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Centre gériatrique spécialisé du Nord-Est

North Simcoe Muskoka Specialized Geriatric Services

Developing & Implementing a Geriatric Emergency Management (GEM) Program

August 1 2023

Provincial Geriatrics Leadership Ontario

Waypoint
CENTRE for MENTAL HEALTH CARE
CENTRE de SOINS de SANTÉ MENTALE

"Senior-friendly change is a slow, incremental, accretive process…

***There is no one single best solution**! Just start making changes that prioritize the needs of older people and your staff's needs to provide care to older people."*

(Melady, D., Schumacher, J. Creating a Geriatric Emergency Department. Cambridge UK. Cambridge University Press. 2022)

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What is Geriatric Emergency Management (GEM)

The Traditional ED Model & Older Adults

Current State:
Traditional ED model

Single chief complaint, acute, specific diagnosis and treatment plan, rapid discharge decision

Challenge:
Older Adults presenting with Complexity

- Increased frailty, sudden change in function, atypical presentation & multiple chronic, sub acute & acute health conditions
- Presence of geriatric syndromes (i.e. Falls, Confusion, Delirium, Polypharmacy)
- Complex social, cognitive and physical challenges; caregiver support needs
- Complex transitions of care

Opportunity:
ED-Friendly Environment

- Integration of best practices for older adults into existing ED programs, processes, space
- Where possible, separate space designated for older adults

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Geriatric Emergency Management (GEM) Defined

- An ED that has made the decision to intentionally implement changes in its people, processes and place in order to improve the quality of care it provides to older adults.
  (Melady, D., Schumacher, J. Creating a Geriatric Emergency Department. Cambridge UK. Cambridge University Press. 2022)

GEM programs have emerged as hospitals recognize older adults and their care partners have presentations, needs, dispositions, and outcomes unique from that of other populations.

GEM: Objective

Older adults are appropriately supported by a highly skilled, integrated and available workforce to optimize their functional ability and quality of life as they age. This is achieved by:

Driving Clinical Excellence

- Knowledgeable GEM and ED staff who integrate geriatric principles and practice into care;
- Advocate for age-related needs

Building Capacity Across the System

- Timely & efficient access to appropriate care & interventions within the health care system
- Actively contribute to & support system integration to advance care of older adults living with frailty

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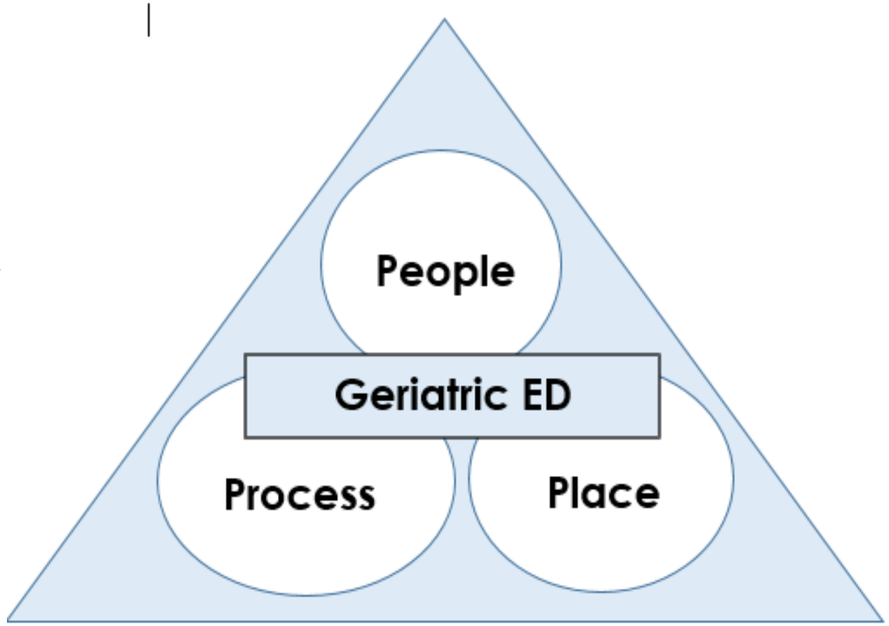
GEM: Core Elements

People:
- Champions: includes physician, clinician & hospital executive
- Often the first step is the implementation of a GEM clinician role.
  - Brings specialized knowledge, assessment skills and leadership to support case consultation, capacity building and policy/procedure/process

Processes:
- Development and implementation of:
  - Education and training geriatric competencies (ED Staff)
  - Protocols and guidelines that inform process of care for complex adults in the ED

Place:
- Modifications to physical environment & resources can influence the process of care:
  - Sensory (i.e. pocket talkers, large faced clocks, lighting)
  - Mobility support (non slip socks/flooring, gait aides)
  - Patient comfort (warm blanket, chair/recliner, access to food/drink)



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Why GEM?

- As the numbers of older medically and socially complex people increase in our communities, EDs must develop a new approach to their care

- Older adults may account for 20% to 40% of total ED visits

- Patients over 75yrs have the highest ED visit rate; this population is also subjected to prolonged ED lengths of stay, and have increased resource utilization and more frequent hospital admissions.

- GEM programs facilitate improved patient experience, utilization of health care resources and quality of care.

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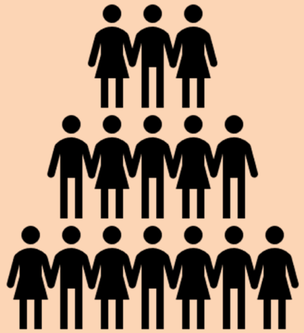


Anticipate Aging Population:

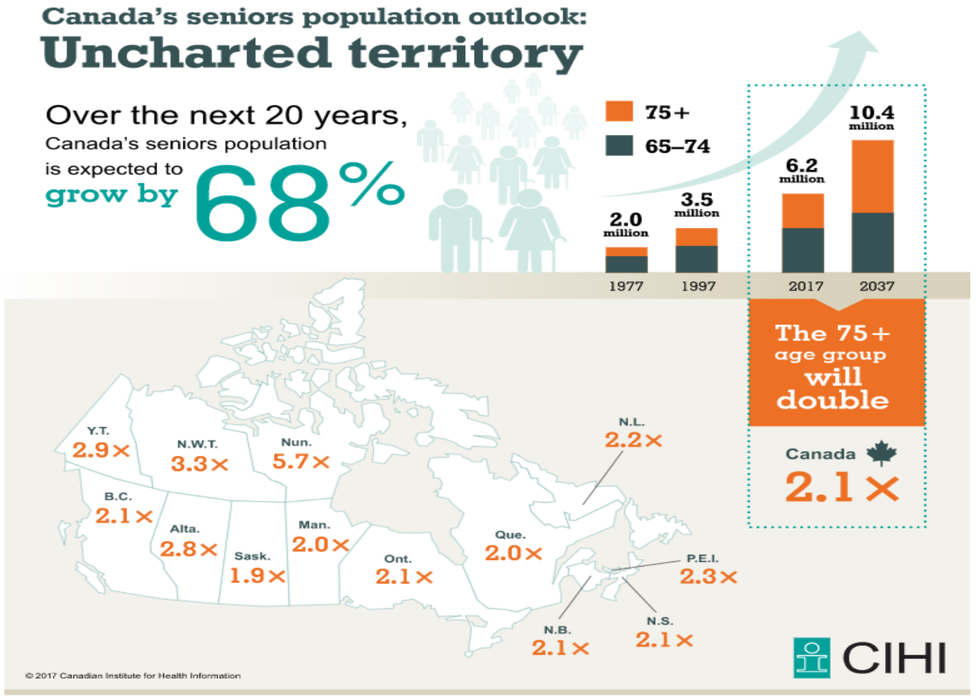
- People are living longer often with multiple chronic diseases / complexity
- Significant population increase in age 65+ over next 20 yrs.

