SENIOR ER

“PERSON CENTRIC”
CARE TRANSITIONS

NOVEMBER 6, 2013

Kathy Dattolo LMSW / J. Michelle Moccia ANP-BC
St. Mary Mercy Hospital: 304 inpatient bed
53 bed ER; 1st Senior ER in State of Michigan July 2010
Trinity Health (48 and Catholic Health East = 82): total 17 with Senior ER
with 3 in process
OUR VISION...
To be a Truly Great Hospital, providing Comprehensive, Coordinated, and Compassionate Care, every time to everyone.

OUR MISSION...
We serve together in Trinity Health, in the spirit of the Gospel, to heal body, mind and spirit, to improve the health of our communities and to steward the resources entrusted to us.
Adding life to years,
not just more years to life
(Gerontological Society of America)
Gray Tsunami

• By 2030, nearly one in five Americans will be over the age of 65. (38.7 million)
• By 2050, this will double to 88.5 million
• Next 19 years, every single day 10,000 baby boomers reach the age of 65
• Centenarians is the fastest age group
• Every hour 10 more Michiganders turn 65
• By 2035, one in 4 Michiganders will be 65 and older
Number of Older Americans shows the large growth of the population 65 and older from 1900 to 2008 and the even greater projected growth from 2008 to 2050. It also shows the growing numbers of persons 85 and older and their large projected growth to 2050.
ENA Position Statement (2010)

ENA recognizes that optimal care of the older adult is best achieved by:

• Members of the team collaborate to assess and treat
• ED nurses must be knowledgeable in physiologic, psychological, sociologic, and economic changes in older adult and how these changes impact assessment, interventions, teaching, discharge decisions, and community referrals
ENA position statement

- Geriatric education needs to be included in basic and continuing education
- Recognize the patient, the spouse, or family members may need assistance – the need for collaboration with other HCPs, organizations, and groups may be necessary to promote a safe and healthy environment
- Medication problems may go unrecognized & screening for elder abuse and reporting must be carried out
- American College of Emergency Physicians also endorses care of older adult
Emergency Departments & older adult

- High acuity
- High stress
- Rapid decision
- Rapid diagnosis
- Rapid disposition
- Task oriented
- ED admission can become a sentinel event
- Incomplete information creates obstacles to provide high quality care
- Joint Commission > 70% communication errors are the root cause of almost 70% of sentinel events and 75% died
New Senior ERs

• Avoid obstacles that prevent high-quality care
• Improve communication especially in those coming from nursing facilities and independent senior residences
• Focus on environment changes to address age related changes
• Focus on lifestyle, social support, function, cognitive ability
Emergency Area for Seniors

Environment Changes
• Improve patient comfort/satisfaction – pressure reducing mattresses, reclining chairs; removal of noise distracters, warm blankets, HCP names and tests ordered on board
• Reduce risks of fall (flooring, lighting, assistant devices, colors, hand rails, gait belts)
• Reduce risk of delirium (visual aids, “pocket talkers”)
Affordable listen device
Risk Factors

- Older individuals are discharged are at greater risk for complications. Independent functioning may be threatened.
- Older adults that were discharged from an ED experienced a revisit, hospitalization or death within 3 months in 27% of the cases (Hwang U & Morrison RS, 2007).
- In one month, office of Inspector General found 14% of Medicare recipients experience and adverse event; 44% were attributed to inadequate monitoring or patient; 60-70% communication errors.
- Assess one’s own values, attitude, perception and beliefs about caring for an older adult.
- Be careful with elder speak – can be demoralizing – cause dependence.
Current Patient safety and concerns

- A patient presenting with **cognitive impairment** can complicate the scenario if they are unable to describe their symptom; self-report pain; no advocate or no one accompanies can add to vulnerability.

- Further stressing emergency HCP are difficulties in **“hand-off” communication** from the referring physician or nursing home.

- The **Emergency Nurse’s Association (ENA)** has recognized this challenge and has created a Safer Handoff for the Older Adult. ([www.ena.org](http://www.ena.org))

- **Medication** history is vital

- **Transition of Care** (STARForUM group to work with SNF, AL, independent livings, group homes etc. to create a seamless hand-off: **Safe Transition of All Residents For yoU & Me**

- STARForUM phone directory to identify services provided
Screening are necessary

- **Screenings** added to identify patients at risk for safety and poor outcomes that are not often captured with a medical screening.
- Greater **diagnostic and disposition accuracy**.
- Recognize **decline in functioning** - enable HCP to provide a specific plan of care thus improve outcomes in the elderly.
- Evaluating **multiple domains of behavior and function** will assist in assurance of positive outcomes.
- Identify need for **palliative care** for long term management of patients with chronic illnesses and or need expert pain control.
- **Special services may be required to support older adult through continuum of care** i.e. housing, transportation, nutrition, durable medical equipment, counseling, caregiver support.
**T.H.I.N.K . 3 D**

- Triage risk screening, Treatment, & Transition
- Here for fall or at risk for falls? Hospital syndrome
- Inquire about medication, pain, alcohol use, advanced directive, immunization
- Nutrition assessment; normal VS may not be so normal
- Katz functional assessment
- “3 D” Dementia, Depression, Delirium

*To age gracefully requires that we stop denying the facto of aging and learn and practice what we have to do to keep our bodies and minds in good working order through all the phases of life”*
Andrew Weil, MD, p. 7 Healthy Aging: A Lifelong Guide to your well-being

(Thank you to Keyaria and Holly Beversdorf Nursing 4040 WSU)
Triage Risk Screening Tool (TRST)

- **Improves case finding**: assessing for cognitive impairment, environment (lives alone, support person, lives in senior apartment, assisted, skilled. Fall history; ED or hospital history; any special needs recognized i.e. caregiver strain; abuse or neglect signs; nutrition; frailty
- The presence of two or more risk factors designates the older person as being “at high risk”.

