



SOCIETÀ ITALIANA
DI GERONTOLOGIA
E GERIATRIA

PROGRAMMA DEFINITIVO

68°

CONGRESSO
NAZIONALE SIGG

Ritorno al futuro

FIRENZE, 13-16 DICEMBRE 2023
PALAZZO DEI CONGRESSI

**IL TEAM GERIATRICO IN PRONTO SOCCORSO PER LA
PRESA IN CARICO DEI PAZIENTI FRAGILI:
L'ESPERIENZA FIORENTINA DEL GIROT**
Enrico Benvenuti (Firenze)

JOURNAL OF GERIATRIC EMERGENCY MEDICINE

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Article 2 | Review Article

JGEM | The Journal of Geriatric
Emergency Medicine

 Advocate Aurora Health[®]

 **GEDC**

The History of Geriatric Emergency Medicine

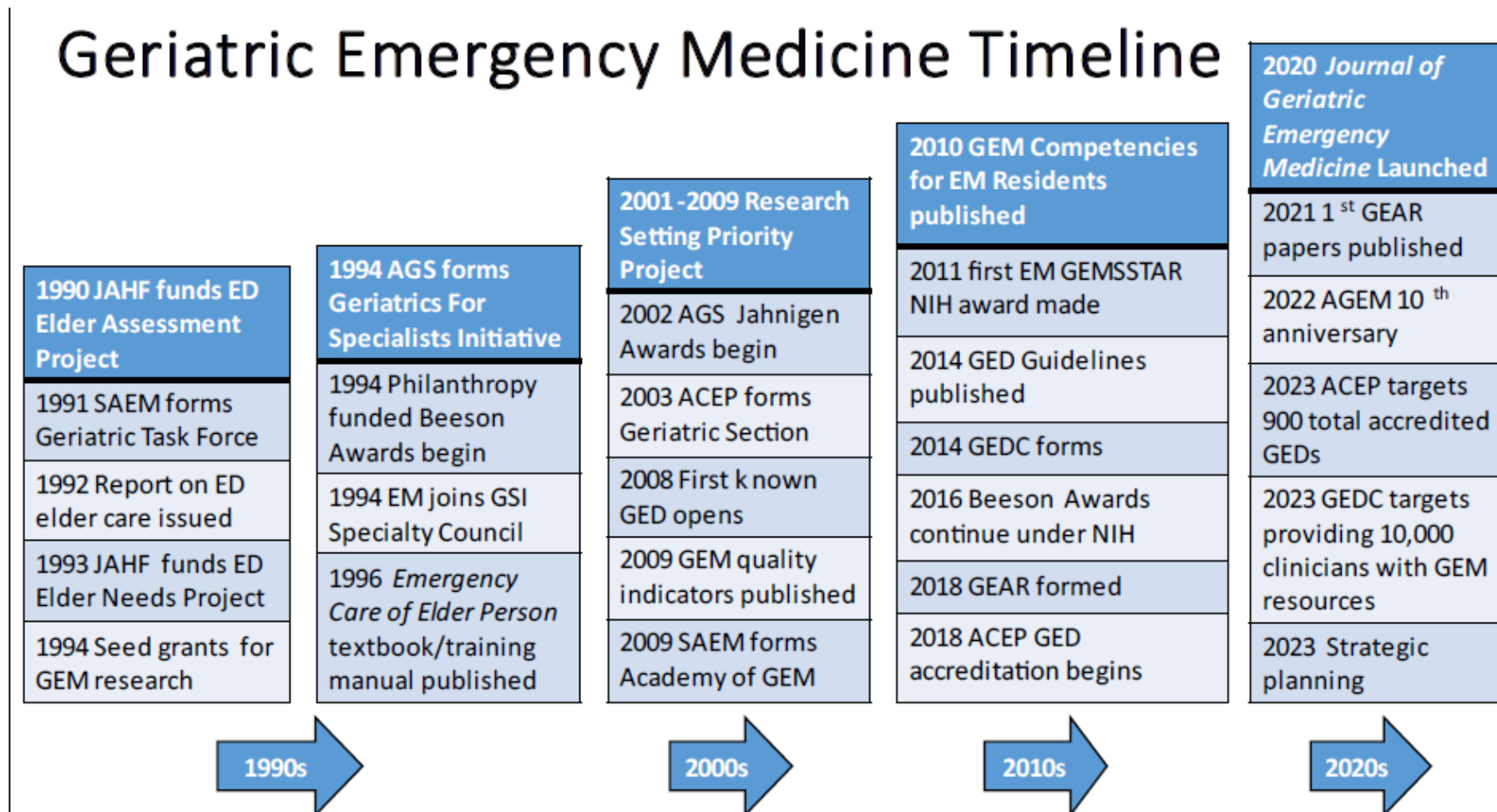
Teresita M. Hogan, MD, Lowell W. Gerson, PhD, Arthur B. Sanders, MD

“Excellent emergency care does not happen by chance. The standard emergency approach that excels in the young, fails in older patients. Older adults experience unnecessary morbidity and excess mortality in our emergency departments”

The History of Geriatric Emergency Medicine

Teresita M. Hogan, MD, Lowell W. Gerson, PhD, Arthur B. Sanders, MD





Figure 1: Geriatric Emergency Medicine Timeline



The History of Geriatric Emergency Medicine

Teresita M. Hogan, MD, Lowell W. Gerson, PhD, Arthur B. Sanders, MD

Figure 3: Lesson Learned Rise of GEM

Lessons Learned Rise of GEM			
 Problem Definition/Recognition		Establish Champions 	Clinical Practice 
Needs Analysis:YES we have a problem! ◦Increased morbidity/mortality ◦Lack of education ◦Demographic “silver tsunami”	Observational Articles Controlled Studies Guidelines Research Network	Inside and Outside of EM ◦Organizations ◦Leaders/Influencers	Individual Experience ◦Doctors and Nurses ◦Patients and Families ◦Some of the above in positions of influence
Focus on important clinical issues and outcomes	Med School and Residency Training → GEM Fellowships	Career Development Grants ◦Funders/Philanthropies ◦NIH Mechanisms, Program Officers ◦GEAR	How to improve clinical care? ◦GEDC ◦GEDA
Lived stories ED staff and patients	Curriculum development and dissemination Residency Leaders (CORD)	ACEP Geriatrics Section	Organizational Intervention and Support Hospital Systems
Numbers of failures in data	Competencies ABEM Testing	SAEM Task Force and Academy	Hospital Leaders and System Changes
External Support: ◦AGS, ◦Hartford, ◦Atlantic ◦Gary and Mary West Foundation	GEDC GEAR		National Accreditation GEDs



GEAR

Geriatric Emergency care
Applied Research

Why GEAR?

With an aging U.S. population, there is an increasing demand for optimal, interactive care for older adults across emergency departments (EDs), hospitals, and health systems. **Older adults use the emergency department (ED) as an important source of acute medical care, making 20 million visits annually. Yet, the amount of strong evidence resulting in improved outcomes in geriatric emergency care is limited.** People with dementia are twice as likely to use the ED and 1.5 times more likely to have an avoidable visit. When in the ED, they often struggle and are at greater risk of poor outcomes; however, little research has studied how to improve emergency clinical care for people with dementia. To address this gap, we must: 1) identify areas for improvement of emergency care for older people, including those with dementia and 2) develop and test strategies to improve the care delivered to this vulnerable population.

The need for research in geriatric emergency medicine (GEM) was acknowledged early on by Lowell Gerson, PhD, who observed the disproportionate use of emergency departments by older persons and, with others, formed the Society for Academic Emergency Medicine Geriatric Emergency Medicine Task Force. Dr. Gerson's work and mentorship has led to several developments, including the establishment of clinical guidelines and accreditation processes for geriatric emergency departments. The Geriatric Emergency Care Applied Research Network (GEAR), which aims to establish infrastructure to support collaborative, interdisciplinary research to improve care for older adults, is yet another result of that work

Developed by leaders in emergency medicine to ensure that our older patients receive well-coordinated, quality care at the appropriate level of every emergency department encounter.



ACEP Geriatric
Emergency Department Accreditation

Improve the Care Provided to Older Patients

by Becoming an Accredited Geriatric Emergency Department

Department Today

Why should my institution seek GED accreditation?

20 million seniors visit our nation's EDs.

With the number of older adults growing rapidly, there is a critical need for more geriatric-focused care.

Preparing for accreditation allows the hospital and ED to focus on the needs of this complex and growing population and to ensure that the resources available to the ED meet the needs of the patients they serve.

Early data from existing models of geriatric emergency care – models that promote best clinical practices and create a more positive and sensitive physical environment – show they have the potential to improve health outcomes, coordinate care more effectively, and reduce costs.

"Accreditation is just one step in the process of providing geriatric attuned healthcare in the Emergency Department. We continue to try out new clinical pathways or equipment to make our care better."

– Lauren T. Southerland, MD, FACEP
The Ohio State University Wexner Medical Center, OH

For More Information, Contact:

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Criteria by accreditation level:



CRITERIA	LEVEL 3	LEVEL 2	LEVEL 1
a) Staffing			
1 emergency medicine MD/DO lead with evidence of focused geriatric EM education	⊘		
1 RN with evidence of focused geriatric EM education	⊘	⊘	⊘
Physician champion/Medical Director with evidence of focused geriatric EM education		⊘	⊘
Nurse case manager/transitional care nurse present > 56 hrs/week		⊘	⊘
Interdisciplinary geriatric assessment team includes > 2 roles		⊘	
Interdisciplinary geriatric assessment team includes > 4 roles			⊘
> 1 executive/administrative sponsor supervising GED program		⊘	⊘
Patient advisor/patient council			⊘
b) Education			
MD/DO geriatric lead/ Physician champion/Medical Director geriatric EM education (in hours)	4	6	8
Staff physician education related to 8 domains of GEM	⊘	⊘	⊘
Nursing education in geriatric EM (NICHE / GENE preferred)	⊘	⊘	⊘
c) Policies/protocols guidelines & procedures			
Evidence of four geriatric emergency care initiatives and adherence plan	⊘		
> 10 items as part of the ED model of care for patients >65yrs		⊘	
> 20 items as part of the ED model of care for of patients >65yrs			⊘
d) Quality improvement			
10 of 27 policies/protocols, guidelines & procedures		⊘	
20 of 27 policies/protocols, guidelines & procedures			⊘
e) Outcome measures			
Track > 3 process and outcome metrics for eligible patients		⊘	
Track > 5 process and outcome metrics for eligible patients			⊘
f) Equipment and supplies			
Access to and proof of mobility aids (canes and walkers)	⊘	⊘	⊘
Access to > 5 supplies (including mobility aids)		⊘	
Access to > 10 supplies (including mobility aids)			⊘
g) Physical environment			
Easy access to free food/drink, 24/7	⊘	⊘	⊘
2 chairs per patient bed		⊘	⊘
Large analog clock		⊘	⊘
Enhanced lighting			⊘
Efforts at noise reduction			⊘
Non-slip floors			⊘
Adequate hand rails			⊘
High quality signage and way-finding			⊘
Wheel-chair accessible toilets			⊘
Availability of raised toilet seats			⊘



The following criteria outline the minimum standards for accreditation of a geriatric ED in three levels. Levels 1 and 2 are designed to reflect an increasing commitment to senior-specific care in the ED. Each level has an accreditation term of three years.



Level 1

An ED with policies, guidelines, procedures, and staff (both within the ED and throughout the institution) providing a coherent system of care targeting and measuring specific outcomes that form an overall elevation in ED operations and transitions of care both to and from the ED, all coordinated for the improved care of older adults.

Accreditation Fee:
\$15,000



Level 2

An ED that has integrated and sustained senior care initiatives into daily operations and demonstrates interdisciplinary cooperation for delivery of senior services. This level has an established supervisor coordinating the staff tasked with the daily performance of senior services.

