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Forging Aligned Partnerships Between Value Based Care Organizations & Geriatric Emergency Departments:

A Toolkit for Value Based Care Organizations

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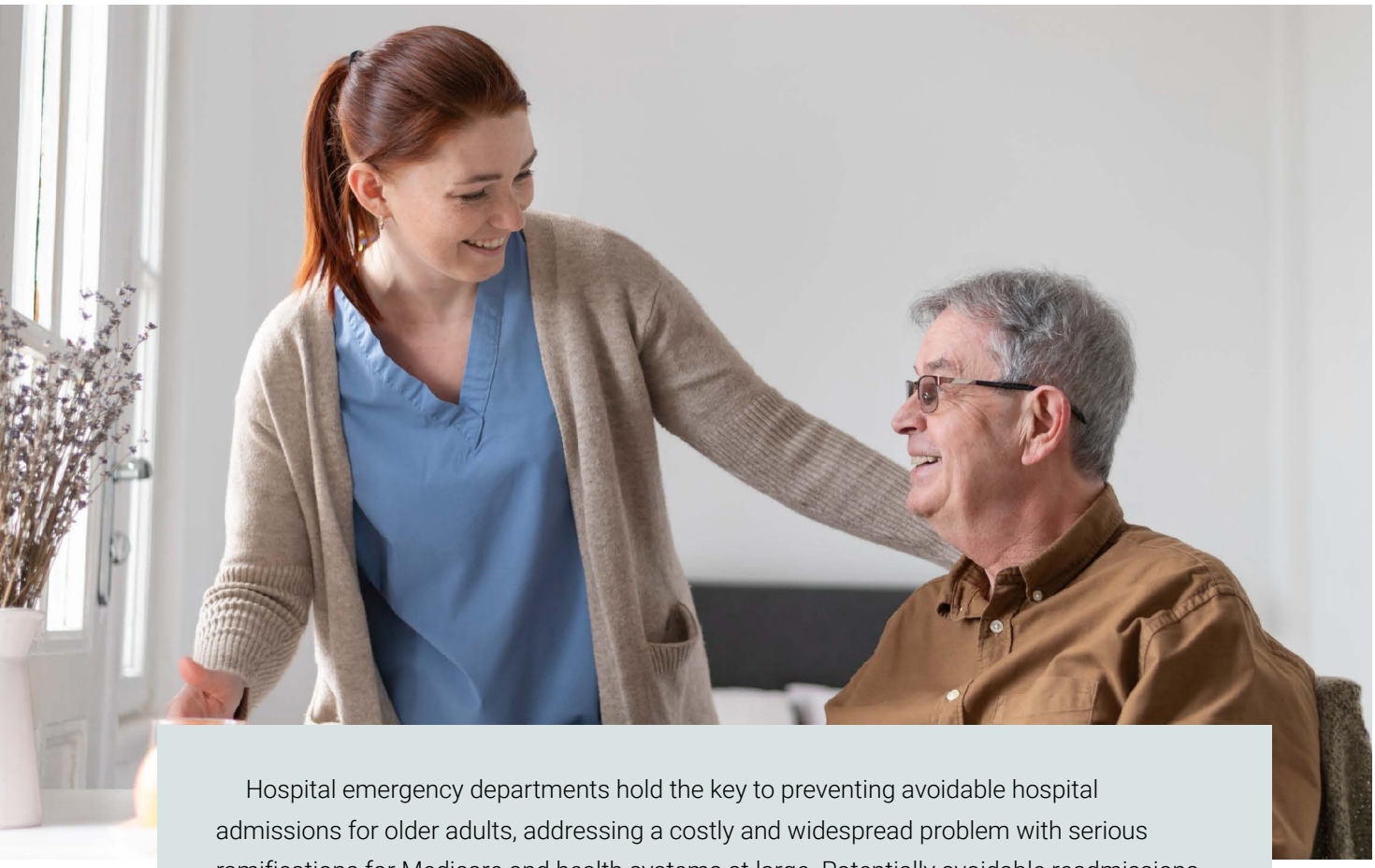
Executive Summary



Hospital emergency departments hold the key to preventing avoidable hospital admissions for older adults, addressing a costly and widespread problem with serious ramifications for Medicare and health systems at large. Potentially avoidable readmissions cost Medicare $17 billion a year[16], in large part because they're so common. Seventy-three percent of hospital readmissions from skilled nursing facilities are rated as potentially avoidable[17], as are 63% of hospital readmissions from long-term care settings[18]. Emergency departments play a central role in the trend; a recent study found that hospital EDs account for nearly 60% of hospital admissions for older adults and, increasingly, also serve as an advanced diagnostic center for primary care physicians[5]. **As a result, reducing potentially preventable ED visits and subsequent hospitalizations or readmissions has become a priority for Medicare and Value Based Care Organizations (VBCOs)[19]. Despite these efforts, Medicare beneficiaries continue to seek care in EDs for non-emergent, primary-care treatable, and preventable or avoidable issues.**

As the primary point of admission, EDs can be a part of the solution to reduce avoidable hospitalizations and connect older adults to the most appropriate level of care. Recognizing the need to address the unique health concerns of older adults, in 2014 the American College of Emergency Physicians (ACEP) in collaboration with the Society for Academic Emergency Medicine, the American Geriatric Society, and the Emergency Nurses Association published Geriatric Emergency Department Guidelines. Per these guidelines, a primary goal is to help EDs recognize those older patients who could benefit from inpatient care, and to effectively implement outpatient care for those who do not require inpatient resources. To be most effective, a senior-focused ED would utilize the resources of the hospital, as well as outpatient resources[20]. In 2018, ACEP in collaboration with West Health created a Geriatric Emergency Department (GED) Accreditation Program (GEDA). The GEDA program was developed to ensure that older patients receive well-coordinated, quality care at the appropriate level at every ED encounter.

We believe that VBCOs are incentivized to forge aligned partnerships with GEDs to connect their outpatient resources to the clinical operations within a GED. Such partnerships could reduce unnecessary admissions and improve transitions of care back to the VBCOs and beneficiary's primary care physician – two central VBCO "must haves" for success. Like VBCOs, GEDs are motivated to ensure patients receive care in the setting best matched to the patient's needs. Due to the influx of patients going to the ED in recent years, EDs are also driven to reduce time spent in the ED and get patients back home if possible. Emergency physicians currently have limited disposition options (admission, discharge, or observation). VBCOs may be able to provide additional disposition options or outpatient resources that ED clinicians are not aware of or do not know how to easily access, which is why partnering could be so valuable.

This toolkit and the resources that follow lay out an approach for VBCOs to forge aligned partnerships with their local GED. The toolkit proposes a framework for VBCOs to understand their local GED capabilities and key GED stakeholders, mobilize action, move towards partnership, remove barriers to partnerships, and launch collaborative projects.

Introduction

In 2020, the Census Bureau released data on the United States older adults (65+), showing growth of over a third (34.2% or 13,787,044) since 2010[1], driven by a variety of factors including aging of Baby Boomers, increased longevity, and lower fertility[2].

Older adults are 45.2% of the top 10% of healthcare utilizers[3]. Not only do older adults utilize healthcare services at a high rate, but they also utilize emergency services at a higher rate.

A 2002 study showed that older adults in the ED[4]:

- Have visits with a greater level of urgency.
- Have longer stays in the ED.
- Are more likely to be admitted to the hospital.
- Are more likely to have a repeat ED visit.
- Have higher rates of more adverse health outcomes after discharge.

Recognizing the need and an opportunity, in 2014 the American College of Emergency Physicians (ACEP) created Geriatric Emergency Department Guidelines and soon followed with an Accreditation Program.

GEDs provide tailored, geriatric-specific care to older adults in the ED with the goal of transitioning patients to the most appropriate setting of care and avoid default in-patient hospital admissions.

We believe that Value Based Care Organizations (VBCOs) and GEDs can forge aligned partnerships to improve the cost and care trajectory for older adults by reducing unnecessary admissions and improving transitions of care.

To exemplify the impact of such a partnership, let us consider a real-world case: JR.

JR is an 82-year-old retired electrical engineer and substitute math teacher, devoted husband of 62 years, father of 6, grandfather of 17, and great grandfather of four. JR was an avid fan of Notre Dame sports, fly fisherman, mountain climber, marathoner, and devout Catholic.

JR's health issues include:

- Chronic kidney disease and a successful transplant managed with an anti-rejection medication regimen.
- Heart disease with three stents; managed with an anti-platelet inhibitor, baby aspirin, beta blocker, statin, and calcium channel blocker.
- Advanced Parkinson's with bouts of dementia; PK symptoms managed with Sinemet.
- Aggressive advanced metastatic skin cancer; daily niacinamide for prevention

JR was doing well and in a period of less than two years, had eight hospital admissions; **seven were preceded by visits to an ED**. The below encounters occurred under the care of eight physicians in t*hree different health systems* within the same metropolitan area. JR's hospital visits included:

- Three cardiac related admissions treated medically then with stents.
- Three falls related admissions: one with intensive care, and two followed by post-acute rehabilitation admissions.
- Dehydration and low blood pressure resulting in a week-long admission, delirium, and antipsychotic administration causing disposition delays.
- Planned admission for radical skin cancer surgery (delirium prolonged stay).
- Two observation stays.

Imagine that JR is a VBCOs beneficiary who has responsibility for his total cost of care. What are the strategies for avoiding hospitalizations, achieving better coordinated care, improving JR's outcomes, enhancing his and his family's experience, and lowering his cost of care? Has the GED been considered as an impactful partner to reduce JR's potentially avoidable admissions?

Imagine what it would mean to have an aligned partnership between the local GED and a VBCO. Imagine a partnership where JR's specialists or PCPs partnered with GED clinicians on decisions regarding the best care pathway for JR, prior to the decision to admit, in order to avoid unnecessary admissions, reduce future ED use and connect JR and his family to resources within the VBCO.

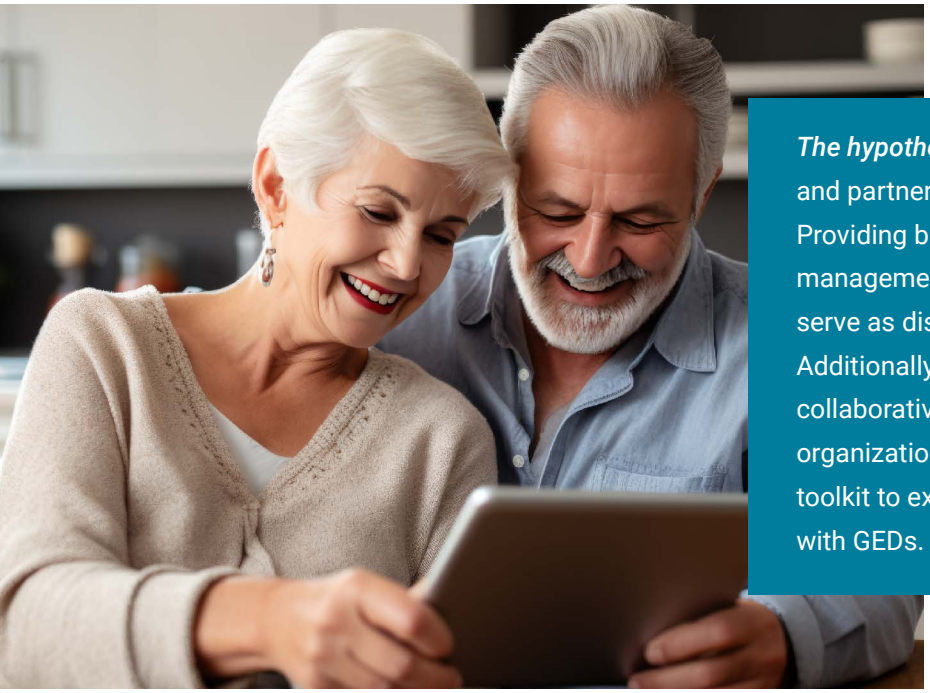
Would it be fair to say that if such partnerships existed that some of JR's hospital admissions could have been avoided? In the case of cardiac events, severe fall with head injury that resulted in an ICU stay and skin surgery admissions, probably not. However, a few other admissions may have been preventable or avoided. If a VBCO was able to partner with the GED clinicians overseeing JR's care in the GED prior to the decision to admit, perhaps some of these hospitalizations could have been avoided. We believe such partnerships are impactful enough to change JR's care trajectory and avoid unnecessary admissions.

