Guide to Geriatrics Programme Development

November 2014
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Ageing Population

Growing Geriatric Population to Pose Challenges

Improving Elderly Patient Care Top Priority Among Health Systems

World's Elderly Population

Millions

In 2010, the elderly population made up 8 percent of the world’s population; this is expected to rise to 16 percent by 2050

2010

2050

1,500

524

Statistics on the Ageing Population

25%
Percentage of the Australian population that will be 65 years or older within two decades

10%
Percentage of the European population that will be 80 years or older by 2050

Source: http://www.who.int/ageing/publications/global_health.pdf;
Global Elderly Care Costs

Treating Elderly Population Especially Resource Intensive

As Population Ages, Risk of Improper Management Becomes Increasingly Costly

Projected Percentage Increases in Elderly Population and Expenditures

2000-2050

- Growth in Population 65 Years or Older
  - United Kingdom: 67%
  - Spain: 76%
  - Italy: 56%
  - Germany: 64%

- Increase in Total Expenditure as a % of GDP
  - United Kingdom: 112%
  - Spain: 149%
  - Italy: 138%
  - Germany: 168%

- Total Expenditure Growth
  - United Kingdom: 392%
  - Spain: 509%
  - Italy: 378%
  - Germany: 437%

Global Health Care Expenditures for Elderly

- Of the 56 million deaths worldwide were due at least in part to chronic diseases
- Rise in age-related social expenditures between 2000 to 2050

Projected Foregone National Income due to Heart Disease, Stroke, and Diabetes

2015

<table>
<thead>
<tr>
<th></th>
<th>Brasil</th>
<th>China</th>
<th>Canada</th>
<th>United Kingdom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Income Loss in Billions</td>
<td>$9.3</td>
<td>$131.8</td>
<td>$1.5</td>
<td>$0.5</td>
</tr>
</tbody>
</table>

Geriatrics Imperatives

Leaders Must Coordinate Across Specialties to Manage Costly Patient Needs

Geriatrics Programme Development Challenges and Imperatives

Operational

- Staff training is critical, though this can be difficult due to limited staff time
- The shortage of available geriatricians and specialised nurse practitioners further exacerbates patient management issues

Financial

- Despite limited relative capital investment needed, geriatric programmes are usually not profitable due to the enhanced staffing requirements
- Care coordination challenging due to longer patient visits, and costs associated with managing patient care pathways

Strategic

- Geriatric patients require longer treatment durations due to special treatment needs and thus are a higher-cost patient population
- Consumers are becoming more savvy in choosing their preferred hospital resulting in new patient loyalty challenges

Imperatives

- Programmes must coordinate to accommodate the needs of their patients across various service lines within the hospital
- Patient treatment must also be coordinated with post-acute providers—whether hospital owned or not—as geriatric patients often require these services

- Volunteers can help enhance geriatric programme profitability
- Furthermore, offering membership programmes for a small fee can create additional revenue, and foster loyalty to the hospital

- Branding as a geriatric-specialised facility can facilitate activity growth
- Geriatrics programmes can promote the hospital as a centre of excellence in quality care for elderly patients

Source: Clinical Investment Insights research and analysis.
Programme Development

To Prepare, Services Must Span Inpatient and Outpatient Care

Variety of Service Lines Impacted Across Care Settings

Geriatrics Care Spans All Service Lines

Service Lines Most Impacted

Inpatient

Cardiovascular
Orthopedics
Neurology
Urology

Outpatient

Radiology
Ophthalmology
Otolaryngology

Case in Brief: A Transition Towards Elderly Care

- Institution: 700-bed, not-for-profit AMC located in the West
- A move towards chronic disease management spurs hospital to integrate specialty services with high utilisation geriatric care.
  - Chief of Geriatrics develops heart failure programme focusing on geriatric patients
  - Hospital implements a co-management model with orthopedic surgeons to coordinate elderly care
  - Geriatrics Institute establishes further partnerships with medical centre leadership, especially vascular surgeons and neurologists

The “Typical” Geriatrics Patient

“The target geriatrics patient is not defined by DRGs, diagnosis, or age. Rather, the patient belongs in a variety [of services] with many diagnosis, cognitive impairments, and social issues which highlight the patient’s high risk for readmissions.”

- Chief of Geriatrics

Source: Service Line Strategy Advisor research and analysis.
Comprehensive Geriatrics Programmes Cover Three Major Areas

Significant Care Infrastructure Required Outside the Hospital

Three Components to Geriatrics Programme Development

### Inpatient Services
- HELP Programme
- Geropsychiatry Unit
- Mobile ACE Unit
- ACE Unit

### Ambulatory Services
- Primary Care Services
- Evaluations Clinic
- Gait and Balance Programme
- Memory Centre
- Transportation Programme

### Geriatrics Service Integration
- Educational Sessions
- Senior Hotline
- Depression Screening
- Affinity Membership Programme
- Fitness and Wellness Programme
- Transition Managers
- House Call and Home Health Programme
- Telemedicine

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**Geriatrics Service Line in Brief**

- The geriatric population has special needs due to frailty, comorbidities, and cognitive impairments in some patients.
- As such, geriatric service lines may not involve a dedicated cost centre as they work closely with other service lines and specialties within the hospital such as cardiology, neurosciences, orthopaedics, and behavioural health.
- In developing this coordinated approach among disparate programmes within the hospital and the ambulatory setting, buy-in from administration is critical.
- Support of specially trained geriatric nurses and NPs, geriatricians, and other internal medicine doctors who routinely manage these patients is key.

Source: Clinical Investment Insights research and analysis.
# Three Core Elements Define a Comprehensive Service Line

Top Questions Answered to Round Out Geriatrics Programme Development

## Three Components to Geriatrics Programme Development

<table>
<thead>
<tr>
<th>1</th>
<th>Inpatient Geriatric Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key Question</strong></td>
<td>What are the programmatic best practice considerations for building a strong inpatient geriatric service line?</td>
</tr>
</tbody>
</table>
| **Components** | • Many progressive hospitals are dedicating programmes solely to geriatric patients, as these patients often require more time from doctors due to special needs  
• Examples of inpatient services include acute care for the elderly (ACE) units, Hospital Elder Life Programme (HELP), and geropsychiatry units |

<table>
<thead>
<tr>
<th>2</th>
<th>Ambulatory Geriatric Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key Question</strong></td>
<td>What are the programmatic best practice considerations to have a strong ambulatory geriatric service line?</td>
</tr>
</tbody>
</table>
| **Components** | • Ambulatory geriatric programmes fulfill a community need and often are the only place the elderly can receive necessary care  
• Gait and balance programmes and affinity and membership programmes are key aspects of an ambulatory service line |

<table>
<thead>
<tr>
<th>3</th>
<th>Geriatric Services Integration</th>
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<tbody>
<tr>
<td><strong>Key Question</strong></td>
<td>How can hospitals partner with nursing homes, home health agencies, and other entities to enhance the care continuum for their patients?</td>
</tr>
</tbody>
</table>
| **Components** | • The transition from a hospital to a post-acute facility can be difficult, so hospitals need to provide maximal support to their geriatric patients during this transition  
• Hospitals can take advantage of house call programmes, telemedicine, and support services to make this transition easier |

Source: Clinical Investment Insights research and analysis.
Inpatient Geriatric Services
While all services provided in the inpatient hospital setting serve a geriatric population, progressive hospitals are seeing the value of dedicating programmes to geriatric patients as these individuals require greater amounts of time from doctors due to special needs and services that are tailored to the level of comorbidities present in the elderly.

Examples of inpatient services include acute care for the elderly (ACE) units—for hospitals who have found it effective to dedicate beds to this population—and the Hospital Elder Life Programme (HELP), a programme dedicated to promoting physical and cognitive wellbeing in the elderly during hospital stays. While dedicating beds to geriatric services has had mixed results at institutions and is not a viable option at some, focusing on the needs of this population through specialised training for hospital staff has been beneficial for many progressive hospitals.

In addition, geropsychiatry units have become an important addition to the spectrum of geriatric care. Mixing younger patients with substance abuse and older patients with dementia in the same unit can create an unpleasant environment that is not conducive to effective care, leading many hospitals to dedicate separate spaces for these patients.

**Inpatient Geriatric Services**

**Inpatient Geriatrics Offerings Vary by Hospital Programme Type**

Inpatient Geriatrics Can Involve ACE Units, HELP, Geropsychiatry Offerings

**ACE Unit**

- An acute care for elders (ACE) unit is space dedicated to inpatient geriatric treatment
- The programme, which involves assigned beds to elderly patients, focuses on acutely ill geriatrics patients and adjusts care to meet their specific needs

**HELP Programme**

- The Hospital Elder Life Programme (HELP) is designed to promote cognitive, physical, and emotional wellbeing in hospitalised elder patients
- Though no space is dedicated on a unit, the specific focus on adjustments required to treat elderly, often frail and cognitively impaired patients is a treatment plan of choice for hospitals focusing on geriatrics where holding beds in a unit is not an option

**Geropsychiatry Unit**

- Geropsychiatry units, generally within the hospital's overall behavioural health department, specialise in geriatric psychiatric care that requires a coordinated team of psychiatrists, therapists, medical staff, and social workers

**Inpatient Geriatric Offerings**

Source: Clinical Investment Insights research and analysis.
An ACE unit integrates general medicine services with geriatric interventions. Doctors on ACE units recommend focusing on early intervention and chronic disease management. The mission of an ACE unit is to rehabilitate a patient for home discharge, rather than to a long-term care facility.