Opportunity to Improve Quality of Care:

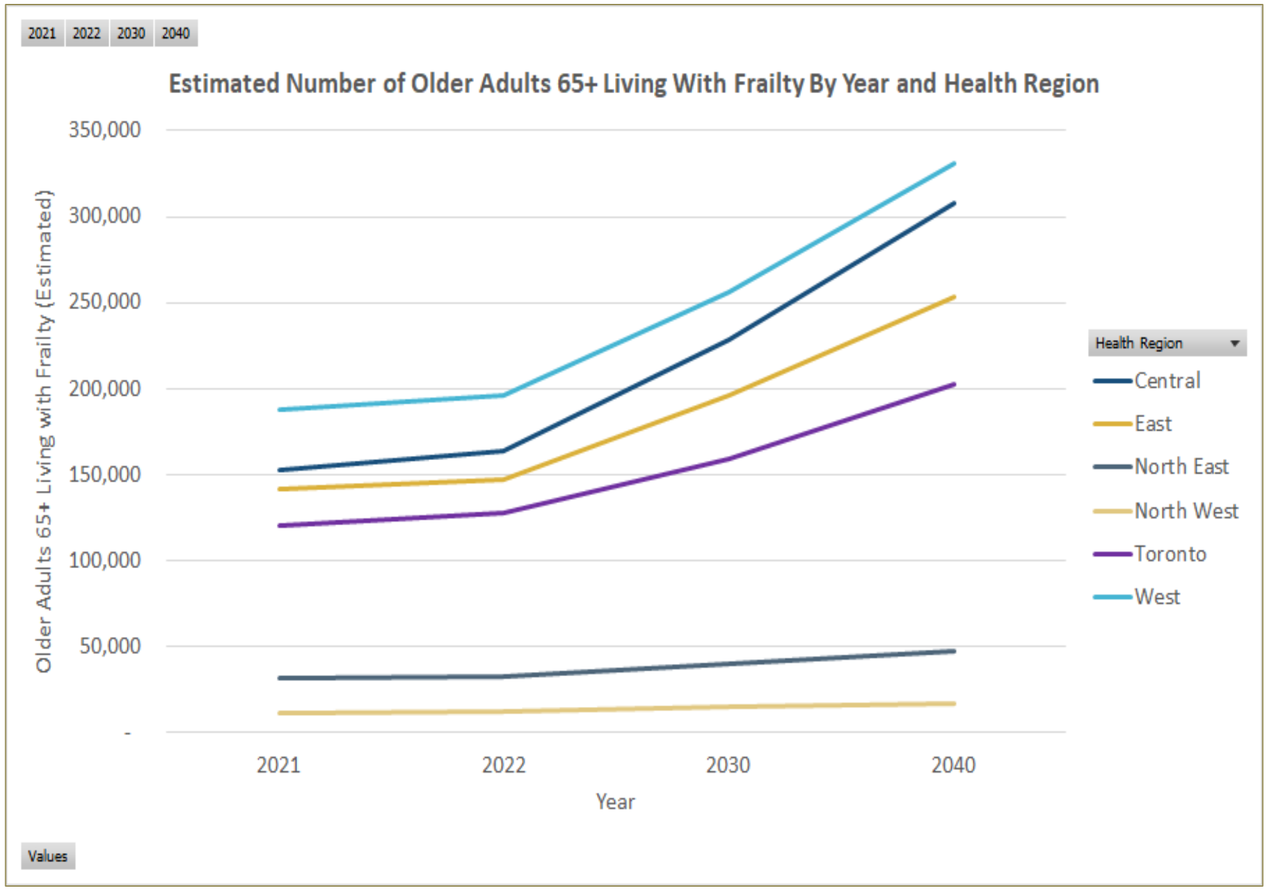
- Older adults often present with multiple medical co-morbidities, polypharmacy, and complex physiologic changes requiring specialized knowledge and skills and additional time to support

Efficient use of Health Care Resources:

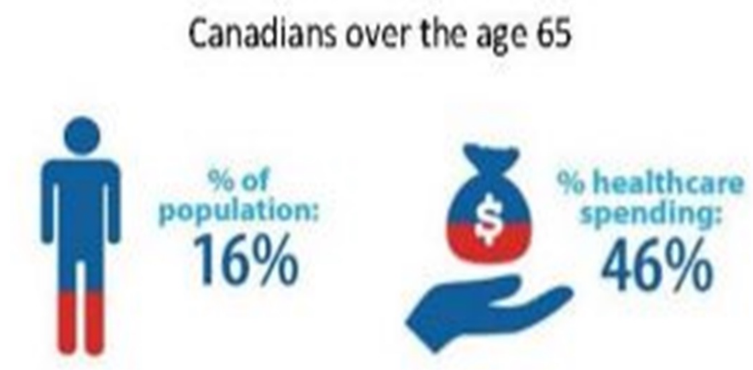
- GEM programs not only impact a patient's condition, but can influence utilization of health care services across the system (i.e. early identification of risk, LOS, ↓ ALC days, in pt vs outpt services)



https://www.cihi.ca/en/infographic-canadas-seniors-population-outlook-uncharted-territory



https://geriatricsontario.ca/resources/frailty-estimates-by-census-division-and-ontario-health-region//



Canadian Frailty Network: Frailty Matters
https://www.cfn-nce.ca/frailty-matters/

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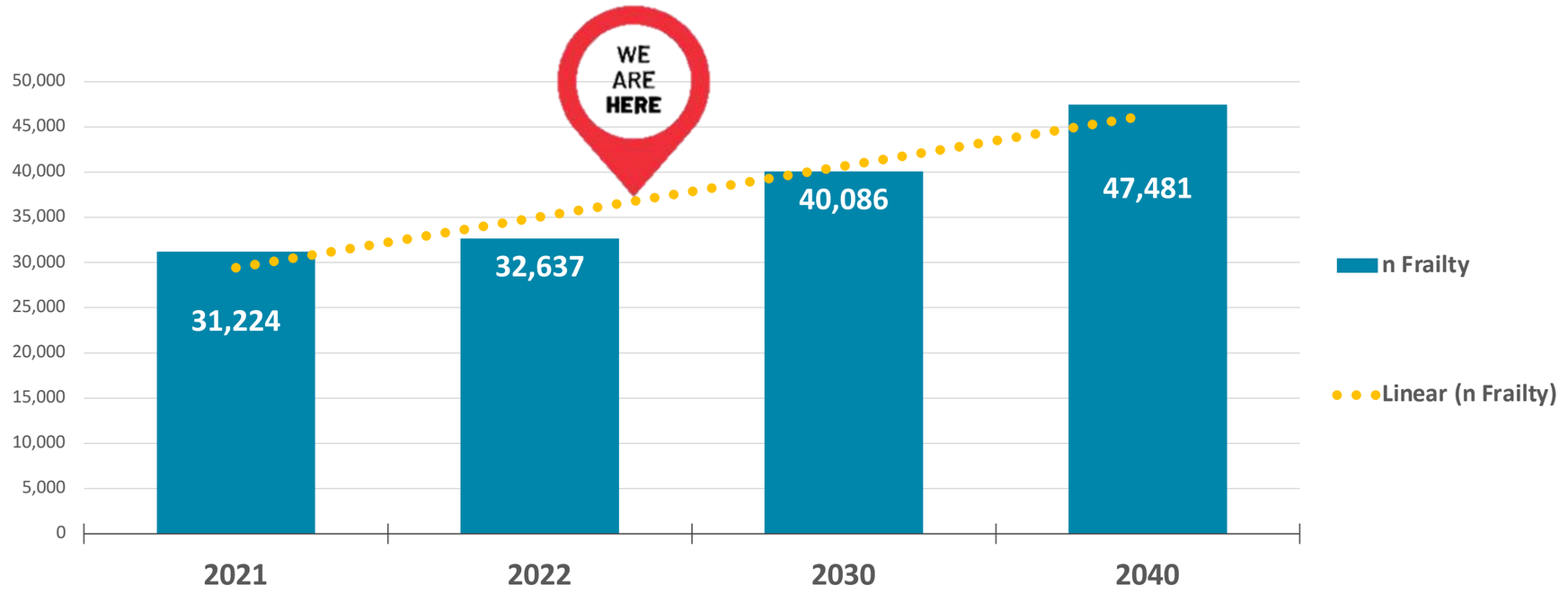
NE Frailty Projections