This toolkit and the resources that follow lay out an approach for VBCOs to connect with their local GED. The toolkit lays out a framework to understand the local GED landscape and key GED stakeholders, mobilize action, move towards partnership, remove barriers to partnerships, and launching collaborative projects.

Purpose

The purpose of this toolkit is to provide education on a structured approach and operational resources to aid VBCOs in partnering with local GEDs. The goal of the toolkit is to foster meaningful connections and provide a framework for organizations to take actionable steps to build a collaborative project with a GED.

Each VBCO and GED collaboration will look different based on the configuration of the delivery system in your area, the needs of older adults in the community, the capabilities of the local GED and the current state of understanding of your local GED.



The hypothesis: there are clear areas for opportunity and partnership between VBCOs and GEDs. Providing bi-directional education or creating a care management connection are key first steps and can serve as discrete collaborative projects themselves. Additionally, we lay out some ideas for potential collaborative projects in the Appendix but encourage organizations and individuals to fully leverage this toolkit to explore mutually beneficial pilot projects with GEDs.

Although the toolkit is laid out in a simple, linear process, it's understand forging aligned partnerships can be messy and occur over longer periods of time than what is proposed. For instance, if conducting a meeting is suggested, there may be preparatory or follow-through conversations that may need to take place to fully enable success.

The approach in the Toolkit is based loosely on the Institute for Healthcare Improvement's Model for Improvement and Dr. John Kotter's 8-Step process for leading change, in an effort to blend healthcare process improvement and business management into an easy-to-use guide. The materials include practical tools, templates, and other resources to aid you in the journey.

What is a Geriatric Emergency Department?

Similar to the concept of pediatric emergency departments, geriatric emergency departments incorporate specially trained staff, who conduct extended assessments and take steps to improve patient experience and outcomes. All of this allows for a better experience for older adults and lowers the risk of adverse events while in the ED. GEDs also facilitate safer transitions to a community setting for those who do not require or want a hospital admission.

A GED has four key areas of differentiation from a traditional ED. First, physicians and nurses receive additional education in geriatrics that provides added expertise in the emergency care of older adults. GEDs are often overseen by a physician while the day-to-day operations of the GED are executed by a registered nurse, frequently referred to as a "nurse champion." Additional education for physicians and nurses focuses on:

- Geriatric specific syndromes and concepts (e.g., atypical presentation of disease, changes with age, transitions of care) relevant to emergency medicine,
- Clinical issues nearly exclusive to older adults (e.g., end of life care, dementia, delirium, systems of care for older adults), and
- Issues common to all ED patients but focused on the unique factors found in older adults (e.g., trauma in older adults, cardiac arrest care for the older adult).

Second, GEDs have enhanced screening processes. Patients receive additional screenings that can quickly uncover physical or mental health risks that are more common in older adults. For example, screening tools uncover geriatric syndromes (like frequent falls, polypharmacy, delirium, and dementia) as well as social vulnerabilities (like food insecurity, isolation/loneliness, or elder mistreatment).

Third, GEDs are often supported by interdisciplinary team members (geriatricians, transitional care nurses, social workers, physical therapists, pharmacists, etc.) that help provide enhanced care, community connections, and transitions of care, for the most vulnerable older adults. Team members can reach out to the local Area Agency on Aging, groups such as Meals on Wheels, physical therapy providers and home health agencies, or help facilitate direct transfers to skilled nursing facilities when in-patient admission is not required.

Finally, a GED is not always a separate space or stand-alone ED, but rather an ED that has structural enhancements to the physical environment and workflow improvements within the core ED to make the patient experience more conducive to older adults. Some GEDs have a designated, quieter, cordoned-off space within an ED, light dimmers, non-stick flooring to minimize fall risks, and comfortable seating and spaces for caregivers. Staff make sure older adults are hydrated, warm, fed, and physically active while waiting for medical evaluation and treatment.

In summary, the goals of GEDs are to improve transitions of care, avoid hospital admissions or readmissions, identify unmet patient needs, improve care quality, and the patient experience.

GEDs do this by:

- Identifying underlying geriatric syndromes and social vulnerabilities through enhanced screenings
- Intervening upon the findings of the screenings and communication with the designated primary care physician
- Connecting the patient to relevant social and community services
- If appropriate and feasible, transitioning the patient to home or community-based settings (hospital at home, primary care provider, etc.)

A glossary of common GED abbreviations, terms, definitions, and key performance indicators is included in the Appendix.

What does it mean to be an Accredited Geriatric Emergency Department?

The move towards geriatric-specific emergency medicine is fairly new. In 2018, ACEP launched the Geriatric Emergency Department Accreditation (GEDA) program, which established criteria for three levels of GED accreditation.

Similar to the categorization of Trauma Centers, a Level 1 GED is the top level of accreditation and thus has the highest level of interdisciplinary and specially trained staff, policies, guidelines, and procedures for geriatric emergency care.

- **Level 1 GEDs** must have at least 20 initiatives chosen from models of care that benefit older adults (e.g., a urinary catheter utilization policy) and quality improvement components, five outcome measures, availability of 10 items of equipment and supplies specific to older adults, and enhancements to the physical environment.
- **Level 2 GEDs** provide many of the same enhancements as a Level 1, but on a smaller scale (e.g., requires 10 geriatric emergency care initiatives) and often with fewer interdisciplinary and specially trained staff.
- **Level 3 GEDs** require physician oversight, a nurse champion, and evidence of at least one geriatric emergency care initiative. Oftentimes, hospitals begin the accreditation journey at a Level 3 and then "level up" as they build their infrastructure and gain core competencies in the operational and clinical requirements necessary to implement higher levels of geriatric specific emergency medical care.

For more detailed information about the differences between Level 1, 2 and 3 GEDs please visit: https://www.acep.org/geda/comparison-overview/

As of 2023, over 400 accredited GEDs exist in the U.S., with the goal to bring GED accreditation to every community. There is also a growing international presence of accredited GEDs, with sites in Brazil, Canada, and Spain.

What makes Value Based Care Organizations and Geriatric Emergency Departments so compatible?

Sixty percent of older adults admitted to the hospital come through the ED making them the most common point of entry to hospital admission[5]. As a result, ED staff have the ability to make decisions that tremendously impact the cost (average admit >$14,900 vs. discharge)[14], quality and trajectory of the patient's entire care experience.

In other words, GED physicians are in the position to make the decision whether to transition a patient to an outpatient setting of care or to admit them, a decision point with tremendous cost implications for VBCOs. The opportunity to create trusted relationships with individual GED physicians and clinicians is even more critical given the significant variation in average admission rates (32%-46%) between ED physicians in the same hospitals[15].

VBCO and GEDs are motivated to help patients receive needed care in an outpatient setting (oftentimes their own home) when admission is not necessary. However, most emergency physicians have limited disposition options (admit, discharge, or observe). VBCOs, in contrast, may have additional disposition options that ED physicians are not aware of or do not know how to easily access. Partnerships can help make these options known and easy to access.

A growing body of literature supports the outcomes of GEDs to lower cost, improve quality and improve the patient experience:

- Up to 16.5% reduced risk of hospital admission[8]
- Up to 17.3% reduced risk of hospital re-admission[9]
- $3,202 savings per Medicare beneficiary after 60 days[10]
- Decreased odds of 30-and-60-day fall-related ED revisit with PT services[11]
- Decreased odds of 30-day ED revisit and 30-day subsequent unplanned hospitalization with post-discharge referral order[22]
- 87.3% satisfaction with the clarity of discharge information and perceived wellbeing[12]
- 21 studies showcasing improved experience across a variety of interventions[13]
- 25-hour decrease in length of stay for admitted patients[21]

The goals of your VBCO and GED are well aligned.

Missed Opportunities: VBCO beneficiaries are seeking care in Geriatric Emergency Departments

Accountable Care Organizations (ACOs) have demonstrated lowered odds of preventable ED visits for older adults[6] and have a high use of evidenced-based care coordination strategies[7]. Yet, ACO beneficiaries continue to seek care in the ED anyway. In fact, an analysis was conducted by West Health Institute, in collaboration with the Institute for Accountable Care, to determine the degree to which Medicare Shared Savings Program (MSSP) ACO beneficiaries were seeking care in GEDs. The analysis revealed that in 2021:

- MSSP ACO beneficiaries were receiving care at hospitals that include 253 GEDs (a 31% increase from 2019)
- 135 ACOs had at least 1,000 patient visits in a GED affiliated hospital (a 35% increase from 2019)
- Close to a quarter of total Medicare ACO ED visits were occurring at a GED hospital.

The above analysis focused on 2021 ACOs and used Q1 2021 provisional MSSP attribution. This analysis did not include Next Generation ACOs or Direct Contracting entities as these program claims were not yet available to researchers.

In short, VBCO beneficiaries are likely seeking care in a GED right now. There are natural synergies between the work and outcomes associated with GEDs and value-based care that should be explored. Below, we lay out a framework and tools for forging an aligned partnership with the GEDs caring for your VBCO beneficiaries.

Framework and tools to partner with your local Geriatric Emergency Department(s)

VBCOs, in general, do not want beneficiaries in the ED. Below are four steps to begin the process of creating mutually beneficial alliances with the GED.

Ahead of these 4 steps, there are two key building blocks to enhance successful partnerships:

1 Bi-Directional Education:

Creating a shared understanding of the VBCOs risk-based arrangement, and knowledge of both VBCOs and local GED's unique capabilities, goals, key outcomes, and metrics. Bi-directional education will be required to create this shared understanding and could take the form of in-person or virtual meetings, presentations and/or training sessions, webinars, online modules, or other engaging educational delivery methods.

2 Care Management Connection:

Creating a mechanism by which VBCOs and GEDs can share real-time beneficiary status is a key action. Such a connection will help VBCOs understand when beneficiaries present to the GED and for GED clinicians to know they are treating a patient in a VBCO arrangement. Only when a care management connection exists will VBCOs and GED clinicians be able to work collaboratively to reduce unnecessary admissions and improve transitions of care back to the VBCOs and beneficiary's primary care physician. More about creating a care management connection is in the Removing Barriers section of the Toolkit.

1 Understand the GED Landscape & Key GED Stakeholder(s)

The first step toward making a meaningful connection with the GEDs caring for VBCO beneficiaries is to gather more information on the GED landscape in your healthcare system or geographic market(s).

First, identify if there are one or more GEDs within the VBCO's geographic market(s) or hospital system and their corresponding level of accreditation. This can be done by downloading the "Geriatric ED Accredited List" located at: https://www.acep.org/geda/ and filtering and sorting by hospital city and state.