Accreditation Fee:
\$7,500



Level 3

An ED with one or more specific initiatives that are expected to elevate the level of senior care. Personnel to implement these efforts are identified and trained. Metrics for the initiatives are followed.

Accreditation Fee:
\$2,500

Developed with support from:



Silver Book II

Quality care for older people with urgent care needs

Welcome to the Silver Book II, written by leading international experts in frailty and hosted by the British Geriatrics Society.

The Silver Book II addresses a wide range of urgent care issues specific to older people. Aimed at clinicians and other healthcare professionals working in emergency departments and urgent care, this updated resource is presented in a highly accessible digital format and is free of charge.

“Written by clinicians for clinicians, we hope this resource will be of help and perhaps some inspiration to colleagues supporting the care of older people with urgent care needs across the world.”

- Simon Conroy, Professor of Geriatric Medicine,
University of Leicester,
Co-lead Author of Silver Book II

Concepts in Practice: Geriatric Emergency Departments

Elements to consider when choosing a Geriatric ED model of care.

	GED Unit	Geriatrics Practitioner Model	Geriatrics Champion	Geriatric-Focused Observation Unit Program
Additional staff required:	<ul style="list-style-type: none"> • Geriatrics Practitioner • Case Manager • Pharmacy support • Physical therapists • Social worker 	<ul style="list-style-type: none"> • Geriatrics Practitioner • Case Manager • Pharmacy support • Physical therapists • Social worker 	<ul style="list-style-type: none"> • Case Manager • Pharmacy support • Physical therapists • Social worker 	<ul style="list-style-type: none"> • Inpatient Geriatrics consult service • Case Manager • Pharmacy support • Inpatient Physical Therapists • Social worker
Initial training costs:	<ul style="list-style-type: none"> • Geriatrics training for unit nurses and providers 	<ul style="list-style-type: none"> • Geriatrics training for all ED nurses and providers • Geriatrics training for practitioner 	<ul style="list-style-type: none"> • Geriatrics training for all ED nurses and providers 	<ul style="list-style-type: none"> • Geriatrics training for all ED nurses and providers
Physical space restraints	Yes	No	No	No
Effect on ED length of stay	unknown	increased	unknown	none or decreased
Effect on hospitalization rates	decreased ^{21, 22}	decreased ^{26, 29, 54}	unknown ⁴⁰	decreased ^{42- 44}



Review Article

Optimal Emergency Department Care Practices for Persons Living With Dementia: A Scoping Review



Scott M. Dresden MD, MS^{a,*}, Zachary Taylor MPH^a, Peter Serina MD MPH^a, Maura Kennedy MD, MPH^b, Annie B. Wescott MLIS^c, Teresita Hogan MD^d, Manish N. Shah MD, MPH^e, Ula Hwang MD, MPH^{f,g}, and The GEAR 2.0-ADC Net

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^g Geriatric Research, Education and Clinical Center, James J. Peters VA Medical Center, Bronx, NY, USA

Discussion

This scoping review demonstrates the state of research on ED care practices for PLWDs. This review demonstrates that studies of components of ED care and emergency care needs for PLWDs are wide ranging with little depth on any topic. Studies on components of ED care for PLWDs included a comprehensive geriatric assessment and dedicated ED unit,²⁶ care partners in the ED and hospital care companions for PLWDs,^{22,30} identifying delirium,^{4,34,36} fall prevention,⁴¹ admission to a home hospital program,⁴² pain assessment and management,^{21,28,31,32,43,44} palliative care,^{23,37} and changes to the physical environment.^{27,33} Four studies showed improvement in patient-centered outcomes or health services use: a comprehensive geriatric assessment and dedicated ED unit,²⁶ stimulation reduction and noncontact monitoring,³³ dementia companions,²² and hospital at home program.⁴² These successful interventions should be considered for future multicentered studies.



Providing care for older adults in the Emergency Department: expert clinical recommendations from the European Task Force on Geriatric Emergency Medicine

J. A. Lucke¹ · S. P. Mooijaart²  · P. Heeren^{3,4,5} · K. Singler^{6,7} · R. McNamara⁸ · T. Gilbert⁹ · C. H. Nickel¹⁰ · S. Castejon¹¹ · A. Mitchell¹² · V. Mezera¹³ · L. Van der Linden^{14,15} · S. E. Lim¹⁶ · A. Thaur¹⁷ · M. A. Karamercan¹⁸ · L. C. Blomaard² · Z. D. Dundar¹⁹ · K. Y. Chueng²⁰ · F. Islam²¹ · B. de Groot²² · S. Conroy²³

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Table 1 Topics for Geriatric Emergency Medicine guidelines selected by experts after modified Delphi procedure

Rank	Topic
1	Comprehensive Geriatric Assessment in the Emergency Department
2	Age/frailty adjusted risk stratification
3	Delirium and cognitive impairment
4	Family involvement
5	Environment
6	Polypharmacy
7	Silver trauma
8	End of life care in the acute setting

Geriatric consultation service in emergency department: how does it work?

Terry Man Yue Yuen,¹ Larry Lap Yip Lee,¹ Ikea Lai Chun Or,¹ Kwai Lin Yeung,¹ Jimmy Tak Shing Chan,¹ Catherine Pui Yuk Chui,² Emily Wai Lin Kun²

Figure 1 Flowchart showing the logistic of geriatric consultation service. CNS, community nursing service; ED, emergency department; EMW, emergency medicine ward.

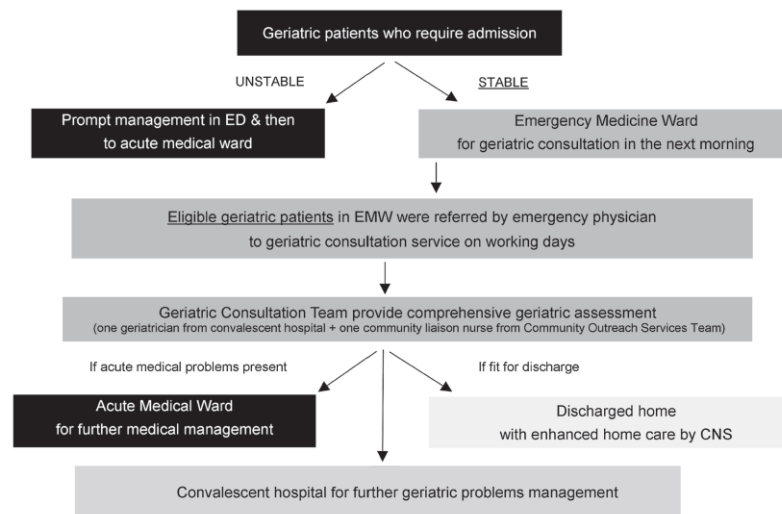


Table 1 List of eligible and ineligible cases of programme 'We Care'

List of eligible cases for programme 'We Care'	List of ineligible cases for programme 'We Care'
<p>Patient aged 65 OR <65 years who was an old age home resident with the following presentation</p> <ol style="list-style-type: none"> 1. Patient is recently discharged from TPH, AHNH or recurrent A&E attendances 2. Patient with known terminal cancer for palliative care 3. Patient with known end organ failure who decided not for active resuscitation or renal replacement therapy and displayed coping problem 4. Patient with recurrent hospital admission (mild COAD, CHF, etc) 5. Patient with multiple medical problems, but not indicated for direct acute hospital admission 6. Patient with poor social support and recent decline in functional level. For example, fall or dizziness, preferably CT scan of brain has been done in selected cases 7. Rehabilitation either in inpatient or outpatient setting is beneficial 8. Patient presented with adverse drug reaction and polypharmacy 9. Patient presented with fever but infectious cause is adequately excluded 	<ol style="list-style-type: none"> 1. Patient clinically and socially can be discharged by emergency physician 2. Patient <65 years old except old age home resident 3. Cases with fever 4. Cases diagnosed with gastroenteritis

A&E, accident and emergency; AHNH, Alice Ho Miu Ling Nethersole Hospital; CHF, congestive heart failure; COAD, chronic obstructive airway disease; TPH, Tai Po Hospital.

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Table 4 Patients' characteristics versus outcomes

	Not required acute medical admission after consultation?				Death <14 days after discharge from geriatric consultation?			
	No AHNH	Yes TPH/home	p Value	OR (95% CI of OR)	No	Yes	p Value	OR (95% CI for OR)
Clinical severity								
Urgent (triage category 1–3)	263	1337	0.021	1.382 (1.049 to 1.821)	1568	32	0.012	0.245(0.075 to 0.804)
Non-urgent (triage category 4–5)	75	527			599	3		
Sex								
Female	180	943	0.367	1.113 (0.882 to 1.403)	1111	12	0.046	2.016(0.998 to 4.073)
Male	158	921			1056	23		

AHNH, Alice Ho Miu Ling Nethersole Hospital; TPH, Tai Po Hospital.

Table 3 Top 10 ED diagnoses for programme 'We Care' geriatric consultation

ED diagnosis	Number of cases	%
COAD	521	23.7
Heart failure	244	11.1
Dizziness	242	11.0
Chest pain	122	5.5
Decreased GC	117	5.3
Hypoglycaemia	83	3.8
Hypertension	80	3.6
Bronchitis	47	2.1
Hyperglycaemia	46	2.1
Syncope	45	2.0

ED, emergency department; GC, general condition.

Geriatric consultation service in emergency department: how does it work?

Terry Man Yue Yuen,¹ Larry Lap Yip Lee,¹ Ikea Lai Chun Or,¹ Kwai Lin Yeung,¹
Jimmy Tak Shing Chan,¹ Catherine Pui Yuk Chui,² Emily Wai Lin Kun²

Table 2 Demographic data, characteristics and outcomes of patients

Total	Number		Percentage	
	2202		100%	
Venue of discharge				
Acute Medical Ward (AHNH)	338		15.3%	
Convalescent Medical Ward (TPH)	825	1864	37.5%	84.7%
Home	1039		47.2%	
CNS referral (for those who were discharged home)				
No	865		83.3%	
Yes	174		16.7%	
Adverse outcomes				
Death within 14 days				
No	2167		98.4%	
Yes	35		1.6%	
Reattendance within 48 h				
No	2166		98.4%	
Yes	36		1.6%	

Table 2 Demographic data, characteristics and outcomes of patients

Total	Number		Percentage	
	2202		100%	
Clinical severity				
Triage category				
Urgent				
1	6	1600	0.3%	72.7%
2	46		2.1%	
3	1548		70.3%	
Non-urgent				
4	594	602	27.0%	27.3%
5	8		0.3%	

Effectiveness of a Geriatric Emergency Medicine Unit for the Management of Neurocognitive Disorders in Older Patients: Results of the MUPACog Study

Results: The study included 801 patients admitted to the ED between January 1, 2015, and December 31, 2018 (400 in the exposed group). Of those, 72.5% were female, and the mean age was 87 ± 5 years. After adjusting for confounding factors, the 30-day readmission rate was significantly associated with the MUPA unit intervention.

Conclusion: CGA in a GEMU improved health outcomes in elderly patients with NCD in the ED. We recommend that all EDs include a geriatric team, such as the MUPA unit, to treat all patients with NCD admitted to the ED.