To develop an ACE unit, leaders should identify key decision makers across the hospital, including nurses, executives, doctors, and other personnel for cross-disciplinary buy-in. Often, a geriatrician medical director and nurse with geriatric experience co-lead a planning team to select an appropriate location for the unit, usually involving a conversion of a general medical unit.

After programme commencement, the team should continue to hold regular staff meetings to map out individualised treatment plans, focusing on patients at greatest risk for functional decline. The team tracks patient progress, functional status, anticipated length of stay, and patient discharge using a checklist disseminated among medical staff members.

As the ACE unit grows, continual evaluation highlights areas for improvement and provides feedback to executives and medical staff.

### Key Elements for Developing an ACE Unit

- **Agree on the need for an ACE Unit by presenting idea to key decision makers**
- **Commence operations by holding regular team meetings for medical staff**
- **Evaluate the unit for its benefit to patients, providers, and the health system**

### Acute Care of Elders (ACE) Unit in Brief

- **ACE unit** is a dedicated inpatient programme that focuses on prevention and early treatment for acutely ill geriatrics patients.
- **Staffing** consists of a multidisciplinary team approach with nurses serving as the central point of communications.
- **Admission criteria** for ACE Units are predominantly age-based.
- **The goals of an ACE unit** is to increase patient satisfaction, reduce average length of stay, and decrease the level of post-charge care needed.

Source: Clinical Investment Insights research and analysis.
An ACE unit requires the reorganisation of the hospital environment to fit geriatric needs. A few fundamental facility changes are recommended, from adding clocks and calendars to patient rooms to building an activity room to accommodate patient socialisation.

In the ACE unit, doctors use an EMR system to quickly access patient information, and an executive at one institution stated that EMR use has significantly reduced the number of Foley Catheter procedures doctors in other departments conducted, thereby increasing efficiency.

Another necessary component which serves as the foundation of an ACE unit is patient education, since dedicated inpatient units seek to promote patient independence post-discharge. Nurses often conduct individualised meetings with patients and their family members to discuss preventative care.

**Organisational Map of ACE Unit**

- **Electronic Medical Records System**
  Doctors use EMR to automatically access other doctor’s requests for diagnostic tests, medications, and treatment recommendations

- **Patient Education**
  Educate patients and families about the model and its benefits; Use face-to-face meetings and information brochures

- **Volunteers**
  Encourage orientation and socialisation through reading newspapers

- **Activity Room**
  Used for ward meetings and communal patient dining

- **Engaged Doctors**
  Geriatricians, specialists and consultants willing to participate in shared model of care

- **Aged Care Liaison Nurse**
  Nurse improve flow of patients out of the hospital into nursing home and hospice

- **Modified Bathrooms**
  Allow room for patients to shower themselves

- **Estimated Discharge Planning**
  A focus on ensuring rapid discharge. Early planning with community based services to ensure discharge timely

Staffing levels for ACE units will depend upon the size of the unit and number of patients. Cross-disciplinary staff members on ACE units include geriatricians, nurses, social workers, dieticians, physical therapists, and occupational therapists.

To implement a team approach, staff involvement in developing documentation tools heightens the level of compliance. Because geriatricians are in short supply, many executives prefer to focus ACE unit staffing around registered nurses (RNs) and nurse practitioners (NPs); nurse to patient staffing ratios average about 1 to 5.6 during the daytime and 1 to 7 at night.

Because nurses play such a central role, ACE units should focus on developing nurse-initiated protocols. Often, only the RNs and geriatricians are dedicated to the unit while clinicians and ancillary staff rotate through other units and support geriatrics when needed. The ACE unit also serves as an educational forum on senior care. Residents and students from affiliated universities can perform daily admissions, management rounds, and interdisciplinary rounds with the department’s attending doctor.

Convergence of Services Requires Cross-Disciplinary Approach

Multidisciplinary Staffing Involvement

Support Staff
- Social Workers
- Occupational Therapist/Physical Therapist

Clinicians
- Geriatricians/Internists
- Doctor Specialists
- Dietician
- Nursing Staff (RNs/NPs)
- Medical Residents

Administrative
- Administrative coordinator
- Medical Assistants

Participation in Protocol Creation Spurs Cooperation

“The team members developed the documentation tools, so they owned them. That's how we get such high compliance.”

John A. Hartford Foundation

Source: John A Hartford Foundation. “Redesigning Hospital Care to Prevent Functional Decline in Older Adults: The ACE Unit Innovation”, Clinical Investment Insights research and analysis.
Mobile ACE Unit a Cost-Saving Alternative to Dedicated Unit

An alternative model can be found at one hospital where staff provide senior services through a “mobile” ACE unit, in which dedicated geriatrics staff, including nurse practitioners, geriatricians, and social workers, conduct rounds in different departments throughout the hospital. Each morning, geriatric executives receive a list of senior patients admitted to the hospital in all departments and update it throughout the day.

In addition to offering geriatrics services, the ACE programme offers two palliative care services—one for patients less than 65 years old, and one for patients over 65 years old. Executives made this transition from an ACE unit in order to create more space for other services lines, increase patient operating theatre turnaround times, and save on costs.

Clinicians are also pleased with the mobile ACE model, as they believe that it allows doctors and nurses greater flexibility and increased opportunity to coordinate care with doctors across departments. Since the mobile ACE programme’s inception, average length of stay (ALOS) for palliative care patients has decreased by two days.

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### Case Study: 1,200-bed, Not-for-Profit AMC

*Average LOS in Days for Palliative Care Patients*

<table>
<thead>
<tr>
<th></th>
<th>Dedicated Unit</th>
<th>Mobile Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average LOS</td>
<td>14 days</td>
<td>12 days</td>
</tr>
</tbody>
</table>

### Advantages of a Mobile ACE Unit

- Greater flexibility of staff to treat patients
- Cost-savings on staffing resources
- Eliminating need for dedicated space
- Geriatricians maintain improved communication with specialists

Source: Clinical Investment Insights research and analysis.
Overall, ACE units demonstrate significant advantages for acutely ill elderly patients. A change in the provision of acute hospital care can lead to improved functional and clinical outcomes, with 21% of patients performing much better functionally after ACE unit stay versus 13% of patients in the standard hospital setting.

Patients receiving care in ACE units are much more likely to regain the ability to perform the basic activities of daily living at the time of discharge and are less likely to be discharged to long-term care facilities. Studies have shown that patient and nursing satisfaction is generally higher in ACE units than on traditional hospital floors.

In many cases, ACE units produce cost savings. In others, they remain budget neutral, with initial development costs offset by shorter lengths of stay and reduced patient costs. As a cost-effective strategy, ACE units decrease LOS in hospitals, with one hospital showing a decrease in LOS of almost one day. By reducing the number of patients who fail to keep appointments through follow-up phone calls and arranging for transportation when necessary, the hospital realised $100,000 in profits for fiscal year 2007.
Medical staffing of a geriatrics service line draws mostly from hospital staff interested in the care of elderly patients. Cross-training efforts and geriatrics education provide them with the necessary knowledge to manage elderly patients who require a higher level of care. Geriatricians play a central role in both ambulatory and inpatient services.

However, given the shortage of geriatricians, internists and general medicine practitioners can fill this gap. Many hospitals also place nursing staff in senior positions and use medical residents to provide basic services, such as routine examinations.

To ensure buy-in from all stakeholders involved in geriatrics services, the Medical Director of Geriatrics Services profiled in the case study created a senior services team consisting of representatives from every level of patient acuity. Collaboration between members is facilitated through methods such as regular meetings, online communication, and even the creation of specific staff roles to oversee service coordination, including a geriatrics care manager. This executive coordinator, along with medical assistants, facilitates scheduling and alignment with post-acute care, especially general practitioners.

![Interdisciplinary Approach Necessary for Care Management](image-url)

**Case in Brief: Creating A Senior Services Team**
- Institution: Multi-hospital, 1,000-bed health system in the Midwest United States
- Medical Director creates a senior service team by drawing representative from every department and level of patient acuity
- Team meets on quarterly basis, with opportunities for networking and education
- Hospital creates an online list-serve to facilitate communications

Source: Clinical Investment Insights research and analysis.
Across the continuum of geriatrics care, nurses serve as the primary care facilitators for patients and as the central point of contact for staff members. Dedicating nurses to patient units rather than geriatricians leads to decreased competition, increased referrals, and stronger relationships with doctors.

Geriatrics education, with a focus on enhancing nurse-patient relationships, should therefore be provided to not only nurses dedicated to geriatrics services but also nurses across all departments. Nurse engagement efforts, such as cross-training play a central role in disseminating shared expertise, while nurse involvement in creating clear protocols on how to handle more frail elderly patients ensures comprehensive, specialised care for patients.