Exhibit #1 | GED Accreditation List

Emergency Department	Accreditation Level	Hospital City	Hospital State	Accreditation Approved
Providence Alaska Medical Center	3	Anchorage	AK	6/26/20
UAB Highlands Hospital	1	Birmingham	AL	7/5/21
Riverview Regional Medical Center	3	Gadsen	AL	10/28/20
Northwest Medical Center Springdale	1	Springdale	AR	10/5/20
Northwest Medical Center Bentonville	3	Bentonville	AR	4/30/21
Banner University Medical Center Phoenix	3	Phoenix	AZ	2/22/19
Banner University Medical Center Tucson Campus	3	Tuscon	AZ	2/7/20
Banner Baywood Medical Center	3	Mesa	AZ	7/21/20
Hospital Sírio Libanês	3	São Paulo	Brazil	9/9/19
UC San Diego Health- La Jolla	1	San Diego	CA	10/25/21
Sharp Grossmont Hospital	1	La Mesa	CA	3/2/21
UCSF Medical Center Parnassus	1	San Francisco	CA	9/16/21
UC Irvine Medical Center	1	Orange	CA	3/7/22

Make note of the accreditation level of the GED(s) within the VBCO's geographic market(s) and begin to understand the basic capabilities of the GED serving beneficiaries by reviewing the Accreditation Level Comparison Overview.

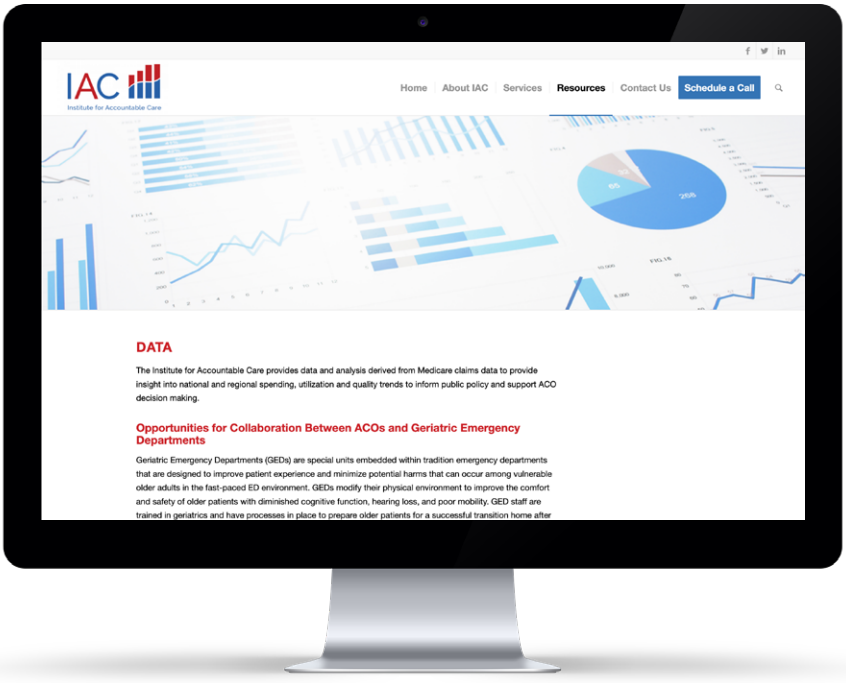
Once the GED(s) within the VBCO's market(s) have been identified and their level of accreditation (and thus basic capabilities), determine who the GED lead physician and nurse champion are by contacting the GEDA program managers:

- Nicole Tidwell, GEDA program manager at: ntidwell@acep.org
- Amber Hartwell, GEDA program coordinator at: ahartman@acep.org

> An email template to the GEDA program managers is included in the Appendix. If you are unable to reach the GEDA program managers within a week, please contact the American College of Emergency Physicians (ACEP) National Headquarters at (800) 798-1822 or (972) 550-0911 and ask to be connected to the GEDA program managers.
>
> If you continue to experience delays in connecting with the GEDA program, please contact Kaylee Knowles, Program and Partnerships Manager at West Health Institute at: kknowles@westhealth.org, or the West Health Institute at (858) 535-7000 and ask to be connected to the GED Program Lead. West Health can help facilitate introductions.

Next, if you are participating in an MSSP ACO, learn to what degree your beneficiaries are seeking care at a GED. A list of Geriatric Emergency Department Visits by ACO Attributed Beneficiaries in 2021 is available here.

Exhibit #2 | MSSP ACO/GED Overlap Analysis



If your VBCO is under another risk-based arrangement, you can conduct your own claims analysis by using the CMS Certification Number associated with each GED. The CMS Certification Number can be accessed at The American Hospital Directory available here.

Knowledge and data are power. Now that you have more information around the GED landscape, key GED stakeholders, and potential overlap between your beneficiaries and your local GED(s), you are ready to take the next step towards mobilizing action.

2 Mobilize Action

The first activity towards mobilizing action is engaging the relevant GED stakeholders. Contact the GED lead physician and nurse champion to introduce the VBCO and its shared objectives.

> Email templates to key GED stakeholders are included in the Appendix. One version is for MSSP ACO participants that know the beneficiary overlap and another version is for other VBCOs with some or no data around beneficiary overlap.
>
> If you cannot reach the GED lead physician and nurse champion within a week, please contact Kaylee Knowles, Program and Partnerships Manager at West Health Institute at: kknowles@westhealth.org or the West Health Institute at (858) 535-7000 and ask to be connected to the GED Program Lead.

Following an e-introduction, schedule a time to meet (virtually or in person), conduct a brief, introductory conversation with the GED lead physician and nurse champion to gain an understanding of the unique capabilities and challenges of the GED(s) where VBCO beneficiaries are seeking care. Additionally, share if your VBCO has any current initiatives or efforts that involve the ED or that the ED can avail themselves to.

The goal of the initial introductory conversation is relationship building and to generate buy-in with the GED lead physician and nurse champion to convene a larger conversation among the VBCOs and GED stakeholders regarding a potential collaboration.

A draft agenda and supporting presentation materials for the introductory conversation is included in the Appendix. A best practice is to send the agenda with a brief reminder about the scheduled conversation a few days in advance of the meeting.

Following the introductory conversation, determine the appropriate stakeholders from the VBCO to form a project team that can help drive greater collaboration between your organization and the GED.

A description of the roles and responsibilities included in successful project teams is included in the Appendix.

Complete the Stakeholder Map included in the Appendix and share it with the GED lead physician and/or nurse champion to generate their buy-in and determine the appropriate GED representatives to include in the guiding project team. A draft email message back to the GED lead physician and/or nurse champion is included in the Appendix.

Once the appropriate VBCOs and GED stakeholders have been identified, conduct a kick-off meeting with the Executive Sponsor and Senior Project Team to generate a mutual understanding of current VBCOs and GED capabilities, goals, metrics (especially any daily-use dashboards), challenges and current applicable work.

If you are seeking support in securing an Executive Sponsor, please refer to the "Making Your Business Case to an Executive Sponsor" toolkit located in the Appendix.

The goal of the kick-off meeting is to generate buy-in from stakeholders to pursue aim-setting. A draft agenda for the kick-off meeting is included in the Appendix.

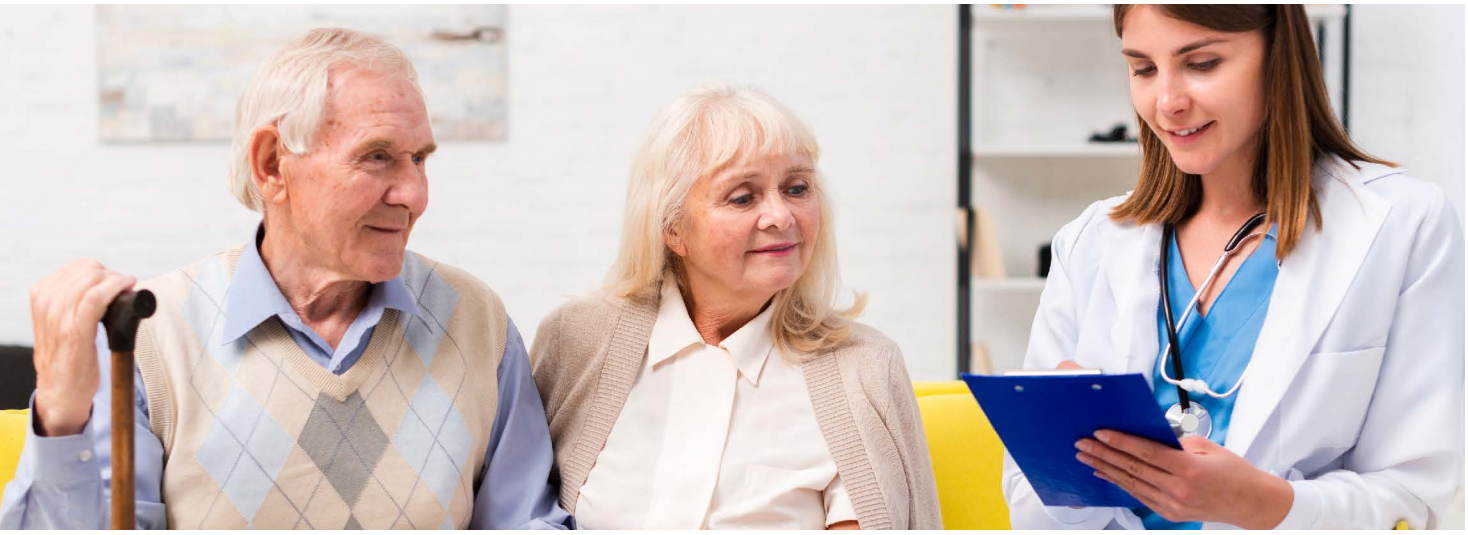
Follow-up from the kick-off meeting by sharing a framework with the stakeholders to begin to think about setting up a collaborative project. A follow-up email message is included in the Appendix. Although the needs of each VBCO may be different, some ideas for collaborative projects with the GED could include:

- Creating a Care Management Connection
- Medication Management
- Physical Therapy Consultations
- Primary Care Follow-Up

A template to use for brainstorming collaborative project aims, as well as an example of the above collaborative projects is included in the Appendix.

After engaging and exchanging with the members of the kick-off meeting via your follow-up email, conduct a follow-up meeting with the Sponsor and Senior Project Team to set the aim of a potential collaboration. The goal of the meeting is to finalize an aim(s) to mutually pursue with a larger coalition of VBCO and GED representatives. A draft agenda is included in the Appendix.

Next up: moving a larger Field Team towards the partnerships you hope to create.



3 Move Towards Change

After making in-roads with the GED lead physician and/or nurse champion in your local GED, engaged Executive Sponsors and kicked off the aim-setting process, now, you must continue to build consensus and move towards forging building relationships with other members of VBCO and the GED, who will be critical to implementing the collaborative project.

After selecting an aim to pursue and identifying the other members of each organization to participate as members of the Field Team, conduct a kick-off meeting with the Senior Project Team and the Field Team. The goal of the meeting is to communicate the vision for the collaborative project to the greater team, while making sure to capture their hearts and minds regarding the rationale for the aligned partnership and collaborative project. A draft agenda is included in the Appendix.

Following the kick-off meeting with the Senior Project Team and Field Team, continue to work towards developing a solidified, collaborative project team. A draft email message is included in the Appendix. One way to achieve this is to work with the group to create a team charter and establish the group's meeting cadence and schedule, general project timeline and goals. A draft team charter and example is included in the Appendix.

Once you have finalized your team, selected a collaborative project aim and determined the measures to ascertain whether the aim(s) lead to an improvement, the next step is to test the aim(s) in the GED. The Institute for Healthcare Improvement's Plan-Do-Study-Act (PDSA) cycle is a framework that can be used for testing change ideas. In other words, the PDSA cycle is "the scientific method, used for action-oriented learning (IHI, 2022)." For more information on the PDSA cycle, please visit: Science of Improvement: Testing Multiple Changes.

A PDSA worksheet and an example of a completed PDSA cycle based on creating a care management connection between the VBCO and GED are included in the Appendix.

