geriatrician in ED), Dr Anvesh Jackson (Geriatrician / Gen Med Physician), Dr Reza Pazhang (Geriatrician in ED), Dr Sumitha Bhaskaran (Director General Medicine MMC / Geriatrician)

Monash Health

ED Physician

Geriatrician

Older People in Hospital

- People over the age of 65
  - 16% of population
  - 21% if all Emergency Department presentations
  - 42% if all inpatient separations

- Reasons for admission beyond presenting complaint
  - ‘carer stress’
  - ‘acopia’
  - ‘mechanical fall’
  - ‘functional decline’
  - ‘confusion / delirium’

Monash Medical Centre Emergency Department

Tertiary Adult Emergency Department

Saw 92271 patients in 2021

Re-development in 2020-2022

Separate Monash Children's Emergency

Monash ED Presentations

32%

Patients > 65 years

18 394 patients

4571 patients are > 85 years old

13.4 hrs

Average LOS

vs 9.8 hours for all adult patients

15 hours for > 85 years

64%

Present via ambulance

(1 out of 2 will be admitted)

For the rest of walked in (1 out of 3 will be admitted)

45%

Admission rate for > 65 yrs

Compared to 20% admission rate for all

Top 5 ED presenting problems of >65year olds

- Chest pain (cardiac)
- CVA Type symptoms
- Shortness of Breath
- Fall
- Abdominal Pain

Life Before GED (Geriatrician in ED)

Pre February 2020

What was available in the ED

- Care Coordinators
  - (0800-2100, patients stayed in SSU overnight, gait assessment mainly)
- ED pharmacist
  - medication reconciliation as requested
- General Medical Registrar
  - for General Medical Admissions and covering MET calls for the hospital
  - rostered 24 hours
- Short Stay Unit Senior Medical Staff
  - 0800-2300

Core ED Business

- Older patients typically **ALL** referred for acute general medical admission if they were:
    - confused/delirious
    - needed IV treatment and/or 02 requirements
    - had complex care needs
    - recurrent falls
    - postural hypotension from polypharmacy
    - ‘carer stress’
    - BPSD symptoms
- RACFs residents represented a significant proportion
- Binary equation : **safe** vs **not safe** for home discharge

Core ED Business

- Delirium screening ad hoc; hypoactive delirium commonly missed
- Significant use of antipsychotics and Code Grey responses
- Depression not screened
- Elder abuse not front of mind
- Polypharmacy recognized as a high risk condition but FACEMs lacked skillset to deprescribe
- Medication interactions not routinely considered
- GOC documentation on EMR ad hoc
- EOL care challenging to deliver in RACFs from ED
- No / lack of knowledge on how to access community clinics eg falls and balance, ACAS, continence, complex pain, CDAMS clinics

Is There A Better Way?

The Literature and Evidence Behind the Geriatrician in ED Model

Older People In Hospital

- Higher risk of functional decline
  - Due to the presence of multiple, complex and often chronic problems
- More likely to experience an iatrogenic adverse event
  - Delirium
  - Falls
  - Hospital Acquired Infections
  - Medication Errors
- Longer Length of Stay

Older People In Hospital

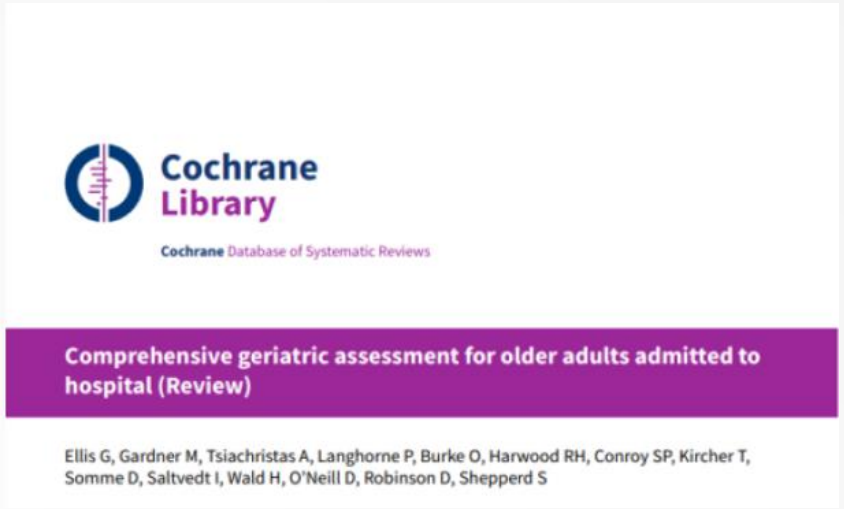
We often focus on an older person's acute health problems that led to the hospital admission