Cleveland project developed to test the Systematic Intervention for a Geriatric Network of Evaluation and Treatment (SIGNET)
### Senior ER Screening

#### Does the patient have any of the following conditions?

- [ ] None
- [ ] Emergency Severity Index (ESI) 1
- [ ] In ER less than one hour
- [ ] Other:

#### Presence/History of Cognitive Impairment

*Examples: disorientation, unable to follow directions, diagnosis of dementia or delirium*

- [ ] Yes
- [ ] No

**Patient admitted to the ER from Sr. residential community**

- [ ] Assisted living facility
- [ ] Independent
- [ ] Skilled nursing facility
- [ ] Group home
- [ ] Long term care facility
- [ ] Other:

#### Patient Lives Alone

- [ ] Yes
- [ ] No
- [ ] Unable to obtain

#### Patient lacks caregiver available, willing or able

- [ ] Yes
- [ ] No
- [ ] Unable to obtain

#### History of Recent Fall within 30 Days *(Includes this visit)*

- [ ] Yes
- [ ] No
- [ ] Unable to obtain

#### Not counting this ED visit, patient has used any ED facility within the past

- [ ] 72 hrs
- [ ] 30 days
- [ ] Unable to obtain

#### Hospitalized within the last 3 months?

- [ ] Yes
- [ ] No
- [ ] Unable to obtain

#### Have you had a weight gain or loss of 10 pounds in the last 3 months?

- [ ] Yes
- [ ] No

#### Pt has difficulty with activities of daily living

- [ ] Walking
- [ ] Bathing
- [ ] Toileting
- [ ] Feeding
- [ ] Transfers
- [ ] Dressing
- [ ] Confusion
- [ ] Other:

#### Patient requires further follow-up at home

- [ ] Suspected abuse, neglect, self-neglect and exploitation
- [ ] Non-compliant pt. fewer than 5 meds. keeps coming back to ED
- [ ] Suspected substance abuse (alcohol or drug)
- [ ] Problems with meeting instrumental activities of daily living
- [ ] Difficulty filling prescriptions
- [ ] Issues with access to food
- [ ] Transportation issues
- [ ] Caregiver strain
- [ ] Palliative care
- [ ] Hospice care
- [ ] Pain management
- [ ] Spiritual care
- [ ] Other:

#### Does patient meet any of the following criteria for a Pharmacy referral for a medication profile review? (Select all that apply)

- [ ] None
- [ ] Admission to the ER due to a fall
- [ ] Admission to the ER with an acute change in mental status
- [ ] Meets other MD-specific criteria for a medication profile review by Pharmacy
- [ ] Other:

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**EMR SENIOR ER SCREENING**
Treatment more complex in older adult

- Higher risk of complications from hospitalization
- Loss of physiologic reserves: impaired renal flow, impaired hepatic flow, and poor homeostatic mechanisms
- Loss of functional ability that may be caused by disease or hospitalization.
- Cognitive impairment, hearing and visual impairment may affect stay in the ED
- Depression more common
- Delirium more common
THINK 3 D

Transition of care

- Broken in both directions
- Facilities and EDs operate independently
- Increases risk of unwanted, unnecessary care
- Increases costs
- Increase medication errors
- Financial liability
- Hospital and Facility reputation
- Patient satisfaction

Patient care in one site affects the care that should take place in another

(Terrel & Miller, 2006)
Key elements identified for transition to Emergency Department

- Reason for admission
- Medication history and time of last dose*
- Medical & Surgical History
- Code status
- Contact information (facility, patient’s emergency contact, primary care provider)
- Fall – mechanism of injury

* Medication errors is a major source of morbidity & mortality in transition of care
Key elements identified for transfer from ED back to Facility

- Discharge diagnosis
- Medications administered in ED
- Recent Vital Signs
- Test performed and results
- Verbal Hand-off
Transition (Transfer) Checklist

- Key elements
- Evolved into SBAR format
- Recent Antibiotic use (help with ED stewardship)
- Immunization history (tetanus etc.)
- Baseline cognitive*
- Baseline functional status**
- The “Why” provided in a Question & Answer Information Sheet
  * Delirium an acute medical emergency
  ** Hospital syndrome
TRANSACTION CHECKLIST

(Name of Facility, Assisted Living, or Independent/phone #)
Resident Name: __________________ Room Number/Apt.: ___________

SITUATION: (Reason for transition):

Transport due to a FALL?  □ Yes  □ No
Witnessed?  □ Yes  □ No
Loss of consciousness?  □ Yes  □ No
Head trauma?  □ Yes  □ No
On anticoagulants?  □ Yes  □ No
□ Coumadin  □ Pradaxa  □ Plavix  □ Aspirin  □ Lovenox  □ PERC Alert*
* Potential Emergency Reversal Candidate Alert (PERC)
Resident's Code Status: __________

BACKGROUND:
Primary Care Provider (Doctor/NP/PA) ___________________________ Phone # ___________
Family/Responsible Person Notified?  □ Yes  □ No
Enclosed COPIES in envelope (check all that apply):
□ Face Sheet or copies of license/state ID and insurance card(s)
□ SBAR/Nurse's Progress Notes
□ Recent MD/NP/PA Orders related to Acute Condition
□ Allergies documented
□ Current Medication list or MAR with DOCUMENTED LAST TIME DOSE GIVEN, if available
□ Nutritional Needs (if applicable i.e. pureed/thickener)
□ Advance Directives/DPOA-Health/Do-Not-Resuscitate
□ Resident Transfer Form including CURRENT:
□ Medical History □ Surgical History
□ Immunization Status (date as accurate as possible)
□ Influenza ______/_________  Pneumococcal ______/_________  Tetanus ______/_________  Zostavax ______/_________
□ Oxygen

ASSESSMENT: Vital signs: BP ______/_____/R_____/Pulse ox______/BS______
□ ADLS; Personal Care Service Company ___________________________ Phone ___________________
□ Mentation baseline ___________________________

Send these documents IF INDICATED and IF AVAILABLE:
□ Most Recent History & Physical and any recent hospital discharge summaries
□ Recent antibiotic use (30 days) Antibiotic ______/_____/Name ______/_____/Dose ______/_____/Date D/C ______/_____/__
□ Relevant Lab Results  □ Relevant X-rays

RECOMMENDATION/Referral/Request: (Treatment, Tests, Next steps etc.)

OTHER: □ PERSONAL BELONGINGS SENT WITH RESIDENT:
□ Eyeglasses  □ Hearing Aid(s)
□ Dental Appliance  □ Other (specify) ___________________________

Signature of Person completing Checklist: __________________ Phone No.: __________
Date: __/____/______

Signature of EMS Staff Accepting Envelope/Checklist: __________
Date: __/____/______
Transition (Transfer) Envelope

ST. MARY MERCY
LIVONIA
SAINT JOSEPH MERCY HEALTH SYSTEM
Emergency Department

PATIENT DOCUMENTS FOR FACILITY RETURN

PLUE LABEL

Destination: ____________________________________________ By: ____________________________
Report called to: ____________________________________
Personal Belongings Returned to Patient: (ED RN)
- Eyeglasses
- Hearing Aid(s)  R  L
- Dental Appliance(s)  Upper  Lower
- Other (specify): ____________________________________

CHECK OFF LIST FOR CLERKS

- History and Physical
  (If available at time of transfer) ________________________
- Face Sheet __________________________________________
- D/C Instructions _____________________________________
- Radiology Report
  - CT ________________________________________________
  - X-Ray ____________________________________________
  - US ________________________________________________
  - Vascular __________________________________________
  - MRI ______________________________________________
- Disc Sent __________________________________________
- 12 Lead EKG _________________________________________
- Emergency Department Summary
  (Medications given in ER, lab results and progress notes) ....