While most older adults live healthy and active lives, a small portion become frail and are at risk of avoidable hospitalization and avoidable or premature institutionalization.[1]

North East Population Projections for Older Adults with Frailty[2]



[1] FAQ CGA and Specialized Geriatric Services. (2016) Regional Geriatric Programs of Ontario.
[2] https://geriatricsontario.ca/resources/frailty-estimates-by-census-division-and-ontario-health-region//

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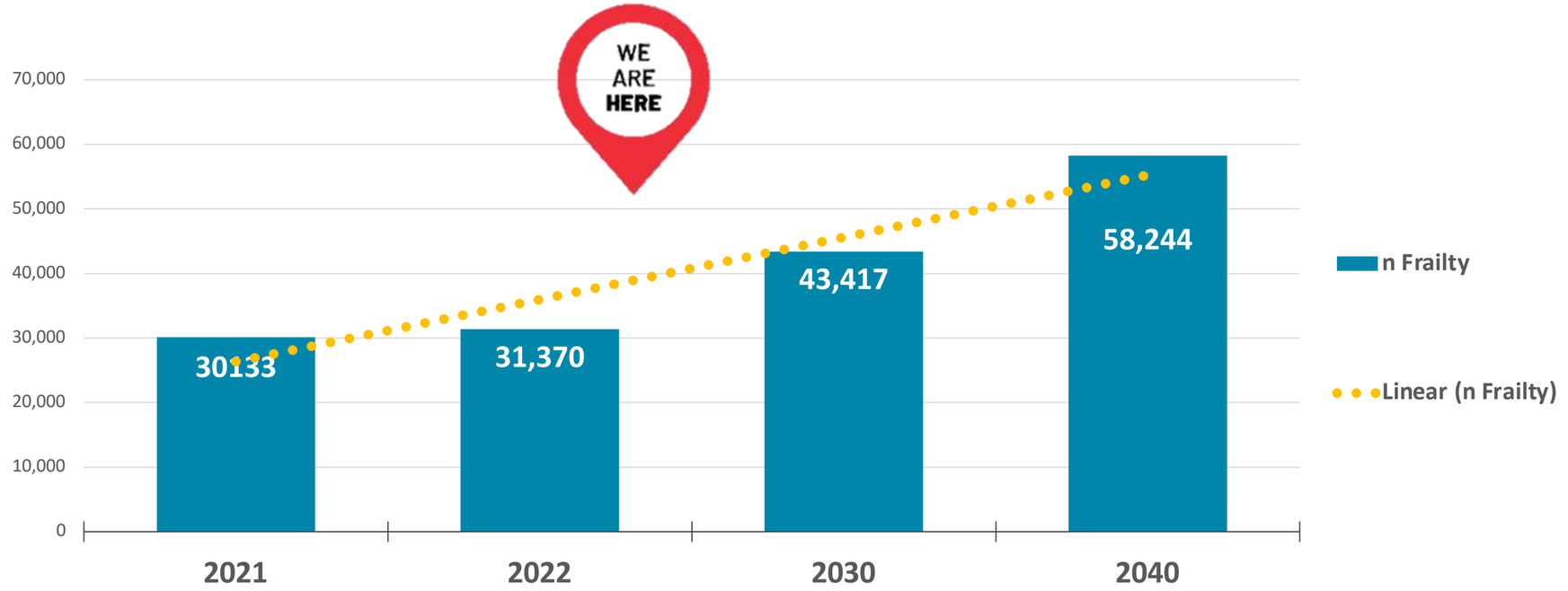
Simcoe-Muskoka Frailty Projections

While most older adults live healthy and active lives, a small portion become frail and are at risk of avoidable hospitalization and avoidable or premature institutionalization.[1]

Simcoe-Muskoka Population Projections for Older Adults with Frailty[2]



[1] FAQ CGA and Specialized Geriatric Services. (2016) Regional Geriatric Programs of Ontario.
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GEM Standards, Recommendations and Guidelines

Provincial Geriatric Leadership of Ontario (PGLO)

PGLO leads the provincial coordination of specialized physical, cognitive, social and mental health services for older adults and advances integrated, person-centered care for older adults living with complex health conditions, (including frailty and dementia), and their care partners, in Ontario.

GEM Initiative:

- Recent government investment related to the goal of reducing Alternate Level of Care designated patient volumes in hospital, means some organizations are implementing a GEM program/clinician for the very first time. PGLO supports the development of a toolkit and resources to facilitate getting started with these initiatives

PGLO Provincial Common Orientation:

- The Provincial Common Orientation is intended to support a holistic approach to geriatric care through learning activities that integrate the complex physical, cognitive, social and mental health concerns frequently experienced among older adults.
- For regulated health professionals working in specialized and focused geriatric services such as GEM, additional continuing education is available through Ontario's Regional Specialized Geriatric Services Programs who provide advanced education that integrates new evidence and advanced clinical concepts

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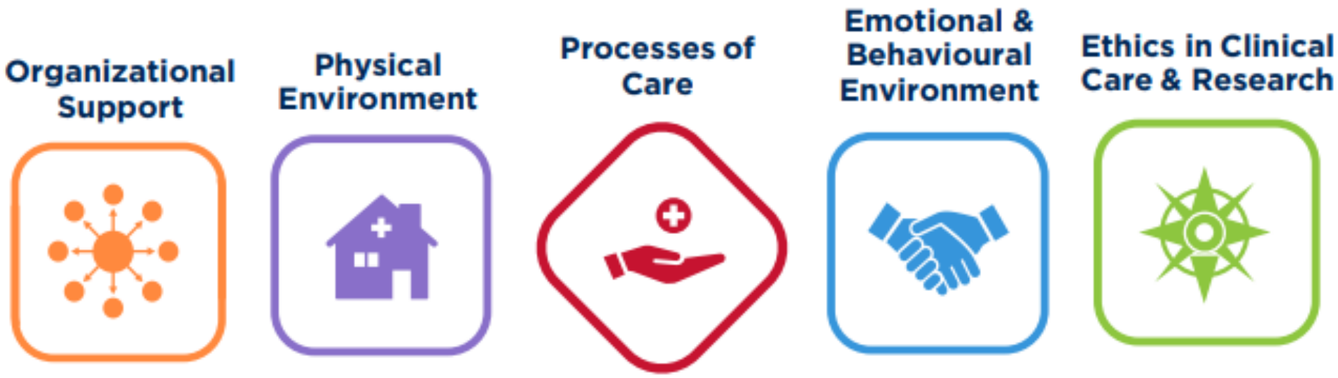
Senior Friendly Care (*sfCare*) Framework