Table 2. Multivariate analyses of the 30-day readmission rate (first step)

Variables	<i>p</i> value* (uni-variate)	Logistic regression [†]		
		OR	95% CI	<i>p</i> value [‡]
Age ≥ 85 years old	0.84	1.07	(0.71–1.61)	0.75
Male	0.05	1.49	(1.00–2.20)	0.53
MUPA unit intervention	0.04	0.68	(0.47–0.98)	0.03
Home	0.94	1.04	(0.71–1.52)	0.83
History of falls	0.38	1.20	(0.83–1.75)	0.33
Charlson index ≥ 5	0.50	0.78	(0.33–1.85)	0.57
Diagnosis of fall risk	0.83	0.98	(0.67–1.44)	0.93
Hospitalization	0.11	0.77	(0.54–1.11)	0.17







CI, confidence interval. * Variables with *p* values ≤ 0.25 in univariate analyses and essential variables (age, sex, and variables identified previously) were included in the model. [†] First step of the stepwise logistic regression with 797 patients. *B* = -1.18 . [‡] *p* values ≤ 0.05 were considered to indicate statistical significance.

Table 3. Multivariate analyses of the 30-day readmission rate (final step)

Variables	<i>p</i> value* (uni-variate)	Logistic regression [†]		
		OR	95% CI	<i>p</i> value [‡]
MUPA unit intervention	0.04	0.65	(0.46–0.94)	0.02
Male	0.05	1.45	(0.99–2.12)	0.06

CI, confidence interval. * Variables with *p* values ≤ 0.25 in univariate analyses and essential variables (age, sex, and variables identified previously) were included in the model. [†] Final step of the stepwise logistic regression with 797 patients. *B* = -1.36 . [‡] *p* values ≤ 0.05 were considered to indicate statistical significance.

Improving outcomes for older people in the emergency department: a review of reviews

Louise Preston ¹, James David van Oppen ^{2,3}, Simon Paul Conroy ²,
Suzanne Ablard ¹, Helen Buckley Woods ⁴, Suzanne M Mason ¹

Conclusions The evidence base describing interventions is weak due to inconsistent reporting, differing emphasis placed on the key characteristics of primary studies (staff, location and outcome) by review authors and varying quality of reviews. No individual interventions have been found to be more promising, but interventions initiated in the ED and continued into other settings have tended to result in more favourable patient and health service outcomes. Despite many interventions reported within the reviews being holistic and patient focused, outcomes measured were largely service focused.



U.S. Department of Veterans Affairs

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J Am Geriatr Soc. 2019 July ; 67(7): 1516–1525. doi:10.1111/jgs.15854.

RESULTS: A total of 2000 citations were identified; 17 articles describing 15 unique studies (9 randomized and 6 nonrandomized) met eligibility criteria and were included in analyses. ED interventions showed a mixed pattern of effects. Overall, there was a small positive effect of ED interventions on functional status but no effects on QOL, patient experience, hospitalization at or after the initial ED index visit, or ED return visit.

CONCLUSION: Studies using two or more intervention strategies may be associated with the greatest effects on clinical and utilization outcomes. More comprehensive interventions, defined as those with all three key intervention components present, may be associated with some positive outcomes.

Similar to previous reviews and the 2014 Geriatric Emergency Department Guidelines, **our finding that bridge designs may be associated with positive outcomes suggests that ED visits should not be considered in isolation but rather as an integral part of the older patient's continuum of care, bridging inpatient and outpatient services.**

HOSPITAL AT HOME[®]

Home-based care for older adults

By Johns Hopkins Medicine

Hospital at Home[®] is an innovative geriatric care model providing hospital-level care in a patient's home as a full substitute for acute hospital care.

The program is currently being implemented at numerous sites around the United States by VA hospitals, health systems (including Presbyterian Health System), home care providers, and managed care programs as a tool to cost-effectively treat acutely ill older adults, while significantly improving patient safety, quality, and satisfaction.

The Hospital at Home[®] solution includes a range of tools to support adoption and implementation by any health care organization including:

- ▲ Clinical eligibility criteria
- ▲ Implementation manual
- ▲ Financial planning and evaluation tools
- ▲ Patient recruitment and education tools
- ▲ Measurement tools
- ▲ Patient-tracking mechanisms

Outcomes of implementing Hospital at Home[®] compared to similar hospitalized patients:

- ▲ Lower mortality rates
- ▲ Lower rates of delirium, sedative medication and restraints use
- ▲ Higher satisfaction of patient and family
- ▲ Less caregiver stress, better functional outcomes
- ▲ Cost savings of 19% to 30% compared to traditional inpatient care
- ▲ Lower average length of stay
- ▲ Fewer lab and diagnostic tests compared with similar patients in hospital acute care
- ▲ Advances the Triple Aim of clinical quality, affordability and exceptional patient experience

{HOSPITAL AT HOME PROGRAMS: enable patients to receive acute care at home reducing complications while cutting the cost of care by 30 percent or more.}

Hospital at Home[®] allows an older adult with an acute illness to remain in the comfort of their own home while receiving hospital-level care. This model helps older adults avoid common iatrogenic complications associated with stays in traditional acute care hospitals such as delirium, polypharmacy, functional decline, and others.

WHY CHOOSE THE JOHNS HOPKINS HOSPITAL AT HOME PROGRAM

Hospital at Home[®] was developed by researchers at the Johns Hopkins University Schools of Medicine and Public Health. The concept was successfully tested in a National Demonstration and Evaluation Study at several Medicare managed care sites and at a VA Medical Center. It was the first implementation of the Hospital at Home model to completely substitute care in the patients' home for acute inpatient care.

Hospital at Home: Feasibility and Outcomes of a Program To Provide Hospital-Level Care at Home for Acutely Ill Older Patients

Bruce Leff, MD; Lynda Burton, ScD; Scott L. Mader, MD; Bruce Naughton, MD; Jeffrey Burl, MD; Sharon K. Inouye, MD, MPH; William B. Greenough III, MD; Susan Guido, RN; Christopher Langston, PhD; Kevin D. Frick, PhD; Donald Steinwachs, PhD; and John R. Burton, MD

Background: Acutely ill older persons often experience adverse events when cared for in the acute care hospital.

Objective: To assess the clinical feasibility and efficacy of providing acute hospital-level care in a patient's home in a hospital at home.

Design: Prospective quasi-experiment.

Setting: 3 Medicare-managed care (Medicare + Choice) health systems at 2 sites and a Veterans Administration medical center

Participants: 455 community-dwelling elderly patients who required admission to an acute care hospital for community-acquired pneumonia, exacerbation of chronic heart failure, exacerbation of chronic obstructive pulmonary disease, or cellulitis.

Intervention: Treatment in a hospital-at-home model of care that substitutes for treatment in an acute care hospital.

Measurements: Clinical process measures, standards of care, clinical complications, satisfaction with care, functional status, and costs of care.

Results: Hospital-at-home care was feasible and efficacious in delivering hospital-level care to patients at home. In 2 of 3 sites studied, 69% of patients who were offered hospital-at-home care chose it over acute hospital care; in the third site, 29% of patients chose hospital-at-home care. Although less procedurally oriented than acute hospital care, hospital-at-home care met quality standards at rates similar to those of acute hospital care. On an intention-to-treat basis, patients treated in hospital-at-home had a shorter length of stay (3.2 vs. 4.9 days) ($P = 0.004$), and there was some evidence that they also had fewer complications. The

Context

Hospital care for older people often means iatrogenic complications and a decline in function. Home hospital care might reduce these adverse outcomes.

Content

Patients were 65 years of age or older and required hospital care for pneumonia, heart failure, chronic obstructive pulmonary disease, or cellulitis. In phase I, they were hospitalized. In phase II, they could choose home hospital care (continuous nursing care followed by at least daily visits from a nurse and a physician). Sixty percent of patients chose home hospital care. Patients who received this type of care had shorter stays; fewer procedures, consultations, and indwelling devices; less delirium; greater satisfaction; and similar functional outcomes.

Cautions

The study was nonrandomized, and data were missing.

Conclusion

Home hospital care may be a good alternative for selected patients.

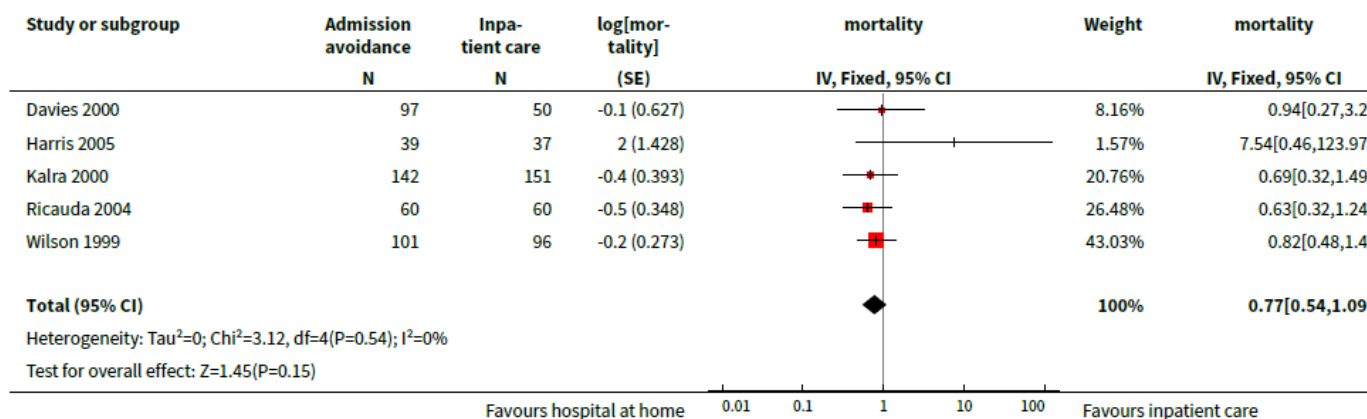
Admission avoidance hospital at home (Review)

Shepperd S, Iliffe S, Doll HA, Clarke MJ, Kalra L, Wilson AD, Gonçalves-Bradley DC

Authors' conclusions

Admission avoidance hospital at home, with the option of transfer to hospital, may provide an effective alternative to inpatient care for a select group of elderly patients requiring hospital admission. However, the evidence is limited by the small randomised controlled trials included in the review, which adds a degree of imprecision to the results for the main outcomes.

Analysis 1.1. Comparison 1 Admission avoidance hospital at home versus inpatient care, Outcome 1 Mortality at 3 months using IPD.



individual patient data (IPD)



Hospital at Home

Guiding principles for service development

January 2020

1.0 Purpose of the guiding principles

This resource is a source of information and evidence for Integration Authorities and NHS Boards in Scotland on the provision of Hospital at Home services.

It is intended to assist in local and regional planning for acute and specialist services to support people, who would ordinarily require admission to acute hospital, to receive treatment in their home.



Hospital at Home Programme

Progress update October 2023

Hospital at Home (H@H):

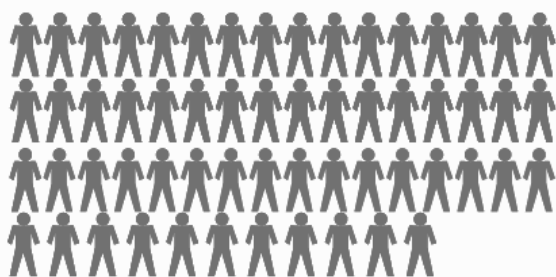
- is a short-term, targeted intervention providing acute level hospital care in an **individual's own home** or homely setting.¹
- has **high satisfaction** and patient preference across a range of measures.¹
- reduces pressure on unscheduled acute care in hospitals by **avoiding admissions** and **accelerating discharge**.¹
- has consistent evidence of **lower costs** compared to inpatient care.¹

What we do:

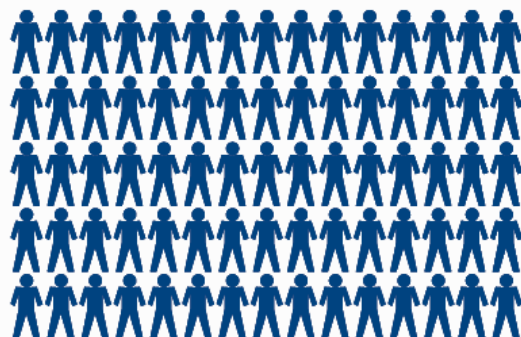
- **Optimise and expand H@H services:** Support NHS boards/HSCPs to optimise and expand their existing H@H services.
- **Develop new H@H services:** Support remote and rural areas across Scotland to implement new H@H services.
- **National Learning System:** Enable H@H services to share and learn from each other.
- **National Infrastructure:** Develop national infrastructure to enable sustainable H@H services.