ADDITIONAL ITEMS

- Rx for Narcotics / Medications _________________________
- Other (i.e. Referrals) ________________________________

36475 Five Mile Road
LIVONIA, MI 48150
Phone: 734-465-1290 (ED)
stmarymercy.org
# Phone Directory – Color coded

**STARForUM Phone Directory**
(Safe Transition of All Resident For yoU and Me)

The STARForUM Phone Directory contains a list of Senior Residences that use SMMI as their primary 911 care provider.

<table>
<thead>
<tr>
<th>Name of Facility</th>
<th>Level of Care</th>
<th>Address</th>
<th>Telephone #</th>
<th>Fax #</th>
<th>Administrator/CNO</th>
<th>On-Site Care Provider (Name, Ph #, Fax #)</th>
<th>RN Coverage Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>American House: Westland</td>
<td>Independent Living</td>
<td>39201 Joy Road</td>
<td>734-4751</td>
<td>734-455-8530</td>
<td>Deborah Stanley</td>
<td>Angela Crawford (LPN) Supportive Care 734-455-1717 Supervisor: CathyReynolds</td>
<td></td>
</tr>
<tr>
<td>Arden Court</td>
<td>Assisted Living</td>
<td>22500 Seven Mile Rd., Livonia, 48154</td>
<td>248-420-7055</td>
<td></td>
<td>Kristie Nagel</td>
<td>Wellness RN 248-943-0565</td>
<td></td>
</tr>
<tr>
<td>Ashford Court Senior</td>
<td>Independent Living</td>
<td>37501 Joy Road, Westland, 48185</td>
<td>734-451-1155</td>
<td>734-451-0177</td>
<td></td>
<td>Homestead Home Health Care Services</td>
<td>734-254-0615</td>
</tr>
<tr>
<td>Autumnwood of Livonia</td>
<td>Independent Living</td>
<td>14900 Middlebelt Rd., Livonia, 48154</td>
<td>734-425-4200</td>
<td>734-425-6057</td>
<td>Rob Russeu <a href="mailto:livonia_admin@cienfacilities.com">livonia_admin@cienfacilities.com</a></td>
<td></td>
<td>24/7</td>
</tr>
<tr>
<td>Berkley Court</td>
<td>Assisted Living</td>
<td>32406 7 Mile Rd., Livonia, 48152</td>
<td>248-442-7780</td>
<td>248-442-4824</td>
<td>Robin Gillis <a href="mailto:robingills@berkleycourt.com">robingills@berkleycourt.com</a></td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Brighton Gardens</td>
<td>Assisted Living</td>
<td>15870 N. Hagerty, Plymouth, 48170</td>
<td>734-420-7917</td>
<td>734-420-7918</td>
<td>Tamyra Pollack</td>
<td>Wellness office will give you information about patient</td>
<td>RN/LPN on call 24 hour</td>
</tr>
<tr>
<td>BrightStar</td>
<td>Private Non-Medical and Skilled</td>
<td>48100 W. Eleven Mile Road Suite 109 Novi, 48375</td>
<td>248-449-5110</td>
<td>248-449-5165</td>
<td>Debbie Wehner (DON)</td>
<td></td>
<td>24 hour on call</td>
</tr>
</tbody>
</table>

RED-Skilled Nursing Facility  YELLOW-Assisted Living (receives on-site provider care)
GREEN-Independent Facility (may receive support services) PURPLE-Home Care (skilled/non-skilled)
MULTI-COLORED-Continuum of Care Facility-all levels of care
THINK 3 D:
Here for a Fall

- Leading cause of injury and injury related mortality
- Leading cause of head injuries
- Factor in over 90% fractures of distal forearm, proximal humerus, and hip
- Nonfatal injuries associated with loss of independence
- Not a normal part of aging
- More likely to be problematic
- As many as 50% who are hospitalized following a fall die within one year
- Highest risk especially those with physical and or cognitive impairment
Fall: ESI 1, 2, or 3*?

- Witnessed?
- Loss of consciousness?
- Sitting or standing?
- Carpet or hard floor?
- Symptoms prior to fall?
- On Anticoagulant? (Coumadin, Pradaxa, Xarelto, including aspirin)

* 5 Level Triage System (2003 ACEP & ENA)
Hospital Syndrome

- NPO
- Diet
- Physical activity
- Sleep
- Discharge
THINK 3 D – Inquire about Medication History

- What medications are you currently taking?
- OTC?
- Vitamins, herbal, home remedies?
- Topicals, eye drops, patches?
- Med reminders i.e. mealtime, pill box?
- How do you know when you miss a med?
Inquire about Med History

Consider new symptoms as a possible drug to drug interaction.

- 5 medications = 70% chance of drug interactions
- 7 medications = 100% chance of drug interactions

Dosing guidelines adjusted to creatinine clearance?

Do they see another PCP?

Any new med started recently?

- Medication errors or interactions cost the US about $8 billion annually
- Medication related problems are 5th leading cause of death

Beers Criteria created by Dr. Mark H. Beers, Geriatrician. (1991)
Updated 2012 to assist HCP improving medication safety in older adult
www.americangeriatrics.org
## BEERS CRITERIA - avoid

### Anticholinergic
- Brompheniramine
- Carbinoxamine (arbinova, palgic)
- Chlorpheniramine (chlor-Trimeton)
- Clemastine (Tavist allergy)
- Cyroheptadine
d- Dextromethorphan
- Diphenhydramine (oral) Benadryl (may need to be used as acute treatment of severe allergic reactions)
- Doxylamine (Unisome sleep tabs)
- Hydroxyzine (Atarax)
- Promethazine (Phenargan)
- Triprolidine (Tripohist)

### TCA’S
- Amitriptyline (elavil)
- Chlordiazepoxide-amitriptyline (Limbitrol)
- Clomipramine (Anafranil)
- Doxepin >6mg/day (Silenor)
- Imipramine (Tofranil)
- Perphenazine-amitriptyline
- Trimipramine (Surmontil)

[www.americangeriatricsociety.org](http://www.americangeriatricsociety.org)
In a medical emergency, minutes matter. **So does accurate information.**

With your safety and health in mind, St. Mary Mercy Hospital is providing the attached “Just In Case” Medical Information Cards. We offer expert emergency medicine to the community, including specialized care dedicated to seniors with our Senior ER™, the first of its kind in the state of Michigan.

