GEM
Geriatric Emergency Management Programs

Supporting Ontario's Emergency Departments to Provide Excellent Care for Older Adults

Developing and Implementing a Geriatric Emergency Management (GEM) Program: Getting Started

A Presentation of the Specialized and Focused Geriatric Services Highlight Series

December 2024

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Regional Geriatric Program of Eastern Ontario

Provincial Geriatrics Leadership Ontario

Session Objectives

1. Introduce organizational supports needed for the implementation of successful GEM programs.
2. Review GEM processes of care, from identifying patients and conducting assessments to responding to atypical presentations in the older adult and supporting discharge or admission with a plan.
3. Identify local, regional and provincial resources to support and sustain GEM program implementation.

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Moderated by:

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Today's Presenters

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GEM Background

- Program started in 1994 as a pilot program at Sunnybrook led by a single nurse, by 2004 Ontario's Regional Geriatric Programs were hosting GEM programs in five major centres and by 2009 there were 80 GEM nurses
- At its height, following Aging at Home funding in (2008-2009), there were approximately 130 GEM nurses across the province.
- Ontario's Geriatric Emergency Management (GEM) program has been implemented as local hospital initiatives involving advanced practice registered nurses (RNs) and nurse practitioners (NPs) with geriatric knowledge, and frequently social workers and care coordinators, providing targeted assessment and care to older adults in emergency departments.
- In 2024, there are approximately 94 dedicated GEM roles in 69 organizations participating in the Provincial GEM Network, which is coordinated by PGLO. These organizations operate GEM services in approximately 76 locations.
- There is strong evidence for the inclusion of geriatric expertise in the urgent/emergent care of older adults. GEM programs have been identified as a strategy to help mitigate high numbers of patients designated as Alternate Level of Care in Ontario Hospitals.

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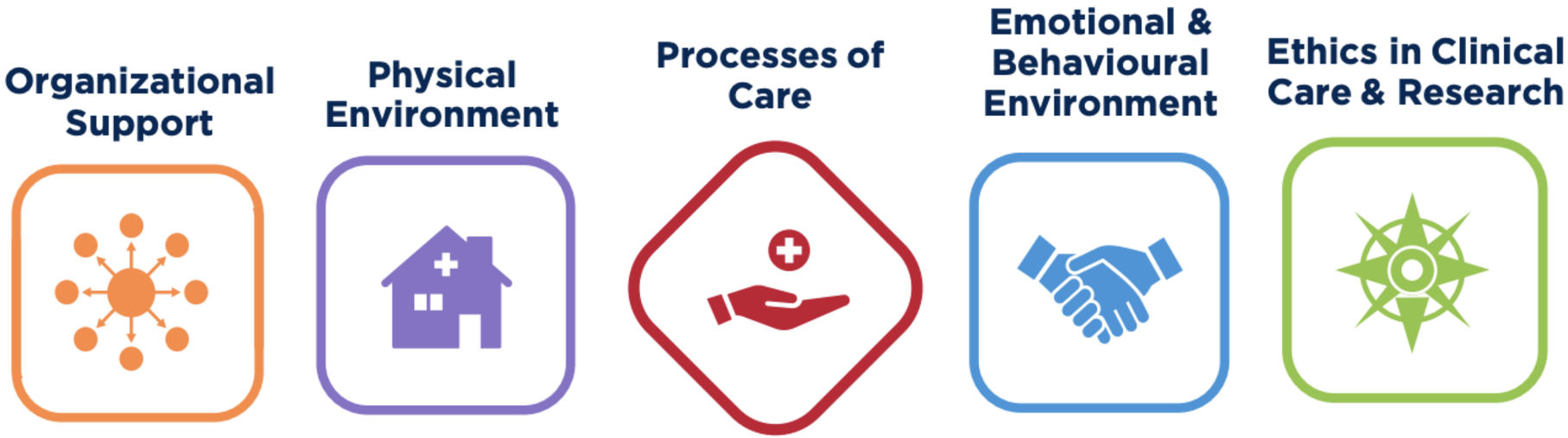
Implementing a GEM Program IS Implementing Senior Friendly Care in the Emergency Department



The Senior Friendly Care Framework

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What are the required Organizational Supports?

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Organizational Support

1. An understanding of the role, goals and objectives of Geriatric Emergency Management (GEM) programs.
2. Recognition of complexity and multimorbidity and its impact on older adults.
3. Management support for the unique GEM role and support for its core work in the context of busy emergency departments.
4. Support for building necessary internal and external relationships.

Sample Geriatric Emergency Management Logic Model (Draft)

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.

Inputs

- Mandate and funding from the Ministry of Health/Ontario Health
- People: Champions and knowledgeable human resources at local organization
- Processes: Protocols and guidelines that inform process of care for complex older adults in the ED
- Place: Modifications to physical environment
- Data: Practice, Organizational and Population Level
- Engagement: With internal and external partners, including older adults and caregivers

Activities

1. **Drive Clinical Excellence**
   - Targeted geriatric assessment in the ED
   - Goal-based care planning
   - Integrate geriatric principles and practice into care
2. **Advocate for Age-Related Needs**
   - Foster linkages
   - Support uptake of Senior and Dementia Friendly Care
   - Support timely & efficient access to appropriate care & interventions within the health care system
3. **Build Capacity Across the System**
   - Build capacity & provide education

Outputs

- # of targeted clinical assessments completed using validated tools and clinical judgement
- Implementation of case finding/identification methodology
- Development and implementation of order sets and clinical pathways (e.g. Delirium order sets)
- Development of program standards and policies
- Personal, staff, partner agency and patient/family training and education sessions
- Senior friendly informed annual business plan for organization
- Relationship building within and external to the organization
- Performance measurement and evaluation planning including regional and provincial reporting

Outcomes

- Knowledgeable GEM and ED staff who integrate geriatric principles and practice into care
- Timely & efficient access to appropriate care & interventions within the health care system
- Patients and families who have effective health management strategies

Impact

- 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

Assumptions:
GEM Nurses use a comprehensive theoretical knowledge base and advanced level of clinical competence in the assessment and care of older patients; act as a resource; and serve as a consultant to individuals and groups within the healthcare professional community.

v. December 10, 2024

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Physical Environment

Designated Space

Where possible, provide separate space designated for older adults.

Support Sensory Needs

Minimize sensory overload and use tools such as:

- Pocket talkers for hearing impaired
- Ear plugs/eye shields – reduce light/noise
- Large faced clock, whiteboard & signage – assists with orientation

GEM

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

Address Patient Comfort

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

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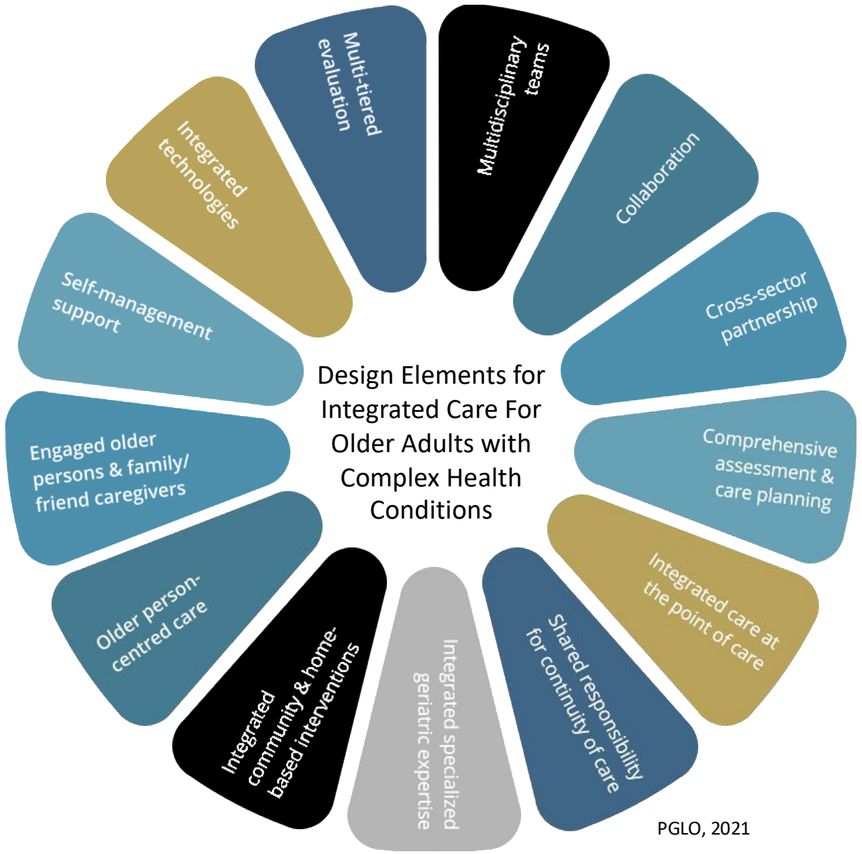
Driven by Evidence

Processes of Care

Standard of Care for Older Adults Living with/at-Risk of Frailty and Complexity			
Core Components			
Core Elements of Care	Older Person & Care Partner Engagement		
	Equitable & Culturally Appropriate Care		
	Interprofessional Teams		
	Specialized Geriatric Expertise		
	Comprehensive Geriatric Assessment (CGA)		
	Evaluation		
Processes of Care	Early Identification		
	Comprehensive Assessment		
	Care Planning (includes Advance Care Planning)		
	Intervention & Follow-up		
	Transitions		
Domains of Care	Cognition	Polypharmacy	Continence
	Social Engagement	Nutrition & Hydration	Pain
	Mobility & Falls	Mood & Mental Health	Delirium
	Skin Integrity	Function	Sleep

With credit to D. Corsi, K. Kay, S. Hawkins, A. Day, M. Briscoe, D. Daly, K. Wong & A. Morrison



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Standard of Care for Older Adults Living with/at-Risk of Frailty and Complexity