Hospital leaders also recommend joining the NICHE network, which allows nurses to access best practice models for training in addition to benchmarking tools to measure clinical outcomes. By placing a structure on the continuity of nursing care from geriatrics ambulatory clinics to post-acute care, hospitals can maximise utilisation of staffing resources and save on costs for hiring extra staff in operationalising the service line.

Nurses Improving Care for Health System Elders (NICHE) Programme in Brief

- National geriatric nursing programme developed training methodology to improve quality of elderly care and functional mobility
- Hospitals can utilise the Geriatric Resource Nurse (GRN) Model to provide training for nurses
- Once trained, geriatric advanced nurses serve as the clinical point person and educates other nurses on care management
- Programme includes protocols and benchmarking tools to assess progress of development
- By linking offering to measurable clinical outcomes, geriatrics programmes can justify costs to executives

Source: Clinical Investment Insights research and analysis.
HELP Programme

HELP Programme Uses Interdisciplinary Staff to Promote Specialty Care

While ACE units address geriatric needs in the form of a dedicated space where staff provide specialised care, the HELP programme utilises a team of hospital employees and volunteers to provide geriatric-specific care.

The HELP or hospital elder life programme attempts to combat the problem of seniors’ increased risk of strength and agility loss, confusion, and delirium while in the hospital. The programme was launched in 2006 at the Yale University School of Medicine and aims to ensure that geriatric patients leave the hospital in the same or better mental condition than when they entered the facility.

HELP volunteers, under the supervision of hospital staff and often in conjunction with a geriatric team, may converse with senior patients, practice relaxation techniques such as stress-relieving imagery sessions or meditation, and perform simple physical exercises and puzzles to encourage mental fitness. Mini-mental state examinations (MMSEs)—a 30-point questionnaire that is used to screen for cognitive impairment—may be given as part of the programme, as well as a geriatric evaluation to determine an appropriate care plan.

Core HELP Staff

- Programme Director
- Elder Life Specialist
- Volunteers
- Nurse Specialist
- Geriatrician

Interdisciplinary Staff Rounding for Consults

- Dietitian
- Psychiatric Liaison Nurse
- Chaplain
- Patient
- Rehabilitation Therapist
- Pharmacist
- Discharge Planner
- Social Worker

Programme in Brief: Hospital Elder Life Programme (HELP)

- The HELP Programme launched in 2006 and was developed by Dr. Sharon Inouye at the Yale University School of Medicine
- The programme is designed to promote cognitive, physical, and emotional well being in hospitalised elder patients
- HELP can serve as a catalyst to stimulate development of interdisciplinary clinical geriatric expertise at hospitals, promoting potential centre of excellence recognition for geriatric care

HELP has shown strong outcomes when practiced at hospitals across the country, as evidenced by the case study on the right of a 300-bed community hospital in the Northeast United States. Executives implemented the programme using an elder life specialist, geriatric trained nurses, and volunteer support.

In a study of 119 patients at the hospital who had stays at least 48 hours long, 80 were assigned to the HELP cohort and 39 were assigned to the control group. Of the 80 HELP patients, none declined by two or more points in MMSE score whereas 23 percent of the 39 patients in the “normal care” group declined by this amount (30 point total on the exam). Further, in a similar study involving 852 patients at HELP’s founding hospital at Yale, 26 percent in the control group declined by two or more points whereas only 8 percent declined in the HELP group.

Given that HELP patients have an average of 2.2 risk factors for delirium, keeping these patients at a functioning mental and physical status upon discharge from the hospital can significantly enhance their likelihood of maintaining a good health status and avoiding future readmissions.

HELP Programme's Reduces Mental Status Decline in the Hospital Setting

Number of Patients Decreasing by 2+ Points on MMSE Exam Upon Discharge

<table>
<thead>
<tr>
<th>HELP Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>-23%</td>
</tr>
</tbody>
</table>

Of study participants, no individuals participating in HELP experienced a mental status decline of two points or more, whereas 23 percent of patients did with normal care.

Case in Brief: HELP Programme in Action

- Institution: 300-bed, not-for-profit community hospital located in the Northeast United States
- Hospital implements HELP Programme using an elder life specialist and a team of specially trained nurses; volunteers assist the programme seven days per week on three four-hour shifts per day
- Patients over the age of 70 are assessed for activities of daily living (ADLs) capabilities as well as other risk factors such as dehydration, sleep deprivation, and physical disability such as hearing loss and mobility issues
- Patients also evaluated using the Mini Mental State Exam (MMSE)
- Seniors may receive other interventions while in the hospital including cognitive orientation and stimulation activities, therapeutic exercises, sleep enhancement strategies, exercise and mobility training, hearing and vision aids, feeding assistance, dehydration prevention, and individualised discharge planning

The number of seniors suffering from major psychiatric illnesses is expected to double between 1999 and 2030. Given that elderly patients in adult psychiatry units are often ignored and require more specialised physical accommodations, hospitals open geriatric behavioural health centres to offer senior patients with neurological conditions, such as Alzheimer’s disease, dementia, depression, as well as concomitant physical conditions, a specialised treatment pathway.

Throughout the day, staff provide a mix of group and individual programming, which typically is tailored to the patients’ specific conditions — for example, an activity that is well-suited to a patient with dementia differs from one that is well-suited to a patient with depression. For the most part, geropsychiatry units operate as a branch of the geriatric institute with physical space or an adult psychiatry unit, with dedicated space and staff to accommodate for senior needs.

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**Geropsychiatry Unit Programme’s “Typical Day”**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:15 am</td>
<td>Community meeting to introduce new patients and discuss various issues</td>
</tr>
<tr>
<td>10:30 am</td>
<td>Group exercise therapy with recreational therapist</td>
</tr>
<tr>
<td>11:30 am</td>
<td>Group spiritual counseling and/or hymn singing</td>
</tr>
<tr>
<td>1:00 pm</td>
<td>Individual work with physical therapist, recreational therapist and speech therapist</td>
</tr>
<tr>
<td>2:00 pm</td>
<td>Group recreational therapy activities, such as music or crafts</td>
</tr>
<tr>
<td>7:00 pm</td>
<td>Social hour</td>
</tr>
</tbody>
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**Geropsychiatry Unit In Brief**

- The lack of physical accommodations and staffing expertise for elderly mental health patients in adult psychiatry units highlights the need for dedicated inpatient geropsychiatry services
- Geropsychiatry units usually operate as a part of the behavioral health centre of the hospital or within a dedicated geriatric institute
- Specialised geriatric psychiatric care requires a coordinated treatment pathway involving psychiatrists, physical therapists, medical staff, and social workers
- Discharge planning is critical for patients with social and environmental needs that affect their mental health status

Source: Clinical Investment Insights research and analysis.
The "cornerstone" of a geropsychiatry unit’s success is the integration of medical and psychiatric treatment. To form a continuous linkage, geropsychiatry units recruit medical staff interested in working with geropsychiatric patients and train them on geropsychiatric care. Coordination between doctors, including specialists and GPs, is central to the staffing of the unit, with daily meetings ensuring that each patient’s case is frequently reviewed. Support staff such as nurses, discharge planners, and social workers also fulfill integral roles in coordination.

Discharge planning is especially important for geropsychiatric patients given that patients face a hard time adapting to socially different environment. The discharge planner is responsible for creating a discharge plan for patients, ensuring that care is coordinated even after the patient leaves the centre. He or she works with a social worker who evaluates the living situation, recommends group homes, and deals with questions to ensure regular patient follow up.

Although dedicated staff is imperative for a geropsychiatry unit, RNs and mental health counselors who work in the hospital’s additional psychiatry units can float to the adult behavioural unit as patient activity dictates.

Source: Clinical Investment Insights research and analysis
Given that many elderly patients with mental illnesses fall through the cracks, hospitals have developed a structured assessment process to capture these patients early on. One hospital insures patients receive a diagnosis within a 24-hour window, with patient admission criteria dependent on their mental illness, the intensity of the service they require.

When a patient is referred to the programme, they are first examined for any physical problems by a nurse or social worker. A psychiatrist decides whether to admit the patient or refer them to ambulatory services for a physical evaluation. Patients are then given a variety of diagnostic lab tests, including a comprehensive medical history taken by ED staff for clearance.

Afterwards, a psychiatrist conducts a thorough evaluation to develop an individualised treatment plan based upon further activity assessment, occupational assessment, and psychiatry social assessment. Once a plan is drawn up, the attending doctor coordinates care with other clinicians to ensure that all patients’ needs are met. This comprehensive structured treatment process allows efficient throughput and coordination with medical staff.