The sfCare Framework was developed by RGP Toronto in collaboration with a broad stakeholder group & provides a foundation for achieving the best possible outcomes for older adults.

sfCare Domains:



sfCare Guiding Principles:

- Support resilience, independence and quality of life
- Compassion and respect
- Informed and empowered older persons and families
- Person and relationship centered partnerships
- Safety and security
- Timely and affordable
- Evidence informed

https://geriatricsontario.ca/initiatives/sfcare/

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Canadian Association of Emergency Physicians (CAEP)

CAEP Position Statement – Care of Older Adults in Canadian Emergency Departments

- Seniors over the age of 75 years now have the highest ED visit rate of any segment of the population and this rate is rising

- CAEP has put forward recommendations that would lead to more efficient department function and better outcomes for this population.

- **Key messages**, include that EDs:
  - Have an explicit policy recognizing older people as core users of ED services and stating that excellent care of older patients is a department priority.
  - Establish a locally appropriate process for interdisciplinary assessment of complex older patients, particularly those likely to be discharged.
  - Involve family members and caregivers in the care of older people during their ED stay.
  - Prioritize training and education of ED staff to develop competence in the emergency care of older people.
  - Develop standardized approaches to common geriatric presentations.
  - Have equipment and modify the physical space to support the needs of older people.
  - Ensure high-quality transitions of care.
  - Identify and collect data about key quality indicators about the care of older ED patients.

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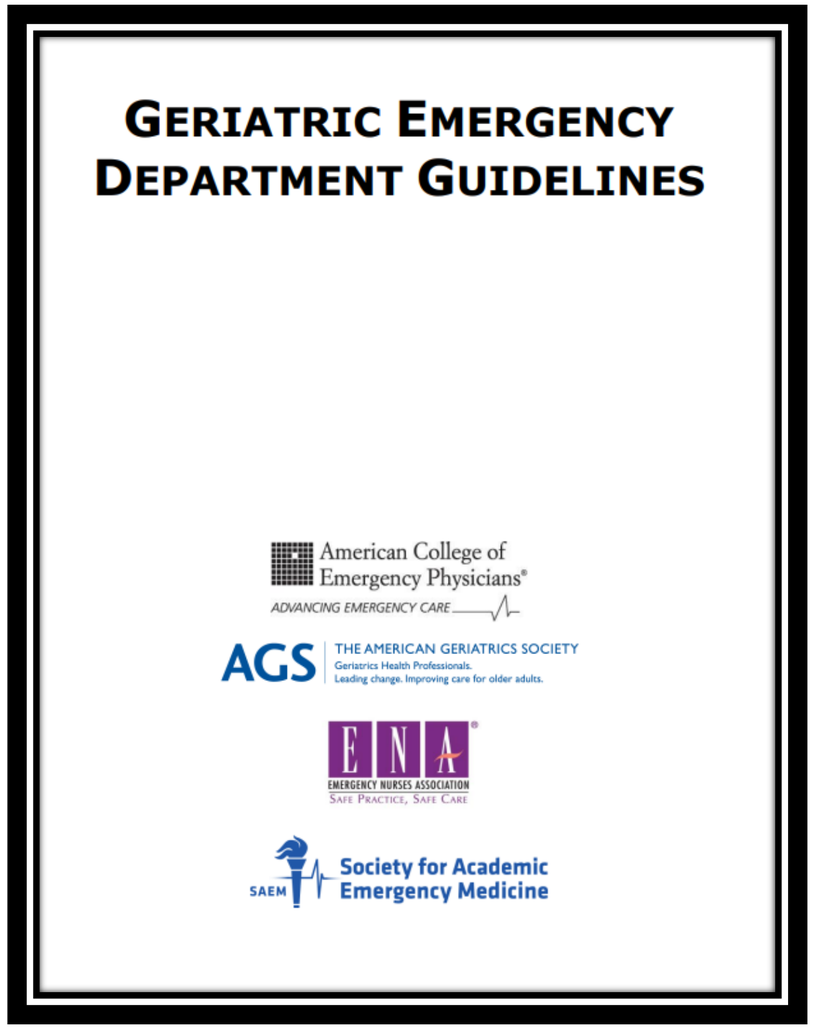
Geriatric Emergency Department Guidelines



In 2014 the American College of Emergency Physicians (ACEP) created Geriatric Emergency Department (GED) Guidelines

Purpose:

- To provide a standardized set of guidelines to improve the care of the geriatric population
- Are feasible to implement in the ED.
- To create a template for staffing, equipment, education, policies and procedures, follow-up care, and performance improvement measures.

https://www.acep.org/siteassets/sites/geda/documnets/geda-guidelines.pdf

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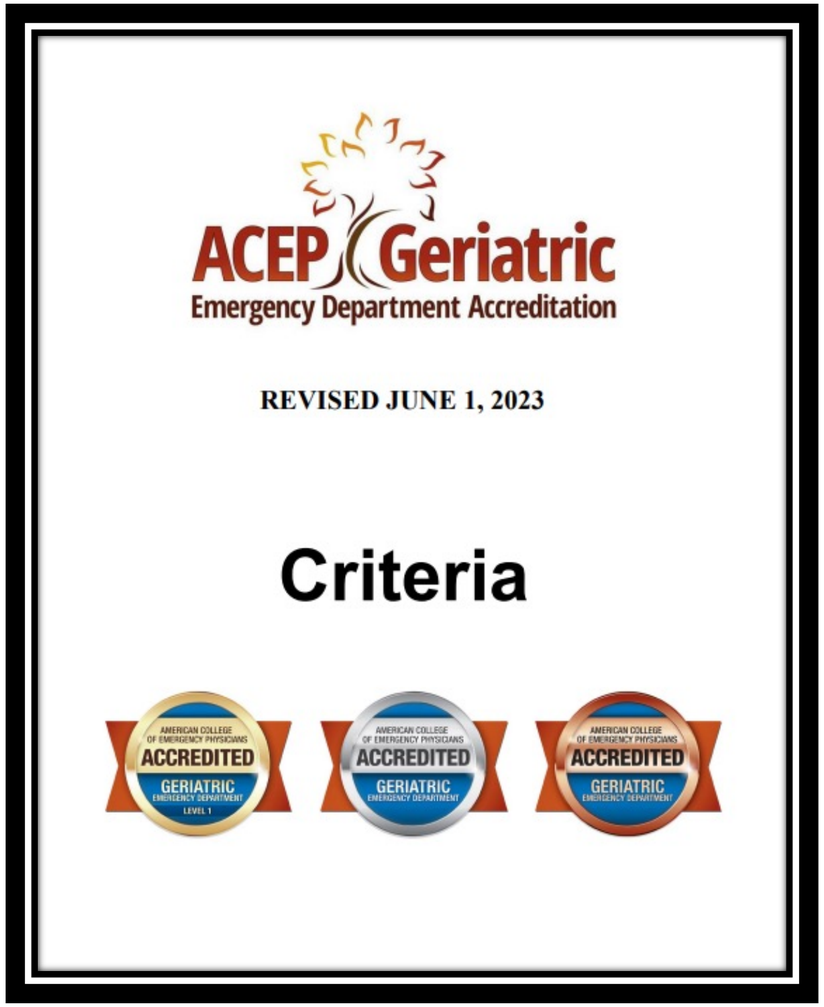
ACEP Geriatric Emergency Department Accreditation



https://www.acep.org/geda/faqs

The Geriatric Emergency Department Accreditation (GEDA) program is an ACEP-governed national accreditation organization which strives to improve the care of older people presenting to the emergency department.