Core Components				Considerations for GEM Programs
Core Elements of Care	Older Person & Care Partner Engagement			Planning, patient and caregiver experience, Essential Care Partner presence
	Equitable & Culturally Appropriate Care			Focus on patient priorities and what matters most
	Interprofessional Teams			Nursing, social work, physio, care coordination, medicine etc.
	Specialized Geriatric Expertise			Linkages to Regional Geriatric Services
	Comprehensive Geriatric Assessment (CGA)			Competency Framework for Interprofessional CGA
	Evaluation			GEM metrics, Regional and Provincial reporting
Processes of Care	Early Identification			Risk identification, referral process for GEM
	Comprehensive Assessment			Geriatric syndromes, clinical screening and assessment tools, Atypical presentations
	Care Planning (includes Advance Care Planning)			Documentation and communication
	Intervention & Follow-up			Clinical pathways, management of high-risk conditions (e.g. abuse, falls, delirium, pain, psychosis, polypharmacy etc.), communication with primary care, general approaches to care in the ED
	Transitions			Navigation processes, communication, partnerships
Domains of Care	Cognition	Polypharmacy	Continence	• GEM training, refresher and ongoing mentorship • Recognition and response to health and social care conditions across multiple domains
	Social Engagement	Nutrition & Hydration	Pain	
	Mobility & Falls	Mood & Mental Health	Delirium	
	Skin Integrity	Function	Sleep	

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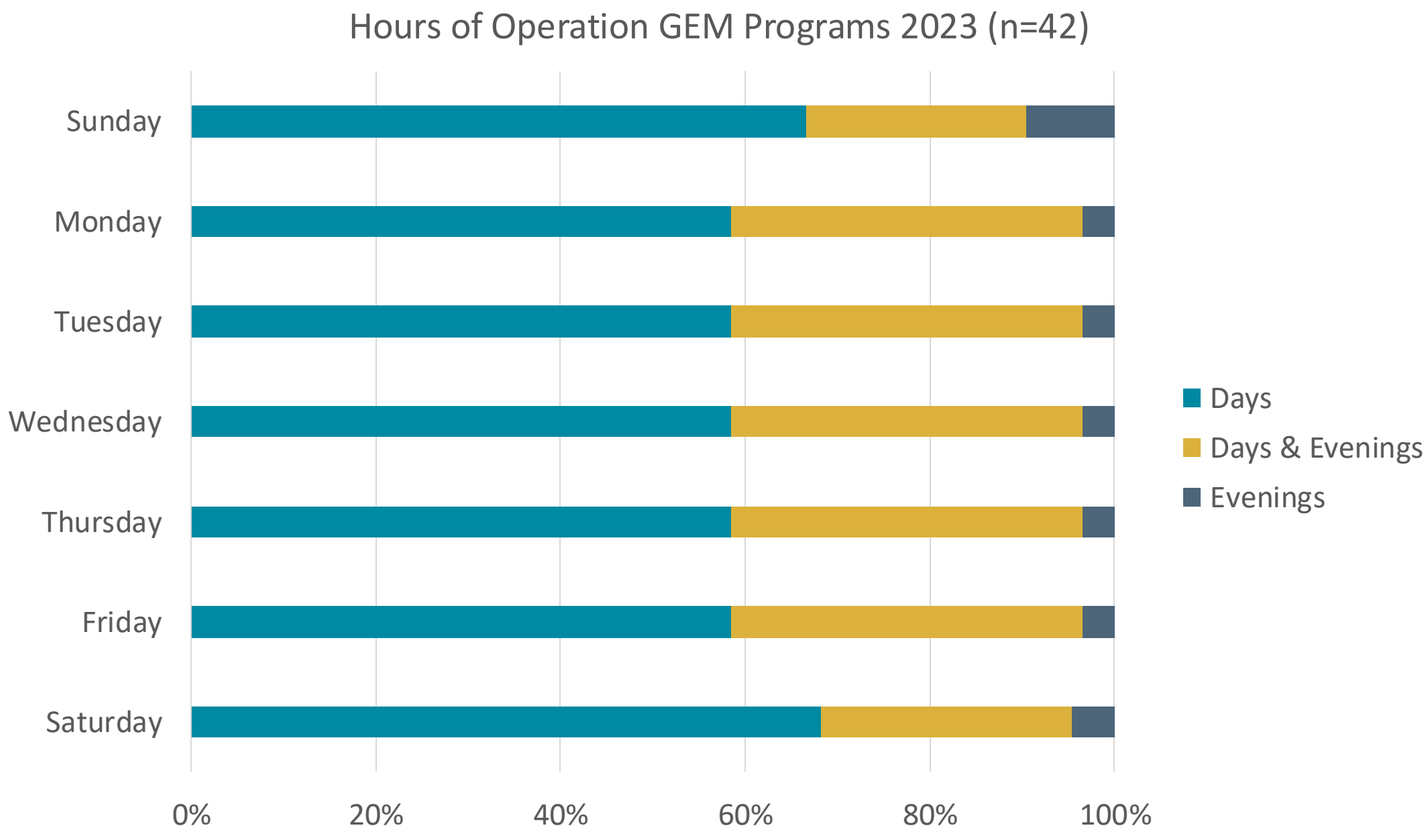
Hours & Coverage

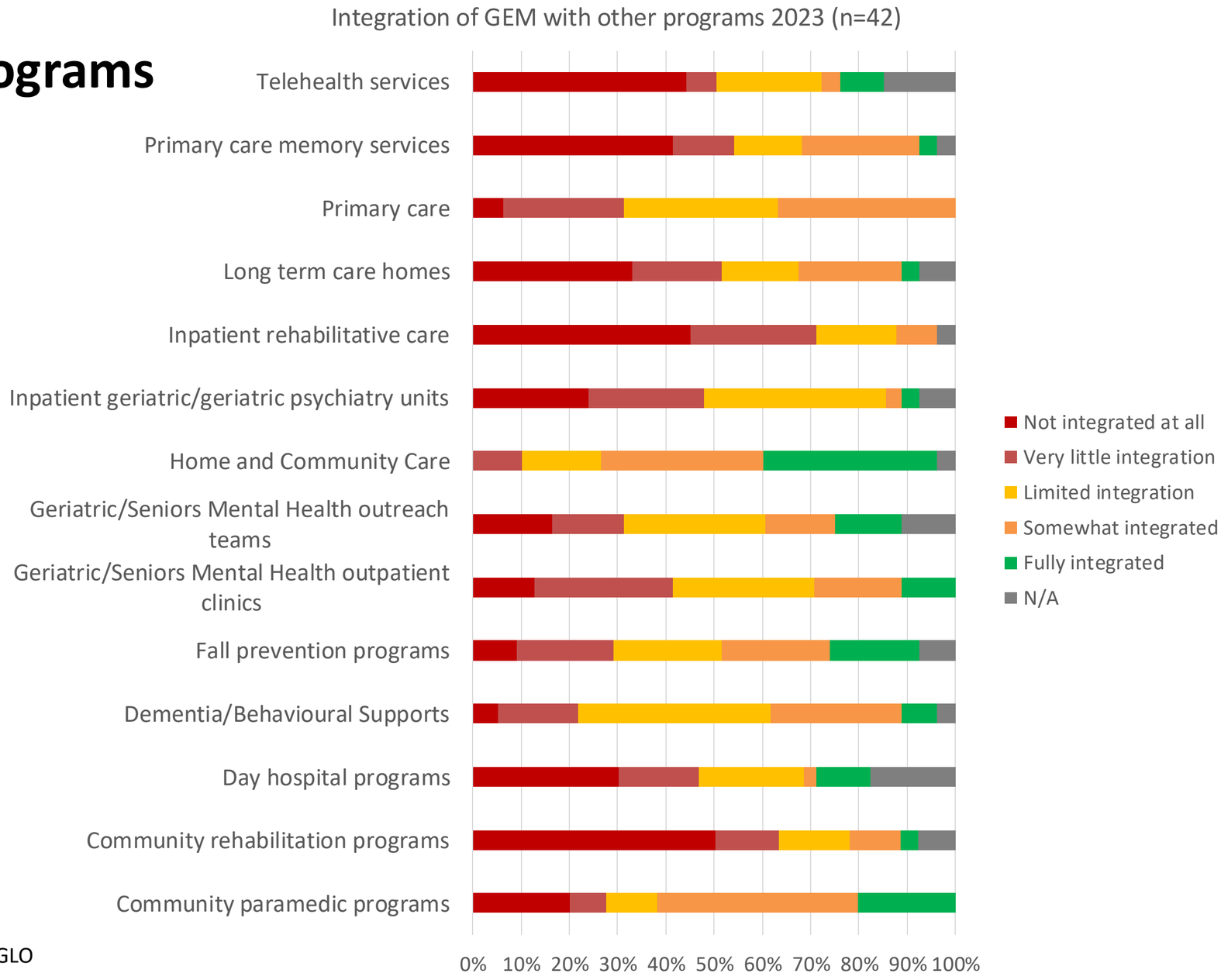
- Hospitals and geographical areas have varied GEM program coverage policies.
- While some programs only run during the week, others provide services on weekends and evenings.
- Compared to metropolitan areas, rural hospitals often have fewer coverage hours.



Ashfa, M. & Kay, K. (2023). GEM Current State Survey Results. PGLO

Integration with Other Programs

- Wide variation
- Highest degree of integration with home care services; in some programs there are dedicated care coordinators attached to GEM
- Growing integration with community paramedicine
- Opportunities with primary care, rehab and other outreach programs.