Moving towards forging aligned partnerships and launching collaborative projects is not a linear process, even though this toolkit may suggest that it is. As a reminder, the steps laid out here are merely a suggestion and a guide to help inform aligning your organization with the work of your local GED. Many times, the steps suggested may take the form of multiple meetings, email exchanges or face-to-face, personal conversations to reach the desired goal.

Effective change management requires ongoing actions and check-ins as the project team begins to work together. There are four key tactics teams can employ to ensure ongoing change momentum:

1 Track quantitative outcomes:

You are only as strong as your data. Monitoring outcomes of the collaborative aim allows teams to determine what is working and what is not and thus, continue to iterate through PDSA cycles. Oftentimes, monitoring quantitative outcomes also provides insights into adoption within the team.

2 Solicit and respond to feedback:

Each one of the project team members brings a unique perspective and skill set to the table. Soliciting feedback (in informal one-on-one settings or through formal surveys or roundtable discussions) and responding to concerns or ideas can go a long way in generating buy-in and building solutions that work for both organizations.

3 Support the team:

At the heart of change are the people. Success will be enhanced in forging aligned partnerships by consistent and frequent communication with and education of the members of the project and larger VBCO and GED teams. Make sure to reinforce what is changing and why it is important through ongoing communications, training, and individualized coaching.

4 Celebrate success:

Do not forget to celebrate the wins along the way! Celebrations can be as simple as handwritten thank-you notes, public moments of recognition or as formal as a launch party or happy hour. It is important to practice gratitude for the hard work of the team and celebrate all the hard work accomplished.

Keep at it! Change is messy and gaining the buy-in of all the stakeholders necessary to launch your collaborative project aim and actively participate in the project is no small feat.

4 Remove Barriers

As you move towards partnership and launching collaborative projects, there will inevitably be barriers along the way. For starters, there are three common concerns you may receive from Emergency Medicine clinicians when working with VBCOs. Below, we lay out those concerns and suggested responses.

— *"We treat all patients the same regardless of whether they are in a value-based contract/arrangement."*

Response: "We do not want you to treat our patients any differently and we do not want to ever suggest that treatment or admission be withheld when you deem it necessary. Instead, our hope is that by understanding when a patient is within our risk pool, you view us as another resource available to that patient (much like adult caregivers or family members are invaluable resources but not available for every patient).

— *"We love this [idea] but are worried that it will contribute to increased boarding time and/or reduced throughput for our patients."*

Response: "Our goal is to be at least throughput neutral. We do not want to inadvertently increase boarding time or reduce throughput. This [idea] will allow you to discharge patients with our additional services, that you otherwise may have to admit or place in observation. This may actually decrease the length of ED stay."

— *"We love this [idea] but we do not have time/we are already stretched too thin/it is not realistic with our current demands."*

Response: "Understood. Can you let us know when there might be more time to explore working together? For what it is worth, our goal is to have [idea] be seamlessly integrated into clinical workflows. Our hope is that our [idea] can happen at the same time as the medical workup and be integrated into existing workflows. A seamless integration would reduce any significant time burdens."

Being able to effectively respond to the valid concerns of your Emergency Medicine clinician partners is one way to remove barriers towards establishing collaborative project aims.

Furthermore, there are two key barriers to remove to establish collaborative project aims between your VBCO and your local GED.

Beneficiary Status. It will be important to inventory how your VBCO and GED currently share beneficiary status. A recognized pain point is that your VBCO does not know when their beneficiary ends up in the ED; likewise, ED clinicians do not know when they are treating a patient in a risk-based arrangement that may have extra resources available to them. Lack of awareness about beneficiary status is a key first barrier to remove.

Communication & Information Sharing. Designing a safe alternative to in-patient admission requires an efficient, durable, provider-provider communication protocol facilitating a GED to Primary Care Physician conversation prior to a decision to admit. Creating communication pathways between the two organizations, such as with an alert mechanism or integrated feature within a hospital's electronic health record, around beneficiaries will be a key to success.

One way this can be achieved is through leveraging your state or county's health information exchange, specifically the Admission, Discharge, Transfer (ADT) notification. Depending on the locality, the ADT feed may be available (either real-time or sometimes in batches every several hours) to qualifying organizations. For example, Gary and Mary West PACE (nonprofit Program of All-Inclusive Care for the Elderly (PACE) has begun to leverage the ADT notification when a beneficiary arrives in an Emergency Department. Other industry solutions, such as Bamboo Health's (formerly PatientPing) "Ping" feature*, exist to address this problem.

Some features of communication information sharing protocols should include:

- The specific communication process (dedicated phone line, text, EHR, etc.)
- Expectations regarding the time to answer the call.
- Required information (Goals of Care, acute change in condition, Surrogate, etc.)

Much of what comes next will depend on how your organizations agree to share beneficiary status, information and communicate with one another. The next step is to determine the resources required to share beneficiary information and the communication channels to coordinate care. Integrating this work into the workflow of your guiding project team will ensure successful completion.

Conclusion

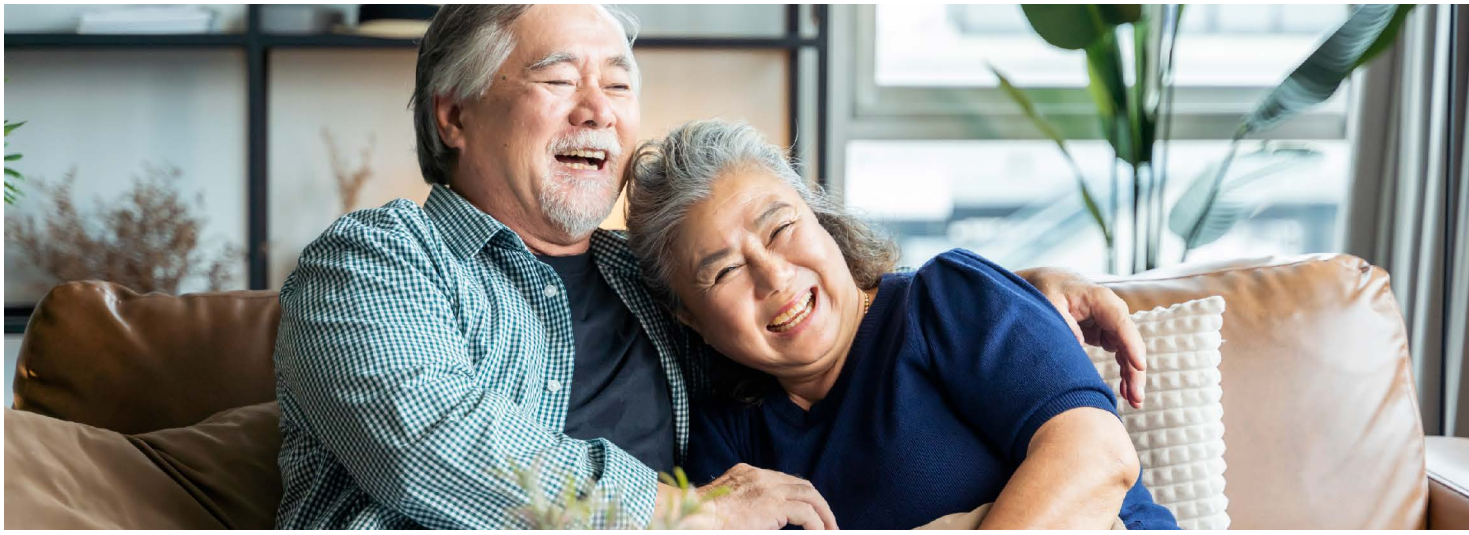
Congratulations! You have done the work to understand the GED landscape and key GED stakeholders, mobilized action, moved towards forging aligned partnerships, and removed barriers hindering your organizations from working successfully together. Our hope is that by forging aligned partnerships and launching collaborative projects that your organization and your local GED can be at the forefront of delivering high-quality, lower cost care for older adults.

For more information on how other VBCOs have forged aligned partnerships with their local GEDs, please refer to the list of exemplary organizations located in the Appendix.

For more information on how you can connect to and work with Geriatric Emergency Departments, please contact Amy Stuck, PhD, RN, Senior Director of Value-based Acute Care at West Health Institute at: arstuck@westhealth.org or the West Health Institute at (858) 535-7000 and ask to be connected to the Director of Value-based Acute Care.

Finally, our gratitude to Accountable Care Organization of Aurora, LLC, Aurora Accountable Care Organization LLC Geriatric Emergency Departments, Advocate Physician Partners Accountable Care, Inc., Gary and Mary West PACE, Mission Health Coordinated Care, St. Joseph's Geriatric Emergency Department, UNC Health Alliance, UNC Hillsborough Medical Center Geriatric Emergency Department for paving the way for other Value Based Care Organizations and Geriatric Emergency Departments to forge aligned partnerships for their expert feedback in enhancing and improving this resource.

*The reference to specific products, services or companies contained in this toolkit does not constitute endorsement or recommendation by West Health.



Appendix

All tools and templates are designed to be flexible and are merely suggestions. When using the tools and templates, please amend them freely to align with your own personal and/or professional brand.

The examples provided in the Appendix are fictional, unless otherwise noted.

Action Checklist

1. Understand the GED Landscape & Key GED Stakeholders by researching and gathering information.
   - Identify if there is a GED within your geographic market and their corresponding level of accreditation.
   - Understand the basic capabilities of the GED based on its accreditation level.
   - Determine who the GED lead physician and/or nurse champions are.
   - Learn to what degree your beneficiaries are seeking care at a GED.

2. Mobilize Action by convening introductory conversations with GED stakeholders to determine shared goals. Once on common ground, identify a guiding coalition/project team, and finalize a collaborative project aim.
   - Contact the GED lead physician and/or nurse champion.
   - Host an introductory conversation with the GED lead physician and/or nurse champion.
   - Determine the appropriate VBC organization and GED stakeholders.
   - Create a Stakeholder Map
   - Conduct a kick-off meeting with the Sponsor and Senior Project Team
   - Follow-up from the kick-off meeting
   - Conduct a follow-up meeting with the Sponsor and Senior Project Team
   - Finalize the project aim.

3. Move Towards Change by sharing a vision and empowering others to act on that vision.
   - Conduct a kick-off meeting with the Senior Project Team and Field Team
   - Create a Team Charter
   - Establish Meeting Cadence & Goals

4. Remove Barriers by determining how to share information and identify VBCO attributed beneficiaries.
   - Inventory how your VBCO and GED currently share information.
   - Outline desired future state.
   - Determine resources required to move to future state.
   - Integrate removal of barriers into workflow of guiding coalition/project team

Glossary of GED Abbreviations, Terms, Definitions and Key Performance Indicators

- 4AT: A very short and simple delirium detection tool designed for clinical use
- 4M's: Stands for What **M**atters, **M**edication, **M**entation, and **M**obility; a framework for evidence-based elements of high-quality care of older adults
- ACEP: The American College of Emergency Physicians; a professional organization of emergency medicine physicians in the United States.
- AGS: American Geriatrics Society; a professional organization for healthcare providers practicing geriatric medicine
- Age-Friendly Health Systems: a health system recognition program that entails reliably providing a set of four evidence-based elements of high-quality care, known as the "4Ms," for all older adults
- B-CAM: Brief Confusion Assessment Method; a type of standardized delirium screening process
- Boarding: The practice of holding patients who have been admitted to the hospital in the ED for prolonged periods. Defined as a time interval, it encompasses the admit decision time to the departure time[1]
- DTS: Delirium Triage Screen; a brief and rapid delirium screening tool
- EASI: Elder Abuse Suspicion Index; an approach for the identification of elder abuse
- ENA: Emergency Nurses Association; professional organization of emergency nurses
- GEAR: Geriatric Emergency Care Applied Research; a research network designed to improve the emergency care of older adults and those with dementia and other cognitive impairments.
- GED: Geriatric Emergency Department; similar to the concept of pediatric emergency departments, geriatric emergency departments incorporate specially trained staff, who conduct extended assessments and take steps to make sure the patient experience is more comfortable and less intimidating for older adults.
- GEDA: Geriatric Emergency Department Accreditation; a program developed by ACEP to ensure that older adult patients receive well-coordinated, quality care at the appropriate level for ED encounters.
- GEDC: Geriatric Emergency Department Collaborative; nationwide, multi-stakeholder collaborative dedicated to improving the quality of care for older people in Emergency Departments.
- GEDG: Geriatric Emergency Department Guidelines; guidelines developed in 2013 by the American College of Emergency Physicians (ACEP), American Geriatrics Society (AGS), Emergency Nurses Association (ENA), and Society for Academic Emergency Medicine (SAEM) to provide a standardized set of parameters that are both feasible for implementation in the ED and supportive of effectively improving the care of the geriatric population[3]
- GEDI-WSE: Geriatric Emergency Department Innovations in Care through Workforce, Informatics, and Structural Enhancements; an integrated multidisciplinary approach that incorporates workforce education, training, and evidence-based geriatric specific clinical protocols; informatics support for patient monitoring and clinical decision support; and structural enhancements to improve patient care, safety, and satisfaction.
- GENIE: Geriatric Emergency Nurse Initiative Expert; a registered nurse who typically oversees the day-to-day operations of a GED. Also called a Nurse Navigator.