Impact so far...

33% increase in patients managed by hospital at home services²



compared to...



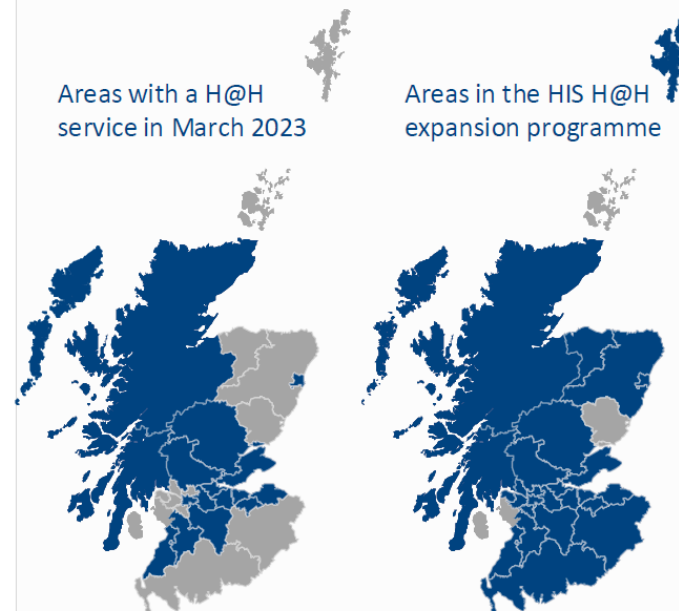
5,322 patients were managed by H@H services from April 2022 to September 2022.

7,076 patients managed by H@H services from April 2023 to September 2023.

H@H services prevented over 7,000 people spending time in hospital during April-September 2023, relieving pressure from A&E and the Scottish Ambulance Service.

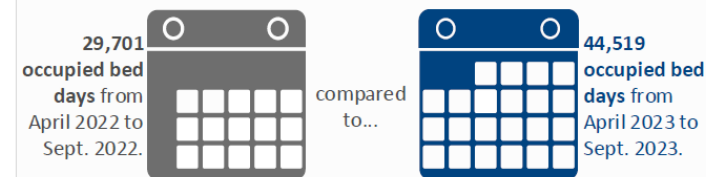
This has been achieved by...

Working with more areas across Scotland¹



More areas than ever now either have a H@H service or are working with Healthcare Improvement Scotland to develop a service. This includes some of the most remote and rural areas of the country. It is equivalent to 370 "virtual hospital at home beds". The expansion programme includes 27 health and social care partnerships, meaning an expansion of up to 10 new HSCP areas.

Increasing bed days by 50%¹



Occupied bed days are counted in H@H when a patient stays overnight in the service. Since 1 April 2023 there has been a change to the way in which these are measured for greater accuracy. This may contribute towards a higher increase in this period compared with the previous year.

Allocating £3.6 million

Scottish Government have allocated £3.6 million to continue the growth of H@H services in 2023/24.

This is being used by H@H services to support more patients by:



Obtaining equipment, including point of care testing, to reduce travel time.



Performing remote consultations to promote equity of access and increase consultant sessions



Recruiting and training staff to build capacity and to free up clinical time.

Networking events in Glasgow and Inverness⁴

Networking events were held for people working in H@H services in September and October 2023.

Of the attendees who provided feedback, **94%** said that the events were useful or very useful.

As a result of the event, attendees said:

- They would develop pathways
- Link with other services including SAS, and
- Develop their point of care testing.

No place like home

Using virtual wards and ‘hospital at home’ services to tackle the pressures on urgent and emergency care

January 2022

No place like home

What will help to relieve the pressure on hospitals?

- > Investment in virtual wards, ‘hospital at home’ services and social care teams
- > A sustainable health and social care workforce.
- > A cross-government strategy on health inequalities.

What support do community resource teams need?

- > Better regional collaboration and clinical networking across health boards.
- > Investment in training more clinicians to work in the community.
- > Rapid access to the right diagnostics and interventions.
- > Closer working relationships with therapists, social care, and palliative care teams.

It’s time to change the way we work

During the second winter of the COVID-19 pandemic, NHS waiting lists are at an all-time high. Hospital emergency departments, primary care and GPs, urgent care and the ambulance service in Wales are all under enormous pressure. Prolonged stay in acute hospitals increases the risk of hospital-acquired infections in older frail patients and disrupts patient flow, an issue that is exacerbated by bed shortages. It is time to think outside the box: radical change is needed.

We’re calling for an expansion of the number of virtual wards and ‘hospital at home’ services that provide specialist medical care in the community across Wales. These teams can help to reduce hospital admissions, get people home more quickly, and improve the quality of patient care.

Wales is getting older

The number of people aged over 65 in Wales is projected to increase by 16.1% between 2020 and 2030. The increase is even larger in older age groups – the number of those aged over 75 is projected to increase by 23.9% in the same time period.

COVID-19 mortality rates rise sharply with age, and COVID-related hospital admissions have consistently been highest among older people. Yet during the second wave of the pandemic in winter 2020/21, a significant number of people with COVID-19 became infected while in hospital – around two in five of these patients in Wales died, and those with hospital-acquired infection were typically older and more frail than those infected within the community.

Where possible, we need to keep people out of hospital

Many of those who died with probable hospital-acquired COVID-19 had been in the hospital for at least a month prior to exposure. Keeping older people out of hospital and in their own home has never been more important. Over the next few months, the vision of care closer to home as set out in *A Healthier Wales* must be supported by a significant investment in community resource and staffing, especially in social and intermediate care.

1. Investment in care closer to home

The long-lasting impact of the COVID-19 pandemic will inevitably place even more pressure on the social care system. The Welsh government must prioritise social care reform, while collaboration between GPs and specialist doctors should be at the forefront of the design and delivery of the care of older people with frailty. Strong professional relationships across primary and secondary care are built on good communication. Intermediate care – including virtual wards and ‘hospital at home’ services – reduces unnecessary hospital admissions and enables people to stay at home for longer.

We need: An ambitious plan to tackle waiting lists and the NHS backlog: not just asking clinicians to ‘do more’, but expanding social care provision and community medicine and supporting patients and the workforce to adopt new technologies to harness innovation and improve resilience.

What are community resource teams?

Community resource teams (CRTs) are made up of health and social care professionals who coordinate care for people living at home. Models vary across Wales: some teams provide intermediate acute healthcare, others are integrated with social care and provide holistic assessment, treatment and support for both short and long-term care. However, CRTs are often under-resourced and under-recognised. During the pandemic, some CRT staff have been redeployed to other parts of the NHS, which has reduced the capacity of community teams to treat patients at home and keep them out of hospital in the first place.

What are virtual wards?

A virtual ward is a multidisciplinary team meeting involving primary care, secondary care, the local authority and voluntary services. The aim is to reduce pressure on unscheduled care by preventing inappropriate hospital admissions and improving flow through hospital by expediting discharge. This is done by providing comprehensive multidisciplinary care in the community. During a virtual ward round, health and care professionals discuss how to support older people with frailty, those with chronic disease and those with increasing social care needs. The aim is to do this within their own community. In addition, virtual wards can improve patient experience, reduce NHS costs and lead to more collaborative working.

What is a ‘hospital at home’ service?

Hospital at home provides short-term, intensive, hospital-level care for acute medical problems in a patient’s home. This is provided by multidisciplinary healthcare teams led by a senior clinician. It can provide urgent access to relevant blood tests, ultrasounds and hospital-level diagnostics and interventions and gives access to the same specialty advice as would be provided for any hospital inpatient. Providing specialist healthcare at home could reduce pressure on NHS resources and be less disruptive to older people with frailty, while leading to higher levels of patient satisfaction.

Hospital in the Home

Guideline



PURPOSE

In NSW, Hospital in the Home (HITH) is defined as the range of service delivery models providing (acute and post-acute) care that is delivered in home (including Residential Aged Care Facilities), clinic or other settings as a substitution or avoidance of hospital.

The *HITH Guidelines* have been developed by clinicians to provide clear, standardised guidance to Local Health Districts and Specialty Health Networks (LHD/SHN) regarding terminology, key elements and principles of HITH in NSW.

The need for the delivery of acute care in the home as an alternative to care in a hospital setting is being driven by advances in medicine, increased pressure on the healthcare system and evidence of improved health outcomes for patients who spend less time in hospital.

The guidelines reflect evidence based best clinical practice, expert consensus and opinion and although the guidelines are not mandatory, they have been endorsed by clinicians and NSW Ministry of Health with an expectation that the key principles will be utilised in standardising practice across NSW.

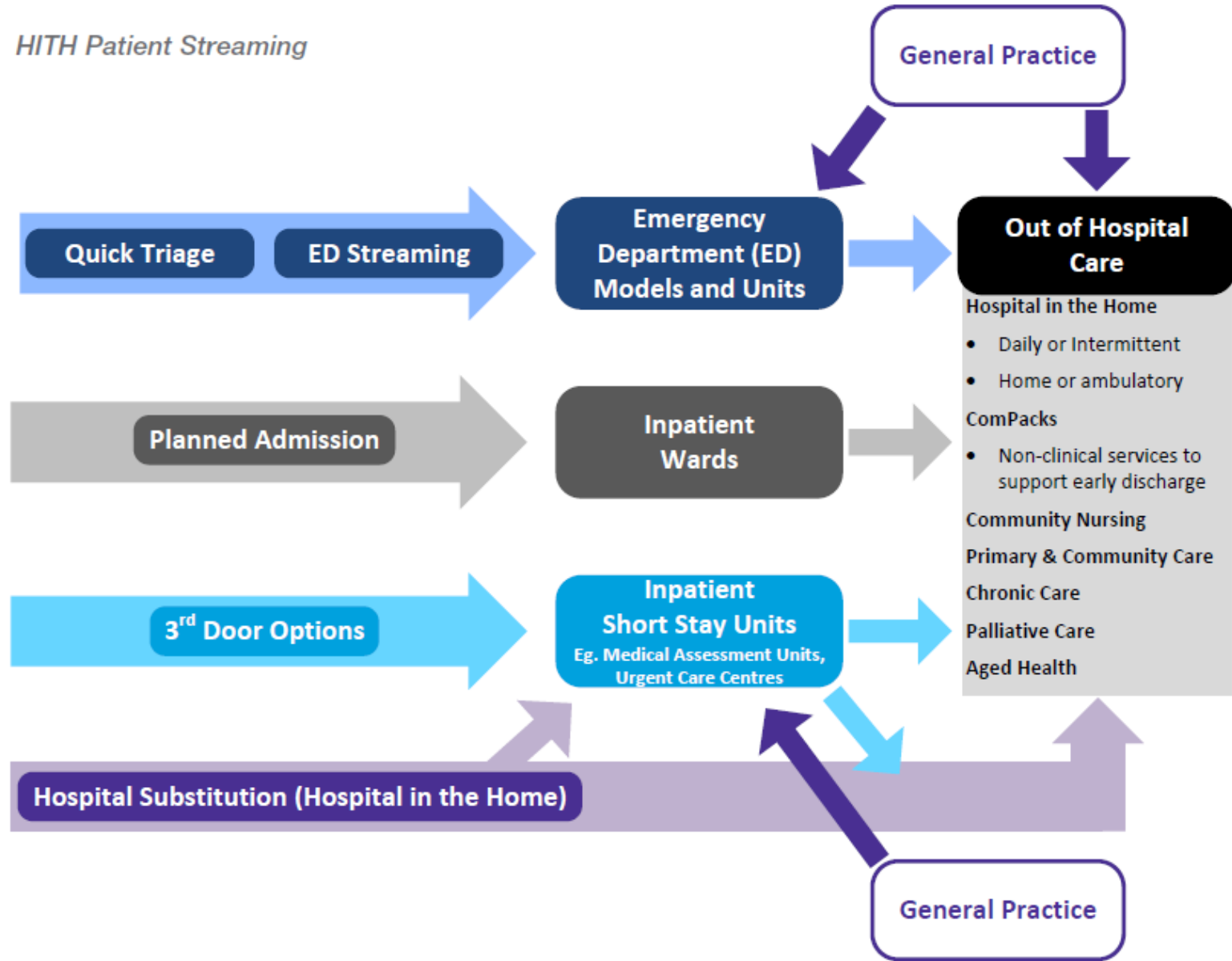
KEY PRINCIPLES

The guidelines underlying principles will support LHDs/SHNs to develop evaluate and monitor HITH services to meet local needs.