Ashfa, M. & Kay, K. (2023). GEM Current State Survey Results. PGLO

Performance Management

Goals & Objectives

- Identifying at-risk older patients in the emergency room
- Performing geriatric-specific evaluations
- Minimizing needless hospital admissions
- Enhancing patient flow
- Simplifying care transitions
- Contributing to continuity of care

Sample Outcome Measures

- Referrals received (demand), unique patients and care partners service (utilization)
- #/% Targeted Geriatric Assessments completed (in-person, phone)
- #/% Consultations to ED Staff
- Unplanned hospital admission rates (e.g., following GEM assessment)
- Hospital length of stay, ALC Days
- Unplanned (re)attendance to the emergency department within a certain period (GEM clients, non-GEM clients)
- Repeat unplanned/unscheduled ED visits
- Referrals (e.g. system navigation, community & social services)
- Wait times
- Patient and caregiver feedback
- Caregiver stress
- Education delivered (hours)

Ashfa, M. & Kay, K. (2023). GEM Current State Survey Results. PGLO
PGLO. (2022). GEM metrics review.

Processes of Care: Early Identification Targeted Geriatric Assessment

Processes Used to Identify Patients to be seen by GEM (may use multiple processes)	Domains of Assessment	Commonly Used Validated Tools to Support Assessment (may use multiple tools)

• **Age Cut-offs** (e.g., 75+ or 65+ with dementia) and/or
• **Screening Tools**
  • **Triage Risk Screening Tool** (TRST)
  • **Identification of Seniors At Risk** (ISAR) Tool
  • **Assessment Urgency Algorithm** (AUA)
 	
41% used another means of triaging patients to be seen by GEM, most commonly physician referral.
	Cognition
	Polypharmacy
	Continence
	Social Engagement
	Nutrition & Hydration
	Pain
	Mobility & Falls
	Mood & Mental Health
	Delirium
	Skin Integrity
	Function
	Sleep
		Confusion Assessment Method (CAM)
		Clinical Frailty Scale (CFS)
		Mini-Cog
		Geriatric Depression Scale (GDS)
		Mini-Mental Status Exam (MMSE)
		Montreal Cognitive Assessment (MOCA)
		Morse Fall Scale
		Other (various)
		Timed Up and Go (TUG)
		General Anxiety Disorder-7 (GAD-7)

Ashfa, M. & Kay, K. (2023). GEM Current State Survey Results. PGLO; Kay et al. 2017

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Emotional & Behavioural Environment

1. Involvement of Care Partners (from arrival onwards)
2. Physical presence of GEM in the ED
   - Relationship building
   - Case finding
   - Huddles and rounds
   - Connection to clinical work
3. A focus on baseline and goal-based care
4. Anti-ageist and anti-stigma approaches
5. Protection of autonomy, choice and dignity and **what matters most**
6. Linking GEM programs with supports and communities (local, regional and provincial)

What does a typical day look like for you? What do we need to do to get you back to that?

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Strengths of the GEM Model: Feedback from GEM Teams

- Strong interdisciplinary collaboration and support.
- Sustainability and commitment to continuous improvement.
- Efficient and effective patient assessment and care coordination.
- Integration within the emergency department and broader healthcare system.

"Collegiality among GEM staff. Support for GEM initiatives from management."

"Sustainable; Many GEM nurses have remained in role for lengthy periods of time; limited turnover."

"We are very efficient as a resource to the emergency physicians and assess many patients efficiently to streamline care needs."

"ED Team recognizes need to involve GEM Nurses and/or OT / SW with more complex older adults presenting in the ED."

"Skilled and knowledgeable team members and ability to service our senior population 7 days a week."

Ashfa, M. & Kay, K. (2023). GEM Current State Survey Results. PGLO

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Ethics in Clinical Care & Research

1. Leveraging the GEM role for quality improvement and research involving older adults
2. Recognizing and responding to moral distress in care partners and health professionals arising from system constraints, elder abuse etc.

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INTRODUCING

Courteney Munch

ADVANCED PRACTICE NURSE

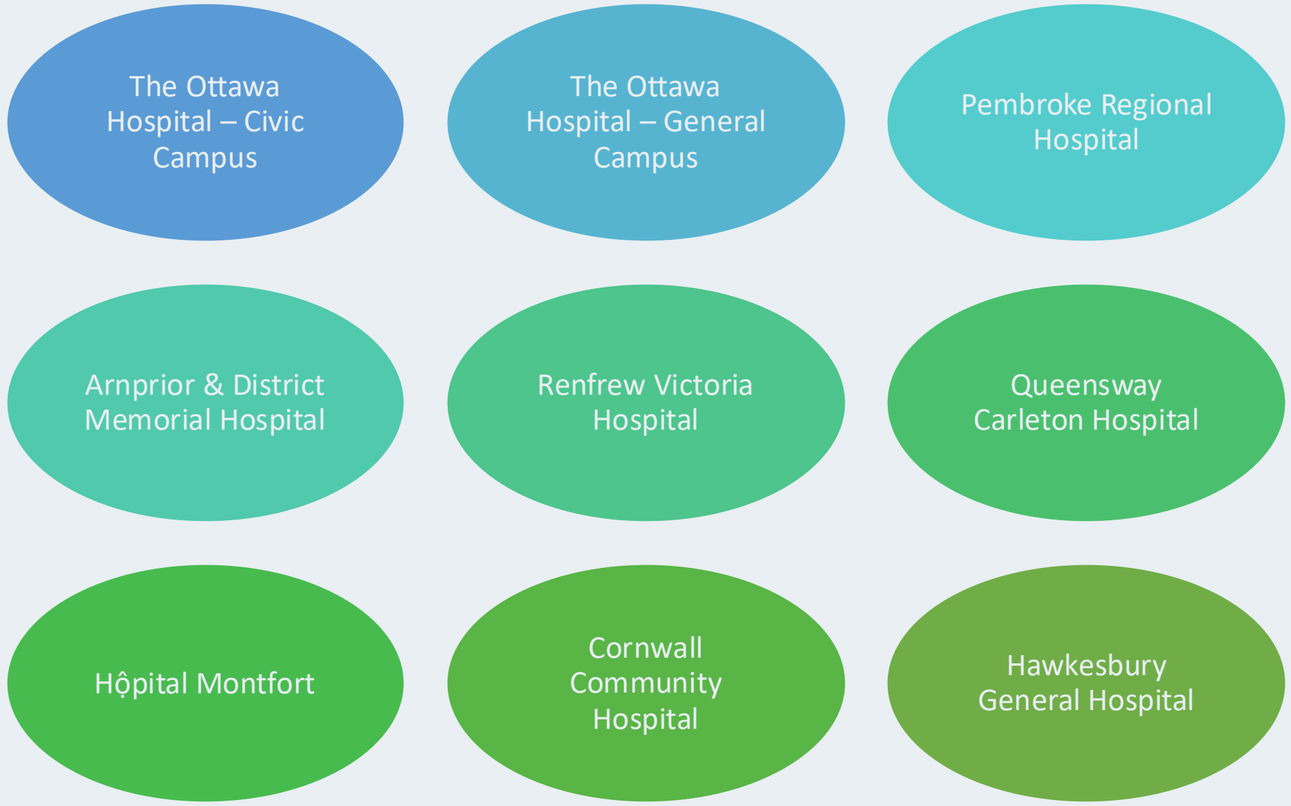
REGIONAL GERIATRIC PROGRAM
OF EASTERN ONTARIO

Courteney Munch graduated from the University of Ottawa in 2009 with a Bachelor of Science in Nursing, completed her Advanced Studies in Critical Care Nursing Certificate in 2017, and completed her Master of Science in Nursing in 2023. Courteney has worked at The Ottawa Hospital since 2007 in various roles including as a Registered Nurse in Medical Oncology, Intensive Care and Post-Anesthesia Care, as the Nurse Educator in Peri-anesthesia and Intensive Care, a Corporate Nurse Educator within Nursing Professional Practice, and as a Nurse Specialist with the Geriatric Medicine Consult Team (GMCT).

Currently, as the Advanced Practice Nurse for the Geriatric Emergency Management (GEM) team and the Geriatric Medicine Consult Team (GMCT) of the Ottawa Hospital, Courteney shares her knowledge and expertise in the assessment and management of frail older adults across the spectrum of care, leads the GEM and GMCT team members, and supports the Geriatric Medicine team to continue to lead and advocate for exemplary care for older adults.

Champlain GEM+ Program

- **9 Separate Hospital Emergency Rooms:**



- **GEM+ Program:**
  - Unique to Champlain
  - Funding extends beyond ED (Funding for SGS and CSS services accounts for 72% of the GEM+ budget)
  - Supports additional capacity in the community → improving access for GEM referred clients

Return on Investment

- **Return on Investment (ROI) Evaluation Approach:** Evaluation framework developed by members of GEM+ Program Evaluation Steering Committee

- **Objectives:**
  - determine the GEM+ Program's sustainability
  - identify opportunities for optimization/standardization
  - determine the degree that program outcomes/impacts are being achieved

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Return on Investment

- **Regional Impact:**
  - 3% reduction on the 30-day admission rate between fiscal years 2015-2016 and 2021-2022.
  - 5% reduction of the 30-day ED revisit rate between years 2015-2016 and 2021-2022.