- **This accreditation system promotes the goals quality of care for older people:** enhanced staffing and education; geriatric-focused policies and protocols including transitions of care; quality improvement and metrics; and optimal preparation of the physical environment.
- **Three levels of accreditation with increasing requirements are available.** Hospitals start at the level most appropriate for their current resources and strive to reach a higher level over time.
- While ACEP is an American program, it is being **used in Canada**. University Health Network is the first Level 1 accredited Geriatric ED in Canada.

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Applying the Canadian Triage & Acuity Scale (CTAS) to the Geriatric Patient

- Canadian Triage and Acuity Scale allows patients to be triaged based on type and severity of presentation; allowing the sickest to be seen first and ensuring patients are reassessed while waiting

- Literature has identified a number of key differences in older adult ED presentation from the general population, along with specific skills, knowledge and attitudes required to provide high quality care to older patients.

Level I	Resuscitation	see patient immediately
Level II	Emergency	within 15 minutes
Level III	Urgency	within 30 minutes
Level IV	Less Urgency	within 60 minutes
Level V	Non Urgency	within 120 minutes

- Challenges for accurate triage and prioritization of older adults include: Atypical Presentation, Cognitive Impairment, Co-Morbid Conditions, Polypharmacy and End of Life/Palliative Care.

- **CTAS Frailty Modifier**: Allows triage nurses to up-triage patients normally rated as a CTAS level 4 or 5 to a CTAS 3. This applies to: any patient completely dependent for personal care; wheelchair-bound; suffers from cognitive impairment that limits their awareness of their surroundings or ability to appreciate time; is in the late course of a terminal illness; shows signs of cachexia and general weakness; over 80 years of age unless obviously physically and mentally robust.

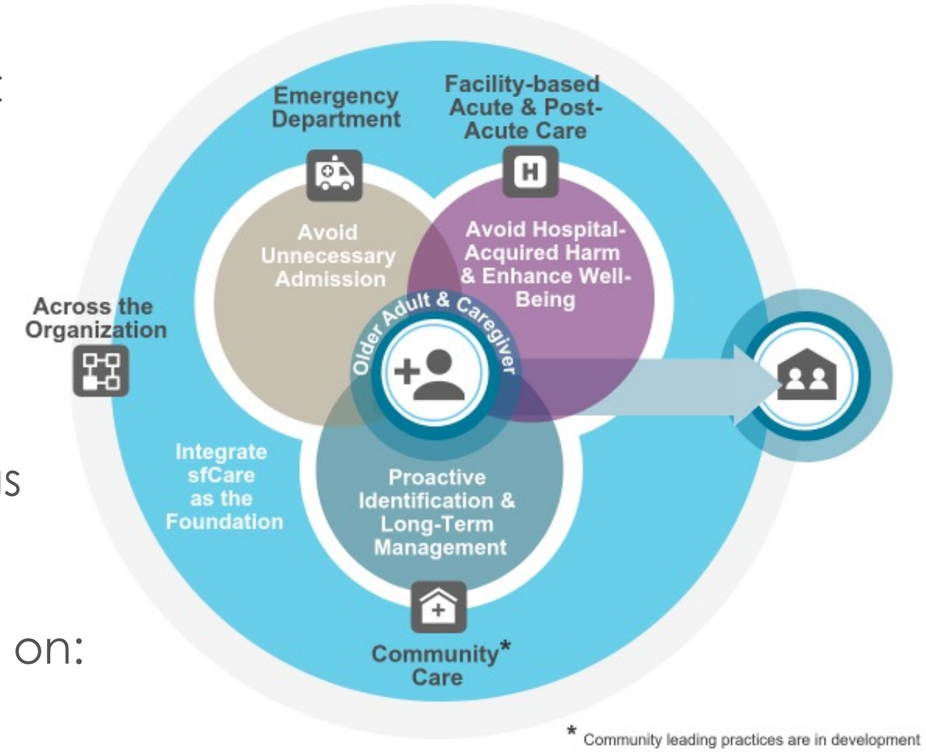
https://www.rgpeo.com/wp-content/uploads/2017/11/dr.-don-melady-keynote-presentation-ottawa-senior-friendly-hospital-symposium.pdf
http://ctas-phctas.ca/wp-content/uploads/2018/05/revisions_to_the_canadian_emergency_department_triage_and_acuity_scale_ctas_guidelines_2016.pdf

Alternate Level of Care (ALC) Leading Practices to Prevent Hospitalization & Extended Stays for Older Adults

- **Developed** in 2021 by the Ontario Alternate Level of Care (ALC) Leading Practices Working Group as an update to the 2017 ALC Leading Practices User Guide, and the 2019 Rural Hospital ALC Leading Practices Guide

- **Identifies** evidence-based leading practices for the care and proactive management of hospitalized older adults at risk of delayed transition to an appropriate setting that can be implemented in the ED, acute care and post-acute care settings

- **Ensures** practices and structures are in place in the ED to avoid unnecessary admission by identifying leading practices focused on:
  - Early Identification & Assessment;
  - Care Plan Development & Ongoing Reassessment;
  - Intervention/ Senior Friendly Care Processes; and
  - Proactive Transitions



https://quorum.hqontario.ca/Portals/0/Indicators-and-change-ideas/ALC%20Leading%20Practices%20Guide%20v1%202021%20(2).pdf?ver=2022-03-30-133617-273

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Resources

Source	Link	Notes
Provincial Geriatric Leadership Ontario (PGLO)	https://geriatricsontario.ca/	• Provincial initiatives, news and resources
Geriatric Emergency Department Collaborative (GEDC)	https://gedcollaborative.com/	• Dedicated to the optimal emergency care of older adults • Nationwide collaborative dedicated to improving the quality of care for older people in EDs with the goal of reducing harm and improving healthcare outcomes. • Accredited education, Webinars, Blogs, Toolkits, Resource Library, Consulting Services
Geriatric ED	https://geriatric-ed.com/	• Resources to support development of a GEM Program
Book	Creating a Geriatric Emergency Department – a Practical Guide (2022). John Schumacher and Don Melady	
Other	• Geriatric Emergency Department Initiative (GEDI) toolkit (Queensland Australia) https://clinicalexcellence.qld.gov.au/resources/gedi-toolkit • Public Health Agency of Canada (2020) Aging and Chronic Diseases: a Profile of Canadian Seniors https://www.canada.ca/en/public-health/services/publications/diseases-conditions/aging-chronic-diseases-profile-canadian-seniors-report.html	