- GEM: Geriatric Emergency Medicine; subspecialty of Emergency Medicine dedicated to improving the care provided to the elderly patient in the ED
- GEMCast: Geriatric Emergency Medicine Podcast; a series of podcast lectures on clinical topics to help physicians, trainees, nurses, and paramedics who take care of older adults in the emergency department
- interRAI Screener: A type of standardized assessment of function and functional decline
- ISAR: Identification of Seniors at Risk; A type of standardized assessment of function and functional decline
- JGEM: Journal Of Geriatric Emergency Medicine; an open access, peer-reviewed, quality education and dissemination platform giving providers in all disciplines the evidence they need to enhance emergency care for older adults.
- LOS: Length of Stay; often measured in average hours; a common key-performance indicator
- LWBS: Left Without Being Seen; a common key-performance indicator
- Mini Cog: A type of standardized dementia screening process
- NICHE: Nurses Improving Care for Healthsystem Elders Program; nursing education and consultation program designed to train nurses, nurse leaders, or other direct care team professionals on how to improve geriatric care in healthcare organizations[3]
- Nurse Champion: A registered nurse who typically oversees the day-to-day operations of a GED
- OBS: Observation; specialized unit designed for efficient, ongoing medical treatment, assessment, and reassessment of patients before the appropriate decision can be made to either discharge or admit[2]
- Overcapacity: The condition of having more patients than treatment spaces in the ED. It may be measured as the time within a 24-hour period spent at overcapacity[1]
- PRISMA-7: Program of Research to Integrate the Services for the Maintenance of Autonomy 7; a type of standardized assessment of function and functional decline
- Return Visit: When a patient returns to the ED after being discharged; typically measured in 72-hour, 7-day and 30-day time periods; a common key performance indicator
- SAEM: Society for Academic Emergency Medicine; a professional organization for emergency medicine academicians
- Short Blessed Test: A type of standardized dementia screening process
- SIS: Six Item Screener; a type of standardized dementia screening process
- Time to Treatment: The amount of time lapsed between arrival in triage and treatment from a clinician; often measured as a rolling average or median; a common key-performance indicator
- Timed Up and Go: A standardized fall assessment protocol
- Ottawa 3DY: A type of standardized dementia screening process

For consideration to include:

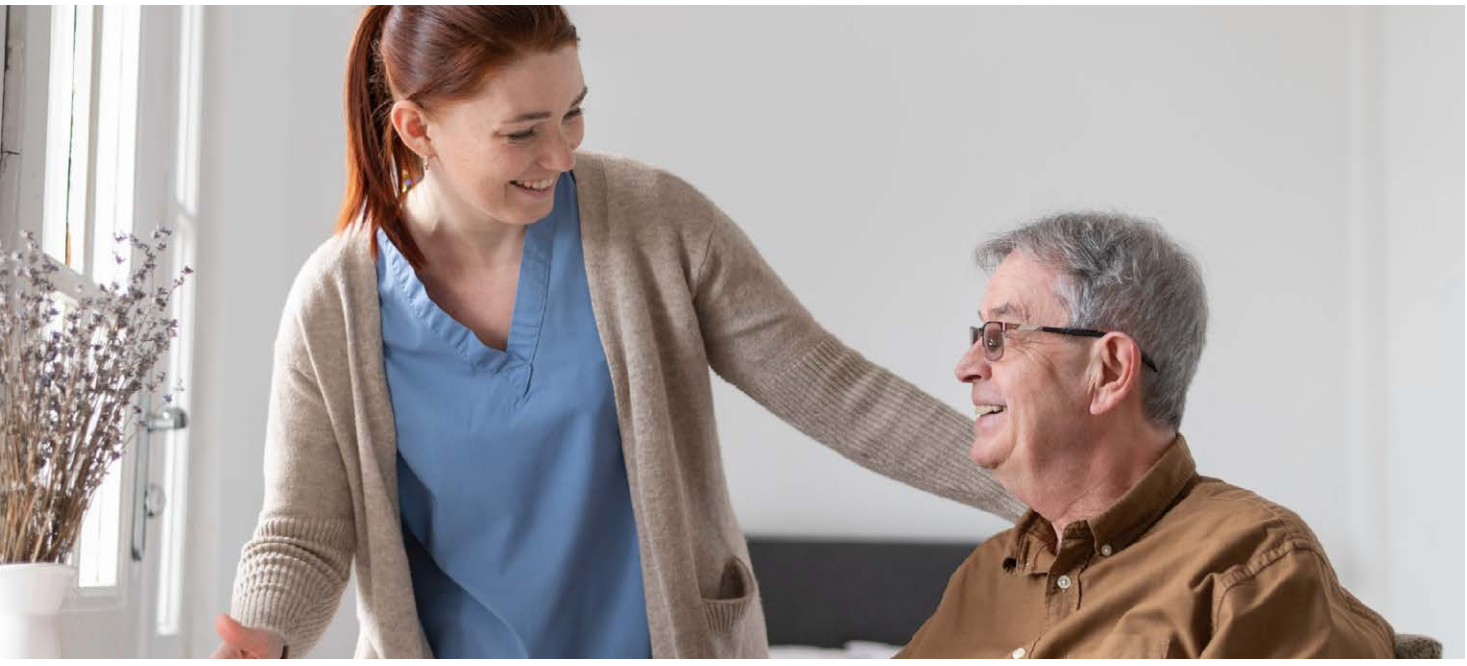
- AMA: Against Medical Advice
- CP: Community Paramedic
- DME: Durable Medical Equipment
- MoCA: Montreal Cognitive Assessment (cognitive screening tool for Mild Cognitive Impairment)
- PIMs: Potentially inappropriate medications
- POLST: Physician Orders for Life-Sustaining Treatment
- RASS: Richmond Agitation and Sedation Scale (of dementia)

References:

1. Welch SJ, Asplin BR, Stone-Griffith S, Davidson SJ, Augustine J, Schuur J; Emergency Department Benchmarking Alliance. Emergency department operational metrics, measures and definitions: results of the Second Performance Measures and Benchmarking Summit. Ann Emerg Med. 2011 Jul;58(1):33-40. doi: 10.1016/j.annemergmed.2010.08.040. Epub 2010 Nov 10. PMID: 21067846.

2. Lam, C., Ditkowsky, J., Sharma, V. K., & Stark, N. (2021, February 3). *Financial impacts of Ed Observation Units: Literature and strategies review.* EMRA. Retrieved January 27, 2023, from https://www.emra.org/emresident/article/lit-review-observation-units/

Communications, W. H. (2021, September 8). *A practical guide to implementing a geriatric emergency department...* West Health. Retrieved January 31, 2023, from https://www.westhealth.org/resource/ged-implementation-guide/



Email Template | GEDA program managers

New Message

To Nicole Tidwell, ntidwell@acep.org, Amber Hartwell, ahartman@acep.org Cc Bcc

Subject GED Lead Physician & Nurse Champion Contact Information

Hi Nicole,

My name is [NAME] and I am the [TITLE] at [NAME OF VALUE BASED CARE ORGANIZATION]. [A SENTENCE DESCRIBING THE TYPE OF VBC ARRANGEMENT, GEOGRAPHIC FOOTPRINT, ATTRIBUTED BENEFICIARY COUNT, ETC.]

I recently reviewed the "Geriatric ED Accredited List" and believe that our beneficiaries may be seeking care at the following GEDs: [LIST OUT GEDs].

Can you please provide me with the name and contact information for the lead GED physician and nurse champion at these GEDs? I would like to establish a connection with these GED leaders to discuss how we can collaborate to better serve our beneficiaries.

Thank you.

Send

Email Template | MSSP ACO Participants to GED Stakeholders

New Message

To GED Lead Physician and Nurse Champion Cc Bcc

Subject Request for Introductory Conversation

Hi [Dr. NAME OF GED LEAD PHYSICIAN AND NURSE CHAMPION],

My name is [NAME] and I am the [TITLE] at [NAME OF VALUE BASED CARE ORGANIZATION]. [A SENTENCE DESCRIBING THE TYPE OF VBC ARRANGEMENT, GEOGRAPHIC FOOTPRINT, ATTRIBUTED BENEFICIARY COUNT, ETC.]

I have recently been learning about GEDs and the wonderful work that they do and was delighted to find out that there is one right here! I was surprised to discover that there were [X] GED visits among our beneficiaries in 2019, accounting for [X]% of all of our beneficiaries ED visits - that's [X]th out of 102 MSSP ACOs, or the [X] percentile.

Obviously, our hope is that our beneficiaries do not end up in the ED but since we know this is happening, I would love to learn more about your GED and what challenges you face. I am interested to know more about the unique screening processes, care protocols, enhanced staffing, or quality improvement projects that you have deployed in your [LEVEL 1, 2 3] GED.

Would you be willing to have a conversation over the coming weeks about your GED's capabilities and challenges? If so, please do not hesitate to provide some dates/times that work for you, and I will follow-up with a calendar invitation with [VIRTUAL MEETING PLATFORM] log-on information.

Thank you.

Send

Email Template | Other VBC organization Participants to GED Stakeholders

New Message

To GED Lead Physician and Nurse Champion Cc Bcc

Subject Request for Introductory Conversation

Hi [Dr. NAME OF GED LEAD PHYSICIAN AND NURSE CHAMPION],

My name is [NAME] and I am the [TITLE] at [NAME OF VALUE BASED CARE ORGANIZATION]. [A SENTENCE DESCRIBING THE TYPE OF VBC ARRANGEMENT, GEOGRAPHIC FOOTPRINT, ATTRIBUTED BENEFICIARY COUNT, ETC.]

I just recently learned that a GED is not only a high school equivalent diploma but also a specialized ED dedicated to the quality care of older adults! [A SENTENCE DESCRIBING THE DATA POINTS, OR LACK THEREOF, YOU HAVE AVAILABLE ABOUT YOUR BENEFICIARY OVERLAP WITH THE GED]

Obviously, our hope is that our beneficiaries do not end up in the ED but since in all likelihood this is happening, I would love to learn more about your GED and what challenges you face. I am interested to know more about the unique screening processes, care protocols, enhanced staffing, or quality improvement projects that you have deployed in your [LEVEL 1, 2 3] GED.

Would you be willing to have a conversation over the coming weeks about your GED's capabilities and challenges? If so, please do not hesitate to provide some dates/times that work for you, and I will follow-up with a calendar invitation with [VIRTUAL MEETING PLATFORM] log-on information.