- **Costing Analysis & ROI:**
  - GEM+ Program effectively reduced admission rates by 19% and reduced ALC rates by 6%.
  - 2020-21 costing analysis at two GEM sites (The Ottawa Hospital) identified a total cost avoidance of $2.7 million, and a savings of 2500 bed days or approximately 7 hospital beds.
  - **Every $1 invested into the GEM+ Program there was a return on investment of $4.36.**

Orientation & Onboarding

GEM Staff

- Standardized orientation plan
  - Multi-modal approach
- Regional networking meetings
- Continuing education initiatives

Organizational Leadership

- Leadership orientation package
- Support understanding of GEM with leadership changeover

GEM Staff

- **Qualifications and Qualities to Consider:**
  - Nurse Led Intervention:
    - Registered Nurses (RNs)
  - Specialized Training & Expertise in Geriatrics
  - Emergency Department or Acute Medicine Experience
    - Clinical knowledge and expertise in acute emergency care
  - Knowledge of Regional Health Care System
  - Adult Education Experience
  - Excellent Communication, Interpersonal, Organization, Problem Solving, and Decision-making Skills
  - Ability to Work Independently and Autonomously
  - Ability to Participate as an Active Member of a Multidisciplinary Team
  - Demonstrated Leadership Ability

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Supporting Roles

GEM Nurse

Social Worker

Ontario Health at Home Care Coordinator

Physiotherapist

Occupational Therapist

Pharmacist

Behavioural Support Clinician

Consultation with Geriatric Physician Specialists

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GEM – North East

Baseline SGS Capacity in the NE - 2022

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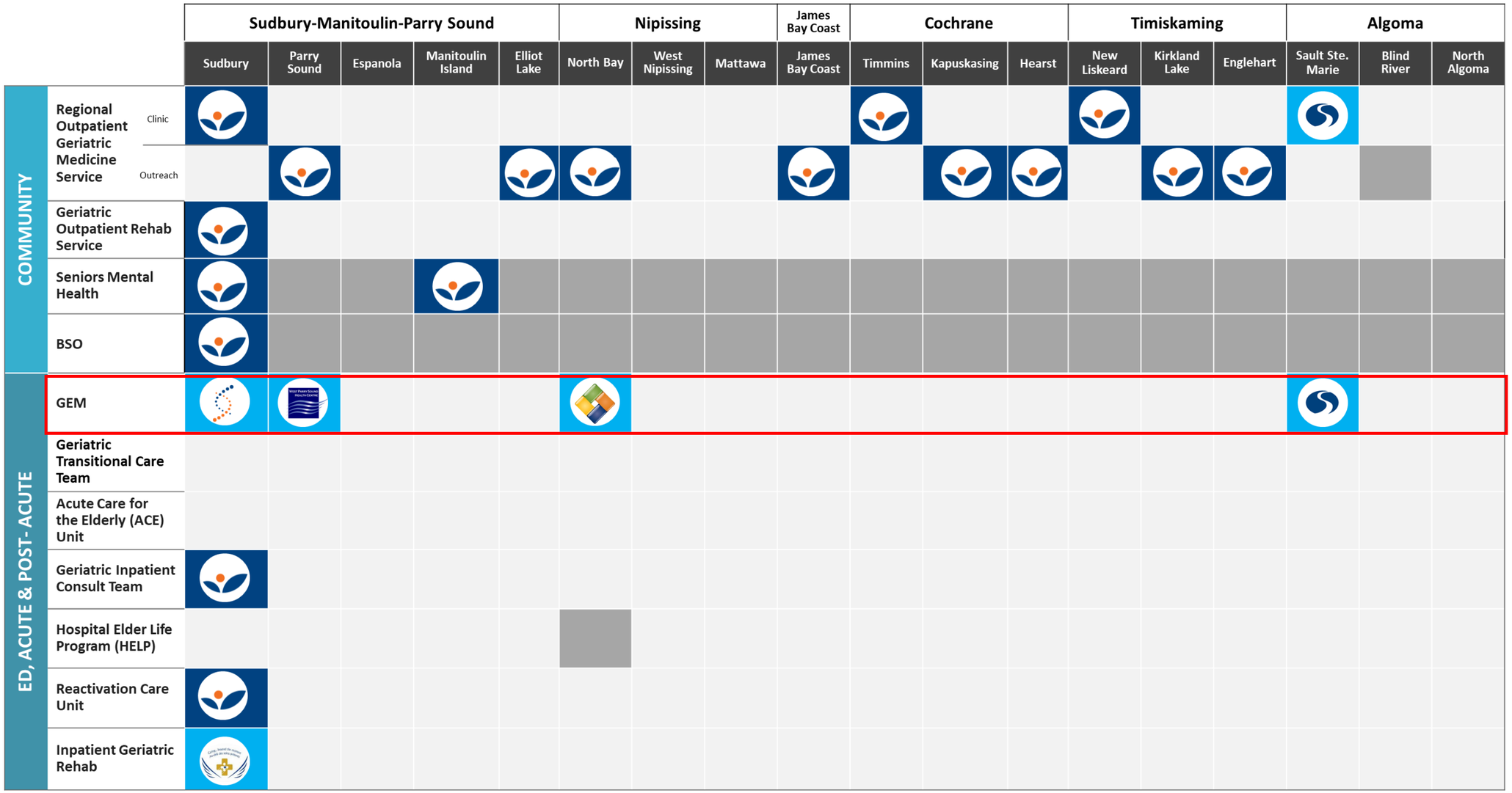
NESGC clinical services

NESGC provides mentorship, training and other leadership support for multiple SGS programs in the NE

SGS programs are delivered by other local health service providers across the North East



NE ALC Investment in SGS - 2022-24

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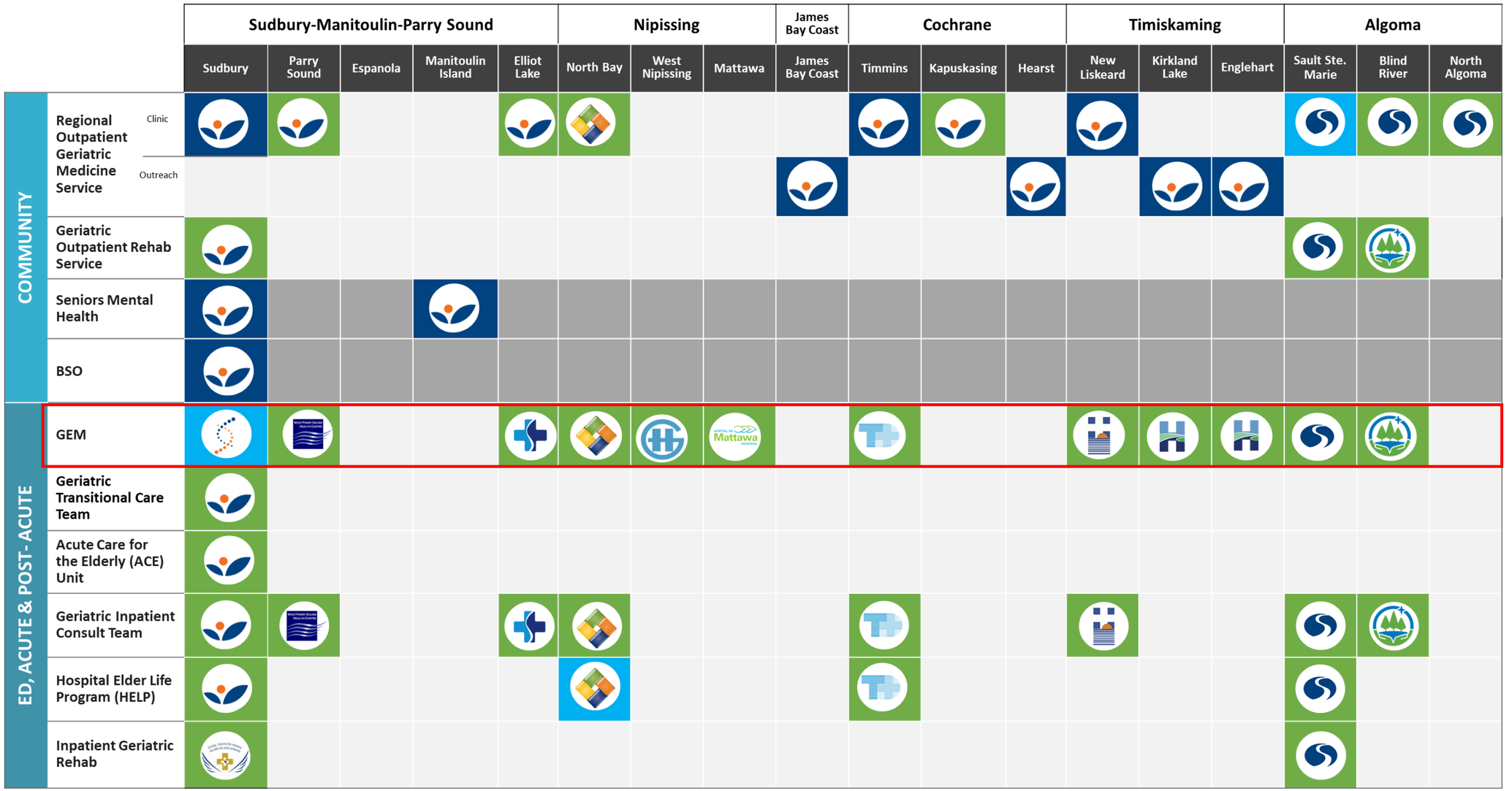
- New temporary investments in SGS as part of the Ontario Health NE ALC Strategy.
- NESGC provides clinical leadership for local implementation including: geriatric training and mentorship, care model development, service integration, and evaluation.
- NESGC's clinical leadership support is built-into SGS funding expectations.



