Proactive Geriatric Trauma Consultation Service

CGA within 72 hours of admission by a clinical nurse specialist and geriatrician, verbal and written communication of recommendations, weekly interdisciplinary meetings with the trauma team, and measurement of quality indicators.

- **9.6%**
  - Reduction in delirium. 50.5% vs 40.9%, p<.05

- **4.8%**
  - Reduction in discharge to long term care. 6.5% vs 1.7%, p=0.03

- **93%**
  - Adherence rate to recommendations.
Sustainability of a proactive geriatric trauma consultation service

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Background: Proactive geriatric trauma consultation service (GTCS) models have been associated with better delivery of geriatric care and functional outcomes. Whether such collaborative models can be improved and sustained remains uncertain. We describe the sustainability and process improvements of an inpatient GTCS.

Methods: We assessed workflow using interviews and surveys to identify opportunities to optimize the referral process for the GTCS. Sustainability of the service was assessed via a prospective case series (July 2012 and December 2013). Study data were derived from a review of the medical record and trauma registry database. Metrics to determine sustainability included volume of cases seen, staffing levels, rate of adherence to recommendations, geriatric-specific clinical outcomes, trauma quality indicators, consultation requests and discharge destination.

Results: Through process changes, we were able to ensure every eligible patient was referred for a comprehensive geriatric assessment. Compared with the implementation phase, volume of assessments increased and recommendation adherence rates were maintained. Delirium and/or dementia were the most common geriatric issue addressed. The rate of adherence to recommendations made by the GTCS team was 88.2%. Only 1.4% of patients were discharged to a nursing home.

Conclusion: Workflow assessment is a useful means to optimize the referral process for comprehensive geriatric assessment. Sustainability of a GTCS was demonstrated by volume, staffing and recommendation adherence.
Who Is Involved

STRENGTHS
• paired leadership
  • MD-MD
• nursing-nursing
• research-research
• students-students

WEAKNESSES
• regular turnover of trainees
• rotating geriatricians
• rotating trauma surgeons

OPPORTUNITIES
• other hospitals interested in adopting this model

THREATS
• succession planning for clinical nurse specialist in geriatrics
**STRENGTHS**

- incorporated into existing larger service
- publication on sustainability of care model

**WEAKNESSES**

- funding model is not based on service volumes

**OPPORTUNITIES**

- research grants to support model evaluation

**THREATS**

- <speaker censored views on trajectory of health care funding>
**STRENGTHS**
- hospital-based policy to operationalize the referrals and program
- American College Surgeon guidelines

**WEAKNESSES**
- lack of awareness of the policy

**OPPORTUNITIES**
- opportunity for Canadian guidelines (Trauma Association of Canada)

**THREATS**
- elder care is not part of the hospital strategic plan
**STRENGTHS**
- co-location of all trauma patients
- high staff retention
- academic Level I trauma centre supports innovation

**WEAKNESSES**
- geriatric clinicians are not co-located on the trauma ward

**OPPORTUNITIES**
- building of a new patient care tower

**THREATS**
- chaotic physical environment
S - STRENGTHS
• multimodal timely communication between geriatric and trauma teams
• 93% adherence rate

W - WEAKNESSES
• some elements are consultative (intentional)

O - OPPORTUNITIES
• Nurses Improving Care for Healthsystem Elders (NICHE)

T - THREATS
• lack of after hours presence of geriatrics
Geriatrician Selection

STRENGTHS
• the secret sauce is the clinical nurse specialist in geriatrics (consistent)

WEAKNESSES
• rotating geriatricians
• rotating trauma surgeons

OPPORTUNITIES
• increase in number of new geriatricians trained

THREATS
• parental leave
Patient Selection

STRENGTHS

- Simple eligibility criteria: 65 years or older admitted to the trauma service

WEAKNESSES

- Triage mechanism is defined by age and trauma, rather than risk stratification by frailty

OPPORTUNITIES

- Current research study on pre-admission frailty and adverse outcomes in geriatric trauma

THREATS

- Patient identification is done by one individual
AGS Person-Centred Care

**STRENGTHS**

- weekly interprofessional care rounds, case manager
- therapeutic harmonization is at the centre of CGA
- delirium education

**WEAKNESSES**

- variable integrated, timely communication with primary care
- more than one point of contact

**OPPORTUNITIES**

- published data on clinical outcomes, but room for patient feedback metrics
- NICHE

**THREATS**

- TQIP quality indicators do not include person-centre outcome reporting
You are invited TO COFFEE WITH TRAUMA. HALLWAY CONVERSATIONS TO FOLLOW.
RESEARCH (EVALUATION) DRIVES SUSTAINABILITY

When you have positive, measurable, published, impact, everyone will want to keep the collaboration model going.
What was challenging.

TRYING TO SPEAK THE SAME LINGO.
There is so much to learn about the other field.
TRUST

There must be mutual respect for one another’s domain of expertise.
EVERYONE WANTS IN.

geriatric cardiology
geriatric nephrology
perioperative geriatrics
geriatric oncology
Opportunities.

Refinement.

Current research focus on using pre-trauma frailty to refine patient selection criteria.
How this model could be more collaborative.

Increasing Collaboration

Integrate Primary Care
Tip for collaborative care models.

GRASSROOTS APPROACH

The passion has to come from the FRONTLINE from both sides of the field.
GERIATRIC TRAUMA

... and they lived happily ever after.