Thank you.

Send

Agenda Template | Introductory Conversation

Introductory Conversation

[DAY OF WEEK, DATE]
[TIME, TIME ZONE]

[VIRTUAL MEETING PLATFORM] Details: [ADD HERE]

Agenda Items

[START TIME - END TIME e.g.: 1:00-1:10]	*Introductions - All*
[START TIME - END TIME]	*Overview of GED capabilities & challenges - [GED LEAD PHYSICIAN AND NURSE CHAMPION NAME]*
[START TIME - END TIME]	*Current ACO efforts in the ED - [YOUR NAME]*
[START TIME - END TIME]	*Next Steps - [YOUR NAME]*

Presentation Template | Introductory Conversation

[ADD IN FINALIZED PRESENTATION TEMPLATE WITH EXPERT FEEDBACK]

Roles & Responsibilities | Project Teams

Project Team Roles & Responsibilities				
Role	Definition	Responsibilities	VBC organization Example	GED Example
Executive Sponsor	A senior executive who will be responsible for the collaboration	Providing executive-level support, needed resources to carry out the collaboration and ability to liaison with other areas of the organization. Not a day-to-day participant in meetings and workflow, but highly involved in the outset of a collaboration and should review the team's progress periodically	Chief Medical Officer	Department of Emergency Medicine Chair Service Line leader for emergency medicine
Senior Project Team	Leaders with ample authority to make decisions	Developing the vision and strategy for the collaboration, providing resources to the team, removing obstacles, resolving conflicts, managing stakeholders. Understands both the clinical implications of proposed changes and the consequences such a change might trigger in other parts of the system.	Senior Vice Presidents Directors	GED Lead Physician and/or Nurse Champion
Field Team	Highly respected and credible individual contributors or mid-level managers who represent key constituencies involved in the collaboration.	Actively engage in the collaboration, suggest areas of ongoing improvement, and bring others along in the collaborative effort. Someone who knows the subject intimately and who understands the processes of care.	Care Managers	• Nurse Champions • Physical Therapists • Social Workers • Geriatricians • Pharmacists
Day-to-day Leadership	The driver of the project.	Day-to-day leader in meetings and workflow, responsible for completion of collaboration deliverables. Manages the collaboration from inception to completion.	If you are reading this toolkit, it is likely that this person is…you.	

Stakeholder Map

Stakeholder	Role	Title	Location	Importance in Approval	Importance in Execution	Notes

Stakeholder	Role	Title	Location	Importance in Approval	Importance in Execution	Notes
Sally Sue	Executive Sponsor	Chief Medical Officer	VBCO Internal	High	High	Advancing our work with EDs is a top priority in the recent strategic plan. Sally has a vested interest in the project
Samantha Smith	Executive Sponsor	Department of Emergency Medicine Chair	GED Internal	High	Low	Sydney will require Samantha's approval to proceed with the project but she has other high priorities
Stacey Salem	Senior Project Team	Vice President for Population Health	VBCO Internal	Medium High	Medium	Stacey is relatively new to the organization and may need additional contextual information while onboarding
Sydney Shiloh	Senior Project Team	GED Lead Physician	GED Internal	Medium High	Medium	Sydney's area of research is Delirium, a potential high interest area for partnership
Serena Stevie	Field Team	Care Manager	VBCO Internal	Low	High	Serena has participated in simillar project at here prior organization and may have expertise to share
Sylvia Shelby	Field Team	GED Nurse Champion	GED Internal	Low	High	Sylvia is first point of contact for GED staff and will coordinate with others as necessary
Savannah Scott	Project Leader	Chief of Staff	VBCO Internal	Low	High	Savannah has wide connections in the industry which can be leveraged if necessary

Email Template | Stakeholder Map

New Message

To GED Lead Physician and Nurse Champion Cc Bcc

Subject Follow-Up from our Introduction

Hi [Dr. NAME OF GED LEAD PHYSICIAN AND NURSE CHAMPION],

It was a pleasure to speak with you the other day and I look forward to our continued collaboration. As I mentioned during our conversation, I would like to convene a larger group of [NAME OF YOUR VCB organization] and GED stakeholders to have a broader conversation around how we can best collaborate.

Attached, please find a stakeholder map of VBC representatives that I would like to attend an initial kick-off conversation. Who from your team should be included?

Thank you.

[YOUR NAME]

Send

Making Your Business Case to an Executive Sponsor

Get informed: Understand the priorities and pain points facing your C-suite

- Create a business case which clearly addresses the top priorities facing your C-suite rather than highlighting your own priorities. Projects that meet the priority strategic initiatives of your health system are more likely to receive a favorable response.

- Find out what the top priorities or initiatives are for your system coming from the C-suite. These have often already been vetted against a return on investment (ROI) and have been packaged into specific objectives to be cascaded through the organization.
    - The American College of Healthcare Executives (ACHE) reports the top issues confronting hospitals are: financial challenges; governmental mandates; patient safety and quality; personnel shortages; patient satisfaction; access to care; physician-hospital relations; population health management; technology; and reorganization.

- Understand the financial impact of your proposal. For example, if making the case for a project aimed at reducing hospital admissions from the ED, calculate patient-level Medicare dollar margins (patient revenue minus cost) for ED-initiated admissions and non-ED-initiated admissions [1] to illustrate the cost differential.

- For some cases, it may be difficult to calculate an actual dollar value. However, you can connect your initiative with other important factors such as full-time employee (FTEs) dollars saved, potentially avoided unnecessary admissions, or other numerators of a quality metric impacted. Your business office can translate those numbers into monetary impact when you do not have the information to do so.

- Understand how the ED is incentivized from a payment/quality perspective.

- Understand the system-level payment/quality drivers, payer mix and payer-led drivers: there may be opportunities to connect your project to an existing initiative that has C-level support and visibility.

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Develop your project's "elevator pitch" to the C-Suite in language they will easily understand

You may have limited time to describe your proposal to your C-suite. Be prepared to present your ideas in a quick and simple format that highlights the sources of ROI and how it directly links to the top priorities for your hospital—priorities the C-suite cares about. This can be a concise "elevator pitch" and/or a visual (such as the table below, which illustrates how two projects (models) can support a goal of reducing readmission penalties.)

*Component	Emergency Department	Hospital
Model	Establish a Geriatric ED	Establish an Acute Care at Home option from the ED
Goal	Provide senior-focused emergency care to prevent avoidable hospitalizations; improve patient outcomes and satisfaction; and reduce iatrogenic complications	Prevent hospital admissions when and where appropriate
Target Population	Seniors experiencing a medical emergency	Seniors experiencing a medical emergency that can be treated at home
Source of Hospital ROI	Reduce ED revisits and readmissions; reduce readmission penalties; reduce penalties for preventable errors; increase patient satisfaction scores	Reduce readmission penalties; backfill beds with high-margin admissions; increase patient satisfaction scores; reduce the cost to treat; reduce low or negative margin Medicare admissions
Source of Societal ROI	Reduce ED crowding and time on divert status; improve patient outcomes and reduce iatrogenic complications	Improve patient outcomes and reduce iatrogenic complications; reduce the cost of care; allow seniors to receive care where they prefer to be treated

*Adapted from [2]

Document the details of the project to support decision-making

A more complete business case will include the following components:

1. Brief, executive summary describing the key points of the project, including the need
2. Introduction and rationale describing the objectives, predicted outcomes and benefits tied to C-suite's priorities
3. Describe how outcomes will be measured and reported
4. A section should provide cost details related to the expenses associated with setting up, assessing, maintaining and ultimately sustaining the program. This section should also describe the expected financial ROI of the program.
    a. It's important to be transparent about what your project will cost in terms of FTEs, equipment, or loss of efficiency in other areas. Any unrealistic or non-transparent information will reduce the credibility of the proposal.
5. Include a section that describes the timeline and resources for implementing the program.

[1] McHugh, et al, 2008
[2] Siu, et al, 2009

Agenda Template | Kick-Off Meeting with Sponsors & Senior Project Team

Invitees: Sponsors & Senior Project Team

Kick Off Meeting

[DAY OF WEEK, DATE]
[TIME, TIME ZONE]

[VIRTUAL MEETING PLATFORM] Details: *[ADD HERE]*

Agenda Items

[START TIME - END TIME e.g.: 1:00-1:10]	*Introductions - All*
[START TIME - END TIME]	*Introduction to VBC organization - [VBC organization REPRESENTATIVE NAME]* • *Define Risk Based Arrangement* • *Overview Unique Capabilities (such as care management, hospital at home, community paramedicine, same day at-home visits, etc.)* • *Goals, key outcomes, and metrics/measurement (share any daily dashboards, if applicable)* • *Challenges* • *Current partnerships, projects, or work in the ED*
[START TIME - END TIME]	*Introduction to the GED - [GED LEAD PHYSICIAN AND/OR NURSE CHAMPION]* • *Overview Unique Capabilities (such as Physical Therapy, Social Work, Community Connections, Palliative Care, Direct to SNF, etc.)* • *Review goals, key outcomes, and metrics/measurement of the ED (share any daily dashboards, if applicable)* • *Discuss challenges.* • *Overview any current partnerships, projects, or work with VBCOs.*
[START TIME - END TIME]	*Next Steps - [YOUR NAME]*

Email Template | GEDA program managers

New Message

To Invitees and Attendees of the Kick-Off Meeting Cc Bcc

Subject Follow-Up from the *[NAME OF VBC organization]*/GED Kick-Off Meeting

Hi all,

It was a pleasure to meet you and I look forward to our continued collaboration. As we discussed at our kick-off meeting, our next step is to reconvene and brainstorm an aim for our collaboration. This will include ensuring our aim is time-specific, measurable and should define the specific patient population we are targeting.

In preparation for our next meeting, please come prepared with 2-3 ideas on potential aims. I have attached a template for your use in capturing your ideas.

Best,

[YOUR NAME]

Send

Template | Potential Collaborative Projects

Project Description	Patient Population	Project Timing	Measurement	Aim Statement

Project Description	Patient Population	Project Timing	Measurement	Aim Statement
Care Management Connection	All At-Risk Beneficiaries	Within 1 year	80%	Connect 80% of at-risk beneficiaries to VBCO care management function within 1 hour of GED admission
Medication Management	All At-Risk Beneficiaries	Within 1 year	75%	Improve medication reconciliation at GED transition points by 75% within 1 year
Physical Therapy Consultations	Join Replacement and/or High Fall Risk Beneficiaries	Within 1 year	75%	Provide PT cpnsults to 75% of joint replacement and/or high dall risk beneficiaries in the GED within 1 year
Primary Care Follow-Up	All At-Risk Beneficiaries	Within 9 months	100%	Offer all patients within one week access to their primary care physician within 9 months

Agenda Template | Aim-Setting Meeting

Invitees: Sponsor and Senior Project Team

Aim Setting Meeting

[DAY OF WEEK, DATE]
[TIME, TIME ZONE]

[VIRTUAL MEETING PLATFORM] Details: [ADD HERE]

Agenda Items

[START TIME - END TIME e.g.: 1:00-1:10]	*Review VBC Organization Aim Ideas - [VBC REPRESENTATIVE NAME]* • *VBC Representative presents their slide on ideas for potential collaborative project aims.*
[START TIME - END TIME]	*Review GED Aim Ideas - [GED LEAD PHYSICIAN AND/OR NURSE CHAMPION]* • *GED Lead Physician and/or nurse champion presents their slide on ideas for potential collaborative project aims.*
[START TIME - END TIME]	*Discuss Aims and Select Aim to Pursue - All* • *What do we know about [AIM]?* • *What is some relevant information we should consider related to [AIM]?* • *What is our experience with [AIM]?* • *What is our initial reaction to the [AIM]?* • *How might this new [AIM] enhance our care for the targeted patient population?* • *What are the implications of launching the [AIM] in the GED?*
[START TIME - END TIME]	*Next Steps - [DAY-TO-DAY LEADER]* • *If we are to move forward with [SELECTED AIM], what needs to happen?* • *If we move forward with [SELECTED AIM], when do we begin?* • *If we move forward with [SELECTED AIM], who else needs to be included in our Field Team?*