Further Expansion & Evolution of SGS - 2024

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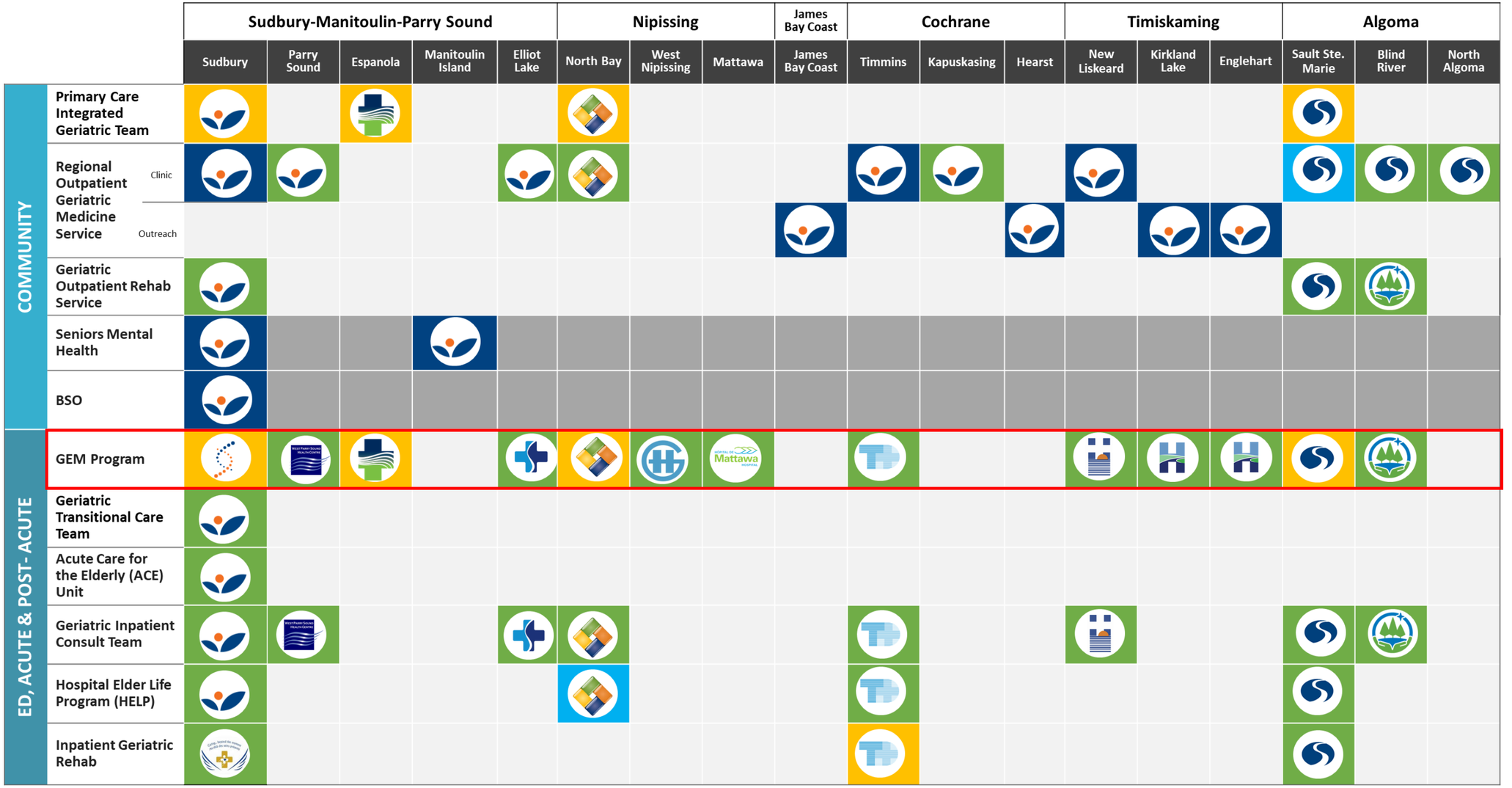
- Additional temporary investments in SGS and ongoing service expansion as part of OH NE ALC Strategy.
- NESGC provides clinical leadership for local implementation /service expansion including: geriatric training and mentorship, care model development & service integration
- NESGC's clinical leadership support is built-into SGS funding expectations.



The Implementation Playbook

1. The Opportunity

WHY are we implementing?

WHAT problem are we trying to solve?

WHAT is the goal?

WHERE will implementation take place?

In what setting/ location?

2. Population Profile	• Who is the target population impacted by the initiative? • What care do they require and what is the ideal state continuum? • Who provides clinical leadership?	**Target Population** **Standard of Care** **Care Continuum** **Clinical Leadership**
3. Implementation Roles	• Who needs to be involved in implementation? • Who benefits from the initiative? • Who is supporting behaviour change? • Who is connecting systems together?	**Patient & Caregiver** **Health Service Providers** **Implementation Support** **Clinical Support** **System Support**
4. Governance & Accountability	• What governance structure is required to support implementation? • What are the expectations for accountability?	**Local** **Regional** **Provincial**
5. Current Capacity	• What capacity is available to address the care needs of the population across the local continuum?	**Programs & Services Inventory** **HHR Inventory**
6. Care Pathway	• How does current capacity align to the Standard of Care? • What are the opportunities for improvement?	**Current State Care Pathway & Gap Analysis** **Improvement Opportunities**
7. Evaluation Framework	• What are the implementation goals? • What are the target outcomes? • What is the planned process?	**Implementation and Outcome Evaluation**

Implementation Roles

Required Roles for Implementation		WHO – Local Implementation of GEM Program
Recipients & Beneficiaries	Older adults & care partners	Older adults and care partners – PFAC, OHT, other
	Providers across the continuum	Hospital – ED, Acute Care, Rehab, CCC; Home and Community Care; Primary Care; Specialty Care – Geriatric care, Rehabilitative care, Palliative care
Delivery System	Organizational leadership	Senior leadership responsible for the work and those impacted by the work for involved providers
	Operational leadership	Managers, Supervisors, etc. for involved providers
	Content-specific champions	Local expertise – quality improvement/change management, geriatric care, rehabilitative care, patient flow, decision support, etc.
	Local implementation team	Interprofessional teams, physicians, patient flow, etc. from hospital, community, other
Support System (primary and secondary)	System leadership & implementation support	Primary – local and regional OH roles, OHTs
		Secondary – regional and provincial OH roles
	Clinical leadership & content-specific capacity building	Primary – RGP resources – local (sfCare Lead) and regional (Geriatric Rehab Lead, Knowledge Translator, Research and Evaluation Lead); BSO leadership, etc.
		Secondary – Regional RGP resources, PGLO, RCA, other

Population Profile - Target Population

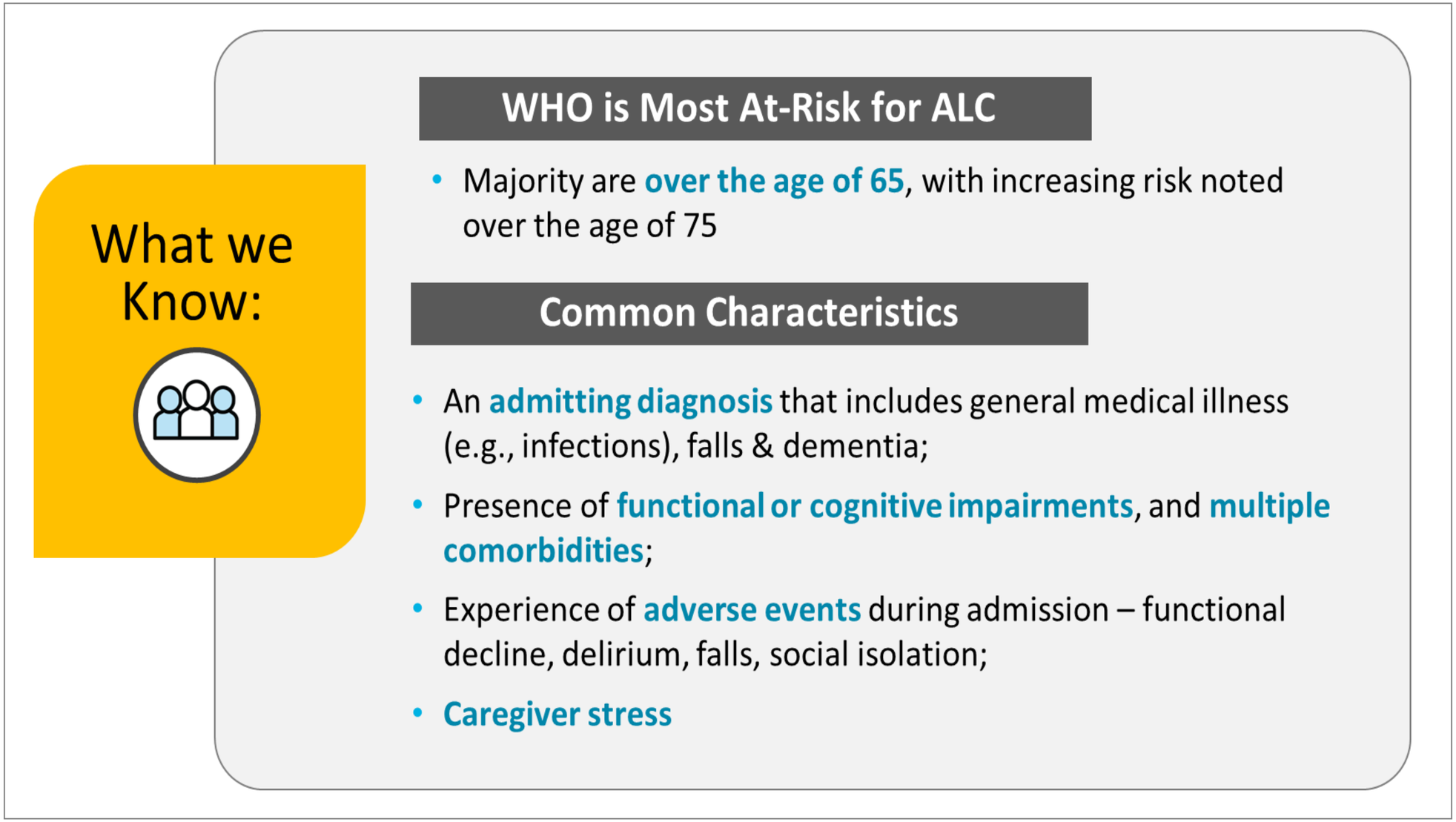


Figure 8. The population most at-risk for ALC

Target Population cont'd.