Take a few minutes now to complete the cards with your most current health information. Keep one in your wallet, and give the other to a family member or caregiver to keep on hand. Take your card to every doctor’s visit, and update the information as it changes. For extra cards, simply visit stmarymercy.org/justincase.

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**Personal Information:**

<table>
<thead>
<tr>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone Number</td>
</tr>
<tr>
<td>Emergency Contact</td>
</tr>
<tr>
<td>Primary Physician</td>
</tr>
<tr>
<td>Specialist</td>
</tr>
<tr>
<td>Durable Power of Attorney</td>
</tr>
</tbody>
</table>

**Specific Instructions:**

- Hearing Impaired
- Vision Impaired
- Aphasia
- Paralysis
- Dialysis (days): M T W Th F Sat Sun
- Chemotherapy (days): M T W Th F Sat Sun

**Medical History:**

- Heart Disease
- Heart Failure
- Stroke
- Irregular Heart Rate
- Pneumonia
- Diabetes
- Breathing Problems
- Glaucoma
- Arthritis
- UTI
- Cancer
- Pacemaker: Company
- Other: ________________________

**Surgical History:**

- Appendicitis
- Gallbladder
- Back
- Abdominal
- Hysterectomy
- Cataracts
- Heart: ________________________
- Other: ________________________

**Vaccination History:**

- Tetanus: ________________________
- Influenza: ________________________
- Pneumonia: ________________________
- Zostavax: ________________________

Date this form was completed or updated

---

**Allergies:**

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**Prescription Medications:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Frequency of Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Dose</td>
<td>Frequency of Use</td>
</tr>
<tr>
<td>Name</td>
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</tr>
<tr>
<td>Name</td>
<td>Dose</td>
<td>Frequency of Use</td>
</tr>
</tbody>
</table>

**Over-the-Counter Pain Relief, Vitamins or Herbal Supplements:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Frequency of Use</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>Name</td>
<td>Dose</td>
<td>Frequency of Use</td>
</tr>
</tbody>
</table>
Plan in a Can
THINK 3 D - Inquire about Advance Directive

- http://www.nhdd.org/
End-of-Life Decisions

• Aim for a “good death” defined by the Institute of Medicine “one that is free from avoidable distress and suffering for pts, families, caregivers; in accord with pts and families’ wishes; and reasonably consistent with clinical cultural and ethical standards” (Reisberg functional Assessment Staging; scale of 1-7)

http://geriatrics.uthscsa.edu/tools/FAST.pdf
THINK 3 D - Inquire about Alcohol Use

- Heavy drinking is reported by 3-9% of people over 65
- Alcohol abuse or dependence is reported by 2-4%
- 1/3 of the elderly who abuse or have alcohol dependency started drinking after age 50
- 14% present to an ER with new diagnosable Alcoholism

Serious cause of mortality and morbidity
THINK 3 D - Inquire about pain

- The elderly under-report pain because it is thought to be a “normal” part of aging.
- The elderly may suffer because the cost of pain medications is too high.
- Those individuals with cognitive impairments may not be able to verbalize that they are in pain.
- Uncontrolled pain? Evaluate a palliative care consult to help relieve suffering and improve QOL.
- The Visual Analogue Scale (VAS), the Numeric Rating Scale (NRS) and the Faces Scale have been used by nursing home patients.
The FACES or the Visual Analog or the Numerical Rating Scale may be used even in the situation of mild dementia.
Pain Scale

- Verbal /Visual-Pain Distress Intensity Scale
- Numeric 0-10
- Pain-AD

(Combination of numeric, Verbal, and Iowa Pain Thermometer)
## PAIN FOR ADVANCED DEMENTIA

### PAINAD Scale

<table>
<thead>
<tr>
<th>SCORE</th>
<th>Breathing</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Normal</td>
</tr>
<tr>
<td>1</td>
<td>Occasional labored breathing; short period of hyperventilation</td>
</tr>
<tr>
<td>2</td>
<td>Noisy labored breathing; long period of hyperventilation; Cheyne-Stokes respirations</td>
</tr>
</tbody>
</table>

### Negative vocalization

| 0     | None |
| 1     | Occasional moan/groan; low level speech/negative or disapproving quality |
| 2     | Repeated troubled calling out; loud moaning or crying |

### Facial expression

| 0     | Smiling/inexpressive |
| 1     | Sad, frightened, frowning |
| 2     | Facial grimacing |

### Body language

| 0     | Relaxed |
| 1     | Tense, distressed, pacing, fidgeting |
| 2     | Rigid, fists clenched, knees pulled up, pulling or pushing away, striking out |

### Consolability

| 0     | No need to console |
| 1     | Distracted or reassured by voice or touch |
| 2     | Unable to console, distract, or reassure |

**Total**

THINK 3 D - Inquire about Immunization(s)*

- Influenza - yearly
- Pneumonia – after age 65 one time may boost one time if received vaccine before age 65 if it has been more than 5 years since vaccinated
- Varicella-zoster vaccine – age 50 years and greater
- Tdap vaccine – every 10 years

*Nursing facility forms
THINK 3D –
Normal VS – is that normal?

- Normal VS may not be so normal after all
- Determine baseline parameter
- Normal BP in normal hypertensive patient maybe a signal of volume loss
- Baseline lactate and base deficit levels
- Base deficit measure good predictor of life threatening injury
Nutrition

- Unintentional weight change > 10lbs within past 3 months?
- A reduction in food intake or hydration: patient reported eating or drinking less than half of the usual intake for the past 7 days?
- Coughing or difficulty with swallowing when drinking fluids?

www.mypyramid.gov
THINK 3 D – What can they do?