Agenda Template | Kick-Off Meeting with Field Team

Invitees: Senior Project Team & Field Team

Aim Setting Meeting

[DAY OF WEEK, DATE]
[TIME, TIME ZONE]

[VIRTUAL MEETING PLATFORM] Details: *[ADD HERE]*

Agenda Items

[START TIME - END TIME e.g.: 1:00-1:10]	*Introduction to VBC organization & VBC Field Team Attendees - [VBC REPRESENTATIVE NAME]* • *VBC Field Team Introductions* • *Define Risk Based Arrangement* • *Overview Unique Capabilities (such as care management, hospital at home, community paramedicine, same day at-home visits, etc.)* • *Goals, key outcomes, and metrics/measurement* • *Challenges*
[START TIME - END TIME]	*Introduction to the GED & GED Field Team Attendees - [GED LEAD PHYSICIAN AND/OR NURSE CHAMPION]* • *GED Field Team Introductions* • *Overview Unique Capabilities (such as Physical Therapy, Social Work, Community Connections, Palliative Care, Direct to SNF, etc.)* • *Review goals, key outcomes, and metrics/measurement of the ED* • *Discuss challenges.* • *Overview any current partnerships, projects, or work with VBCOs.*
[START TIME - END TIME]	*History of the Collaboration - [DAY-TO-DAY LEADER]* • *Describe impetus for the partnership by reviewing beneficiary overlap data.* • *Describe work thus far to bring your VBC and the GED together.*
[START TIME - END TIME]	*Vision Statement / Review Aim - [VBC REPRESENTATIVE NAME & GED LEAD PHYSICIAN AND/OR NURSE CHAMPION]* • *Review and discuss identified collaborative project aim.* • *Benefits of the aim for identified patient population.* • *Cutting edge nature of the collaboration*
[START TIME - END TIME]	*Next Steps - [DAY-TO-DAY LEADER]* • *Review what needs to happen in order to begin.* • *Review when intend to begin.* • *Overview team charter process and what to expect next.*

Email Template | Follow-Up to Kick-Off Meeting with Field Team

New Message

To Invitees and Attendees of the Kick-Off Meeting with Field Team Cc Bcc

Subject Follow-Up from the *[NAME OF VBC]*/GED Kick-Off Meeting

Hi all,

It was a pleasure to meet you and I look forward to our continued collaboration. As we discussed at our kick-off meeting, our next step is to [NEXT STEPS DISCUSSED/IDENTIFIED AT KICK OFF MEETING].

[INSERT OTHER RELEVANT PROJECT UPDATES SINCE THE KICKOFF MEETING AND/OR FURTHER DISCUSSION AROUND NEXT STEPS OR IMMEDIATE ACTION ITEMS.]

Best,

[YOUR NAME]

Send

Template | Team Charter

[NAME OF ORGANIZATION(S) / TITLE OF COLLABORATIVE PROJECT]

Primary Goals & Objectives

The primary goal is the *[FILL IN PRIMARY GOAL]*.

This project aims to *[INSERT COLLABORATIVE PROJECT AIM]*.

The project will be a *[PROVIDE SOME BASIC DETAILS ABOUT WHAT IS REQUIRED FOR THE PROJECT]*.

Defining Success

The move towards value-based care and the standardized care protocols and processes of a Geriatric Emergency Department care are important initiatives to both *[NAME OF ORGANIZATION(S)]*. A successful project is able to *[INSERT GENERAL SUCCESS STATEMENT.]*

Specific measure of success include:

1. *[LIST OUT SUCCESS MEASURE(S) OF COLLABORATIVE AIM]*

The general timing for the *[TITLE OF COLLABORATIVE PROJECT]* will be:

- *[KICK-OFF DATE]*
- *[MIDPOINT DATE]*
- *[CONCLUSION DATE]*
- *[ANY OTHER RELEVANT KEY MILESTONES]*

Team Roles & Responsibilities

Team Member	Role	Responsibilities
[NAME, CREDENTIALS OF TEAM MEMBER]	*[ROLE OF TEAM MEMBER, VBC organization OR GED]*	*[LIST RESPONSIBILITIES OF TEAM MEMBER]*

Operational Plan (Logistics, Procedures, Communications)

- When and where will the project team meet?
  - Consider meeting frequency, timing, and location.
- What platform will the project team use for Virtual Meetings and how will the team conduct these?
- What are our expectations of each other for team meetings?
  - Include information regarding meeting protocol, leading the meetings, setting the agenda, individual team member preparation, team etiquette for meetings, taking minutes and recording action items and next steps, and other relevant information.
- Who will take and post the minutes of each meeting, including action items and next steps?

Project Management

- What is our platform and process to share deliverables and manage document versions?
  - (e.g., Dropbox, Email, Google Docs, Other)
- Include platforms and etiquette for data sharing, communication, and final documents.

Version Control

We will accept the below naming convention for all documents:

- *[LIST DOCUMENT NAMING CONVENTION]*
  - Example: *[PROVIDE EXAMPLE OF DOCUMENT NAMING CONVENTION]*

Team Profile

Team Member	Strengths	Weaknesses
[NAME, CREDENTIALS OF TEAM MEMBER]	*[PERSONAL STRENGTHS TO BRING TO THE PROJECT]*	*[PERSONAL WEAKNESSES TO BE AWARE OF]*

Example | Team Charter

St. Simon's Health Partners & St. Simon's Hospital's Geriatric Emergency Department
Creating a Care Management Connection

Primary Goals & Objectives

The primary goal of the project is timely notification that St. Simon's Health Partners beneficiaries have presented to the GED.

This project aims to utilize the health information exchange to send a text message to a designated St. Simon's Health Partners care manager, alerting them to the beneficiary presenting to the GED.

The project will be a joint initiative between St. Simon's Health Partners & St. Simon's Hospital's Geriatric Emergency Department. The project will culminate in a shared process map, roles and responsibilities matrix, and operational procedures for creating a care management connection between our two organizations.

Defining Success

Providing high-quality, better coordinated care and lowering costs, and the standardized care protocols and processes of a Geriatric Emergency Department care are important initiatives to both St. Simon's Health Partners & St. Simon's Hospital's Geriatric Emergency Department. A successful project is able to create a care management connection between our two organizations that leads to optimal dispositions and reduces unnecessary admissions. .

Specific measure of success include:

1. Notification of St. Simon's Health Partners beneficiary presenting to the GED within 1 hour of arrival
2. Care management hand-off completion rate of 75% between St. Simon's Hospital's Geriatric Emergency Department & St. Simon's Health Partners
3. At least 5 avoided hospitalizations per quarter, for a total of 20 avoided hospitalizations for the year

The general timing for the Creation of a Care Management Connection Initiative will be:

- January 2022 - Project Kick Off
- April 2022 - Finalized Project Aim Statement & Initial Data Collection
- July 2022 - PDSA Cycle #1 Test
- August 2022 - PDSA Cycle #2 Test
- September 2022 - PDSA Cycle #3 Test
- December 2022 - Project Wrap-Up

Team Roles & Responsibilities

Team Member	Role	Responsibilities
Sally Sue CMO VBCO	Executive Sponsor VBCO	Providing executive-level support, needed resources to carry out the collaboration
Samantha Smith Department of Emergency Medicine Chair GED	Executive Sponsor GED	Providing executive-level support and ability to liaison with other areas of the organization
Stacey Salem Vice President for Population Health VBCO	Senior Project Team VBCO	Developing the vision and strategy for the collaboration, providing resources to the team, removing obstacles, resolving conflicts, managing stakeholders.
Sydney Shiloh GED Lead Physician GED	Senior Project Team GED	Understands both the clinical implications of proposed changes and the consequences such a change might trigger in other parts of the system.
Serena Stevie Care Manager VBCO	Field Team VBCO	Actively engage in the collaboration, suggest areas of ongoing improvement, and bring others along in the collaborative effort.
Sylvia Shelby Nurse Champion GED	Field Team GED	Subject matter expert who understands the processes of care.
Savannah Scott Chief of Staff VBCO	Project Leader VBCO	Day-to-day leader in meetings and workflow, responsible for completion of collaboration deliverables. Manages the collaboration from inception to completion.

Operational Plan (Logistics, Procedures, Communications)

Virtual Meetings will be conducted weekly (when deemed necessary) via Microsoft Teams. Savannah, or her assistant, will take the lead on scheduling or canceling all meetings. A weekly meeting Agenda will be sent in advance by Savannah.

Team Members will come on-time and prepare for meetings, as requested in the meeting agenda or pre-meeting communication(s). Serena will take meeting notes, including recording action items and next steps. Meeting agendas and notes will be housed in a shared Google Doc for all to access at any time.

Project communication will be primarily through email, although collaboration on project documents will occur via Google Docs.

Executive sponsors will attend optionally or when the project team requests attendance.

Project Management

Savannah will take the lead on creating a Google Drive folder for the team to collaborate on and share project documents. Savannah will be the manager of all internal project files in the Google Drive, including but not limited to creating new folders and archiving information. In the interim, documents will be shared via email.

Version Control

We will accept the below naming convention for all documents:

- *TYPE_describe item_version_date (yyyy.mon.dd)*
  - Example: PROCESS MAP_St. Simon's VBCO & GED_v3_2022.Aug.02

Team Profile

Team Member	Strengths	Weaknesses
Sally Sue CMO VBCO	Harmony Developer Futuristic Adaptability Self-Assurance	Find it difficult to enjoy the present moment. Difficulty in getting other people to understand my vision.
Samantha Smith Department of Emergency Medicine Chair GED	Significance Focus Empathy Responsibility Realtor	Often perceived as overly concerned about reputation and success, due to masking vulnerability. Often told it makes it difficult for others to know how to support me.
Stacey Salem Vice President for Population Health VBCO	Individualization Developer Strategic Arranger Harmony	Can tend to put individual needs and goals ahead of what is best for the group, which can appear like favoritism and bias.
Sydney Shiloh GED Lead Physician GED	Activator Focus Command Analytical Discipline	Tend to become absorbed in work, and may be slow to respond to others' immediate needs. Can appear emotionally distant.
Serena Stevie Care Manager VBCO	Analytical Individualization Focus Maximizer Learner	Have a desire to explore and exhaust all possible outcomes before coming to a conclusion, which can frustrate those who want to move forward
Sylvia Shelby Nurse Champion GED	Strategic Intellection Consistency Belief Relator	Been told that others find it difficult to follow or understand my thought process
Savannah Scott Chief of Staff VBCO	Responsibility Developer Empathy Arranger Maximizer	Find it difficult to turn down others' requests so I can often overcommit

Template | PDSA Worksheet

PDSA Worksheet (Short-form)

Template: PDSA (Short-form)

For instructions to use this tool, please see the *QI Essentials Toolkit*.

Date: _____ Change Idea: _____ PDSA#: _____

Objective (What question(s) do we want to answer?): _____

4) Act: "What's next?"

- Adapt? Adopt? Abandon? Run again?

1) Plan: "What will happen if we try something different?"

- What will you do? When and where will you do it? Who will do it?
- What data will you collect and how will you collect it?
- What do you predict will happen?

3) Study: "What happened?"

- Did the test go as planned?
- What did you learn?
- Was your prediction right or wrong?

2) Do: "Let's try it."

- Run the test: Carry out the plan. Collect and record the data.