Acute Care FY 2023-24	Ontario Health North East	Hospital A	Hospital B	Hospital C	Hospital D	Hospital E	Hospital F
ALC Cases (n; % of Total cases)	4,262 (8%)	1,671 (8%)	1,014 (13%)	411 (5%)	298 (5%)	130 (6%)	102 (7%)
ALC Days (n; % of Total days)	126,719 (27%)	40,934 (25%)	20,149 (30%)	19,274 (32%)	5,339 (15%)	4,244 (23%)	12,538 (50%)
Age 65+	86%	86%	83%	88%	85%	87%	93%
Age 75+	66%	66%	63%	66%	59%	70%	83%
Top Case Mix Groups (CMGs) by ALC Cases	Dementia	Falls, Weakness, Frailty	Dementia	Dementia	Dementia	Dementia	Dementia
	Falls, Weakness, Frailty	Delirium	Hip Fracture	Delirium	Convalescence	Palliative Care	Rehabilitation
	Delirium	COPD	Ischemic Stroke	Falls, Weakness, Frailty	Falls, Weakness, Frailty	Convalescence	Palliative Care
	CHF	CHF	Hip Replacement with Trauma..	Hip Fracture	Palliative Care	Delirium	CHF
	Hip Fracture	Dementia	CHF	Hip Replacement with Trauma..	Hip Fracture	CHF	
	COPD	Hip Fracture	COVID	Parkinson's Disease	CHF	Ischemic Stroke	
	Hip Replacement with Trauma..	Hip Replacement with Trauma..	Delirium	Rehabilitation	COVID		
	COVID	Palliative Care	Fracture/Dis. Pelvis...	COPD	Ischemic Stroke		
	Palliative Care	COVID	COPD	Fracture/Dislocation Pelvis...	Hip Replacement with Trauma..		
	Ischemic Stroke	Lower UTI	Lower UTI	Reduc./Fix. Ankle...	Delirium		
% of ALL ALC Days	44%	47%	41%	54%	41%	41%	47%

Table 3. Using data to understand the population experiencing ALC

QBPs/ ICPs

Geriatric Syndromes

The Standard of Care

Using a provincial clinical guideline (ALC Leading Practices) to implement The Standard of Care

Standard of Care for Older Adults Living with/ at-risk of Frailty			
Core Elements of Care	Older Person & Care Partner Engagement		
	Equitable & Culturally Appropriate Care		
	Interprofessional Teams		
	Specialized Geriatric Expertise		
	Comprehensive Geriatric Assessment (CGA)		
	Evaluation		
Processes of Care	Early Identification		
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	Care Planning (includes Advanced Care Planning)		
	Intervention		
	Transitions		
Domains of Care	Cognition	Polypharmacy	Continence
	Social Engagement	Nutrition & Hydration	Pain
	Mobility & Falls	Delirium	Mood & Mental Health
	Skin Integrity	Function	Sleep

Provincial Clinical Guidelines for Older Adult Care

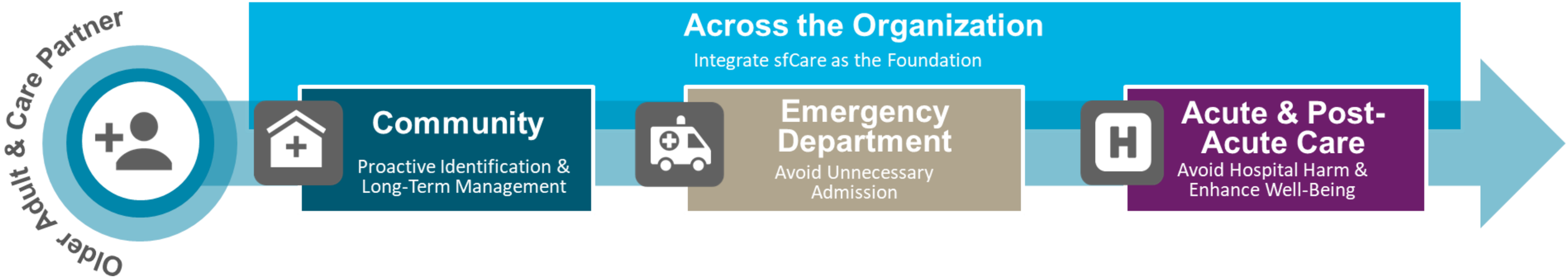
- ✓ Senior Friendly Hospital (2010) & Senior Friendly Care Frameworks (2017);
- ✓ Aging at Home Strategy (2010);
- ✓ Caring for our Aging Population and Addressing Alternate Level of Care (2011);
- ✓ Home First Implementation Guide & Toolkit (2011);
- ✓ Living Longer, Living Well (2012);
- ✓ Assess & Restore Guideline (2014);
- ✓ Direct Access Priority Process (updated 2024);
- ✓ Competency Framework for Interprofessional Comprehensive Geriatric Assessment (2018);
- ✓ Rehabilitative Care Best Practice for Older Adults Living With/At-Risk of Frailty (2021);
- ✓ Post Fall Rehabilitative Care Pathways;
- ✓ Quality Standards:

  Dementia (updated 2024); Behavioural Symptoms of Dementia (updated 2024); Delirium (2021); Transitions from Hospital to Home (2020); Hip Fracture (updated 2024), etc.;
- ✓ The Alternate Level of Care (ALC) Leading Practices Guide (Hospital - 2021), (Community – 2022);
- ✓ My Personhood Summary©;
- ✓ My Transitional Care Plan©

Ontario Health · LHINCollaborative · Provincial Geriatrics Leadership Ontario · RGP Regional Geriatric Program of Toronto · Rehabilitative Care Alliance · Behavioural Supports Ontario

Figure 11. Using a provincial clinical guideline (ALC Leading Practices) to implement The Standard of Care

Current Capacity



Care Pathway

GEM – Ideal State

Purpose	Quality Indicators (Desired Outcomes)	Target Population	Key Stakeholders	Planned Availability	Training Needs	Infrastructure/Resources Needed

• With 85% of ALC designations within north east (NE) hospitals attributed to older adults (65+) in 2021-22, ensuring that this population receives evidence-based care that meets their specialized needs is a key factor in improving health outcomes and system flow.
• In order for SJGH to bring down ALC numbers, admission diversion is a key factor. Starting point is GEM in ED.
• Early identification of at risk OA that includes assessment of all geriatric domains impacting overall function and risk of ELOS.
	• Reduction with re-presentation to ED of patients that have seen GEM clinician
	• 2 targeted geriatric assessments/day/GEM clinician (10/week)
	• 1 follow up per day/GEM clinician on patients that were referred to GEM but not seen while in ED
	• Screening all registered patients over 65 during GEM hours
	• Track number of patients over 65 that were eligible for GEM but not assessed
	• ED staff (nursing and physician) report understanding of GEM role and process (*survey)*
	• ED staff understand community supports available and referral process
	• Reduction in # of admissions
		• 65+
		• + ISAR 2+
		• Frail
		• When a patient has the presence of one or more geriatric syndrome:
		  ○ Impaired mobility
		  ○ Falls
		  ○ Pain
		  ○ Polypharmacy
		  ○ Incontinence
		  ○ Impaired Nutrition
		  ○ Impaired sleep
		  ○ Cognitive impairment (dementia, delirium)
		  ○ Depression
		• Experience functional decline
		• Frequent emerge visits - ? need benchmark
		• Visual/hearing impairment
		• 6 or more medications
		• Caregiver stress/burnout or no identified caregiver/support system
		• Lives alone
			Core Group:
			• ED manager (Danielle McGeachie)
			• VP/CNE (Leslie Saunders)
			• GEM nurse (Helen Schryer)
			• Staff nurse
			• ED physician/NP/PA
			• HCCSS
			• Inpatient consult team
			•
			
			Ad-Hoc Members:
			• Inpatient consult team
			• Community partners:
			  ○ NESGC
			  ○ CP
			  ○ March of Dimes
			  ○ HCCSS
			  ○ SMH
			  ○ BSO
			  ○ Red Cross – PATH/My way Home
			  ○ Palliative care
			  ○ RH's
			  ○ Food systems
				2 – 3 FTE's:
				7 days a week 10-12hrs/day (7am to 7pm)
					GEM Staff:
					• Provincial Common Orientation
					• Shadowing minimum one other site with experienced GEM nurses on initial start and 3-6 months into role
					• Mentorship for targeted GA/CGA
					• Geriatric certificate program
					• Meditech training
					• Orientation to ED including processes
					• One on one time with ED educator
					• Sharing and support within other disciplines (ie OT vs nursing)
					Emerge staff (nursing and physicians)
					• Orientation to GEM role
					• Expectations of staff nurse on referral process
					• Understanding of geriatric syndromes
					• Community resources
					• Triage risk indicator (eg ISAR/TRST/Frailty Modifier)
						• Job description
						• Office space near ED that provides confidential space
						• Computer (laptop and 2nd screen)
						• Work phone with headset
						• Supplies: Large filing cabinet; holders to keep patient brochures, printer
						• GEM binder – for staff that provides information on GEM role, referral process, ISAR tool etc
						• Meditech expanse
						• Access to other systems – HPG (full access – interRAI), connecting Ontario, Accuro (NESGC), BSO access, Caredove, SMH database, Community Paramedicine)
						• Patient and care partner resources

Care Pathway

GEM PROCESS

1. Identification

a) Patient identification process:
- Physician identification and referral
- Nursing identification and referral. ISAR tool utilized as well as identifying Geriatric Syndromes
- Case finding by GEM Nurse by reviewing older adults currently in ED

b) Referral process:
- Once patient identified, GEM referral entered by the Triage nurse or the emergency room nurse if patient comes in via ambulance.
- The nurse that triages the patient is the one that identifies the need for the GEM referral and then order enters the referral in Meditech.
- If patient is identified by GEM nurse through case finding, GEM nurse will enter her own GEM referral through order entry in meditech
- Referrals are listed in Meditech for GEM Nurse to review and triage further through GEM process.

c) Triage:
- Review referrals to determine if patient remains in ED
  - For patients admitted to acute care prior to being assessed, GEM cancels the referral and will then refer to the appropriate area. This may include:
    - a report to the charge nurse with suggestions of further referrals,
    - a referral to the Geriatric Assessor and/or a referral to Social Work.
  - If GEM has already assessed the patient in emergency and the patient is admitted, the GEM assessment is included in the EMR and a warm verbal handoff should be given to the geriatric assessor and/or charge nurse in acute care
  - For patients already d/c from ED: referral is kept for follow up. The GEM nurse attempts x 3 to follow up with these patients and do a targeted GEM assessment via telephone. These referrals are not priority over in person referrals. Priority is given to all in person assessments that can be done during working hours of the GEM nurse.
- Triage remaining GEM referrals of patients remaining in ED:
  - GEM to review medical history on Meditech
  - Criteria for triage includes:
    - 65+
    - + ISAR 3+
    - Frail
    - When a patient has the presence of one or more geriatric syndrome:
      - Impaired mobility
      - Falls
      - Pain