Underpinning these guidelines are the following key principles:

- keeping people healthy and out of hospital
- local and system level strategic planning for growth of HITH to meet acute bed demand
- mandatory reporting and data collection framework
- consistency of evaluation
- leveraging of funding streams including Activity Based Funding

HITH Patient Streaming



Hospital Care in the Comfort of Home



How Does Hospital at Home Work?

Is Your Organization Ready for Hospital at Home?

Hospital at Home Toolkit

Hospital at Home® provides safe, high-quality, hospital-level care to older adults in the comfort of their own homes.

Developed by the Johns Hopkins Schools of Medicine and Public Health and tested at medical centers across the country, this innovative care model lowers costs by nearly one-third, and reduces complications. It is highly rated by patients and caregivers alike.

If your hospital wants to implement Hospital at Home in a safe and effective manner, [contact us to learn more.](#)

History

Overview

History

How it Works

Safety & Quality

- 1995 Dr. John Burton, of Johns Hopkins School of Medicine, and Dr. Donna Regenstein of [The John A. Hartford Foundation](#) conceived a new program to provide safe and effective hospital-level care in the home. A geriatric study team led by Dr. Bruce Leff developed medical eligibility criteria and the basic clinical model and designed the study and measurement methodology.
- 1996-1998 A 17-patient [pilot trial](#) showed that Hospital at Home® was feasible, safe, and cost effective.
- 2000-2002 A [National Demonstration and Evaluation Study](#) tested Hospital at Home in three Medicare managed care organizations and one Veterans Affairs medical center. Hospital at Home met disease-specific quality standards at rates similar to the acute hospital. The average patient length of stay was shorter, and overall costs were a third lower than an inpatient stay. Patients also had a lower chance of developing delirium, requiring sedatives, or needing chemical restraints. In addition, both patients and family members were more satisfied with care compared to those treated in the hospital, and family member stress was lower. Patients also regained their ability to do usual tasks more quickly.
- 2002-Present Hospital at Home is in practice or is being developed at numerous sites throughout the country, including:
 - Presbyterian Health Services, Albuquerque, New Mexico
 - Veterans Affairs Medical Center, Boise, Idaho
 - Veterans Affairs Medical Center, Honolulu, Hawaii
 - Veterans Affairs Medical Center, New Orleans, Louisiana
 - Veterans Affairs Medical Center, Philadelphia, Pennsylvania
 - Veterans Affairs Medical Center, Portland, Oregon
 - Veterans Affairs Medical Center, Bend, Oregon
- 2010 A public/private partnership tested a modified model of Hospital at Home, in which home-based care is provided by nurses, with physician consult via biometrically enhanced two-way telemedicine-video. The new model is also managed by a physician group, instead of a hospital.
- 2011 [Clinically Home](#) was formed to develop and commercialize the telemedicine-based care model. The Hospital at Home team is a partner and clinical consultant to Clinically Home, while continuing to offer and consult on the traditional Hospital at Home model.
- 2015 Funded by a CMS Innovation Center challenge grant, the Icahn School of Medicine at Mount Sinai, New York is currently testing Hospital at Home to inform a possible 30-day bundled payment model for fee-for-service Medicare. In addition, the John A. Hartford Foundation is funding a research evaluation of the study, and supporting development of technical assistance resources in anticipation of a successful demonstration.



GRUPPO INTERVENTO RAPIDO OSPEDALE TERRITORIO

Modello assistenziale
costituito da un **team multiprofessionale specialistico medico** (geriatri ed internisti) **ed infermieristico** responsabile della presa in carico degli ospiti SARS-COV₂ positivi - in collaborazione con medici di famiglia e USCA - mediante la creazione di **unità di Cure Intermedie** direttamente **all'interno delle RSA**, con reparti «bolla» destinati all'accoglienza degli ospiti positivi dotati assistenza infermieristica h24

«HOSPITAL-AT-NURSING HOME»





Caring for nursing home residents with COVID-19: a “hospital-at-nursing home” intermediate care intervention

Enrico Benvenuti¹ · Giulia Rivasi² · Matteo Bulgaresi¹ · Riccardo Barucci¹ · Chiara Lorini³ · Daniela Balzi⁴ · Antonio Faraone⁵ · Giacomo Fortini¹ · Gabriele Vaccaro³ · Iliaria Del Lungo¹ · Salvatore Gangemi¹ · Sante Giardini¹ · Cecilia Piga¹ · Eleonora Barghini¹ · Serena Boni¹ · Giulia Bulli¹ · Paolo Carrai⁵ · Andrea Crociani⁵ · Aldo Lo Forte⁵ · Letizia Martella¹ · Simone Pupo¹ · Irene Marozzi² · Giulia Bandini⁶ · Primo Buscemi³ · Claudia Cosma³ · Lorenzo Stacchini³ · Lorenzo Baggiani⁷ · Andrea Ungar² · Enrico Mossello² · Guglielmo Bonaccorsi³ · Giancarlo Landini⁸

Table 1 GIROT members and roles

Member	Role
Medical specialists • Geriatricians • Internal medicine specialists	Team coordination and direction Clinical management of COVID-19 infection (diagnostic exams, clinical evaluation and therapy) Prevention and management of geriatric syndromes Communication with families End of patients' isolation after infection
Local Health District Nurse	Advice and support to NH nurse management Staff training for COVID-19 on PPE use and cleaning procedures Setting up of residents' and staff testing Advanced nursing care, including management of complicated pressure sores and feeding tubes
Local Health District Direction	Nursing care coordination and direction Staffing management, including supply of health workers in case of staffing shortage Provision of PPE stocks
Local Health District Physiotherapy	Conventional geriatric rehabilitation Respiratory training Coordination of patients' mobilization
Palliative specialists	Early palliative care Provision of palliative medications Communication with families
Public hygiene experts and occupational health professionals	Setup of COVID-19 “bubbles” and dedicated pathways including donning and doffing stations Other environmental interventions for transmission control, including creation of COVID-19 signs and posters Management of NH staff occupational health issues End of patients' isolation after infection

GIROT

Membri e ruoli

- ❑ Azienda Sanitaria USL CENTRO
- ❑ AOU Careggi
- ❑ ACOT area fiorentina

Con il sostegno economico di:

- ❑ Fondazione Santa Maria Nuova
- ❑ CRF

Table 2 GIROT interventions provided in each nursing home during the outbreak

At the beginning of the outbreak

Environmental interventions to limit transmission: cleaning procedures, room changes and setup of “COVID-19 bubbles” including with donning and doffing stations

Residents’ and staff testing to identify all SARS-CoV-2 cases

Use of ID bracelets to favor residents’ identification (particularly in presence of external staff)

Comprehensive geriatric assessment of SARS-CoV-2-positive residents and risk stratification according to symptoms severity (Green/Yellow/Red code); medical therapy review and optimization (including COVID-19 protocol-based therapy), blood testing

Direct provision of oxygen and first-line medications (Table 2) within 24 h of outbreak

Supply of caloric nutritional supports including specific diets for dysphagia

Identification of staff shortage and supply of nurses and other healthcare workers from local hospitals as appropriate

Provision of PPE and staff training on appropriate PPE use and other transmission control procedures

During the course of the outbreak

Regular medical assessment according to color coding, including interventions for prevention and management of geriatric syndromes

Activation of palliative comfort-based care services, when deemed appropriate based on comprehensive geriatric assessment

Regular residents’ and staff SARS-CoV-2 testing for infection monitoring

Daily clinical report to GPs and regular update to families

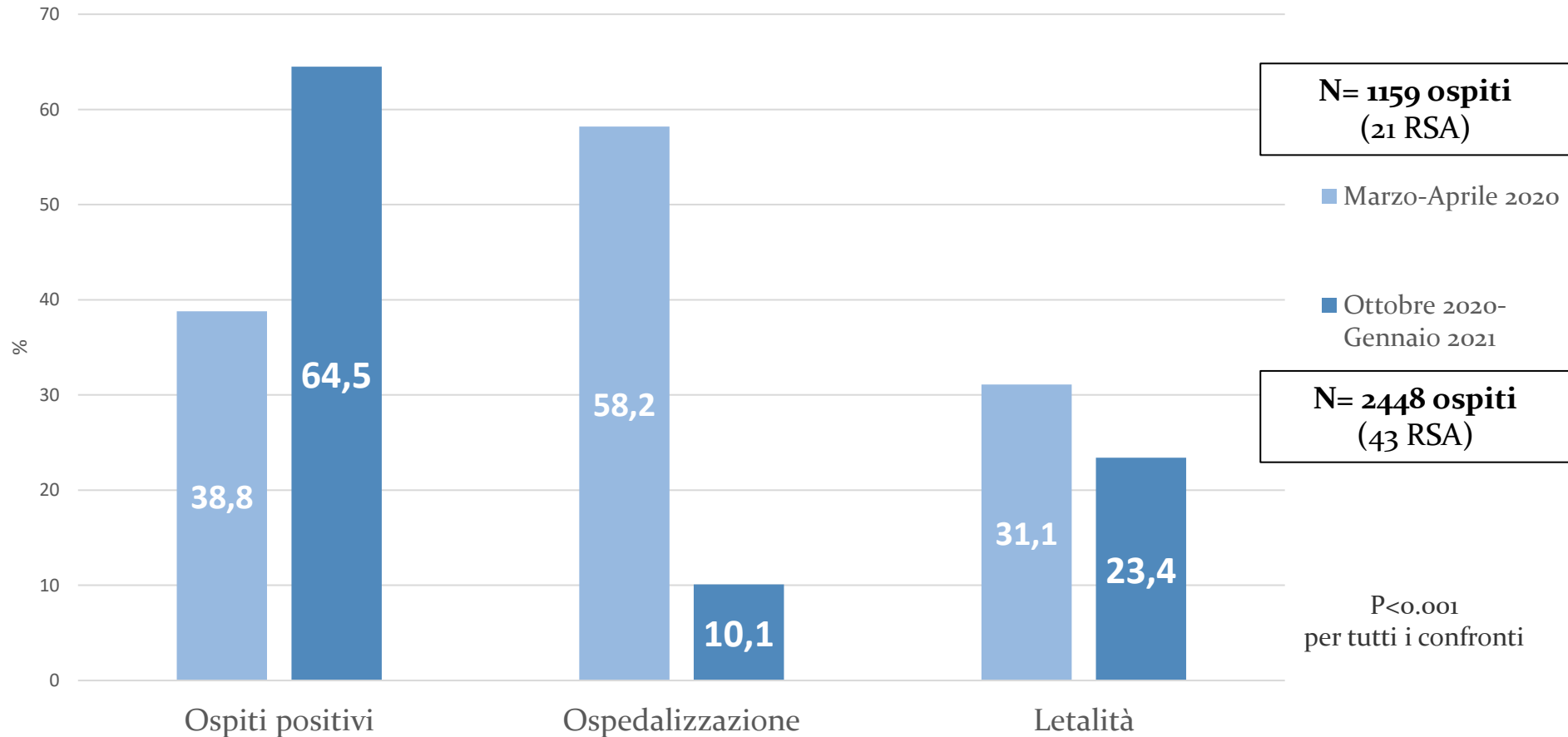
Discontinuation of residents’ isolation at the end of the infection, according to a symptom-based approach^a