### Structured Assessment Process Captures Patients Early On

#### 24-Hour Treatment Timeline for Initial Assessment

1. Initial assessment by social worker or nurse
2. Psychiatrist decides whether to admit the patient or refer to ambulatory services
3. If admitted, patient is sent to ED for medical clearance, including lab tests
4. Psychiatrist evaluation conducted to develop individualised treatment plan

### Case in Brief: Admission and Discharge Criteria

- **Institution**: 600-bed, not-for-profit hospital located in the South of the United States.
- The hospital built a 50-bed geropsychiatry unit to serve a significant market of elderly patients with Alzheimer's disease and other cognitive impairments.
- Staff members assess specific guidelines for admission and discharge criteria, based on:
  - Reimbursement
  - Severity of patient’s illness
  - Intensity of services required

### Treatment Statistics

- **Occupancy**: 96%
- **Average LOS in days**: 20

Source: Clinical Investment Insights research and analysis.
Geropsychiatry Care a Necessary Component to Increased Cognitive Function

Although it is often difficult to document outcomes of geropsychiatry units, one method to measure patient progress is the GPNRS—a team-based assessment tool to gauge functional outcomes. It consists of a rated scale based on 16 categories, including the ability to communicate and the capacity to feed oneself as evaluated by the patient’s primary nurse. This evaluation is administered within the first five days of admissions, within five days of discharge and two weeks after discharge.

One institution using the GPNRS model shows that patients in geropsychiatry units demonstrate improved functional status, with 26% of patients showing marked improvement, and 61% of patients showing slight improvements over the course of their hospital stay. The data reveals, as symptoms of depression begin to improve through specialised treatment, patients also experience consistent improvements in physical ability.

The director of geropsychiatry unit can use the GPNRS model to continually track patient outcomes and justify its existence to hospital executives.

Geropsychiatry Unit Improves Functional Status of Elderly Patients

![Change in GPNRS Scores From Admission to Discharge, by Percentage of the Population](chart)

- **Marked Improvement**: 61%
- **Slight Improvement**: 26%
- **Scored the Same**: 5%
- **Slight Decline**: 7%
- **Marked Decline**: 2%

**Study in Brief: Improved Patient Outcomes**

- 800-bed, not-for-profit AMC conducted a study on 57 subjects within an inpatient 21-bed geropsychiatry unit over a six month period
- Study used the Geriatric Psychiatry Nurse Rating Scale (GPNRS) as a metric to assess the functional changes of geriatric patients based on 16 diverse categories, including the ability to feed oneself
- The results from the study shows that from admission to discharge, patients show a positive change in functional and cognitive status with 61 percent of patients demonstrating slight improvements

In addition to ACE units, the HELP programme, and geropsychiatry, additional measures in the area of information technology have the ability to impact the quality of inpatient geriatric care at hospitals. Several hospitals have utilised computerised decision support systems or medical informatics—the acquisition, storage, management, retrieval, and optimal use of medical information—to maximise geriatrics services through pilot studies in recent years. These gero-informatics systems can retrieve individualised, updated information from a health system’s data repository and feed it directly to clinicians to assist them in making decisions about treatment pathways for geriatric patients.

For example, a 400-bed, state-run teaching hospital integrated an IT gero-informatics solution with computerised doctor order entry (CPOE) to create a system that alerts doctors when they prescribe various medications that can be harmful to geriatric patients with cognitive impairment.

Similarly, as the use of restraints and catheters in the elderly has shown negative effects to their recovery process, the system suggests alternatives for these means.

In addition to the high activity of geriatric patients with CI, this hospital experienced a 48 hour lag between when patients were admitted to the hospital and when they received care from the geriatric service.

Gero-Informatics

Gero-Informatics Avoids Harmful Practices, Enhances Inpatient Treatment

Cognitively Impaired Elders Leads to Creation of Informatics Solution

Informatics Solution Enables Teaching Hospital to Improve Outcomes for Seniors

Study Flowchart of Gero-Informatics Implementation

- Each time a 65+ year-old patient is admitted to a medical service, they are screened for CI and delirium by study staff
- Patients with CI and/or delirium are randomised to the intervention or control arms using the computerised order entry system
- Each time a doctor enters an order for a patient randomised to the intervention arm, the CDSS will notify the doctor of CI
- The system will then recommend a referral to the geriatric service due to CI
- If doctors order a urinary catheter at least once per day, the CDSS will suggest avoiding catheter use or discontinuing the catheter as early as possible
- CDSS then offers recommendations regarding appropriate substitutes for any inappropriate medications (either stopping the drug, suggesting an alternative, or recommending dose modification); doctors can accept, reject, or modify orders

Seniors With Cognitive Impairment

- Seniors with Cognitive Impairment, 52%
- Seniors without Cognitive Impairment, 45%


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Adding to informatics solutions, other protocol and education-driven methods can enhance inpatient care for the geriatric population such as fall prevention programmes on hospital units. With a growing link between quality indicators and insurance reimbursement, hospital executives are increasingly considering implementing these types of preventative measures to limit fall risk, assess causes for falls when they do occur, and educate families on home environment risk factors to avoid future falls.

Hospitals have come up with a variety of best practices and care models regarding fall prevention, including tactics that target patient and family education, patient-friendly technologies, and assessment-driven critical thinking by nurses and other staff.

Key to implementing these programmes is nurse buy-in on initiatives to prevent falls and identifying ways to identify those most at risk for accidents. The graphic at the top of the page depicts metrics among patients in a high fall risk category. Further, the practices at the bottom of the page outline practices hospitals have found to optimise fall prevention and management.

**Characteristics of Elderly Patients at Risk of Falls**

<table>
<thead>
<tr>
<th>Pharmaceutical Regimen</th>
<th>Medical History</th>
<th>Medical Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticoagulants</td>
<td>Cardiopulmonary change</td>
<td>Frequent toileting</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>Delirium</td>
<td>Impaired mobility</td>
</tr>
<tr>
<td>Antihistamines</td>
<td>Disequilibrium</td>
<td>Impaired vision</td>
</tr>
<tr>
<td>Cardiovascular agents</td>
<td>Hypotension</td>
<td></td>
</tr>
<tr>
<td>Nocturia-targeted</td>
<td>Musculoskeletal weakness</td>
<td></td>
</tr>
<tr>
<td>Psychotropic</td>
<td>Vertigo</td>
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</table>

**Practices to Reduce Fall Risk in Geriatric Population**

1. Automating and integrating risk assessments, such as the Heidrich II Fall Risk Model, with patient care plans using electronic documentation effective
2. Identifying systemic failures through analysis of post-fall diagnostics such as rapid diagnostic imaging protocols assist with action plan improvement
3. Creating safe toileting schedules targeting vulnerable times of day
4. Having teach-back protocols assists nurses in identifying patients with CIs
5. Using patient-centred technologies like foam chairs, Velcro alarm belts, and voice-recorded alarms
6. Educating family about education tools at admission and after falls
7. Using a multiple-room monitor model where LPNs have a clear line of sight into each targeted patient room
8. Having mandatory assisted toileting extremely effective, though it requires nurse buy-in
9. Investing in video surveillance necessary when other solutions prove ineffective

Source: United States Department of Veteran Affairs (VA), "VHA NCPS Fall Prevention and Management," (2009).
www.va.gov/NCPS/CogAids/FallPrevention/index.html (Accessed September 24, 2009); Clinical Investment Insights research and analysis.
Ambulatory Geriatric Services
Ambulatory geriatrics programmes are central to hospitals’ missions. According to leaders, these programmes not only fulfill a community need, but are often the only place that the frail elderly can receive necessary primary and chronic care. An ambulatory clinic can be located within the hospital, but executives find that ambulatory centres located in a separate facility near the hospital is more profitable. It provides patients with easy access to care and minimises transport for patients who often have trouble walking and navigating a large facility.

The first step to developing an ambulatory programme is to build a geriatrics evaluation clinic and incorporate a general practice. Executives can then focus on adding sub-specialties clinics to consolidate the most prevalent ambulatory geriatric services. To maintain profitability, the ambulatory clinic can also provide key services that raise patient activity and increase referrals, such as educational programmes, mental health screenings, and geriatrics hotlines. As adults continue to live longer—particularly the frail elderly—ambulatory programmes will likely fulfill widespread community needs by meeting increasing demand for geriatric care.

**Comprehensive Service Line Begins with Ambulatory Unit**

**Potential Locations for Ambulatory Clinic**

- Ambulatory area located away from hospital
- Ambulatory area located within hospital

**Potential Timeline for Growth of Unit**

<table>
<thead>
<tr>
<th>Early Development stages</th>
<th>Middle Development Stages</th>
<th>Late Development Stages</th>
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<tbody>
<tr>
<td>Begin geriatric service line with ambulatory services, such as a half-day ambulatory clinic. Then add a primary care clinic, which will serve as a critical referral channel for geriatric services.</td>
<td>Develop geriatric component of subspecialties across the range of service lines most frequently accessed by geriatric patients, including cardiology, orthopedics, and urology. Consider adding specialty ambulatory clinics such as memory and falls clinics.</td>
<td>Add supplementary services that focus on revenue generation, such as fitness and wellness services and patient education. Consider the addition of palliative care.</td>
</tr>
</tbody>
</table>

Source: Clinical Investment Insights research and analysis.
Primary care and ambulatory evaluations serve as the foundation of a geriatric service line. Often, patients will seek primary care or visit ambulatory evaluations clinics because they are suffering from mental conditions. Upon evaluation in an ambulatory setting, they are found to have multiple complicating conditions. Thus, the evaluations clinic and primary care practice represent critical referral channels for bringing patients to the hospital that will require revenue-generating surgeries and other procedures.