2. Assessment

a) Initial work up:
- Gathering information from various databases (ie HPG, Meditech, current and previous visits, Ontario clinical viewer, Community Paramedicine notes, Accuro, mental health databases); review previous visits in Meditech ** I DO NOT HAVE ACCESS TO CLINICAL VIEWER, COMMUNITY PARAMEDICINE OR MENTAL HEALTH DATA BASES
- Chart review, discussion with nurse or physician for understanding of current state

b) Assessment: (60-90 min)
- With patient and care partner (if present)
- Targeted Geriatric Emergency Management Assessment (see template).

c) Collateral information: (30-60min)
- If care partner not present, obtain consent from patient and call family/supported living to gather collateral history
- Should review all domains especially if concerns with cognition

d) Opportunity for in person mentoring of bedside nurse and interdisciplinary team with immediate action items.

e) Documentation
- Targeted Geriatric Assessment is fully documented and available within EMR under notes
- Includes all recommendations and referrals made to external agencies

4. Communication with team/physician
- After completion of targeted geriatric assessment, GEM nurse to discuss assessment findings and recommendations with ED physician and ED nurse

5. Interventions
- Education/discussion re: recommendations to both patient/families, interdisciplinary team, physicians
- Recommendations may include:
  - Referrals to community agencies such as HCCSS, Community Paramedicine, Community geriatric services (NESGC), Red Cross PATH or My Way Home, Meals on Wheels, Alzheimer's Society, SMH, CAMH, CCEA, Huron Lodge Programming, Elliot Lake Family Health Team Allied Health, BSO etc
  - Food, pharmacy, medication, counselling, care for the caregiver programs, self-referrals for patients and caregivers
  - ED interventions such as:
    - Delirium work-up, prevention, management
    - Mobilization
    - Nutritional supplementation
    - Hydration

Care Pathway

Workplan GEM

Item	Description/Action	Lead(s)	Status	September	October
GEM Process					
Finalize GEM ideal state and process document	Core group to review and determine if any changs are required	Nicole and Renee	**IN PROGRESS**		
Engaged ED manager	Review ideal state, processes and support required for implementation	Brooke	**IN PROGRESS**		
Referral process to GEM/identification	screening process Team lead expectations		**IN PROGRESS**		
Identify physician champion	must identify a physician to understands the role and can champion to others and nurses	ED manager/Brooke/Renee	**NOT STARTED**		
Process for warm handoff to inpatient team (GICS, Terri, BSO)		Renee/Lise/Teri/Shelley	**IN PROGRESS**		
process for referrals that require physician order (ie NESGC, inpatient consult etc)		Brooke/ED manager/Renee	**NOT STARTED**		
link to early identification opportunities as hospital wide initiatives	Link to any work being completed by home first initiative; Renee must be part of the planning	Brooke/ED manager/Renee	**NOT STARTED**		
ED diversion	need to establish process for out-pt follow up on patients that presented to ED (included in overall GEM process)	Brooke/Renee/support from Dr. Colleen Davies/Dr. Scott.	**NOT STARTED**		
IT					
ED space for GEM	alcove currently not in use; 2 chairs	Brooke/Nat to discuss			
Data & Evaluation					
Adapt NESGC GEM Data Tracking	- Adapt the tracking sheet to the Needs of Temiskaming		**IN PROGRESS**		
GEM Data Tracking Evaluate Plan	- Determine frequency and method fo data evaluation - Monthly auto generated		**IN PROGRESS**		
development of tools/surveys for data tracking	support with developing survey for staff knowledge on GEM role		**IN PROGRESS**		
GEM rapid evaluation	NESGC to support first rapid evaluation		**NOT STARTED**		
Promotion & Education					
Education and Communication Plan for entire organization	purpose of each SGS service - target population - desired outcomes - how to refer	Renee, Lise, Brooke	**NOT STARTED**		
Educate ED and ED Physicans	includes above	Renee, Brooke	**IN PROGRESS**		

Evaluation Framework

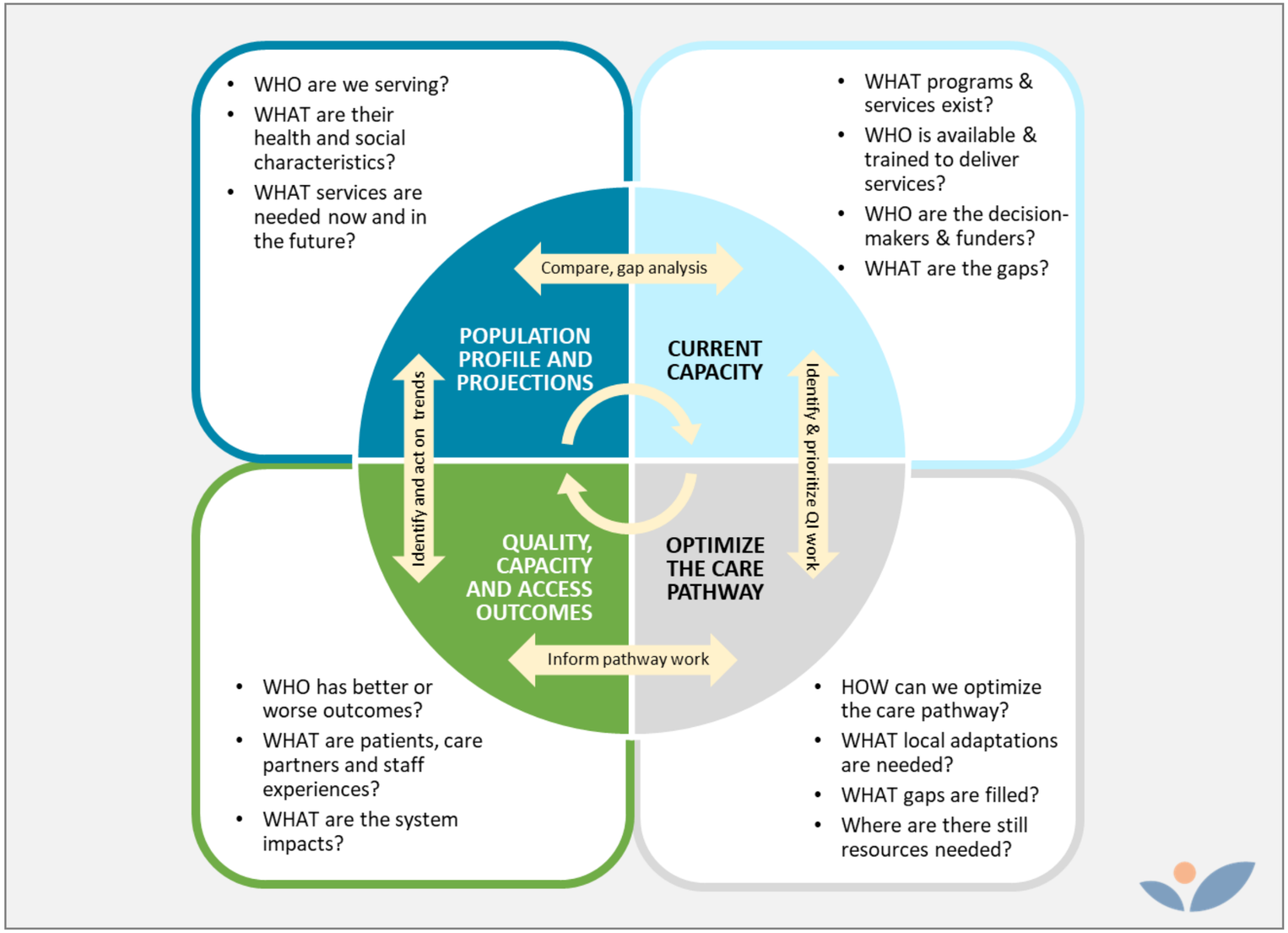
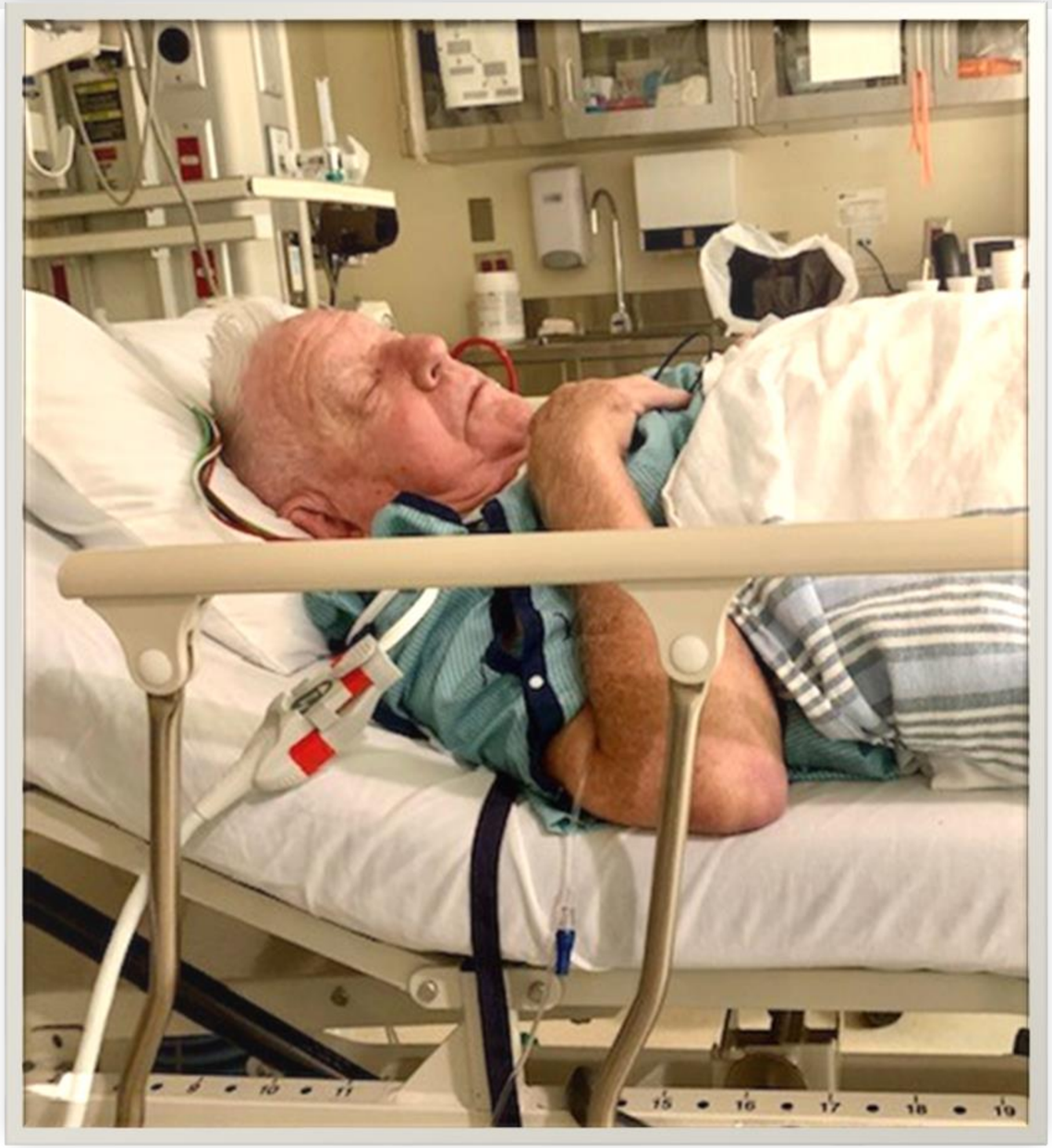