PPE personal protective equipment

^aThe symptom-based approach [26] allowed patients to be released from isolation also in presence of a positive virus test, provided that they were asymptomatic for at least 21 days

ORIGINAL ARTICLE

Caring for nursing home residents with COVID-19: a “hospital-at-nursing home” intermediate care intervention





GRUPPO INTERVENTO RAPIDO OSPEDALE TERRITORIO

2020

Nascita del GIROT come risposta
all'emergenza del COVID-19 nelle RSA





Caring for nursing home residents with COVID-19: a “hospital-at-nursing home” intermediate care intervention

Enrico Benvenuti¹ · Giulia Rivasi² · Matteo Bulgaresi¹ · Riccardo Barucci¹ · Chiara Lorini³ · Daniela Balzi⁴ · Antonio Faraone⁵ · Giacomo Fortini¹ · Gabriele Vaccaro³ · Ilaria Del Lungo¹ · Salvatore Gangemi¹ · Sante Giardini¹ · Cecilia Piga¹ · Eleonora Barghini¹ · Serena Boni¹ · Giulia Bulli¹ · Paolo Carrai⁵ · Andrea Crociani⁵ · Aldo Lo Forte⁵ · Letizia Martella¹ · Simone Pupo¹ · Irene Marozzi² · Giulia Bandini⁶ · Primo Buscemi³ · Claudia Cosma³ · Lorenzo Stacchini³ · Lorenzo Baggiani⁷ · Andrea Ungar² · Enrico Mossello² · Guglielmo Bonaccorsi³ · Giancarlo Landini⁸

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vaccines



Article

Course and Lethality of SARS-CoV2 Epidemic in Nursing Homes after Vaccination in Florence, Italy

Giulia Rivasi^{1,*}, Matteo Bulgaresi², Enrico Mossello¹, Primo Buscemi³, Chiara Lorini³, Daniela Balzi⁴, Riccardo Barucci², Ilaria Del Lungo², Salvatore Gangemi², Sante Giardini², Cecilia Piga², Eleonora Barghini², Serena Boni², Giulia Bulli², Paolo Carrai⁵, Andrea Crociani⁵, Antonio Faraone⁵, Aldo Lo Forte⁵, Letizia Martella², Simone Pupo², Giacomo Fortini², Irene Marozzi¹, Giulia Bandini⁶, Claudia Cosma³, Lorenzo Stacchini³, Gabriele Vaccaro³, Lorenzo Baggiani⁷, Giancarlo Landini⁸, Guglielmo Bonaccorsi³, Andrea Ungar¹, Enrico Benvenuti²

Received: 1 December 2021 | Revised: 2 March 2022 | Accepted: 12 March 2022

DOI: 10.1111/jgs.17773

BRIEF REPORT

Journal of the
American Geriatrics Society

Long-term effects of SARS-CoV-2 vaccination in the nursing home setting

Giulia Rivasi MD¹ | Matteo Bulgaresi MD² | Chiara Bandinelli MD² | Daniela Balzi BSc³ | Francesca Tarantini PhD¹ | Silvia Tognelli MD² | Chiara Lorini PhD⁴ | Primo Buscemi MD⁴ | Lorenzo Baggiani MD⁵ | Giancarlo Landini MD⁶ | Andrea Ungar PhD¹ | Guglielmo Bonaccorsi MD⁴ | Enrico Mossello PhD¹ | Enrico Benvenuti MD²

Aging Clinical and Experimental Research
https://doi.org/10.1007/s40520-023-02415-w

SHORT COMMUNICATION



Impact of SARS-CoV2 infection on mortality and hospitalization in nursing home residents during the “Omicron era”

Matteo Bulgaresi¹ · Giulia Rivasi² · Francesca Tarantini² · Sofia Espinoza Tofalos² · Lorenzo Maria Del Re² · Caterina Salucci² · Giada Turrin² · Riccardo Barucci¹ · Chiara Bandinelli¹ · Letizia Fattorini³ · Daniele Borchi³ · Marta Betti³ · Saverio Checchi³ · Lorenzo Baggiani⁴ · Francesca Collini⁵ · Chiara Lorini³ · Guglielmo Bonaccorsi³ · Andrea Ungar² · Enrico Mossello² · Enrico Benvenuti¹

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Impact of SARS-CoV2 infection on mortality and hospitalization in nursing home residents during the “Omicron era”

Matteo Bulgaresi¹ · Giulia Rivasi²  · Francesca Tarantini² · Sofia Espinoza Tofalos² · Lorenzo Maria Del Re² · Caterina Salucci² · Glada Turrin² · Riccardo Barucci¹ · Chiara Bandinelli¹ · Letizia Fattorini³ · Daniele Borchini³ · Marta Betti³ · Saverio Checchi³ · Lorenzo Bagglioni⁴ · Francesca Collini⁵ · Chiara Lorini³ · Guglielmo Bonaccorsi³ · Andrea Ungar² · Enrico Mossello² · Enrico Benvenuti¹

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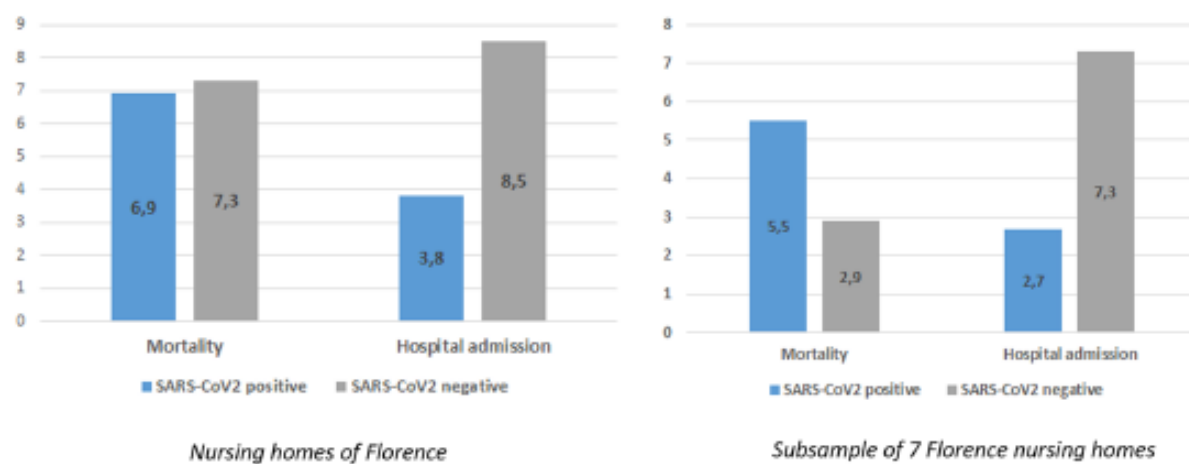
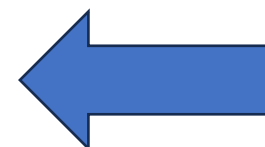


Fig. 2 Mortality and hospitalization rates by SARS-CoV2 status in residents of the nursing homes of Florence (left panel) and in a sample of seven randomly selected nursing homes (right panel) during the Omicron era (December 27th, 2021–March 31st, 2022)

Table 3 Multivariate logistic regression for the composite outcome of death and hospital admission

	OR	95% Confidence Interval	p
Age	1.005	0.975–1.035	0.769
Nr. BADL lost	1.433	1.141–1.801	0.002
SARS-CoV2 status (positive vs negative)	0.790	0.374–1.672	0.538
Chronic obstructive pulmonary disease	4.290	1.975–9.320	< 0.001
Previous SARS-CoV2 infection	0.302	0.112–0.813	0.018



GIROT

(Gruppo Intervento Rapido Ospedale Territorio)

- Il Girot è una equipe multiprofessionale (USL TOSCANA CENTRO e AOU Careggi) composta da geriatri, internisti, palliativisti, che prende in carico il paziente insieme agli infermieri di famiglia e comunità. L'attività del GIROT può iniziare già in DEA, dove è presente un geriatra per la presa in carico precoce del paziente.
- Si rivolge a **persone di solito anziane con disabilità motoria e cognitiva, in corso di scompenso clinico**, per i quali l'ospedalizzazione può essere addirittura dannosa.
- Può essere attivato dal: **MMG**, dal medico in dimissione ospedaliera/DEA o dalle cure intermedie/ospedale di comunità, ACOT, Medico emergenza urgenza (118)

OGNI PERCORSO E' CONDIVISO E GESTITO IN COMANAGEMENT
CON IL MEDICO DI MEDICINA GENERALE

Diagnostica dedicata



ECG ed Ecografo portatile grazie a donazione Fondazione Santa Maria Nuova, CR Firenze



Radiologia «a casa»

Diagnostica strumentale portatile

- Ecografo portatile multifrequenza
- ECG automatico
- Pulsossimetro
- Emogasanalizzatore portatile che esegue anche ematocrito, creatinina, elettroliti e lattati
- Glucometro
- Dermatoscopio digitale



Emogas-analizzatori portatili

Dati GIROT 2022 – no covid

Pazienti totali (n°)	5884
Età media (anni)	88,05
Min (anni)	43,00
Max (anni)	103,00
Mediana (anni)	89,00
Interventi totali (visite + televisite) - (n°)	5656
Televisite (n°)	2584
Visite (n°)	2942
Degenza media	8

Diagnosi di Demenza		
Demenza con disturbo comportamentale	71	22,3 %
Demenza senza disturbo comportamentale	82	25,8 %

Delirium_durante	
n. 19	5,0 %
Contenzione_farmacologica	
n. 10	3,1 %
Contenzione_fisica	
n. 4	1,3 %
Difficoltà_assistenza	
n. 16	18,0 %
BPCO	
n. 56	17,6 %
Scompenso_cardiaco	
n. 95	29,9 %
Disfagia severa	
n. 26	8,2 %

Delirium nei reparti ospedalieri
20-30%

Attivazione cure palliative
10%

Setting	Decessi a 30 giorni	tot	%
Geriatrica OSMA	98	402	24,4
GIROT	41	244	16,8

Girot in DEA



ACCESSO IN DEA



INTERVENTI IN COGESTIONE CON MEDICO del DEA

- Valutazione multidimensionale
- Radiografia del torace
- Emogasanalisi: insufficienza respiratoria
- Terapia diuretica ed antibiotica per via endovenosa

Prescrizione di:

Ossigeno, liquidi, terapia antibiotica a domicilio
Ausili



Modello Acute Frailty Unit Leicester 2014



Rivalutazione del GIROT a 24/48 ore con INFERMIERE DI FAMIGLIA.

- esecuzione di terapia endovenosa ad orario
- Programmazione esami ematici di controllo
- Attivazione del fisioterapista di comunità
- Educazione al caregiver

A controlled evaluation of comprehensive geriatric assessment in the emergency department: the 'Emergency Frailty Unit'

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Abstract

Background: the ageing demographic means that increasing numbers of older people will be attending emergency departments (EDs). Little previous research has focused on the needs of older people in ED and there have been no evaluations of comprehensive geriatric assessment (CGA) embedded within the ED setting.