Staffing geriatric evaluations clinics involve nurse practitioners to perform initial evaluations and geriatricians to provide chronic care management by focusing on preventative measures. In ambulatory clinics, geriatricians often specialise in a specific geriatrics condition, such as dementia, rehabilitation, or Alsheimer’s and coordinate treatment pathways with other doctor specialists and GPs. Ancillary support staff involve pharmacists, social workers, and medical assistants.

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**Ambulatory Geriatrics Evaluation Clinic & Primary Care Practice**

1. Staff members send patients with upcoming appointments a form asking medical history
2. Patient meets with the geriatric Nurse Practitioner, who performs a full examination
3. Doctors meet with patients and their families after examination to discuss conditions and appropriate treatment

**Ambulatory Clinic Patient Profile**

- **Average Age:** Over 70
- **Exams Performed:** Nutritional assessments, balance scales, geriatric depression scales
- **Diagnosis of at least two conditions:**
  - Depression
  - Diabetes
  - Hypertension
  - Incontinence
  - Obesity
  - Osteoporosis

---

Source: Clinical Investment Insights research and analysis.
Ambulatory centres also offer sub-specialty clinics and supplementary programmes. Memory programmes are important given the high number of patients with Alzheimer’s Disease. A social worker often partners with psychiatrists and geriatricians to run the programme, working with families to integrate the patient back into the community. Disease-specific education is integral to both revenue generation and preventative care. Group seminars serve as advertising for the hospital to draw in new patients, while individual sessions with nurse practitioners on self-management improves independence and leads to reduced readmissions. Hospital employees can attend sessions to self-educate and learn how to handle elderly patients. A toll free senior hotline serves as a central point of intake for the hospital and generates a significant stream of referrals for hospital services. Volunteers on the hotline can address issues pertaining to medical finance as well. Ambulatory services also often include transportation services for elderly with disabilities to make sure patients receive care before serious disease progression. An cost-effective alternative is a free shared ride programme, in which the hospital partners with the municipal government and other medical centres to enable geriatrics patients to receive public transportation.

Case in Brief: Hospital Builds Memory Centre to Address Alzheimer’s Disease

- Institution: 300-bed, not-for-profit community hospital located in the Midwest
- Hospital established a memory centre for seniors experiencing cognitive changes and memory loss with a focus on Alsheimer’s Disease
- Multidisciplinary staff consist of psychiatrists, a psychiatric nurse, nurse practitioner, family counselor, and Alsheimer’s educator
- First time patients, accompanied by caregivers, undergo a one-two hour initial diagnostic assessment, including physical examination, psychiatric evaluation, and neuropsychiatric screening
- The centre also provides ongoing medication management for seniors, in addition to educational sessions and ongoing support for family caregivers

Source: Clinical Investment Insights research and analysis.
Given the current focus on preventing unnecessary readmissions, hospital executives are increasingly considering implementing services linking geriatric care with orthopaedics, neurosciences, and rehabilitation by creating gait and balance programmes as part of the scope of hospital ambulatory geriatric services.

These programmes vary in focus but often target elderly patients who have suffered a stroke and have impaired walking ability, those who have suffered a fall in the past year, patients who are on new medications or a large number of medications, and individuals with impaired vision.

Gait enhancement programmes can provide analysis of functional gait, balance drills incorporating strength and movement training, exercise programmes focusing on leg strength and range of motion, posture training for those who have curvature in their backs, and shoe choice discussions for ankle stability depending on patients’ individual needs.

**Case in Brief: Gait and Balance programme Incorporating Easy Street Village Model**

- 200-bed, not-for-profit, minor teaching hospital located in the Northwest using Easy Street model as part of their Gait Enhancement Programme (in place since 1989)
- Programme targeted toward the elderly and those with neurological problems and is intended to reduce injury risk from falls by improving mobility skills and balance
- Physical therapists (two .5 FTEs) perform gait training using an Easy Street Environment within the PT gym at the hospital’s centre for Medical Rehabilitation (average number of visits is six per patient)
- Easy Street’s mock theater, grocery store, and household carpets of different thicknesses teach patients how to walk on various surfaces and approach curbs in a safe manner
- Referrals largely from primary cares, neurologists, and patient word-of-mouth or self-referrals

**Gait and Balance Programme Overview**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Assessment</td>
<td>During programme</td>
<td>Final Assessment</td>
<td>Follow up</td>
</tr>
<tr>
<td>One hour initial assessment involves staff taking patients’ general medical history</td>
<td>Patients come back to the Gait Enhancement programme for subsequent hour-long visits on a weekly basis for 4 to 8 weeks</td>
<td>On the last visit, staff conduct a retest comparing the results of the first assessment on balance scales, walk tests, and dynamic strength tests to their final scores to measure outcomes</td>
<td>Follow-up at home on a daily basis for approximately two months or longer is expected as part of the programme</td>
</tr>
</tbody>
</table>

Source: Clinical Investment Insights research and analysis.
Hospitals are also implementing senior membership or affinity programmes with more frequency as part of their suite of geriatrics services. These programmes can include some elements of ambulatory clinic activities such as assessments, various screenings, memory programmes, and educational sessions. Some programmes also include transportation services to the hospital, durable medical equipment (DME) services, medication reviews and even home visits. Members typically join these programmes for a small fee and seniors often use them as a way to remain physically and mentally fit and active in the community; as such, many membership programmes include non-medical offerings such as exercise or gym memberships, social events with other seniors to maintain ties with others, or educational dinners where various topics (such as a heart healthy diet or maintaining memory) are presented by hospital staff.

These programmes, while not largely profitable, can offset some losses incurred through other geriatric services and provide other downstream benefits to the hospital such as enhanced brand recognition and loyalty. Additionally, screenings through affinity programmes can result in some downstream revenue.

**Affinity and Membership Programmes**

**Affinity Programmes Create Hospital Loyalty, Referrals Through Membership**

**Gait and Balance, Fall Prevention Programmes Target Issues Among the Elderly**

**Sample Affinity Programme Staffing**

- **Director**: Oversees the programme
- **Clinical nurse specialist** (1 FTE)
- **Education coordinator/nurse** (0.8 FTE): conducts community case management and health coaching
- **Nurse Practitioner** (0.1 FTE): performs rounds in affiliated nursing homes; contracted and not employed directly by the programme
- **Programme assistant** (1 FTE): assists with special events and administrative tasks
- **Social worker** (1 FTE): creates newsletter for caregivers, takes intake calls and other phone calls from members with questions
- **Volunteers**
- **Walking programme coordinator** (0.4 FTE)

**Survey Results from Hospital Senior Programme Members**

Where Elders Prefer to be Hospitalised for Medical Services

- **Hospital with membership programme, 60%**
- **Other Hospital, 40%**

**Case in Brief: Spirit of Women Membership Programme**

- Spirit of Women is a network of over 80 U.S. hospitals that is based on the premise that women make most of health care decisions for families
- Individual hospitals join the network for an annual fee and are provided a toolkit of programmes and templates that allow institutions to choose strategies, best practices, and educational programmes
- Programme has experienced 30 percent growth each year
- Hospitals aim to track downstream benefits of Spirit of Women by, for example, asking when patients are admitted to the hospital if they are a Spirit member and keeping records of what services members utilise

**Source:** Clinical Investment Insights research and analysis.
Given low reimbursement and significant costs due to build-out, staffing, and operations, ambulatory programmes are generally not profitable and are “money losers” although they produce downstream referrals to specialty departments. The ambulatory unit can be complemented by geriatric services, such as fitness and wellness services, for which patients will need to pay out-of-pocket. By offering these services, the hospital attracts younger, healthier patients willing to pay to stay healthy, instead of solely caring for frail geriatric patients with chronic conditions that can be cost drains to the service line. Also, supplementary services raise self-referrals, and patients will return to the hospital for inpatient stays and surgeries, which are more profitable than ambulatory procedures. To defray cost, the ambulatory programme can also partner with community organisations and long term facilities, in addition to soliciting donations by maintaining relationships with patient families. Other strategies to increase profits include performing low-risk procedures at doctors’ offices and aligning private ambulatory clinic with the hospital.

**Different Strategies to Increase Profitability, Mitigate Costs**

- **Focus on Fitness and Wellness Centre**
  - Services include medically focused fitness centre, preventative screenings, and education programmes that seniors pay out-of-pocket
  - Programme attracts seniors looking to stay healthy - most profitable geriatric population

- **Partner with Community Organisations**
  - Staff can establish relationships with patients and families of patients to incentivise donations, charitable bequests upon patient death
  - Hospital can form partnerships with community organisations and health care providers to attract further donations

- **Perform Low-Risk Procedures in Doctor Offices**
  - Minimally invasive procedures, such as joint injections, can generate considerable revenue when performed in doctor offices

- **Convert Ambulatory Practice to Hospital-Affiliated Clinic**
  - Hospital receives higher reimbursement if ambulatory geriatric services performed at hospital-affiliated clinic instead of private practice associated with hospital

Source: Clinical Investment Insights research and analysis.
Geriatric Services Integration
The transition from the hospital to a post-acute facility can be difficult for seniors and a process fraught with lapses in communication for hospitals and PAC facilities. Hospitals and various post-acute providers, even if home health agencies or SNFs are owned by the hospital, often do not have the same electronic medical record system, which can result in missing or incomplete patient information. Further, as patients retain the right to select the PAC provider they prefer, hospitals must work with an often large and disparate group of facilities that they may or may not be closely aligned with.