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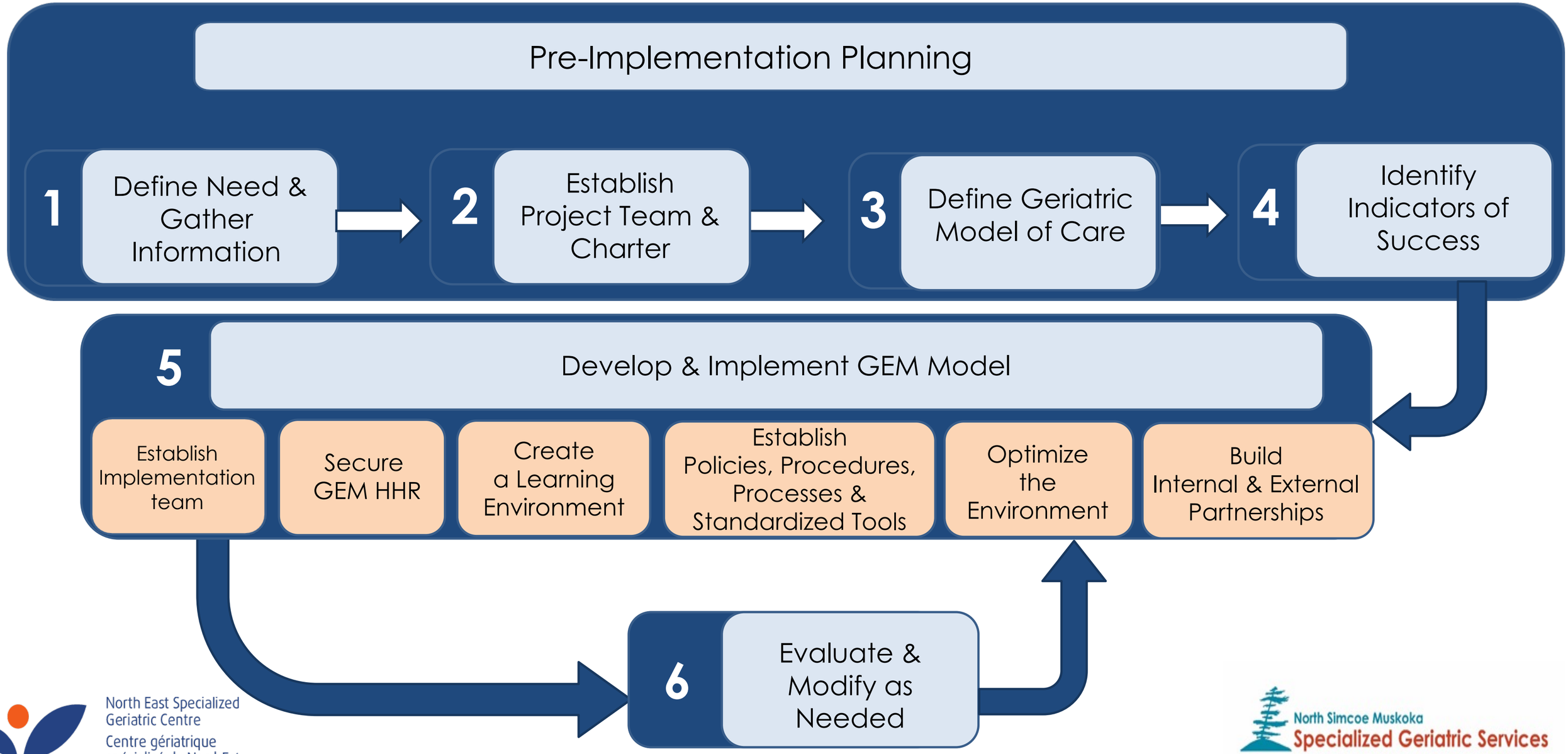
Developing & Implementing a Geriatric Emergency Management Program

Steps to Support Success of GEM Implementation



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STEP 1

Define Need & Gather Information

A. Understand the opportunity **GEM** may provide:

- Educate and **become informed** about GEM and GEM models of care
  - Consider visiting or reaching out to other GEM programs; understand different ways GEM programs have been operationalized
  - Review GEM articles, expert resources & research
- **Identify the need** for a GEM program; anticipate impact of this initiative & strategies to manage change
- **Review current state** and gather information
  - Review corporate & department goals, regional OHT and provincial priorities
    - *How will the GEM program support or advance these goals?*
  - Determine level of organization support; consider champions & stakeholders
  - Understand pressure points & challenges when caring for older adults within the ED; gather feedback from clinicians, clients & community partners
  - Identify and review competing priorities, programs or services; consider synergies and barriers
  - Assess state of readiness
  - Consider data sources available to support analysis of data outcomes for older people presenting to the ED

STEP 1

Define Need & Gather Information

B. Understand & anticipate pressures, priorities and trends using **data**:

Consider data for your catchment area and/or your Ontario Health Team (OHT). Look for patterns, trends, strengths, gaps. Consider:

- **Population Data:**
  - # age 65 +
    - By age category (50-64, 65-74, 75-84, 85+); 85+typically higher intensity ED user[1]
    - Include socio-economic status, gender, race
  - # of age 55-64 (forecast growth of 65 + into 2030)

- **ED Visit Data:**
  - ED visit volumes by age category (65-74; 75-84; 85+)
  - ED length of stay – 65-74, 75-84, 85+
  - ED revisit age 65+
    - within 72hr - by reason
    - within 28 days – by reason
  - Top 5 reasons for admission – 65-74, 75-84, 85+
    - Trend annual data for 3-5 yrs.

- **ED Disposition Data:**
  - ED discharge diagnosis – look at trends
  - ED disposition - What proportion of clients are admitted, discharged home or discharged to a different institution

[1] Schumacher, J. Melady, D. (2022). Creating a Geriatric Emergency Department. Cambridge University Press

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STEP 1

Define Need & Gather Information

C. Consider the **costs and benefits** of adding GEM:

Perform and document risk assessments, considering financial, organizational and clinical risks. Consider:

- **Visit Cost & Flow**
  What is the average cost of an ED visit? Would your older adults have an average cost equal to or greater than the rest of the population if you consider complexity and LOS? If you could safely redirect 2% of cases and prevent 2% of return ED visits, what would the cost savings look like?

- **Staff Time**
  On average, how much time is required by staff to support ED visits? Would older adults have an average time equal to or greater than the general ED population served? What is the cost of this extra time?

- **Staff Experience**
  On average, how knowledgeable and comfortable are ED clinicians in providing quality care to older adults? How confident are you that atypical presentations are being identified, appropriate linkages are being made and effective timely communication is occurring? What is the staff experience cost?

- **Patient Experience**
  How satisfied are older adults and their caregivers with their ED experience? How confident are you that they are receiving the clinical care and communication they need to meet their unique needs. What is the patient experience cost?

STEP 2

Establish Project Team & Charter

A. Establish a **Project Team structure** to support success:

- Identify a **Project Sponsor** from within the hospital Senior Leadership Team
- As an important initial step, engage and secure the buy-in and support of key **ED Champions**: Director/Manager, Chief of Department, other key change agents
- Align the project with **key committees** for ongoing input, support and reporting. This will help hold the Project Team to account around progress. Align with:
  - Relevant internal committees (i.e. ED Care Team, SLT, ALC); and,
  - Where possible, at least one key external regional committees focused on the care of older adults (i.e. Ontario Health Team, regional seniors planning group, ALC committee)
- Establish a small **Project Team**. Consider:
  - ED champions, including clinicians, physicians, geriatrician,
  - Key hospital team partners important to flow, data, quality
  - 2-3 external partners important to quality, transitions, flow that would be key to have at the table on a regular basis. Other partners can be engaged as needed.
  - 1-2 patients and/or care partners to support co-design. If this is a challenge, focus groups could also be used.