- Neglecting to prioritise issues such as
  - Nutrition and hydration
  - Maintaining mobility
  - Providing good pressure care
  - Their psychosocial and emotional needs

Comprehensive Geriatric Assessment

CGA

- Multi-dimensional and multi-disciplinary
- Assesses medical, psychiatric, functional and social needs
- The review includes assessment of cognition, medication review, activities of daily living and social supports



"CGA has been shown to improve the likelihood that patient will be alive and in their own home after an emergency admission to hospital"

Geriatrician in the Emergency Department

CLINICAL PRACTICE — *Clinical Medicine* 2013, Vol 13, No 6: 561–4

Effectiveness of a geriatrician in the emergency department in facilitating safe admission prevention of older patients

Sally Jones and Peter Wallis

ABSTRACT – The decision to admit a frail older patient is rarely made by a geriatrician and often falls to staff in the emergency department (ED), who may not have the training to balance the risks, benefits and alternatives. We based a consultant geriatrician in the ED with the primary aim of facilitating admission prevention for older patients and this was achieved for 64% (543/848) of patients. A secondary aim was to facilitate direct admission to elderly care wards wher admission was necessary, and this was achieved for 57% of admitted patients (174/305). The geriatrician was able to facilitate discharge from the ED for over half of potential 30-day readmissions seen. The overall 7-day ED re-attendance rate was 10.1%, but only 3.4% of patients were admitted with the same problem, indicating true admission prevention rather than admission delay. In conclusion, the placement of a consultant geriatrician in the ED is effective in facilitating admission prevention for older patients.

KEY WORDS: Geriatrician, emergency department, admission prevention, frail

Introduction

Frail older patients constitute a large proportion of patients attending emergency departments (ED) in the UK, with 28,651 patients over the age of 75 attending the ED at the Heart of England Foundation Trust in 2012/13. The proportion of ED attendances resulting in an acute hospital admission rises with age,[1,2] and yet the risks associated with hospital admission – such as falls, delirium, hospital-acquired infection and de-conditioning – are greatest in the frail elderly. Older patients and those with multiple comorbidities have longer lengths of stay than younger patients,[3] thus increasing their exposure to the problems

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SYSTEMATIC REVIEWS

Can consultant geriatrician led comprehensive geriatric assessment in the emergency department reduce hospital admission rates? A systematic review

Samuel Jay, Paula Whittaker, Jerome McIntosh, Nicholas Hadden

University of Manchester, Manchester M13 9PL, United Kingdom of Great Britain and Northern Ireland

BMC Geriatrics

ARTICLE — Open Access

The Geriatric Emergency Department Intervention model of care: a pragmatic trial

Marianne Wallis[1*], Elizabeth Marsden[1,2], Andrea Taylor[1,2], Alison Craswell[1], Marc Broadbent[1], Adrian Barnett[3], Kim-Huong Nguyen[4], Colleen Johnston[1], Amanda Glenwright[1] and Julia Crilly[5,1]

Abstract

Background: To evaluate a Geriatric Emergency Department Intervention (GEDI) model of service delivery for adults aged 70 years and older.