Template | PDSA Worksheet Example for Creating a Care Management Connection

PDSA Worksheet (Short-form)

Template: PDSA (Short-form)

For instructions to use this tool, please see the *QI Essentials Toolkit*.

Date: July 2022 Change Idea: Health information exchange sends text to designated ACO contact PDSA#: 1

Objective (What question(s) do we want to answer?): Timely notification that ACO beneficiaries are in the GED

4) Act: "What's next?"

- Adapt? Adopt? Abandon? Run again?

We will revise the process map based on what we learned and will plan to test the process with one beneficiarie's notification from HIE's ADT feed text to the ACO rep.

1) Plan: "What will happen if we try something different?"

- What will you do? When and where will you do it? Who will do it?
- What data will you collect and how will you collect it?
- What do you predict will happen?

Develop proposed workflow for real-time/near real-time notification by HIE's ADT feed to designated ACO contact
Conduct virtual table top simulation of process with HIE representative and ACO contact representative the week of July 11th
We will collect data on the areas of the process that failed and were successful.We predict the simulation of the ADT feed to the ACO contact representative will reveal barriers to successful and timely notification

3) Study: "What happened?"

- Did the test go as planned?
- What did you learn?
- Was your prediction right or wrong?

Yes, the simulation went as planned and our prediction was correct. We learned that there is a delay of about 2 hours before the ADT feed prompts the text message to be sent, and it comes in batches with other ADTs feeds (specialist visits, hospital discharges, etc.)

2) Do: "Let's try it."

- Run the test: Carry out the plan. Collect and record the data.

We ran the simulation on July 11th with a rep from the HIE and our designated ACO contact. We simulated a patient registering in the ED, HIE receiving the ADT feed and sending a text message to the ACO representatives cell phone. We carefully logged where the process map needed revising

Exemplars in Forging Aligned Partnerships

Forging Aligned Partnerships Between Value Based Care Organizations & Geriatric Emergency Departments Exemplars				
	ACCOUNTABLE CARE ORGANIZATION OF AURORA, LLC Aurora Accountable Care Organization Advocate Physician Partners	Gary and Mary West PACE	MissionHealth Coordinated Care	UNC Health Alliance
VBCO Name	Accountable Care Organization of Aurora, LLC Aurora Accountable Care Organization LLC Advocate Physician Partners Accountable Care, Inc.	Gary and Mary West PACE	Mission Health Coordinated Care	UNC Health Alliance
VBCO Location	Illinois Wisconsin	San Diego, CA	New Jersey	North Carolina
VBCO Contact Name	Mike Barbati	Ross Colt, MD, MBA, FAAFP	James Giordano	Tony Rodriguez, MD
VBCO Contact Title	Vice president of Government and Value-Based Programs at Advocate Aurora Health	Medical Director	Executive Director	Medical Director
VBCO Contact Email	michael.barbati@aah.org	rcolt@westpace.org	giordanoj@sjhmc.org	antonio.rodriguez@unchealth.unc.edu
VBCO	MA, MSSP, ACO REACH,	Fully Capitated	MSSP Basic E, BPCIA,	MSSP Enhanced, MA
Arrangements	Capitated, Shared Savings, Quality		MA	APMs
Percent Beneficiary Visits at GED in 2021	74.0% - 66.2% for MSSP ACO	98%	85.0% for MSSP ACO	N/A
GED System Name	Advocate Aurora Health	Palomar Health Tri-City Medical Center	St. Joseph's Health	UNC Health
GED Accreditation Level	Level 2 - 1 Level 3 - 16	Level 3	Level 1 - 1	Level 2 - 1 Level 3 - 2
GED Contact Name	Aaron Malsch RN,MS, GCNS-BC	N/A	Nilesh Patel, MD	Katie Davenport, MD
GED Contact Title	GED Program Manager	N/A	Vice Chair, Emergency Medicine	Medical Director
GED Contact Email	aaron.malsch@aah.org	N/A	patelnin@sjhmc.org	katie_davenport@med.unc.edu
Scope of Pilot Project Participation	Integrating VBCO data with GED EHR for dashboard performance improvement; identification of VBCO beneficiaries presenting in the GED	Brand and awareness building among local GEDs; near real-time notification of VBC beneficiary presentation to GED through ADT feed	Real-time notification of VBC beneficiary presentation to GED through Bamboo Health; care coordination of VBC beneficiaries to outpatient care settings to avoid unnecessary hospital admissions	Bi-directional education for VBCO and GED staff on capabilities of VBCO and GED for alternative beneficiary dispositions

References

1. Bureau, U. S. C. (2021, October 8). *65 and older population grows rapidly as baby boomers age*. Census.gov. Retrieved May 18, 2022, from https://www.census.gov/newsroom/press-releases/2020/65-older-population-grows.html
2. Roberts, A. W., Ogunwole, S. U., Blakeslee, L., & Rabe, M. A. (2018). (rep.). *The Population 65 Years and Older in the United States: 2016* (pp. 1–25). Washington, D.C.: U.S. Census Bureau.
3. Zayas CE, He Z, Yuan J, et al. Examining Healthcare Utilization Patterns of Elderly Middle-Aged Adults in the United States. Proc Int Fla AI Res Soc Conf. 2016;2016:361-366.
4. Aminzadeh F, Dalziel WB. Older adults in the emergency department: a systematic review of patterns of use, adverse outcomes, and effectiveness of interventions. Ann Emerg Med. 2002 Mar;39(3):238-47. doi: 10.1067/mem.2002.121523. PMID: 11867975.
5. Gonzalez Morganti, Kristy, Sebastian Bauhoff, Janice C. Blanchard, Mahshid Abir, Neema Iyer, Alexandria Smith, Joseph Vesely, Edward N. Okeke, and Arthur L. Kellermann, The Evolving Role of Emergency Departments in the United States. Santa Monica, CA: RAND Corporation, 2013. https://www.rand.org/pubs/research_reports/RR280.html. Also available in print form.
6. Wang, N., Amaize, A. and Chen, J. (2021), Accountable Care Hospitals and Preventable Emergency Department Visits for Rural Dementia Patients. J Am Geriatr Soc, 69: 185-190. https://doi.org/10.1111/jgs.16858
7. Anderson AC, Chen J. ACO Affiliated Hospitals Increase Implementation of Care Coordination Strategies. Med Care. 2019;57(4):300-304. doi:10.1097/MLR.0000000000001080
8. Hwang, U., Dresden, S.M., Rosenberg, M.S., Garrido, M.M., Loo, G., Sze, J., Gravenor, S., Courtney, D.M., Kang, R., Zhu, C.W., Vargas-Torres, C., Grudzen, C.R., Richardson, L.D. and (2018), Geriatric Emergency Department Innovations: Transitional Care Nurses and Hospital Use. J Am Geriatr Soc, 66: 459-466. https://doi.org/10.1111/jgs.15235
9. Dresden SM, Hwang U, Garrido MM, Sze J, Kang R, Vargas-Torres C, Courtney DM, Loo G, Rosenberg M, Richardson L. Geriatric Emergency Department Innovations: The Impact of Transitional Care Nurses on 30-day Readmissions for Older Adults. Acad Emerg Med. 2020 Jan;27(1):43-53. doi: 10.1111/acem.13880. Epub 2019 Dec 1. PMID: 31663245.
10. Hwang U, Dresden SM, Vargas-Torres C, et al. Association of a Geriatric Emergency Department Innovation Program With Cost Outcomes Among Medicare Beneficiaries. JAMA Netw Open. 2021;4(3):e2037334. doi:10.1001/jamanetworkopen.2020.37334
11. Lesser A, Israni J, Kent T, Ko KJ. Association Between Physical Therapy in the Emergency Department and Emergency Department Revisits for Older Adult Fallers: A Nationally Representative Analysis. J Am Geriatr Soc. 2018 Nov;66(11):2205-2212. doi: 10.1111/jgs.15469. Epub 2018 Aug 21. PMID: 30132800.
12. Guttman A, Afilalo M, Guttman R, Colacone A, Robitaille C, Lang E, Rosenthal S. An emergency department-based nurse discharge coordinator for elder patients: does it make a difference? Acad Emerg Med. 2004 Dec;11(12):1318-27. doi: 10.1197/j.aem.2004.07.006. Erratum in: Acad Emerg Med.2005 Jan;12(1):12. PMID: 15576523.

13. Berning MJ, Oliveira J E Silva L, Suarez NE, Walker LE, Erwin P, Carpenter CR, Bellolio F. Interventions to improve older adults' Emergency Department patient experience: A systematic review. Am J Emerg Med. 2020 Jun;38(6):1257-1269. doi: 10.1016/j.ajem.2020.03.012. Epub 2020 Mar 12. PMID: 32222314.

14. Moore BJ (IBM Watson Health), Liang L (AHRQ). Mho HCUP Statistical Brief #262. August 2020. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/reports/statbriefs/sb262-Medicare-Advantage-Costs-2009-2017.pdf.

15. Zaborski L, Landon BE. Variation in Rates of Hospital Admission from the Emergency Department Among Medicare Patients at the Regional, Hospital, and Physician Levels. Ann Emerg Med. 2021 Oct;78(4):474-483. doi: 10.1016/j.annemergmed.2021.03.020. Epub 2021 Jun 18. PMID: 34148659.

16. Offices of Enterprise Management, & Brennan, N., Real-Time Reporting of Medicare Readmissions Data27–43 (2014). Washington, D.C.; CMS.

17. Vasilevskis EE, Ouslander JG, Mixon AS, Bell SP, Jacobsen JM, Saraf AA, Markley D, Sponsler KC, Shutes J, Long EA, Kripalani S, Simmons SF, Schnelle JF. Potentially Avoidable Readmissions of Patients Discharged to Post-Acute Care: Perspectives of Hospital and Skilled Nursing Facility Staff. J Am Geriatr Soc. 2017 Feb;65(2):269-276. doi: 10.1111/jgs.14557. Epub 2016 Dec 16. PMID: 27981557; PMCID: PMC5311021.

18. Ouslander JG, Lamb G, Perloe M, Givens JH, Kluge L, Rutland T, Atherly A, Saliba D. Potentially avoidable hospitalizations of nursing home residents: frequency, causes, and costs: [see editorial comments by Drs. Jean F. Wyman and William R. Hazzard, pp 760-761]. J Am Geriatr Soc. 2010 Apr;58(4):627-35. doi: 10.1111/j.1532-5415.2010.02768.x. PMID: 20398146.

19. Reyes B, Ouslander JG. Care transitions programs for older adults-a worldwide need. Eur Geriatr Med. 2019 Jun;10(3):387-393. doi: 10.1007/s41999-019-00173-5. Epub 2019 Feb 22. PMID: 34652789.

20. ACEP, AGS, ENA, & SAEM. (2014). Geriatric Emergency Department Guidelines. Geriatric Emergency Department Accreditation Program. Retrieved September 1, 2022, from https://www.acep.org/geda/

21. Keene SE, Cameron-Comasco L. Implementation of a geriatric emergency medicine assessment team decreases hospital length of stay. Am J Emerg Med. 2022 May;55:45-50. doi: 10.1016/j.ajem.2022.02.027. Epub 2022 Feb 21. PMID: 35276545.

22. Simpson, M, Sergi, C, Malsch, A, Ryer, S, Rubach, C, Singh, M. Association of Geriatric Emergency Department post-discharge referral order and follow-up with healthcare utilization. J Am Geriatr Soc. 2022; 1- 11. doi:10.1111/jgs.18137

23. Bethke M, Gordon R, Elsner N, Valia, H. Equipping physicians for value-based care: What needs to change in care models, compensation, and decision making. Findings from the Deloitte 2020 Survey of US Physicians. Deloiite Insights. 2020. https://www2.deloitte.com/us/en/insights/industry/health-care/physicians-guide-value-based-care-trends.html

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