STEP 2

Establish Project Team & Charter

B. As a Project Team, identify the **problem** you are trying to solve.

- **What does your data tell you** about older adults and your ED?

- **Consider what GEM programs can accomplish**:
  - Avoid unnecessary hospital admissions; impact on ALC
  - Improve identification and assessment of geriatric syndromes and other missed diagnoses
  - Prevent, delay or reverse declines in independence
  - Improve the structure, flow and resources available within the ED environment for older adults
  - Improve the knowledge and skills of ED teams
  - Improve and foster linkages and partnerships with community resources
  - Improve communication between patients, care partners and providers
  - Decrease/address repeat ED visits

- While your main goal may be to address flow, **consider whether you need a program focused on navigation, one focused on GEM or maybe you need both**? While there may be overlap, navigation and GEM are NOT the same. It may be challenging for one clinician to do both roles.

How does Patient Navigation differ from GEM?

Patient Navigation

Knowledge/Skill

- Community and health care resources
- Partnerships in community to help people access care they need to be as healthy as possible
- Case Management Skills

Focus: Managing ED Journey (Diversion)

- Ensures clinical services are delivered within targeted timeframes (i.e. wait times), including test results, appointments, referrals to area resources to support discharge
- Assist patients to overcome barriers to care and move through an often complex health care continuum

Navigation

GEM

Knowledge/Skill

- Aging processes and geriatric syndromes
- Atypical presentations in older adults

Assessment skills, intervention and prevention strategies to optimize independence and wellbeing

- Geriatric resources in the area

Focus: Geriatric Assessment & Support (Diversion)

Targeted geriatric assessment and case consultation

- Linking the older adult, care partner with relevant resources in the area
- Education of older adults and care partners
- Capacity building within the ED related to the care of older adults (education, mentoring, processes, policies, etc.)
- Building relationships between the ED and geriatric resources in the area

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STEP 2

Establish Project Team & Charter

C. Implement a small **Project Charter** and work plan.

- Develop a **project charter and associated work plan** that clearly defines:
  - Scope
  - Deliverables, timelines and responsibilities
  - Potential risks and mitigating strategies

- **Review progress regularly**. This will help promote communication, hold partners to account around deliverables and allow you to address issues as they arise

- Ensure regular **progress reports** are provided to key internal / external committees as appropriate.

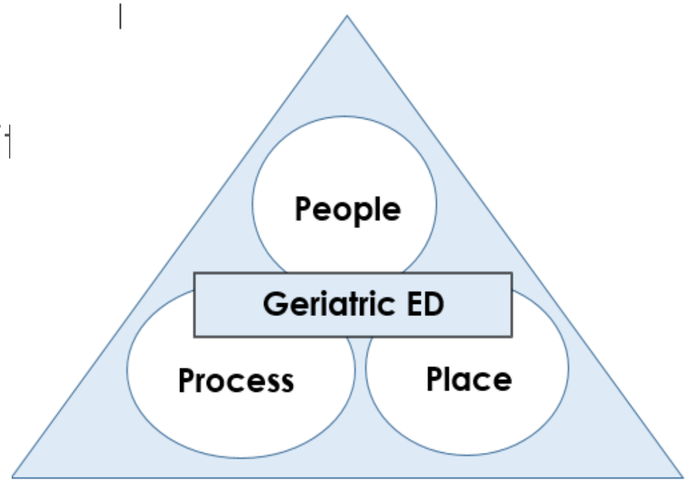
STEP 3

Define Geriatric Model of Care

A. Determine Model **structure**:

- **Distinguish** Geriatric ED model from Traditional ED model
  – May involve a change in philosophy and approach to practice

- Decide on the **structure**.
  – GEM programs vary across organizations, provinces and internationally - Separate Geriatric ED; GEM program within a regular ED; Geriatric observation unit Senior Friendly ED Care



- Address the **core elements**:
  – People: build core team or clinician role,
  – Processes: such as client flow, education/training, protocols/guidelines & tools
  – Place: introduce/implement senior friendly resources

- **Determine** what is possible and what is not an option:
  Implementing all recommended GEM guidelines may not be possible in part d/t
  – Limited financial and/or HHR resources
  – Size of the Organization/Emergency Department
  – Needs and priorities
  – Level of readiness

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STEP 3

Define Geriatric Model of Care

B. Define Health Human Resources (**HHR**) model

Reflect on the problem you are trying to solve, the size of your department, available department resources and your data. Consider starting with a clinical role such as GEM Clinician (RN, OT, PT or other allied clinicians) and identify an ED Physician/NP Champion. You can build toward a GEM Team but plan your model early.

- **ED Physician / NP Champion**
  Identify an ED physician/NP with a special interest in geriatrics to: support facilitation and implement the GEM program; influence & facilitate change; and, promote acceptance of the model & practice

- **GEM Clinician/Practitioner**
  The first step is often implementation of a GEM RN or Clinician role. The position brings specialized knowledge, assessment skills and leadership to support case consultation, capacity building and policy/procedure/process development.

- **GEM Multi-Disciplinary**
  The care of older adults is best supported through an interprofessional team to support the complex needs of older adults and their caregivers. Consideration should be given to Occupational Therapy, Physiotherapy, Social Work, Pharmacist and Dietitian support.

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STEP 3

Define Geriatric Model of Care

C. GEM as part of an **integrated system of care** for older adults.

- Improving outcomes for older persons in the ED requires an integrated system of health service delivery. Consider your **relationships** with key area partners and providers; as well as relationships and structures built within your OHT as an option to support this project.
- Links are established between the most appropriate health services to ensure the best possible health outcomes for all clients
- GEM integration supports a broader system-wide approach where multiple organizations and sectors work formally together to support GEM clients.
- Through **accountability agreements or memorandums of understanding** between the ED and key area partners, the GEM program is given priority access to partner services to prevent unnecessary hospital admissions and/or unnecessary return ED visits.

STEP 4

Identify Indicators of Success

Identify key **indicators** that will help you monitor success.

- Identify short, medium and long-term ***outcomes and indicators***:

Short	Medium	Long-Term
Changes in skills, attitudes and knowledge. For example: *ED staff can describe the difference between delirium, dementia, depression.*	Changes in behavior and decision-making. For example: *ED staff accurately identify older adults at risk of adverse functional outcomes.*	Changes in status or conditions (i.e. social / well-being, economic, environmental). For example: *There is a reduction in repeat ED visits among older adults.*

- Think about outcomes as they relate to the objectives of the ***Quintuple Aim***:
  - Improving the patient and caregiver experience
  - Improving the health of populations
  - Reducing the per capita cost of health care
  - Improving the work life of providers
  - Improving health equity and inclusion

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Operationalizing GEM

STEP 5

Develop & Implement GEM Model

A. Establish an **Implementation Team** to continue the work of the small project team.

- Confirm/revise team/working group **membership**.
- Review and continue implementation of project work plan (operational).
- **Review progress regularly**. This will help promote communication, hold partners to account around deliverables and allow you to address issues as they arise.
- Establish **regular huddles** (i.e. 30min q2wks) for the first 2-3 months at minimum to support planning and monitor progress on charter/plan action items. Frequency can be gradually reduced when the project is progressing to everyone's satisfaction.
- Ensure **regular progress reports** are provided to key internal / external committees as appropriate.