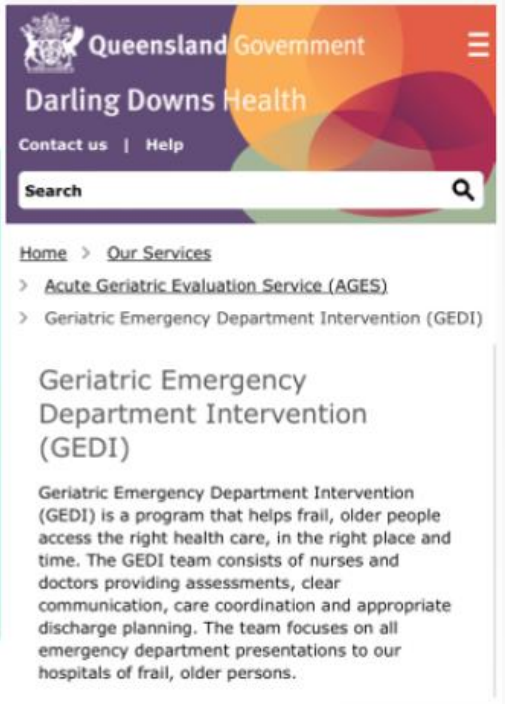
Methods: A pragmatic trial of the GEDI model using a pre-post design. GEDI is a nurse-led, physician-championed, Emergency Department (ED) intervention; developed to improve the care of frail older adults in the ED. The nurses had gerontology experience and education and provided targeted geriatric assessment and streamlining of care. The final format included 2.4 full time equivalent nurses working 7 days from 0700 h to 1730 h (1530 h at weekends). There were three implementations periods: pre-implementation (2012); a developmental phase from January 2013 to August 2015; and full implementation from September 2015 to August 2016. The outcomes measured were disposition (discharged home, admitted or died); ED length of stay; hospital length of stay; all cause in-hospital mortality within 28 days; time to ED re-presentation up to 28 days post-discharge; in-hospital costs. The setting was a tertiary hospital ED, with 385 beds, in Queensland, Australia. Approximately 53,000 patients presented to the ED annually with 20% aged 70 years and older. All patients over the age 70 who presented to the ED between January 2012 and August 2016 (n = 44,983) were included in the trial.

Results: Older persons who presented to the ED when the GEDI team were working had increased likelihoods of discharge (Hazard ratio (HR) = 1.19; 95% CI: 1.13–1.24) and reduced ED length of stay (HR = 1.42; 95% CI: 1.33–1.52) compared with those who presented when GEDI were not working. There was no increase in the risk of mortality (HR = 1.01; 95% CI = 0.23–4.43) or risk of same cause re-presentation to 28 days (HR = 1.21; 95% CI: 0.99–1.49). The GEDI service resulted in average cost savings per ED presentation of $35 [95% CI, $21, $49] and savings of $1469 [95% CI, $1105, $1836] per hospital admission.

Conclusions: Implementation of a nurse-led physician-championed model of ED care, focused on frail older adults, reduced ED length of stay, hospital admission and if admitted, hospital length of stay and cost, without increasing mortality or same cause re-presentation. These increases were sustained over time and after the initial implementation team had changed roles.

Trial registration: Australian Clinical Trials Registration Number ACTRN12615001157561 - retrospectively registered on 29/10/2015. Data were retrieved via retrospective access to clinical information systems. First data access was on 1/7/2015.

Keywords: Geriatric, Emergency medical services, Nurses' practice patterns, Hospital, Homes for the aged, Delivery of health care, Protocol, Outcomes, Evaluation, Pragmatic paradigm



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> Acute Geriatric Evaluation Service (AGES)

> Geriatric Emergency Department Intervention (GEDI)

Geriatric Emergency Department Intervention (GEDI)

Geriatric Emergency Department Intervention (GEDI) is a program that helps frail, older people access the right health care, in the right place and time. The GEDI team consists of nurses and doctors providing assessments, clear communication, care coordination and appropriate discharge planning. The team focuses on all emergency department presentations to our hospitals of frail, older persons.