Percentage of Medicare enrollees age 65 and over who have limitations in activities of daily living (ADLs) or instrumental activities of daily living (IADLs), or who are in a facility, selected years 1992–2007

<table>
<thead>
<tr>
<th>Year</th>
<th>IADLs only</th>
<th>1 to 2 ADLs</th>
<th>3 to 4 ADLs</th>
<th>5 to 6 ADLs</th>
<th>Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>14%</td>
<td>4%</td>
<td>6%</td>
<td>6%</td>
<td>0%</td>
</tr>
<tr>
<td>1997</td>
<td>13%</td>
<td>13%</td>
<td>5%</td>
<td>5%</td>
<td>0%</td>
</tr>
<tr>
<td>2001</td>
<td>13%</td>
<td>17%</td>
<td>5%</td>
<td>5%</td>
<td>0%</td>
</tr>
<tr>
<td>2005</td>
<td>12%</td>
<td>18%</td>
<td>3%</td>
<td>3%</td>
<td>0%</td>
</tr>
<tr>
<td>2007</td>
<td>14%</td>
<td>18%</td>
<td>2%</td>
<td>4%</td>
<td>0%</td>
</tr>
</tbody>
</table>

NOTE: A residence is considered a long-term care facility if it is certified by Medicare or Medicaid; has 3 or more beds and is licensed as a nursing home or other long-term care facility and provides at least one personal care service; or provides 24-hour, 7-day-a-week supervision by a caregiver. ADL limitations refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: bathing, dressing, eating, getting in/out of chairs, walking, or using the toilet. IADL limitations refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: using the telephone, light housework, heavy housework, meal preparation, shopping, or managing money. Rates are age adjusted using the 2000 standard population. Data for 1992, 2001, and 2007 do not sum to the totals because of rounding.

Reference population: These data refer to Medicare enrollees.

SOURCE: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.
Risks of inactivity

FUNCTION FOCUSED CARE
- Inactivity rapidly contributes to muscle shortening
- Bed rest diminishes aerobic activity
- Loss of muscle strength leads to falls

40% of ER patients have functional decline within 30 days of ER discharge!!!

* Red Flag: A decrease in function maybe the indicator the patient is ill

GOAL: Keep people functioning – prevent the revolving door; keep out of skilled facility
THINK 3 D
Geriatric Depression Screen

• Depression is common late in life, affecting nearly 5 million of the 31 million Americans aged 65 and older (Blazer, 2002).

• Depression may be reversed if identified early enough; left untreated, depression may result in physical, social and cognitive impairment as well as cause delayed recovery from illness and may be severe enough to cause suicide (Kurlowicz & Greenburg, 2007).
Depressive Symptoms – shows a modest increase in clinically relevant depressive symptoms for older age categories. Also shows lower levels for men except at the 85 and over group where the levels are similar.
Geriatric Depression Scale (GDS-5)

Does the patient have any of the following conditions?
- Dementia/Alzheimer's
- Delirium
- Behavioral issues/Suicidal
- Adverse drug effects/Sedated
- Positive for alcohol
- Patient declines
- Comfort Measure/Palliative Care
- Re-Admit within 30 days
- Unable to articulate
- Admitted from Long Term Care Facility
- Unable to complete
- None
- Other.

Ask all 5 questions. Total score will automatically calculate once ALL questions have been answered.

Are you basically satisfied with your life?
- Yes
- No

Do you often get bored?
- Yes
- No

Do you often feel helpless?
- Yes
- No

Do you prefer to stay at home, rather than going out and doing things?
- Yes
- No

Do you feel pretty worthless the way you are now?
- Yes
- No

GDS TOTAL Score

Scores: two or more indicates possible depression.
- Indicates possible depression
- Not indicative of depression
- Possible depression continue with screening
- Patient is not depressed
Self-Harm Screening

"I'd like to ask you some questions that we ask all our patients who are in the hospital."

"As I ask these questions, think about the past two weeks."

Have you ever wished you could go to sleep and not wake up?
- Yes
- No
- Unable to obtain

Have you had thoughts of killing yourself?
- Yes
- No
- Unable to obtain

Have you been thinking about how you might accomplish this act?
- Yes
- No
- Unable to obtain

Are you intending to act on these thoughts?
- Yes
- No
- Unable to obtain

Have you started working out details on how to kill yourself?
- Yes
- No
- Unable to obtain

Clinician/family believes suicidal intent/behavior may exist?
- Yes
- No

Right click to add comment when "Yes" or "Unable to obtain" is selected.

Right click for reference text.

Taken from Columbia-Suicide Severity Rating Scale (C-SSRS) Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo and Mann.
Cognitive impairment increases with advancing age and increasing age is the greatest risk for Alzheimer’s disease. One in eight >65 (13%)

Early identification of the disease may enable health care providers to start treatment in the early phase of the disease which usually results in a better response. (Cholinesterase inhibitors)

“My father started growing very quiet as Alzheimer’s started claiming more of him. The early stages of Alzheimer’s are the hardest because that person is aware that they’re losing awareness. And I think that’s why my father started growing more and more quiet.”

Patti Davis, regarding her father President Ronald Reagan.
The Mini-Cog Screening Tool

- Takes 3 minutes to complete
- Performs as well as or better than the Mini-Mental State exam that takes much longer to administer
- Results not affected by culture, ethnicity or education

http://consultgerirn.org/resources
Mini-Cog Assessment

Does the patient have any of the following conditions?

- Dementia/Alzheimer's
- Delirium
- Behavioral issues/Suicidal
- Adverse drug effects/Sedated
- Positive for alcohol
- Language barriers
- Patient declines
- Comfort Measure/Palliative Care
- Physical/Visual impairment
- Admitted from Long Term Care Facility
- Mini-Cog within 30 days
- Unable to complete
- None
- Other

The test is administered as follows: Please listen carefully. I am going to tell you three unrelated words. I want you to remember the words and repeat them to me (the nurse may repeat the same three words up to three times to the patient if necessary).

Document three words given to patient

- Cup
- Train
- Blue

Instruct the patient to draw the face of a clock, either on a blank sheet of paper or on a sheet of paper that already has the clock circle drawn. After the patient puts the numbers on the clock face, ask to draw the hands of the clock to read 11:10.

Did the clock drawn by the patient include all numbers in the correct sequence and position AND do the hands readily display the time 11:10.
Length of hands is not considered in the scoring.

- Yes
- No

Ask the patient to recall and state the three words given to him at the beginning of the test.