Given these challenges, progressive programmes are dedicating FTEs to the patient transition process, whether discharge planners, nurse liaisons, or “transition managers” as they are deemed at the institution described in the case study to the right. These staff can meet with patients before they leave the hospital to assess their needs, ensure that information is passed through the right channels, and follow-up with patients once they reach their PAC destination. This process is often assisted by the home health agency or SNF as well when these facilities send their staff to the hospital in advance of the patient’s move out of the institution.

### Primary Duties of Transition Managers in Hospital to PAC/Home Transfer

- Coordinate with HHAs, SNFs, assisted living facilities, and LTACHs to facilitate the hospital discharge process and information transfer
- Look at readmission rates for areas of improvement
- Visit patients in various PAC facilities to assess patients’ recovery progress
- Facilitate appointment scheduling with the ambulatory geriatric clinic to further avoid likelihood of readmission

### Case in Brief: Geriatric Hospital Utilising Care Transition Managers

- 100-bed, not-for-profit minor teaching geriatric hospital
- Geriatric hospital uses transition managers as part of a pilot project who work with home health agencies the hospital often uses, several local skilled nursing facilities, and hospital-owned assisted living facilities and long term care hospitals
- On a weekly basis, transition managers look at 30-day readmissions and analyse which are unavoidable versus avoidable
- Managers aim to schedule patient appointments with the geriatric ambulatory clinic within one week of hospital discharge
- The hospital improved the information transfer process between the main facility and home health agencies by establishing a protocol of what data is needed by the HHA on the patient’s condition, who the information is sent to, and how information is transmitted
To further assist patient transitions to post-acute care and build a robust geriatrics programme that is well aligned with community providers that manage patients after they leave the hospital, progressive programs are working to build stronger relationships with PAC facilities in their local area. As preventing unnecessary readmissions is top-of-mind for hospital leaders as well as determining the most appropriate treatment location for patients in an era of health reform, these partnerships are even more important.

To strengthen these relationships, hospitals may develop contractual relationships with SNFs, home health agencies, LTACHs, and other community organisations; these contracts can involve giving hospital staff opportunities to take on stretch roles such as medical directorships at SNFs or nursing homes or research coordinator positions. These roles give staff insights into the challenges faced at other facilities, enabling them to provide better care at the hospital before patients reach these institutions. Such partnerships can also lead to increased hospital donations and referrals: in the case study to the right, hospital doctors round at four nursing homes but have relationships with 10 of these facilities who routinely admit to them when patients require care.

**Work with Nursing Homes to Provide Higher Quality Care, Garner Referrals**

**1,430-Bed, Not-for-Profit AMC in the Northeast Region of the United States with Robust Geriatric Programme**

- **Multidisciplinary Consultations**
  - Hospital doctors provide multidisciplinary consultations at the nursing home on geriatric conditions, psychological issues in coordination with NH social workers

- **Hospital Doctors Working on NH Floors**
  - Hospital doctors round on the nursing home floor to address any complex concerns

- **Hospitalist Service Serving Nursing Homes**
  - Hospital maintains inpatient hospitalist service that provides care for four local staffing model nursing homes
  - This allows NH doctors to remain at the facility rather than having to travel to the hospital to see their patients

- **Educational Services**
  - Hospital staff provide best practices education to nursing home staff, medical directors
  - The hospital also brings medical students and fellows to the nursing home visits as well as house calls to educate them about issues specific to the senior population

**Source:** Clinical Investment Insights research and analysis.
In addition to home health, house call programmes are another method by which hospitals are investing in comprehensive geriatric care in the affordable setting of the patient’s home. Though doctor house calls have declined over the last 70 years due to liability concerns and the perception that these programmes are not profitable or well reimbursed, the homebound population continues to rise, prompting some progressive programmes to invest in providing these services. In fact, JAMA estimates a 43 percent increase yearly in house calls from 1998 to 2004 (over 600,000 per year).

House calls are largely “low-tech” visits from doctors that include cognitive, functional and physical examinations, medication management, vaccinations, and lab testing, though they can include tests such as EKGs, Holter monitors, pulmonary function tests, X-rays, echocardiograms, and ultrasounds. As technologies continue to advance, services on doctor house calls may become more progressive for homebound seniors.

In addition to preventing travel to the hospital for this frail elderly population and allowing seniors to “age in place,” house calls can be a cost effective way to provide care.

### Need for House Call Programmes Great Among Elderly

#### Many Patients Not in Nursing Homes with Equal Functional Dependency, Medical Complexity

- 1.5M Patients in Nursing Homes
- 4.5M Patients not in Nursing Homes

#### AMC Doctor House Call Programme Generates Profit Due to Hospitalisations Among Cohort

- $1,411 Cost per Patient
- $335 Revenue per Patient
- $3,670 Revenue from Patient Hospitalisations

Though the house call programme made up for only 24 percent of its costs through billing for home services, subsequent IP/OP visits from these patients enabled an average $2,927 contribution margin.

### Case in Brief: Doctor House Call Programme at Academic Medical Centre (AMC)

- 1,200-bed, not-for-profit AMC in the Northeast region in the United States implementing a doctor house call programme annually seeing 1,000 patients
- Programme employs 10 doctors (5.7 FTEs), 3 NPs (2.1 FTEs), 1 PA (0.7 FTE), 2 nurses, 2.6 FTE social workers, 5 clerical staff, and 1 data analyst
- Doctors and NPs, conduct four home sessions per week that are comprised of 5 to 6 visits, and each have approximately 90 to 100 patients that are geographically located near each other
- Affiliated medical school funds 15 percent of the programme while the hospital funds 85 percent (grant support covers roughly 7.5 percent)
Telemedicine is another method by which hospitals can continue to treat and manage geriatric patients outside the hospital setting. Telemedicine can include any programme in which staff follow-up with patients over the phone, whether staff are manually calling patients or an automated phone call is placed. Similarly, remote monitoring can include devices that track patient vital signs, such as blood pressure and heart rate, either actively or passively. Telemanagement can benefit both patients and clinicians by effectively transmitting these vital signs quickly and accurately. By using telemedicine technology to gather this information, patients become more educated on their illness and likewise become actively involved in their treatment. Through telemedicine and remote monitoring, an open line of communication between the patient and their health care providers increases the clinician’s awareness of the patient’s condition, allowing them to intervene quicker if conditions take a turn for the worse.

Remote monitoring and telemedicine are most frequently used to measure patient vital signs—blood pressure, weight, and pulse oximetry—especially among patients with chronic diseases like heart failure and diabetes. If a significant change in vitals occurs, the device alerts the patient's doctor.

### Primary Uses for Remote Monitoring

<table>
<thead>
<tr>
<th>Study Examining Vital Signs Measured Using Remote Monitoring</th>
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<tbody>
<tr>
<td>Blood Pressure</td>
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<td>100%</td>
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**Telemedicine and Remote Monitoring in Brief**

- **Real-time telemedicine:** any technology through which patient and provider maintain live connection and interact in the moment (ex: videoconferencing)
- **Store-and-forward telemedicine:** any telecommunications device that collects patient data, stores it temporarily, and transmits it to providers for analysis
- **Remote monitoring:** any device that keeps health providers and patients connected regardless of location
  - Devices can track patients’ vital signs and provide educational materials
  - Technology can transmit data to providers’ system and alert providers to abnormalities
Telemanagement can be utilised in geriatrics services in a number of ways spanning the inpatient setting to the ambulatory and home setting. Telemedicine is often used in the management of HF patients either from an ambulatory HF clinic or staff within the hospital monitoring patients once they return home.

These HF remote monitoring programmes can include dedicated nurses who call patients on schedules based on acuity or comprehension of discharge instructions and medications. Nurses may also be dedicated to analysing any data that comes in from automated telemedicine devices such as the Pharos system in which data on weight and blood pressure is collected using a scale linked to wireless transmission capability; other vendors in this space include McKesson’s Telehealth Advisor and Cardiocom’s Telescale.

Having dedicated staff for remote monitoring ensures that nurses develop relationships with patients and that the often high activity of HF patients is contacted regularly. Interviewed executives noted that patient selection is a vital component of any telemanagement programme as not all heart failure patients require regular follow-up for an extended period of time.