- Summary
  - 64% admission prevention
  - 57% admissions direct to elderly care units
  - 50% of 30-day readmissions successfully discharged
  - Representations of diverted patients
    - 10% within 7 days
    - Only 3% admitted, none with same presenting complaint

Along Came the GED (Geriatrician in ED)

February 2020

Monash Health – Geriatrician in ED (GED)

Referrals from ED Clinicians, General Medicine, Care Coordinators

Our Approach:

Targeted Geriatric Assessment

Utilise existing supports –

Care Coordinator and ED pharmacists for MDT assessments

Facilitate delivery of care in the most appropriate setting

Monash Health – Geriatrician in ED

Disposition

- Inpatient
  - Acute Medical admission
  - Direct Subacute admission
- Ambulatory admission
  - Hospital In The Home (HITH)
  - GEM@home
- Outpatient
  - Residential In Reach (RIR)
  - Rehabilitation In The Home (RITH)
  - High Acuity Discharge Clinic
  - Complex Care
  - Fast Track Community Allied Health
  - Specialty clinics – FAB, CDAMS, Continence
  - My Aged Care

“In God we trust, all others bring data”

W. Edwards Deming, *statistician, professor, author, lecturer and consultant*

Monash Medical Centre GED trial Audit

- Single centre intervention improvement project involving multiple medical departments
  - Phase 1- *Pilot:* 1 month (part-time service, Monday-Friday)
  - Phase 2- *Implementation:* 6 months (full-time service, Monday-Friday)
- ED Physicians referred older adults to GED to assist decision-making related to ED discharge disposition, or to provide ‘Geriatric optimisation.’
- Descriptive statistics to analyse data

Demographics

	Phase 1	Phase 2
Total number	52	221
Female gender, n (%)	31 (59.6%)	131 (59.3%)
Average age (range)	81.4 (62-93)	84.3 (66-102)
Residence		
Home total, n (%)	36 (69.2%)	134 (60.6%)
Home with spouse or family, n (%)	19 (36.5%)	82 (37.1%)
Home alone, n (%)	17 (32.7%)	52 (23.5%)
RACF, n (%)	15 (28.8%)	86 (38.9%)
Other	1 (1.9%)	1 (0.5%)

Primary ED Diagnosis

	Phase 1	Phase 2
Geriatric-related, n (%)	18 (34.6%)	101 (45.7%)
Fall, n	9	62
Musculoskeletal or functional decline, n	6	14
Altered mental status, n	3	25
Cardiac, n (%)	6 (11.5%)	38 (17.2%)
Infection, n (%)	6 (11.5%)	34 (15.4%)

ED Referrals

	Phase 1	Phase 2
For 'Geriatric optimisation,' n (%)	34 (65.4%)	92 (41.6%)
For hospital admission, n (%)	18 (34.6%)	129 (58.4%)
Patients referred for hospital admission		
Residing at home, n (%)	13 (72.2%)	85 (65.9%)
Residing at RACF, n (%)	5 (27.8%)	43 (33.3%)
Residing in supported accommodation, n (%)	0	1 (0.8%)

Hospital Admission Deferment

	Phase 1	Phase 2
Referred for hospital admission, n (%)	18 (34.6%)	129 (58.4%)
Total deferred	10 (55.6%)[1]	70 (54.3%)[2]
Deferred, originally residing at home	8 (61.5%)	44 (51.8%)
Deferred, originally residing at RACF	2 (40%)	25 (58.1%)

[1] One patient each from community dwelling and RACF were cleared for ED discharge, however, were admitted due to practical issues (to subacute n=1, back to RACF n=1). One patient each from community dwelling and RACF were re-referred and admitted under another Unit. These patients were not included in hospital admission deferment numbers.

[2] Four patients from community dwelling were cleared for ED discharge to other sites, however, were admitted due to unavailability of beds (to subacute n=3, to an external hospital n=1). Three patients from community dwelling and four patients from RACF were re-referred and admitted under another Unit. These patients were not included in hospital admission deferment numbers.