Number of words correctly recalled

- 0 words
- 1-2 words
- 3 words

Mini-Cog Result

- Demented
- Non-Demented

- Patient is demented, notify physician immediately
- Patient is not demented, continue with GDS Evaluation
• Acute brain injury insult
• Delirium occurs frequently (25-60%) in hospitalized adults (Waszynski, 2007).
• Affects 7% to 10% of older patients in the ED
• Acute, reversible and fluctuating central nervous system dysfunction with an organic cause.
• Lasts from a few hours to a few months if left untreated
• Left untreated = higher death rates, longer LOS, accelerated functional and cognitive decline
• Signs/symptoms: Acute onset of mental status changes, inattention, altered level of conscious, disorganized thinking

• http://consultgeriRN.org/resources
Risk Factors

Predisposing Factors

• Advanced Age
• Dementia or family history
• Depression
• Co-Morbidities
• Severity of illness
• Hearing/visual impairment
• Smoking, ETOH, drug use
• Surgery
• Male gender

Precipitating Factors

• Medications (Sedatives, antipsychotics, analgesics)
• Hypoxia
• Room changes
• Restraints
• Availability of clock
• Pain
• Electrolyte imbalance and dehydration
• Immobility
• Infection
• Fractures
**Confusion Assessment Method (CAM)**

<table>
<thead>
<tr>
<th>Does the patient have any of the following conditions?</th>
</tr>
</thead>
<tbody>
<tr>
<td>- ESI 1 or LOS less than 1 hr due to acute illness</td>
</tr>
<tr>
<td>- Unresponsive</td>
</tr>
<tr>
<td>- Unconscious</td>
</tr>
<tr>
<td>- None</td>
</tr>
<tr>
<td>- Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Acute Mental Status Change from Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Yes</td>
</tr>
<tr>
<td>- No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fluctuating Course of Abnormal Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Yes</td>
</tr>
<tr>
<td>- No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Difficulty Focusing Attention</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Yes</td>
</tr>
<tr>
<td>- No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Incoherent or Disorganized Thinking</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Yes</td>
</tr>
<tr>
<td>- No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Patient's Level of Consciousness</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Alert</td>
</tr>
<tr>
<td>- Vigilant</td>
</tr>
<tr>
<td>- Lethargic</td>
</tr>
<tr>
<td>- Stupor</td>
</tr>
<tr>
<td>- Coma</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CAM Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Positive finding - Notify physician immediately</td>
</tr>
<tr>
<td>- Negative</td>
</tr>
<tr>
<td>- CAM Positive, all questions answered</td>
</tr>
<tr>
<td>- CAM Negative, continue on Mini-Cog Evaluation</td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Depression</th>
<th>Delirium</th>
<th>Dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Onset</strong></td>
<td>Weeks</td>
<td>Short, rapid, abrupt, hours, days</td>
<td>Months to years</td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td>3-6 months, may be chronic</td>
<td>Days to 3 weeks</td>
<td>5-15 years</td>
</tr>
<tr>
<td><strong>Initial Presentation</strong></td>
<td>Flat affect, hypochondrial, focus on symptoms, apathy, little effort to perform</td>
<td>Disorientation, clouded, consciousness, fluctuation in moods, disordered thoughts</td>
<td>Vague symptoms, loss of intellect, easily distracted, great effort to perform tasks</td>
</tr>
<tr>
<td><strong>Recent Memory</strong></td>
<td>Normal or recent/past both altered</td>
<td>Partial impaired or remains intact</td>
<td>Impaired</td>
</tr>
<tr>
<td><strong>Intellect</strong></td>
<td>Slower, may be unwilling to respond</td>
<td>Impaired</td>
<td>Impaired concrete thinking</td>
</tr>
<tr>
<td><strong>Judgment</strong></td>
<td>Poor judgment, many “I don’t know answers”</td>
<td>Impaired, difficulty separating facts, hallucinations</td>
<td>Impaired, had inappropriate decisions, denies problem</td>
</tr>
<tr>
<td><strong>Pattern</strong></td>
<td>Worse in the morning, sleep impaired</td>
<td>Day drowsiness, nighttime hallucinations, insomnia, nightmares</td>
<td>Worse in the evening, sundowning, reverse sleep cycle</td>
</tr>
<tr>
<td><strong>Attention/Affect</strong></td>
<td>Withdrawn, apathy, hopeless, distress</td>
<td>Labile, fear/panic, periods of lucidity</td>
<td>Easily distracted, labile, inappropriate, anxiety, depression, suspicious</td>
</tr>
<tr>
<td><strong>Orientation</strong></td>
<td>Intact</td>
<td>Disoriented but not to person. Periods of lucidity</td>
<td>Disoriented</td>
</tr>
<tr>
<td><strong>Level of Consciousness</strong></td>
<td>Intact</td>
<td>Disturbed</td>
<td>Intact</td>
</tr>
<tr>
<td><strong>Psychiatric symptoms</strong></td>
<td>Delusions</td>
<td>Delusions</td>
<td>Hallucinations</td>
</tr>
</tbody>
</table>
### Total ≥65 ER Visits

<table>
<thead>
<tr>
<th>Hospital Location</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Livonia</td>
<td>4,065</td>
</tr>
<tr>
<td>Oakland</td>
<td>2,975</td>
</tr>
<tr>
<td>Holy Cross</td>
<td>4,600</td>
</tr>
<tr>
<td>Port Huron</td>
<td>1,015</td>
</tr>
<tr>
<td>Ann Arbor</td>
<td>4,870</td>
</tr>
<tr>
<td>Chelsea</td>
<td>1,162</td>
</tr>
<tr>
<td>Livingston-Brighton</td>
<td>1,704</td>
</tr>
<tr>
<td>Ann Arbor-Chelsea-Livingston/Brighton</td>
<td>7,736</td>
</tr>
<tr>
<td>Dubuque</td>
<td>1,801</td>
</tr>
<tr>
<td>Clinton</td>
<td>1,160</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>24,605</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>% Ch '10-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Livonia</td>
<td>4,605</td>
<td>4,583</td>
<td>4,900</td>
<td>23.0%</td>
</tr>
<tr>
<td>Oakland</td>
<td>3,388</td>
<td>3,843</td>
<td>3,811</td>
<td>23.0%</td>
</tr>
<tr>
<td>Holy Cross</td>
<td>4,672</td>
<td>4,999</td>
<td>5,060</td>
<td>10.0%</td>
</tr>
<tr>
<td>Port Huron</td>
<td>1,093</td>
<td>1,115</td>
<td>1,195</td>
<td>17.7%</td>
</tr>
<tr>
<td>Ann Arbor</td>
<td>5,516</td>
<td>5,971</td>
<td>6,641</td>
<td>21.3%</td>
</tr>
<tr>
<td>Chelsea</td>
<td>1,165</td>
<td>1,215</td>
<td>1,365</td>
<td>17.3%</td>
</tr>
<tr>
<td>Livingston-Brighton</td>
<td>2,264</td>
<td>2,525</td>
<td>2,537</td>
<td>17.7%</td>
</tr>
<tr>
<td>Ann Arbor-Chelsea-Livingston/Brighton</td>
<td>8,945</td>
<td>9,711</td>
<td>10,543</td>
<td>30.0%</td>
</tr>
<tr>
<td>Dubuque</td>
<td>1,963</td>
<td>1,854</td>
<td>2,025</td>
<td>10.0%</td>
</tr>
<tr>
<td>Clinton</td>
<td>1,266</td>
<td>1,427</td>
<td>1,478</td>
<td>10.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>27,178</strong></td>
<td><strong>28,986</strong></td>
<td><strong>30,525</strong></td>
<td><strong>30.0%</strong></td>
</tr>
</tbody>
</table>