Methods: a pre-post cohort study of the impact of embedding CGA within a large ED in the East Midlands, UK. The primary outcome was admission avoidance from the ED, with readmissions, length of stay and bed-day use as secondary outcomes.

Results: attendances to ED increased in older people over the study period, whereas the ED conversion rate fell from 69.6 to 61.2% in people aged 85+, and readmission rates in this group fell from 26.0% at 90 days to 19.9%. In-patient bed-day use increased slightly, as did the mean length of stay.

Discussion: it is possible to embed CGA within EDs, which is associated with improvements in operational outcomes.

	Usual care	Intervention period
Setting	Emergency decision unit within the emergency department	Unchanged
Integration with main emergency department	Short walk, tannoy system and pathways	Unchanged except for additional frailty pathways
Clinical leads	Emergency physicians	Emergency physicians and geriatricians
Nursing	Emergency medicine	Emergency medicine with some additional training in geriatric syndromes and manual handling
Care coordination	Primary care coordinators with good knowledge of and access to community services	Unchanged
Comprehensive geriatric assessment (medical diagnoses, medication, problem list, mental health, basic and instrumental activities of daily living, social circumstances, environmental issue and spirituality)	Primary care coordinators working with nurses and therapists, supported by emergency physicians	As before with specialist geriatrician input and integrated clerking proforma Additional education and training and team-working
Access to specialist geriatrician	Via ad hoc phone calls or outpatient referrals	Embedded geriatrician available 8-6pm seven days per week
Access to community services	All community hospital and intermediate care service available	Unchanged but greater promotion and use of community services

Girot in DEA



DEA



Casa/RSA con GIROT o Cure palliative o attivazione infermieri del territorio



UGA



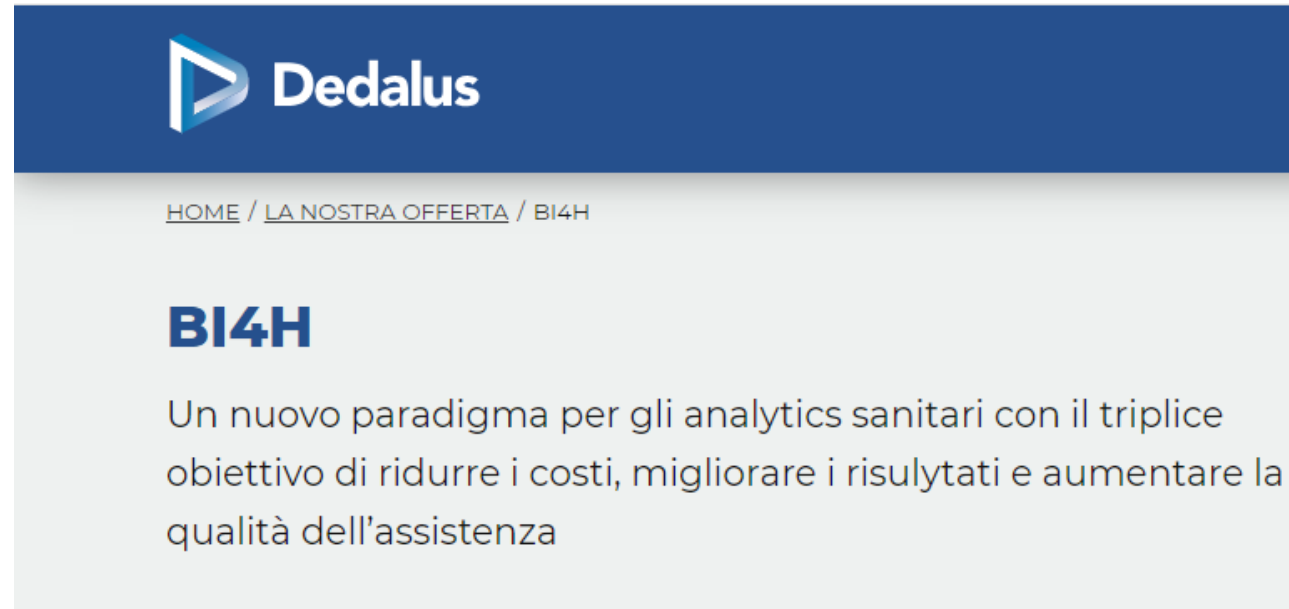
Cure Intermedie/Hospice

Analisi Dati con Dedalus

BI4H

1 Gennaio 2023 – 30 Novembre 2023

DEA OSMA-SMN-SGD



The screenshot shows the Dedalus website interface. At the top, there is a dark blue header with the Dedalus logo (a stylized play button icon) and the word "Dedalus" in white. Below the header, a breadcrumb trail reads "HOME / LA NOSTRA OFFERTA / BI4H". The main content area features the heading "BI4H" in a large, bold, dark blue font. Below this heading, a paragraph of text describes the service: "Un nuovo paradigma per gli analytics sanitari con il triplice obiettivo di ridurre i costi, migliorare i risultati e aumentare la qualità dell'assistenza".

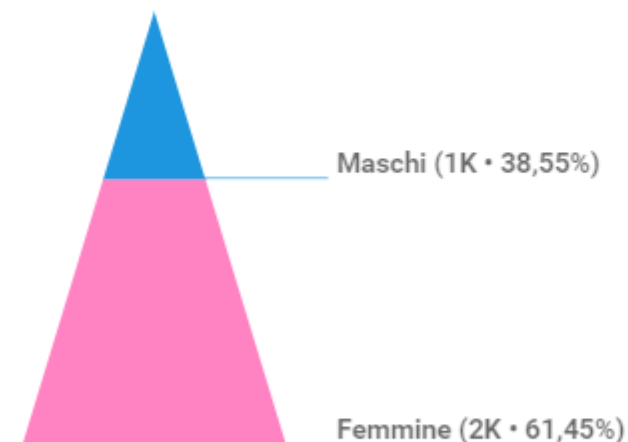
Estrazione dati utilizzando come filtro PRESTAZIONE «Visita Geriatrica»

Tipologia di Pazienti

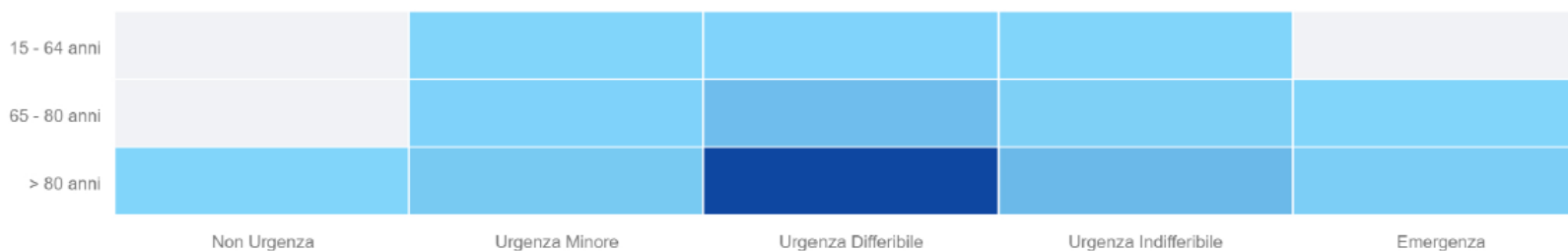
Accessi 3.502 🔍 Dettaglio	Ricoverati 317 🔍 Dettaglio	Trasferiti 437 Deceduti 23 🔍 Dettaglio 80 % a domicilio
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Primo Codice Urgenza Triage	Numero Accessi	Numero Accessi %
Non Urgenza	4	0,11%
Urgenza Minore	242	6,91%
Urgenza Differibile	2755	78,67%
Urgenza Indifferibile	393	11,22%
Emergenza	108	3,08%

Accessi per Sesso



Accessi per Urgenza Triage-Fascia d'Età



Girot in DEA – anno 2023

	DEA SMN (%)	DEA OSMA (%)	DEA SGD (%)
TOTALI	1068	1273	1161
Maschi	377 (35,30)	527 (41,40)	446 (38,42)
Femmine	691 (64,70)	746 (58,60)	715 (61,58)
Età < 70 anni	24 (2,22)	31 (2,43)	29 (2,49)
Età 70 – 79 anni	100 (9,36)	138 (10,84)	131 (11,28)
Età 80 – 89 anni	454 (42,50)	604 (47,44)	575 (49,52)
Età 90 – 99 anni	478 (44,75)	480 (37,70)	414 (35,65)
Età 100 – 110 anni	12 (1,11)	20 (1,57)	12 (1,03)
DOMICILIO	862 (80,71)	939 (73,76)	912 (78,55)
RICOVERATI	61 (5,70)	165 (12,96)	91 (7,83)
TRASFERITI CDC	129 (12,07)	160 (12,56)	148 (12,74)
DECESSI	4	9	10

Tipologia di Pazienti



Modalità Invio	Numero Accessi	Numero Accessi %
Autopresentazione	166	4,74%
C.O. 118	3,328	95,03%
Medico di continuità assistenziale	3	0,09%
Medico di medicina generale / Pediatra libera scelta	2	0,06%
Specialista	3	0,09%

Prime 10 diagnosi di presentazione

SCOMPENSO CARDIACO CONGESTIZIO
INSUFFICIENZA RESPIRATORIA ACUTA
DEMENTIA CON DELIRIUM
INFEZIONE DELLE VIE URINARIE
POLMONITE IN CORSO DI INFLUENZA
BRONCOPOLMONITE POLMONITE
SINCOPE E PRESINCOPE
SEPSI
OCCLUSIONE / SUBOCCLUSIONE INTESTINALE
TRAUMA CRANICO LIEVE NON COMMOTIVO

Dea Ospedale SGD

1 gennaio - 30 aprile 2022/1 gennaio - 30 aprile 2023

Filtro: «Pazienti >80 Anni» AND «Codice Triage 3»

	Anno 2022 senza GIROT		Anno 2023 con GIROT	
	N°	%	N°	%
Accessi	1774	100	1841	100
Ricoveri	611	34,4%	437	23,7%
Trasferimenti	134	7,5	159	8,6
Deceduti	15	0,8	9	0,48

Riduzione dei ricoveri del 10%

Miglioramento del filtro di ricovero

TOP 100 TERAPIE PRESCRITTE

Terapie Somministrate

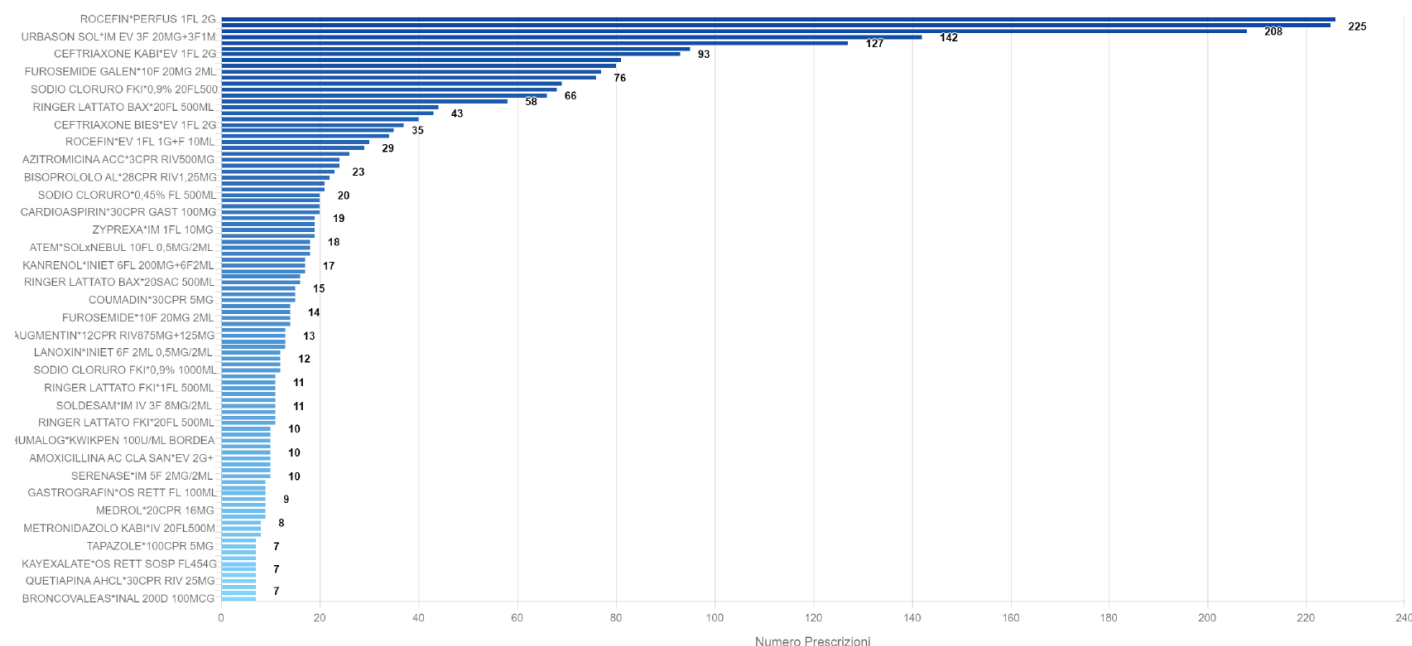
Somma delle quantità di farmaci somministrati per forma