STEP 5

Develop & Implement GEM Model

B. Secure GEM **HHR**

- Define **staffing hours**. Consider:
  - ED flow and analysis of ED data related to client flow into ED
  - Available funding
  - Availability of other ED resources to optimize GEM collaboration

- Develop **posting(s) and recruit**:
  - Consider requirements of experience, geriatric knowledge, ability to build and sustain partnerships, comfort coaching/mentoring, experience developing & implementing policy, leadership potential.

- Develop **orientation plan, skill development & mentoring opportunities.** The following should be included:
  - Assessment and identification of: atypical presentations of disease, geriatric syndromes, trauma (including falls), frailty (functional assessment), cognitive and behavioural issues, mental health and mood disorders
  - Transitions of care
  - Effect of comorbid conditions/poly-morbidity
  - Targeted risk assessment/documentation

STEP 5

Develop & Implement GEM Model

C. Create a **Learning Environment**

- **Physician orientation and training** addresses issues common to all ED patients but focused on the unique factors found in older adults as well as geriatric syndromes & atypical presentations

- **ED Staff orientation and training** including consideration of the following:
  - Ongoing training/mentoring, sim lab/ class development, on-line; build into training expectations/Performance Appraisals
  - Screening for GEM patients & risk assessments
  - Adoption of clinical pathways, care processes
  - Management of geriatric trauma (acute illness and injury)
  - CTAS Frailty Modifier

- Build **system partnerships/relationships** and promote shared learning, including principles and support of **integrated care**

- Develop **education resources** for older adults and their care partners

- Encourage and support development and adoption of Senior Friendly Care (**sfCare**) best practices, including environmental best practices

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STEP 5

Develop & Implement GEM Model

D. Establish **policies, procedures, processes and standardized tools**

- Using your data, **define the target population** to be seen. Will your GEM program focus on supporting a subset of the older adult population:
  - Presenting with targeted geriatric syndromes (i.e. dementia, delirium, falls, etc.); OR
  - Identified as high risk using a screening tool (i.e. ISAR, TRST). Just always remember to ask "high risk for what?"

- Consider completing a **process mapping** exercise to understand opportunities to implement and facilitate change (i.e. current/future state)

- Develop **workflows**; consider referral process for GEM clinician; navigation processes (internal and external workflows)

- Develop **clinical assessment tools** and resources:
  - Will GEM staff be competing a targeted geriatric risk assessment or a Comprehensive Geriatric Assessment (CGA)?
  - Are there standardized assessment tools and risk assessment tools that should be used?
  - How will you capture and report summaries and associated action plans to optimize communication and support successful transitions?

STEP 5

Develop & Implement GEM Model

- Develop **documentation** tools and processes. Will they be part of your electronic health record or will they be paper-based or both? Maybe they start as paper-based and transition to electronic.

- Determine how you will screen for and manage **high-risk conditions**. What clinical pathways or medical directives do you need to develop? (i.e. functional decline, frailty, delirium, falls and fractures, elder abuse, polypharmacy, psychosis, pain, etc.)

- Define **general approaches to care** within the ED:
  - Urinary catheter management (minimize catheter usage)
  - Access to food & drink; minimize NPO
  - Promote mobility and minimize use of physical restraint
  - Pain management pathway
  - Comfort cart

- Identify a plan to promote **successful transitions of** care:
  - As part of an integrated system of care, how will these patients transitions across system and access required resources, including specialized geriatric services?
  - What will communication look like to key partners, including reports to primary care providers?

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STEP 5

Develop & Implement GEM Model

E. Optimize the **Environment**

Modifications to the physical environment and providing resources can improve the quality of care provided to older adults and their care partners.

- ***Support sensory needs and minimize sensory overload:***
  - Pocket talkers for hearing impaired
  - Ear plugs/eye shields – reduce light/noise
  - Large faced clock, whiteboard & signage – assists with orientation

- ***Support and encourage mobility and reduce fall-risk:***
  - Non slip socks; non slip flooring
  - Gait aides (walker, cane)
  - Brighter lighting; tunable LED lights
  - Chairs at bedside for care partners and/or patients to utilize
  - Maintain independent continence

- ***Patient comfort***
  - Access to food/drink
  - Warm blankets
  - Mattress / surfaces to reduce skin breakdown
  - Recliners – help pts to change position and reduce pressure

STEP 5

Develop & Implement GEM Model

F. Build internal and external **partnerships**

- **Internal can include:**
  - ED Team (i.e. Chief of ED, ED manager, ED nurses/team leads)
  - Internal Geriatric services (Geriatrician, geriatric teams & programs, behavior supports)
  - Acute in-patient teams, allied teams, pharmacy
  - QI resources (i.e. data, reporting metrics, evaluation) and Project Management
  - Committees (i.e. Senior Friendly Hospital, pharmacy, ED care team)
  - Senior Leadership / Physician-Lead champion

- **External can include:**
  - OHT: Align with OHT priorities, opportunities for integration & system navigation
  - Community geriatric services and resources for older adults (HCC-SS, CSS partners, LTCHs and Retirement Homes, Community Paramedicine programs, Hospital to Home programs, clinics for non-rostered clients, etc.)
  - Specialized Geriatric Services (i.e. local SGS Clinics, Geriatricians and Geriatric Psychiatrists, SGS Teams, etc.)

GEM Programs support and contribute to:
- Client Care Pathways
- Referral Pathways

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STEP 6

Evaluate & Modify as Needed

Continually **evaluate and modify** the program as needed.

The Implementation Team should **monitor progress regularly** through regular huddles, providing progress reports to key stakeholders as per defined timelines. Using a continuous quality improvement approach, the Team should make **modifications to the GEM program** to optimize outcomes. The Team should:

- Monitor progress as per the **Project Charter and associated workplan**.
- Monitor **data** using the key indicators identified during planning. This could include:
  - Pt volumes (by age category)
  - Repeat ED visits and readmissions
  - Referrals to GEM Clinician/Team; # clients seen; reason for referral
  - Referral/navigation
  - Growth in ED team knowledge, skills; number of training events, change in knowledge
  - Patient and care partner experience
- Using this information and the PDSA cycle, **improvements** can be implemented, including: new care pathways or practice standards; education/huddles; identification and building of new partnerships; changes in communication; etc.

Resources

Geriatric ED (Mt Sinai/UHN) https://geriatric-ed.com/

Geriatric Emergency Department Collaborative https://gedcollaborative.com/

Provincial Geriatrics Leadership Ontario GEM initiative https://rgps.on.ca/initiatives/gem/

Creating a Geriatric Emergency Department (book)

Geri-EM, Personalized e-Learning in Geriatric Emergency Medicine https://geri-em.com/

North Simcoe Muskoka Specialized Geriatric Services https://www.nsmsgs.ca/

Geriatric Emergency Department Accreditation Program https://www.acep.org/geda/

- Geriatric Emergency Department Guidelines & Geriatric Emergency Department Criteria

Geriatric Emergency Department Initiative (GEDI) toolkit (Queensland Australia)
https://clinicalexcellence.qld.gov.au/resources/gedi-toolkit

Public Health Agency of Canada (2020) Aging and Chronic Diseases: a Profile of Canadian Seniors
https://www.canada.ca/en/public-health/services/publications/diseases-conditions/aging-chronic-diseases-profile-canadian-seniors-report.html

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