### Total <65 ER Visits

<table>
<thead>
<tr>
<th>Hospital Location</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Livonia</td>
<td>8,138</td>
</tr>
<tr>
<td>Oakland</td>
<td>12,089</td>
</tr>
<tr>
<td>Holy Cross</td>
<td>26,812</td>
</tr>
<tr>
<td>Port Huron</td>
<td>5,584</td>
</tr>
<tr>
<td>Ann Arbor</td>
<td>20,462</td>
</tr>
<tr>
<td>Chelsea</td>
<td>4,125</td>
</tr>
<tr>
<td>Livingston-Brighton</td>
<td>7,836</td>
</tr>
<tr>
<td>Ann Arbor-Chelsea-Livingston/Brighton</td>
<td>32,423</td>
</tr>
<tr>
<td>Dubuque</td>
<td>4,937</td>
</tr>
<tr>
<td>Clinton</td>
<td>5,318</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100,339</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>% Ch '10-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Livonia</td>
<td>8,777</td>
<td>8,720</td>
<td>10,081</td>
<td>23.0%</td>
</tr>
<tr>
<td>Oakland</td>
<td>12,468</td>
<td>13,108</td>
<td>13,750</td>
<td>13.7%</td>
</tr>
<tr>
<td>Holy Cross</td>
<td>29,918</td>
<td>28,290</td>
<td>29,604</td>
<td>10.4%</td>
</tr>
<tr>
<td>Port Huron</td>
<td>5,555</td>
<td>5,638</td>
<td>5,914</td>
<td>10.4%</td>
</tr>
<tr>
<td>Ann Arbor</td>
<td>12,468</td>
<td>13,108</td>
<td>13,750</td>
<td>13.7%</td>
</tr>
<tr>
<td>Chelsea</td>
<td>4,124</td>
<td>3,762</td>
<td>3,996</td>
<td>-3.1%</td>
</tr>
<tr>
<td>Livingston-Brighton</td>
<td>13,208</td>
<td>12,799</td>
<td>12,395</td>
<td>58.2%</td>
</tr>
<tr>
<td>Ann Arbor-Chelsea-Livingston/Brighton</td>
<td>38,942</td>
<td>38,503</td>
<td>40,298</td>
<td>24.3%</td>
</tr>
<tr>
<td>Dubuque</td>
<td>5,168</td>
<td>5,391</td>
<td>5,193</td>
<td>5.2%</td>
</tr>
<tr>
<td>Clinton</td>
<td>5,998</td>
<td>6,222</td>
<td>5,889</td>
<td>10.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>111,752</strong></td>
<td><strong>110,829</strong></td>
<td><strong>115,455</strong></td>
<td><strong>30.0%</strong></td>
</tr>
</tbody>
</table>

### Total ER Visits

<table>
<thead>
<tr>
<th>Hospital Location</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Livonia</td>
<td>12,203</td>
</tr>
<tr>
<td>Oakland</td>
<td>15,064</td>
</tr>
<tr>
<td>Holy Cross</td>
<td>31,412</td>
</tr>
<tr>
<td>Port Huron</td>
<td>6,599</td>
</tr>
<tr>
<td>Ann Arbor</td>
<td>25,332</td>
</tr>
<tr>
<td>Chelsea</td>
<td>5,287</td>
</tr>
<tr>
<td>Livingston-Brighton</td>
<td>9,540</td>
</tr>
<tr>
<td>Ann Arbor-Chelsea-Livingston/Brighton</td>
<td>40,159</td>
</tr>
<tr>
<td>Dubuque</td>
<td>6,738</td>
</tr>
<tr>
<td>Clinton</td>
<td>6,478</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>124,944</strong></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>% Ch '10-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Livonia</td>
<td>13,382</td>
<td>13,303</td>
<td>15,011</td>
<td>23.0%</td>
</tr>
<tr>
<td>Oakland</td>
<td>15,856</td>
<td>16,951</td>
<td>17,561</td>
<td>16.6%</td>
</tr>
<tr>
<td>Holy Cross</td>
<td>34,580</td>
<td>33,289</td>
<td>34,664</td>
<td>10.4%</td>
</tr>
<tr>
<td>Port Huron</td>
<td>6,648</td>
<td>6,753</td>
<td>7,109</td>
<td>7.7%</td>
</tr>
<tr>
<td>Ann Arbor</td>
<td>27,126</td>
<td>27,913</td>
<td>30,548</td>
<td>10.4%</td>
</tr>
<tr>
<td>Chelsea</td>
<td>5,289</td>
<td>4,977</td>
<td>5,361</td>
<td>-1.3%</td>
</tr>
<tr>
<td>Livingston-Brighton</td>
<td>15,472</td>
<td>15,324</td>
<td>14,932</td>
<td>56.5%</td>
</tr>
<tr>
<td>Ann Arbor-Chelsea-Livingston/Brighton</td>
<td>47,887</td>
<td>48,214</td>
<td>50,841</td>
<td>26.6%</td>
</tr>
<tr>
<td>Dubuque</td>
<td>7,131</td>
<td>7,245</td>
<td>7,218</td>
<td>-1.3%</td>
</tr>
<tr>
<td>Clinton</td>
<td>7,264</td>
<td>7,649</td>
<td>7,367</td>
<td>-3.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>138,930</strong></td>
<td><strong>139,815</strong></td>
<td><strong>145,980</strong></td>
<td><strong>16.8%</strong></td>
</tr>
</tbody>
</table>