**Case Example of Heart Failure Telemanagement Programme**

**Transition to Ambulatory Care**
- Inpatient care managers hand off patients with HF who have been discharged from the hospital to the ambulatory telemanagement team using the hospital’s electronic medical record
- Hospital sees approximately 1,800 HF patients per year

**Telemangement Team**
- Telemanagement team comprised of 5.5 FTE ambulatory clinical care coordinators who are fully dedicated to telemanagement and have prior experience working with HF patients
- Patients participate in the telemanagement programme if they have been in the hospital during the past 18 months

**Patient Classification**
- Patients are assigned a priority level for phone follow-up based on a 7-item algorithm that predicts their risk for readmission
- Algorithm developed by nurses and the programme director
- Patients given a scale (if needed) and a blood pressure cuff
- Patients initially called within 2 days of discharge

**Follow-Up Calls**
- Follow-up call schedules range from 2-3 times per day to once every 2 months
- Coordinators communicate lab results and titrate medications
- Telemanagement programme has significantly reduced readmissions to the hospital ED for highly acute HF patients

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Source: Clinical Investment Insights research and analysis.
For elderly heart failure patients, small changes in health status such as weight or fluid retention can pose significant risks, highlighting the ways that telemedicine can assist these patients; by alerting clinic, hospital, or home health staff to any worsening symptoms in advance, remote monitoring devices or telemanagement systems can prevent readmissions and significant worsening of patient conditions through interventions in diet or visits to an ambulatory setting.

Further, telemedicine for elderly patients is a more cost effective way to provide care than frequent hospital visits and seniors largely prefer to remain at home, which telemedicine allows them to do. However, telemedicine has not been as widely adopted outside progressive centres due to its sometimes high costs—depending on the modalities used—and the limited evidence on return-on-investment. Hospitals struggle with determining which patients would be most appropriate and compliant with telemedicine capabilities as well, since many seniors have limited health literacy and a lack of a family support system. Further advances in these technologies will likely increase adoption rates as well as increasing willingness of insurers to reimburse for these devices in the chronic disease management senior population.
In the future, researchers anticipate that telemedicine and remote monitoring capabilities will have even further applications in the home for geriatric patients by being able to detect information on daily mobility, sleep patterns, and medication adherence. This data can be used to assess overall health as well as detect any early signs of cognitive decline, dementia, or Alzheimer's disease. These monitors and sensors, however, are far into the future as many programmes are only beginning to put some basic remote monitoring solutions to use.

Nevertheless, the projected growth of telemedicine is evident. Studies from InMedica, the medical research division of IMS Research, predict that, by 2013, shipments of home-use telehealth devices like digital blood-glucose meters and pulse oximeters will reach two million in the United States (U.S.). In fact, the U.S. has been on the forefront of the application of telemedicine in many areas; for example, the Veterans Association is the single largest user of remote monitors to date with more than 30,000 subscribers for these devices. As the importance of reducing readmissions and cutting costs continues into the reform era, hospitals will likely look into whether they consider these technologies viable opportunities.

Remote Technologies for the Elderly to Grow, Have Expanded Capabilities

Home Technologies to Detect Mental Status Declines, Mobility

- Hallway sensors monitor gait and mobility
- Computer kiosk assesses cognitive function
- Sensors capture variations in mobility

Future Forecasting of Remote Monitoring Devices

- Blood Glucose Monitors
- BP Monitors

- 2009: 50,000
- 2013: 500,000
- Under 25,000: 300,000

Case in Brief: Oregon Centre for Ageing and Technology (ORCATECH)

- Part of the Oregon Health & Sciences University located in Portland, Oregon
- Established in 2004 to provide an infrastructure for developing technologies to support independent ageing
- Partners with senior living communities to provide living laboratories for testing home-care technologies
- ORCATECH research funded by National Institute on Aging and Intel Corporation
- Programme studies leverage longitudinal data generated by home-based seniors to detect early onset of dementia, Alzheimer's disease

Conscious Marketing Efforts Foster Patient Loyalty

Marketing geriatric programmes specifically—whether a membership programme or progressive inpatient and ambulatory services—can redefine the hospital as a destination of choice for elderly individuals. While geriatric patients are often not the most profitable population aside from the niche cardiovascular or orthopaedic procedures they require, by promoting this level of high quality care, hospitals can enhance patient loyalty to the health system brand and bring in additional patients who may require more profitable procedures down the line. Few hospitals have tracked the quantifiable downstream revenue brought in from these patients after they seek out other geriatric services like assessments and routine care, though interviewed programmes continually cite the benefits these programs bring to the community and the hospital as a whole. Seniors who visit the hospital regularly for services or are members of an affinity programme may even give back to the hospital by serving as volunteers, for example.

There are a number of ways these programmes are advertised to potential patients and the community. Executives noted to not underestimate the power of word of mouth among seniors as well to informally market the programme.

Marketing Tactics Enhance Geriatric Services, Senior Membership Programmes

**Marketing Tactics**

**Advertising**

- Website advertising increases brand awareness to a broader population
- Radio shows featuring geriatric programme staff
- Newspaper advertisements or brochures at senior centres to enhance geriatric programme activity
- Quarterly newsletters, magazines, or e-blasts featuring upcoming programmes and new discounts

**Outreach**

- Staff promoting the programme to seniors on hospital floors and in the community
- Community Senior Health Coalitions submitting articles for local newspapers about the programme
- Partnering with local businesses to advertise specialty programmes and screenings

**Reputation Branding**

- Word of mouth among seniors
- Decals for car windows to foster logo and name recognition for the hospital
- Personal postcard invitations sent to senior membership programme participants prior to upcoming events

**Major Benefits of Marketing, Promoting Geriatric Services**

- Enhanced patient loyalty to the hospital
- Downstream revenue resulting from other CV, ortho, or neuro procedures this patient population may require satisfied seniors may give back to the hospital by serving as volunteers
- High quality reputation in geriatrics may enhance the hospital's reputation as a whole

Source: Clinical Investment Insights research and analysis.
Models and Case Profiles
### Best Practices for Geriatric Programme Development

1. **Determine geriatric service offerings based on need assessments**
   - In order to successfully implement an effective geriatrics programme, a hospital must be aware of its community needs.
   - Several health systems have utilised needs assessments to determine which geriatric services have the highest demand.

2. **Garner high geriatric patient activity through geriatric assessment services**
   - Geriatric assessments are comprehensive examinations performed by geriatricians to identify new and existing problems associated with ageing.
   - Hospitals can use these assessments to introduce their specialised geriatric care to the local community.
   - Ambulatory geriatric assessment services can be a first step in building a geriatric service line.

3. **Enhance geriatric programme outreach to create downstream benefits**
   - Geriatric programmes are usually not profitable, but they remain a wise investment due to the downstream benefits they can provide.
   - Geriatric patients may require additional hospital services, often increasing patient activity and creating downstream revenue.
   - Geriatric programmes can reduce readmission rates, presenting cost savings opportunities for hospitals.

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### Models and Case Profiles Overview

- **Inpatient and Ambulatory Geriatric Service Models:** This profile gives a brief overview of the different inpatient and ambulatory services a hospital can as part of a comprehensive geriatric service line; the benefits and drawbacks of each service offering are also highlighted.

- **Gait and Balance Programmes:** Three hospitals’ gait and balance programmes were profiled in order to illustrate the range of services a hospital must decide whether or not to include. These profiles also outline the necessary infrastructure and staff for successful programme development.

- **Affinity and Membership Programmes:** Four hospitals’ affinity and membership programmes were profiled to highlight the variety of programme services a hospital can offer. These profiles offer insight into the different ways hospitals have marketed their various services and the potential downstream benefits these programmes offer.

Source: Clinical Investment Insights research and analysis
Geriatric Programme Background

Geriatric Services Variable or Fragmented Across Many Hospitals

Hospitals Today Provide Geriatric Care to Patients Through a Variety of Programme Structures