Hospital Re-representation

	Phase 1	Phase 2
ED re-presentation	4 (16%)	22 (15.9%)
Same primary diagnosis on ED re-presentation	1	16

Other Findings – Data from Phase 2 Study

Clinical Frailty Scale

- Correlation of increasing frailty with age
- 65-75 age group: 4.3 (vulnerable)
- >95 age group: 5.8 (mild-mod frail)

Abbreviated Mental Test Score

- Correlation of decreasing AMTS score with age
- 65-75 age group: 9.5
- > 95 age group: 8

Polypharmacy

- Seem in all age group strata
- 65-75 age group: 8.2
- >95 age group: 8.7

Data are just summaries of thousands of stories – Let’s tell a few of those stories

A Day in the Life of a Geriatrician in ED (Case 2)

- 88 year old man from an RACF with a history of dementia with BPSD presenting to ED for the second time in one week with PR bleeding

- On the 1st presentation to ED:
  - Reviewed by surgeons recommended medical management
  - DC back to RACF for GP follow up
  - In ED given oral risperidone for agitation and restlessness

- On 2nd presentation:
  - Large volume malena, NH unsure how to manage him
  - Given blood transfusion
  - More agitation and given multiple olanzapine injections

- ED physicians asked Gen Med and GED:

"Does he need an admission under gen med given that it is his 2nd presentation in a week and RACF is not coping?"

Shared Decision Making Approach

- Contacted son (NOK)
  - Provided a medical update
  - Agreed on medical management and not for invasive management given comorbidities
  - Discussed options around managing patient's distress and risk of behavioural issues requiring use of antipsychotics and informed consent obtained for ongoing use
  - Came to agreement that the focus of care should on comfort and symptom management as patient approached EOL
  - Agreed that this would be best provided at the RACF
  - Son in agreement that further hospital / ED transfers should be avoided as long as adequate care could be provided at the RACF

Coordination of Care to Facilitate Safe Discharge

1. Discussed with palliative care physician to optimise palliative medications for the RACF
2. Discussed with palliative care CNC who liaised with nursing staff at RACF to ensure that EOLC can be provided safely.
3. Referral made to community palliative care to support RACF
4. Contacted patient's GP to provide medical update, ensure that he was comfortable with the plan – GP supportive of palliative approach
5. Contacted RIR – who would monitor progress and symptoms
6. Contacted NIC at RACF and update provided on plan and referrals

Outcome

- Patient safely discharged from ED
- No further representations

Life After GED role Embedded into ED

ED Focus Group and Staff Feedback Results

- Myths that were busted by GED:
  - **About CGAs**
    - *“ That a comprehensive geriatric assessment has to take half a day and that it did not have to be that way”*
  - **Challenged care coordinators in ED to think out of the box**
    - *“… with the Geriatrician in ED he would go with me sometimes to see patients together and then ask “what do you think? Do you think we could get them home?” and it was more like the team meetings on the ward, it was faster and nicer and we got where each other were coming from…”*
  - **Challenged the hierarchy**
    - *“ … when I spoke to the geriatrician he treated me like it was a horizontal hierarchy… Having someone showing up on time, being diligent, having the patient perspective at heart these are things we cannot teach, these are things we cannot train.”*