### ≥65 vs. <65 Total % Change

<table>
<thead>
<tr>
<th>Location</th>
<th>≥65 vs. &lt;65</th>
<th>≥65 % Change</th>
<th>&lt;65 % Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Livonia</td>
<td>21.3%</td>
<td>23.9%</td>
<td></td>
</tr>
<tr>
<td>Oakland</td>
<td>28.1%</td>
<td>13.7%</td>
<td></td>
</tr>
<tr>
<td>Holy Cross</td>
<td>10.0%</td>
<td>16.6%</td>
<td></td>
</tr>
<tr>
<td>Port Huron</td>
<td>17.7%</td>
<td>5.9%</td>
<td></td>
</tr>
<tr>
<td>Ann Arbor</td>
<td>36.4%</td>
<td>16.8%</td>
<td></td>
</tr>
<tr>
<td>Chelsea</td>
<td>17.5%</td>
<td>3.1%</td>
<td></td>
</tr>
<tr>
<td>Livingston-Brighton</td>
<td>48.9%</td>
<td>58.2%</td>
<td></td>
</tr>
<tr>
<td>Ann Arbor-Chelsea-Livingston/Brighton</td>
<td>36.3%</td>
<td>24.3%</td>
<td></td>
</tr>
<tr>
<td>Grayling</td>
<td>18.4%</td>
<td>6.2%</td>
<td></td>
</tr>
<tr>
<td>Dubuque</td>
<td>12.4%</td>
<td>5.2%</td>
<td></td>
</tr>
<tr>
<td>Clinton</td>
<td>27.4%</td>
<td>10.3%</td>
<td></td>
</tr>
</tbody>
</table>
Social Work Role

• Dedicated Social Worker for the Senior ED
• Separate role from the Behavioral Medicine Social Worker
• Contact with all patients who present to the Senior ED during work hours and follow-up phone calls to those who were seen off shift and d/c’d home.
Social Work Intervention: Risk Screening

Environment assessment
a. Live alone?
b. Resides in assisted or skilled facility?

Interventions
✓ Psychosocial assessment
✓ Home environment
✓ Support system
✓ Nutritional, transportation
✓ Follow-up phone calls
Risk Screening and Intervention continued…

Fall risk?

**Interventions**

- Durable Medical Equipment
- Life Link
- Home care: Beyond Balance Program

ER visit past 72 hours or past 30 days?

**Interventions**

- Potential for sub-acute rehab in skilled nursing facility
Screening & Intervention continued…

**Functional assessment**

**Intervention**

- Dependent on KATZ ADL score (bathing, dressing, toileting, transferring, continence, feeding)

**Cognitive assessment** (delirium, dementia, depression)

**DELI RIUM**

**Intervention**

- Delirium protocol

**DEMENTIA**

**Intervention**

- Assess environment, medications, caregiver
Cognitive assessment continued…

**Depression** (Geriatric Depression Scale (GDS) contingent on score)

**Intervention**
- Psychosocial counseling
- Consult for psychiatric need
- Senior counseling services
Screening continued

Nutritional assessment
(unintentional weight change, eating less, or difficulty swallowing)

*Intervention*
(Determined by deficits assessed)

- Meals on Wheels
- Dietary consult with education
- Liquid nutrition program
Abuse and Neglect

- 2.1 million older Americans are victims of abuse, only 10% is reported
- Elderly females are the most frequently abused
- 90% of the abusers are family members
- People over the age of 80 are abused 2 to 3 times more than any other age group
- Victims often abused in several forms

Interventions

✓ Adult Protective Services
✓ Resources
✓ Counseling
Types of Abuse

- Physical
- Emotional/Psychological Abuse
- Sexual Abuse
- Financial Abuse
- Neglect of ADLs, confinement, abandonment
- Coercion abuse, verbal abuse
- Exploitation

“Elder abuse is defined as the action or the omission of actions that result in harm or threatened harm to the health or welfare of the older adult.” American Medical Association
Caregiver Strain

**Interventions**

- Caregiver support groups
- Family counseling
- Education
- Finances
- Resources
- Advance Directives
- End of Life Issues
Case Management Role

- Collaboration with the Senior Social Worker
- Level of Care Determination
- Avoid unnecessary hospital admission
- Avoid unnecessary observation status
Improving Services

• Care needs and costs are high
• Focus on accessing available community resources
  • Visiting Physicians
  • Adult Day Programs
  • Homecare and private duty
  • Senior wellness programs
Broader Senior Service Line

- Senior Service Line Administrator (also the Director of Case Management)
- Transition Coach program
- NICHE designated hospital
- Patient Advisory Committee
- Senior Steering Committee
- STAR Forum (Safe Transition of all residents)
What Have We Learned???

- Our Attitude and Patient’s Attitude
- Language – Must be tailored not foreign
- Recognize Deficits – hearing, vision loss, cognitive ability, function, social support, caregiver burden
- Informed consent – capacitance
- Time and energy levels – process data more slowly, fatigue easily
- Environment – quiet, lighting, temperature, fresh flowers
- Caregiver input
- Older adults are lonely, love to share stories, eager to please, polite (very thankful), spiritual, often are greatest mentors
What Have We Learned? continued

- Core Team and Social Worker essential
- Chart audit/memos/praise
- Dashboard for data
- EMR integration for seamless transition
- Ongoing Education/Reinforcement
- Story telling
- Thank you notes to staff and facilities
- Partnership with EMS, Assisted Living, Independent Living, Nursing Homes, Community Centers
- Caregivers and patient conversation
- Follow up phone calls, PCP letters
- In-hospital Hand-off
“We should all be concerned about the future because we have to spend the rest of our lives there”
C.F. Kettering

“Caring for your future self”
Dr. Daniel Keys (EPMG)
Every time you Smile at Someone, it is an Action of Love, a Gift to the Person, a Beautiful Thing
~ Mother Teresa
WE’RE ALL IN !!!

ARE YOU?

Because the Rewards are Endless...
Resources

- Improving on Transitions of Care: How to Implement and Evaluate a Plan [http://www.ntocc.org](http://www.ntocc.org)
- Better Outcomes for Older Adults Through Safe Transitions (BOOST) [http://www.hospitalmedicine.org/BOOST](http://www.hospitalmedicine.org/BOOST)
- Project Re-Engineered Discharge (RED) [http://www.bu.edu/fammed/projectred/](http://www.bu.edu/fammed/projectred/)
- INTERACT [http://interact.geriu.org](http://interact.geriu.org)
- Remington Report (Interventional strategies and programs to improve care transitions with supporting evidence) [www.remingtonreport.com](http://www.remingtonreport.com)
- Safer Handoff [www.ena.org](http://www.ena.org)
- AORN toolkit for hand-off [www.aorn.org](http://www.aorn.org)
Bibliography


Bibliography


Top Ten Tips for Living a Long and Happy Life

http://www.youtube.com/watch?v=JgHXJ7x_Yb0