### Inpatient & Ambulatory Geriatric Service Models

<table>
<thead>
<tr>
<th>Model</th>
<th>Components</th>
<th>Benefits</th>
<th>Drawbacks</th>
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<tbody>
<tr>
<td>Geriatric Inpatient Unit</td>
<td>• Involve dedicated hospital beds and support staff&lt;br&gt;• Unit services can include:&lt;br&gt;  - Cardiology&lt;br&gt;  - Orthopaedics&lt;br&gt;  - Urology and incontinence services&lt;br&gt;• Staff are typically geriatric specialists&lt;br&gt;• Unit nurses require additional training to accommodate geriatric patients</td>
<td>• ACE care is comprehensive and focused on prevention and early treatment&lt;br&gt;• Units can reduce unnecessary patient readmissions&lt;br&gt;• Patients experience decreased LOS, better quality of life</td>
<td>• Not fully occupied units create an inefficient use of beds&lt;br&gt;• It is difficult to train nurses to deliver care to a wide range of medical conditions; patients may be better off with individual hospital specialty care</td>
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<tr>
<td>Geriatric Assessment Centre/Ambulatory Clinic</td>
<td>• Assess seniors’ ability to live independently by analysing overall health, living situation&lt;br&gt;• Examines cognitive, medical, psychological, and social functioning&lt;br&gt;• Assessment centre and OP clinics involve appointments with the following individuals:&lt;br&gt;  - Dieticians&lt;br&gt;  - Geriatricians&lt;br&gt;  - Gerontological nurse practitioners (NPs)&lt;br&gt;  - In-home specialists&lt;br&gt;  - Social workers&lt;br&gt;• Can incorporate home visits, functioning exams performed at an ambulatory facility, follow-up appointments from hospital stays, meetings with family members</td>
<td>• Service can generate downstream revenue for hospitals by garnering specialist referrals in areas such as orthopaedics and cardiology&lt;br&gt;• Clinic provides care in an ambulatory setting that is accessible for patients</td>
<td>• Assessment requires additional time and staffing, and services are not generally profitable</td>
</tr>
<tr>
<td>Geriatric General Practice</td>
<td>• Services often offered in a separate building from the hospital&lt;br&gt;• Patients may be seen by geriatric doctors, social workers, or NPs&lt;br&gt;• Care involves initial assessments that can last several hours and follow-up appointments&lt;br&gt;• Ambulatory services can include:&lt;br&gt;  - Alzheimer’s and dementia evaluation&lt;br&gt;  - Fall treatment&lt;br&gt;  - Ophthalmology&lt;br&gt;  - Radiology services&lt;br&gt;  - Urinary incontinence evaluation</td>
<td>• Practice serve as referral channels to bring patients requiring revenue-generating procedures to the hospital&lt;br&gt;• A separate facility provides easy access to care and minimises transport and concerns with frail patients navigating large facilities</td>
<td>• Executives must add fee-for-service components to the practice, such as fitness and wellness programmes, to negate the lack of profitability</td>
</tr>
<tr>
<td>Geriatric Affinity Programme</td>
<td>• Provides educational, wellness, and recreational programmes to seniors&lt;br&gt;• Activities designed to improve and maintain health, encourage social interaction, and stimulate the mind (generally ages 50 and up)&lt;br&gt;• Programmes often offered free of charge or for a one-time fee if services such as consults or screenings are included</td>
<td>• Programme enhances senior care and prevents the need for more advanced medical services in some cases&lt;br&gt;• Service helps increase awareness for other hospital services&lt;br&gt;• Care promotes loyalty to hospital among members, future referrals</td>
<td>• Service requires additional time and staffing, and services are not typically profitable</td>
</tr>
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Balance, Fall Prevention Programme Structures Vary, but Largely Serve Seniors

Gait and Balance Programmes Across the United States Have Varying Focuses

### Gait and Balance Programmes

<table>
<thead>
<tr>
<th>Institution</th>
<th>Services and Centre Features</th>
<th>Required Investment/Staff</th>
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</thead>
<tbody>
<tr>
<td><strong>Neuro Rehab and Balance Centre</strong>&lt;br&gt;(350-bed, not-for-profit teaching hospital in the Midwest U.S.)</td>
<td>• Ambulatory rehab centre located inside a system facility that focuses on neurological and balance disorders&lt;br&gt;• Employs 15 staff members (PTs, Orthotists, etc.)&lt;br&gt;• Conditions addressed within the centre:&lt;br&gt;  − Cerebral palsy, stroke, multiple sclerosis (MS)&lt;br&gt;  − Vestibular disorders&lt;br&gt;  − Parkinson’s disease&lt;br&gt;  − Amyotrophic lateral sclerosis (ALS)&lt;br&gt;• Services:&lt;br&gt;  − Pelvic floor therapy for incontinence issues&lt;br&gt;  − Physical therapy (PT) for vestibular problems&lt;br&gt;  − Occupational therapy (OT) and speech therapy (ST)&lt;br&gt;  − Post-concussion treatment&lt;br&gt;  − Neuro-wellness services&lt;br&gt;  − Post-rehab services&lt;br&gt;  − Wheelchair, brace/splint evaluation&lt;br&gt;• Aims to achieve 13,000 visits in its first year</td>
<td>• 15,000-sq. ft., 41.4 million space&lt;br&gt;• Executives purchased $500,000 in specialised equipment for the centre&lt;br&gt;  − Including: SMART EquiTest, where patients enter a booth and stand on a sensor-equipped plate that detects how individuals overcompensate for balance problems or are off-balance without the aid of visual cues&lt;br&gt;  − Overhead harness and track systems suspended from the ceiling</td>
</tr>
<tr>
<td><strong>Balance and Fall Prevention Programme</strong>&lt;br&gt;(275-bed, not-for-profit community hospital in the Midwest U.S.)</td>
<td>• Clinicians conduct interview about patients’ home environment (recommend bathroom safety equipment or walking assistance)&lt;br&gt;• Individualised programmes are designed to include strengthening and balance exercises, gait retraining, and safety education&lt;br&gt;• Patient population:&lt;br&gt;  − Those with low blood pressure or a recent acute illness&lt;br&gt;  − Individuals starting a new medication or taking 4+ medications&lt;br&gt;  − Those with a history of falls in the past year&lt;br&gt;  − Poor posture, decreased strength or joint motion&lt;br&gt;  − Urination frequency or poor vision</td>
<td>• Staff include Ots, PTS, and other rehab specialists&lt;br&gt;• These staff work in conjunction with patients’ GPs to ensure treatments continue long-term</td>
</tr>
<tr>
<td><strong>Movement Disorders &amp; Parkinson’s Care Programme</strong>&lt;br&gt;(350-bed, not-for-profit teaching hospital in the Northeast U.S.)</td>
<td>• Programme’s diagnostic and therapeutic rehab services provided through a local rehab hospital and the Neuroscience Institute&lt;br&gt;• Therapy services include the following:&lt;br&gt;  − Speech and language therapy address cognitive, communication, voice, and swallowing problems&lt;br&gt;  − PT enhances muscle strength, balance, coordination, endurance and range of motion&lt;br&gt;  − OT improves activities of daily living (ADLs) for elderly individuals such as dressing and bathing&lt;br&gt;• Gait and balance centre within the programme treats balance and walking abnormalities:&lt;br&gt;  − Focuses on fall prevention and mobility training to enhance safe mobility and decrease the risk of falls&lt;br&gt;• Programme also affiliated with the medical neurology department</td>
<td>• Innovative technologies used with gait and balance centre&lt;br&gt;• Staff investment&lt;br&gt;• Deep Brain Stimulation (DBS) provided for Parkinson’s disease, tremors, and dystonia through affiliated neurosurgery department</td>
</tr>
</tbody>
</table>

Source: Clinical Investment Insights research and analysis.
Affinity and Membership Programmes Serve Screening, Education Needs

Senior Membership Programmes Can Take a Variety of Forms and Include a Wide Range of Services

### Sample Affinity and Membership Programmes

<table>
<thead>
<tr>
<th>Institution</th>
<th>Senior Programme Services</th>
<th>Dedicated Space?</th>
<th>Outreach Methods</th>
<th>Downstream Benefits</th>
</tr>
</thead>
</table>
| 125-bed, state-run community hospital located in the Midwest U.S. | • Cafeteria, pharmacy, and hospital gift shop discounts  
• Claims assistance and document checks  
• Prescription reviews  
• Blood pressure screening in the ED/A&E  
• Wellness facility discount  
• Durable medical equipment (DME) and optometrist discounts  
• Bone density and blood-flow screenings  
• Transportation service to drive patients to their appointments | No | • Word of mouth advertising among seniors  
• Staff advertising the programme to seniors on hospital floors  
• Website outreach  
• Quarterly newsletter | • Centre enhances hospital brand awareness  
• Light activity as a result of screenings  
• Loyalty to visiting the hospital for any medical need |
| 300-bed, not-for-profit community hospital located in the West U.S. | • Health screenings, including:  
  - Full lipid panel  
  - Bone density  
  - Weight and body mass index (BMI)  
  - Cholesterol  
• Education sessions on smoking cessation and other relevant topics | Only a designated office area | • Local businesses partnering with the hospital to advertise the programme  
• Quarterly magazine  
• Monthly newsletter  
• Newspaper advertisements  
• Personal invitations to screening events on postcards  
• Monthly e-mail blasts | • Programme serves to advertise the hospital’s scope of services  
• Offerings Increase patient comfort level with the hospital |
| 200-bed, not-for-profit minor teaching hospital located in the Northeast U.S. | • Health screenings including: osteoporosis, cholesterol, and diabetes  
• Education sessions on topics such as:  
  - Maintaining a healthy heart  
  - Osteoporosis  
  - Pain management  
  - Fall prevention  
• Social events including dances, lunches, and other entertainment options | No | • Newspaper listing  
• Brochures and direct mailings advertising upcoming events, including a monthly calendar  
• Word of mouth advertising (80%) | • Loyalty to visiting the hospital for any medical need  
• Seniors often give back by serving as volunteer staff for the programme  
• Relationships enhanced with local ageing counsel and assisted living facilities |
| 175-bed, not-for-profit minor teaching hospital located in the Northeast U.S. | • Inpatient geriatric consults  
• Ambulatory programmes: memory and geriatric assessment  
• Community and hospital-wide geriatric nurse education  
• Work with assisted living patients | Yes | • Public relations department sends out newsletters  
• Website advertising  
• Senior centre brochures  
• Word of mouth  
• Newspaper ads  
• Radio shows | • Hospital staff awareness increased for geriatric issues  
• Seniors’ comfort level enhanced with the hospital  
• Likelihood of recommending the hospital increases |

Source: Clinical Investment Insights research and analysis.