Figure 25. The NESGC Evaluation Framework

GEM implementation



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GEM
Geriatric Emergency Management Programs

Supporting Ontario's Emergency Departments to Provide Excellent Care for Older Adults

A few take aways….

North East Specialized Geriatric Centre

Regional Geriatric Program of Eastern Ontario

Provincial Geriatrics Leadership Ontario

GEM Provincial Accomplishments

- Network welcome message to all new GEM nurses (if you let us know)
- Improved webpage https://geriatricsontario.ca/initiatives/gem/
- Updated contact list
- Training support for new GEM nurses via **Provincial Common Orientation to the Care of Older Adults**
- GEM program implementation guidance (August 2023, December 2024)
- GEM Conference May 2024 (archived presentations remain available)
- Collegial GEM-led support on clinical questions
  - Approaches to charting
  - GEM role
  - Linkages between GEMs to support repatriation
  - Management approaches to lengthy admit wait times in the ED
- Feedback on ***Ontario Health Emergency Department Nurse Onboarding Geriatrics Module***.

With thanks to the ad hoc review team: Natalie Kidner, Janny Lee, Audriana Di Ruzza, Naomi Cheechoo, Sandra Bauer, Lana Black, Leon Petruniak, Inderjeet Singh, Laurie Angle, Kelly Kay

Resources

bitly

GEM
Geriatric Emergency Management Programs

Provincial Website

Developing and Implementing a Geriatric Emergency Management (GEM) Program: Getting Started

GEM
Geriatric Emergency Management Programs
Supporting Ontario's Emergency Departments to Provide Excellent Care for Older Adults

Date and Time: December 19, 2024, 1:00 to 2:00 pm

Intended audience:

- Organizational and emergency department leaders currently implementing a GEM program (including GEM nursing and other roles).

Register for this webinar

Session Objectives

1. Identify the organizational supports needed for the implementation of successful GEM programs.
2. Review GEM processes of care, from identifying patients and conducting assessments to responding to atypical presentations in the older adult and supporting discharge or admission with a plan.
3. Identify local, regional and provincial resources to support and sustain GEM program implementation.

Provincial Geriatrics Leadership Ontario
North East Specialized Geriatric Centre
Regional Geriatric Program of Eastern Ontario

Provincial Common Orientation

Tier 1 & 2 Facilitated Series

Winter 2025

January 10th, 2025 – March 25th, 2025

Enhancing Knowledge in the Care of Older Adults

Fridays and Tuesdays from 1:30 – 3:00 PM

Weekly 90-minute Sessions

An 11-week interactive virtual series suitable for a variety of health and social care professional audiences.

Facilitated by professionals experienced in the care of older adults

Scan for full Program Outline

Topics Covered in Tier 1
Foundations in Geriatrics for Interprofessional Teams (Three Weeks)

- Understanding what older adults want (Goals of care)
- Identifying the roles and responsibilities of partners on the care team (including caregivers)
- Recognizing age related changes
- Recognizing and responding to ageism
- Communicating with older adults
- Defining frailty and conducting a frailty screening and functional inquiry

Topics Covered in Tier 2
Enhanced Knowledge and Skill Development in the Care of Older Adults (Eight Weeks)

- Adapting processes of care
- Recognizing and responding to the care needs of older adults (With respect to medications, delirium, dementia, mental health, pain, sleep, falls, mobility, nutrition, continence and sexuality)
- Fostering social connectivity
- Recognizing and responding to the unique needs of caregivers
- Contributing to care plans, treatments, and interventions
- Facilitating system navigation

Registration Link: https://forms.office.com/r/mxfG9rPzhy

(When registration closes, the link will not work, if this occurs, please contact programs@geriatricsontario.ca)

The Provincial Common Orientation is currently delivered free of charge. PGLO also welcomes organizational sponsorships to support low facilitator to participant ratios and enhance interaction.
Interested organizations are invited to contact the PGLO team to discuss sponsorship opportunities.

Contact us at info@geriatricsontario.ca and programs@geriatricsontario.ca
Visit our website at https://geriatricsontario.ca/

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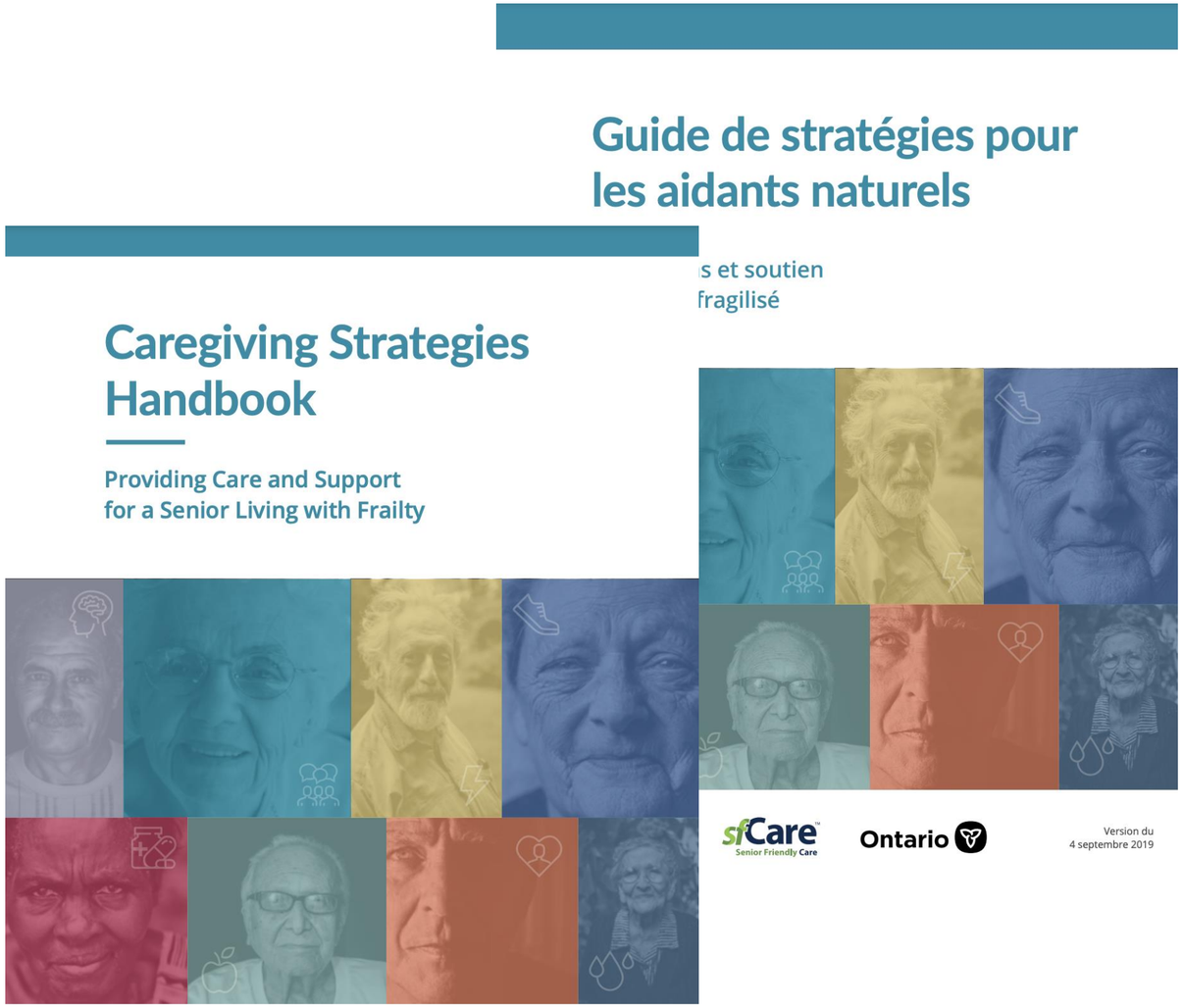
Resources for Care Partners



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Thank you

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