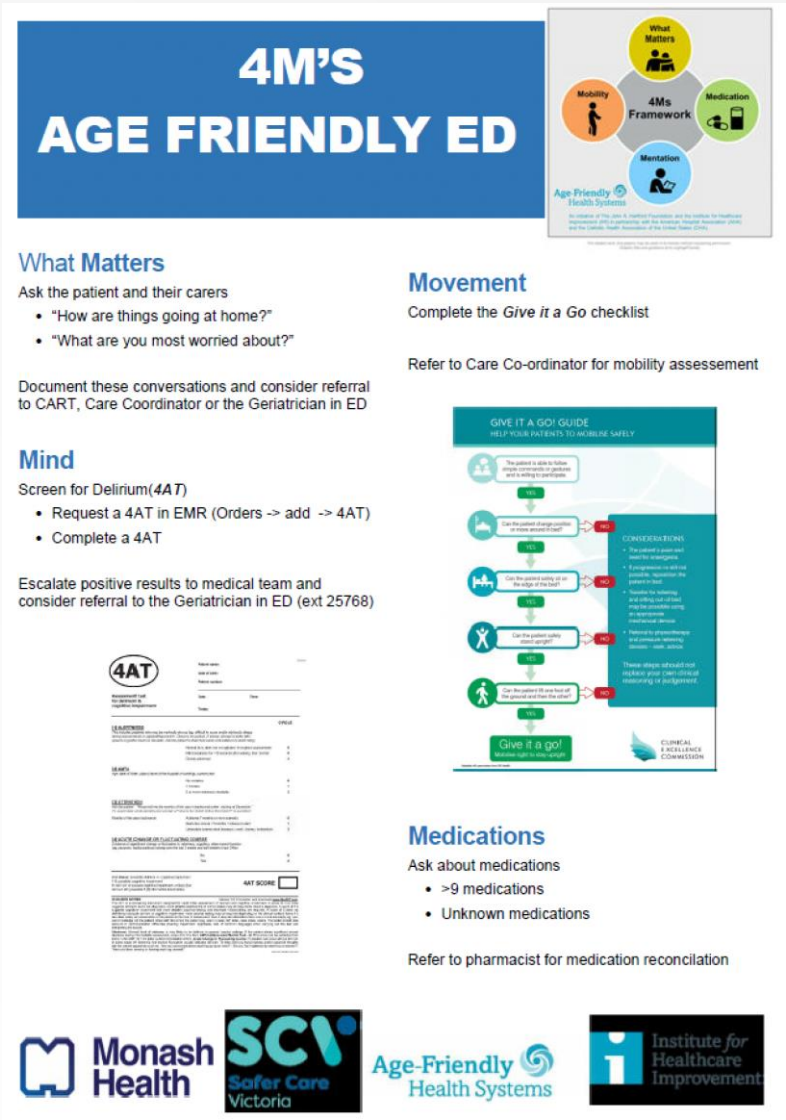
ED Focus Group and Staff Feedback Results

Why was the Geriatrician in ED successful?

"… collaborative approach – he liaised with external services and everything was quite well rounded and he improved patient flow by collaborating with community services and hospital services as well."

The Future

- Education
  - Formal ED JMS and SMS education sessions
  - Informal teaching and learning
- Safer Care Victoria: Age Friendly Systems 4M
- A Geriatric Hub



What did we learn?

- There is a need / gap for the Geriatrician in ED service or similar
- Silos need to be broken down
  - ED – Aged Care Services – General Medicine – Community Services – Primary Care -- RACFs
- Accountabilities and Governance structures are important

Setting up GED service – what do you need?

- Co-designed model from the start between Geriatrics, General Medicine and Emergency
- Dedicated Emergency consultant project lead and champions
- Governance sitting with the Emergency Department– employed by and reporting to
- Community Engagement – RIR, HITH, CART GEM @home
- Cross service expertise – GED and community service
- ED pharmacist and allied health engagement
- Right candidate – Geriatrician with interest in acute medicine - Champion of Geriatric Care


Adult Short Stay
aspire

PANEL:

Questions & Comments

Let’s take a poll

Clinical Conversations Webinars

Contact the Older PeopleTeam, Centres of Clinical Excellence at:

olderpeople.clinicalnetwork@safercare.vic.gov.au

Emergency Care Clinical Network at:

Emergencycare.clinicalnetwork@safercare.vig.gov.au

COVID + Pathways Learning Network Webinars

SCV is also hosting a COVID + Pathways Webinar series for consumers, healthcare workers and leaders to share experiences and learnings.

If you are interested in receiving these webinar invites, please email:

centresofclinicalexcellence@safercare.vic.gov.au