Farmaco	Unità Posologica	Quantità Totale
Non Valorizzato	Non Valorizzato	28.593
LASIX*INIET 5F 2ML 20MG/2ML	FIALA	7.376
ROCEFIM*PERFUS 1FL 2G	FIALA	5.728
URBASON SOL*IM EV 3F 20MG+3F1M	FIALA	3.003
OSSIGENO*COMPR 100BAR 2LT VI	LT/MIN	16.036
CLEXANE*6SIR 4000UI 0,4ML	FIALA	1.495
URBASON SOL*IM EV 40MG+1F 1ML	FIALA	1.711
SODIO CLORURO EUROS*0,9% 500ML	FLACONE	3.503
FUROSEMIDE GALEN*10F 20MG 2ML	FIALA	2.631
AUGMENTIN*IV 1F 2000MG+200MG	FIALA	2.269
TRITTICO*IM EV 3F 50MG 5ML	FIALA	4.092

Ceftriaxone
Piperacillina/tazobactam
Amoxicillina/Clavulanato
Idratazione
Furosemide

Antipsicotici:
Serenase
Olanzapina
Quetiapina

Terapie Prescritte (top 100)



Trasferimento diretto in RSA da reparto/DEA

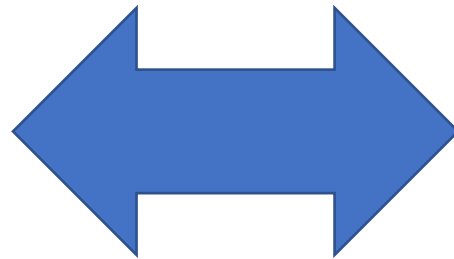


- Valutazione Multidimensionale
- Attivazione dell'ACOT per UVM in urgenza
- Erogazione del Codice Rosso (Comune di Firenze) o attivazione dei Pacchetti FSE con concessione di una RSA 20 giorni
- Verifica disponibilità al Servizio Rette Aziendale
- Trasferimento in brevissimo tempo (24 - 48 ore) del paziente

Collaborazione Centrale Operativa 118 e GIROT



Centrale Operativa del 118



GIROT

AMA/AMU Geriatrico/Internistico anno 2023

Ospedale SGD e OSMA



filtro «visita Geriatrica» e Unità di Chiusura «AMA»

Effectiveness of acute medical units in hospitals: a systematic review

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Abstract

Purpose. To assess the effectiveness of acute medical units (AMUs) in hospitals.

Data sources. (i) Controlled and observational studies in peer-reviewed journals retrieved from PubMed, EPOC, CINAHL and ERIC databases published between January 1990 and July 2008; and (ii) reports from non-peer-reviewed websites combined with Google search.

Study selection. Articles reporting effects of the introduction of an AMU on mortality, length of stay, discharge disposition, readmissions, resource use and patient and/or staff satisfaction.

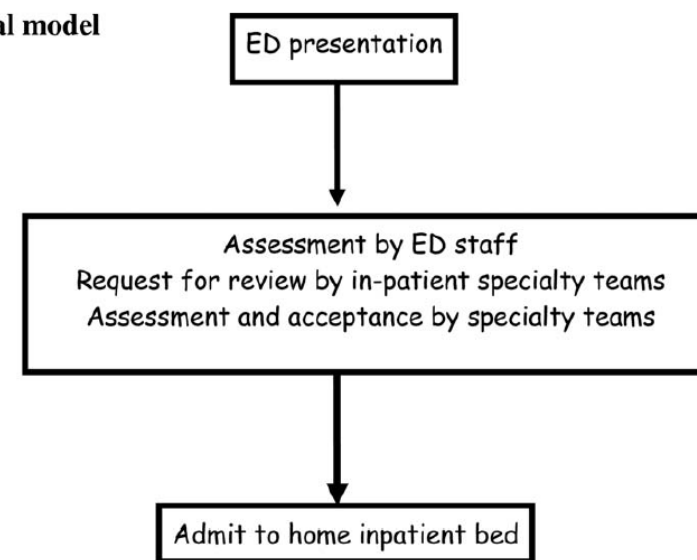
Data extraction. Data on unit operations and outcome measures were extracted by a single author and confirmed by a second author, with disagreement settled by consensus.

Results of data synthesis. Nine peer-reviewed reports of before–after analyses of seven units introduced into the UK and Ireland were analysed. Two studies, one prospective, reported significant reductions in in-patient mortality between 0.6 and 5.6% points following commencement of AMU. Four studies reported significant reductions in the length of stay between 1.5 and 2.5 days. Waiting times for patient transfer from emergency departments to medical beds decreased by 30% in one study. In three studies, the proportion of medical patients discharged directly home from the AMU increased by 8–25% points. Three studies noted no increase in 30-day readmission rates following unit commencement. Two studies described significant improvements in patient and staff satisfaction with care. Eight non-peer-reviewed reports relating to 48 units confirmed reductions in the length of stay.

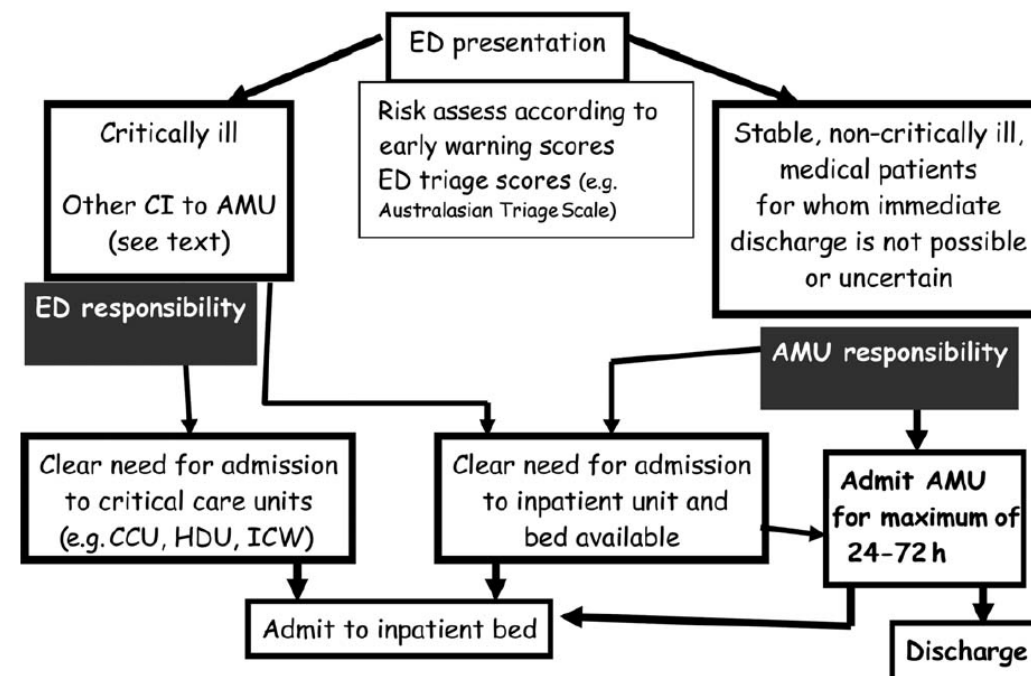
Conclusion. Limited observational data suggest AMUs reduce in-patient mortality, length of stay and emergency department access block without increasing readmission rates, and improve patient and staff satisfaction.

Keywords: acute medical unit, systematic review

Traditional model



AMU model



OBI/AMA GERIATRICA a SMN


 *Ministero della Salute* LINEE DI INDIRIZZO NAZIONALI SULL'OSSERVAZIONE BREVE INTENSIVA - OBI

TABELLA 3: INDICATORI OBI

		INDICATORE	RIFERIMENTO	CALCOLO	SOGLIA
DI UTILIZZO	1	TEMPO DI PERMANENZA IN OBI	24 H DALL'INGRESSO IN PS O IN OBI	N° CASI CON PERMANENZA IN OBI > 24 H / TOTALE ACCESSI IN OBI	≤ 5%
	2	PAZIENTI DIMESSI	N° PAZIENTI e N° TOT ACCESSI OBI	N° CASI DIMESSI / TOTALE ACCESSI OBI	≥ 90 %
	3	PAZIENTI RICOVERATI	N° PAZIENTI e N° TOT ACCESSI OBI	N° CASI RICOVERATI / TOTALE ACCESSI OBI	≤ 10 %
	4	PATOLOGIE IMPROPRIE	TABELLA PATOLOGIE CON CRITERI di INCLUSIONE IN OBI e N° TOT ACCESSI OBI	N° CASI INAPPROPRIATI / TOTALE ACCESSI OBI	< 5 %
DI PERFORMANCE	5	PAZIENTI CHE RIACCEDONO AL PS < 24H	N° PAZIENTI CHE RIACCEDONO AL PS < 24 H DALLA DIMISSIONE DA OBI E TOTALE DIMESSI OBI	N° CASI CON RIENTRO IN PS < 24 H DALLA DIMISSIONE DA OBI/TOTALE DIMESSI DA OBI	< 5%

	Esiti	Esiti	Esiti	Esiti
Presidio	Numero Dimessi	% Dimessi	Numero Ricoverati	% Ricoverati
[Santa Maria Nuova] - f1- OBI di PS	324	91,01%	32	8,99%
[Santa Maria Nuova] - f2- HDU	40	90,91%	4	9,09%

AMA

1 gennaio -30 novembre 2023

PAZIENTI PRESI IN CARICO totali	16444
Ricoverati	10054(61%)
Dimessi a domicilio	4747(29%)
Altri esiti	1466(9%)

Dettaglio flussi Ottobre- Novembre 2023

AMA

H	AMA	Ricoverati	Dimissione a domicilio	Trasferimento ad altro istituto	DAY SERV Ott/NOV
PRATO	702	262 (37%)	397 (56%)	74 (6.6%)	29 (4.1%)
EMPOLI	482	362 (75%)	104 (21%)	11 (2.2%)	
PISTOIA	387	129 (33%)	256 (66%)		
SGDD	354	213 (60%)	86 (24.2%)	37 (10%)	

Il Paziente al Centro

Preso in carico TRASVERSALE

GIROT in
DEA

Cure
Intermedie/RSA

GIROT in
OBI/AMA

Cure Palliative
simultane



UGA

DAY service
territoriale

