A Roadmap to Successful Geriatric Emergency Department Accreditation Across a Healthcare System

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Introduction

In 2020, the US Census Bureau released updated data on the United States aging population, which has grown by over a third (34.2% or 13,787,044) since 2010[1], driven by a variety of factors including aging of Baby Boomers, increased longevity and lower fertility rate[2].

A global pandemic of historic proportions has constrained the healthcare ecosystem in systemic ways that are still reverberating throughout the country and world: staffing shortages, staff burn-out, lack of in-patient beds, increased boarding times in the emergency department, and decreased access to preventative care services, among many other impacts.

Avoidable hospital admissions and readmissions for older adults is incredibly costly. It is estimated that potentially avoidable readmissions cost Medicare $17 billion a year[3]. As a result, reducing potentially preventable emergency department (ED) visits and subsequent hospitalizations or readmissions has become a priority for Medicare and other value-based care organizations, as the reimbursement landscape shifts away from fee-for-service to value-base care[4].

Such a confluence of factors: the aging demographic, constrained healthcare resources, and changing reimbursement landscape, has resulted in many healthcare systems placing a wide-scale, strategic emphasis on caring for older adults.

Emergency Departments, specifically those that address the needs of older adults, are one tactic that healthcare systems are utilizing to reduce avoidable hospitalizations and connect older adults to appropriate outpatient resources. Recognizing the need to address the unique health concerns of older adults, in 2014 the American College of Emergency Physicians (ACEP) created [Geriatric Emergency Department (GED) Guidelines](#) and soon followed with an [Accreditation Program](#). Per the GED guidelines, a primary goal of the GED is to "recognize those older patients who will benefit from inpatient care, and to effectively implement outpatient care for those who do not require inpatient resources[5]."

Early adopters of healthcare system-wide GED accreditation include Advocate Aurora Health, Cleveland Clinic, Dartmouth-Hitchcock, Kaiser Permanente, the Mayo Clinic, Northwell Health, University Health Network - Toronto, the Veterans Administration and Yale New Haven Health, among others. All of these systems have recognized that Geriatric Emergency Department accreditation throughout their healthcare systems will dramatically improve the quality of care older adults receive in their communities, while also resulting in reduced hospitalizations.

Purpose

What follows is a roadmap that provides an overview of these key steps necessary to successful system-wide implementation of GED accreditation. This roadmap was created for individual GED administrative and clinical leaders (MD, RNs) who are interested in the process of accreditation throughout their entire healthcare system but may not have any idea where or how to start the accreditation journey.

For information on how to implement an individual geriatric emergency department, please see: [A Practical Guide to Implementing a Geriatric Emergency Department](#).

Steps to Successful GED Accreditation Across a System

Collectively, early adopters of healthcare system-wide GED accreditation, have followed a similar six-step journey towards successful GED accreditation across their systems:

1. Garner executive leadership support
2. Build interdisciplinary and cross-site teams
3. Generate Buy-In
4. Integrate older adult triage, screening and treatment tools within standard workflows and electronic health records (EHRs)
5. Begin and complete the GEDA Application Process
6. Create standardized outcome metrics and management dashboards

Step #1 - Garner Executive Leadership Support

The first step towards successful system-wide GED implementation is to garner executive leadership support from your health system's Chief of Emergency Medicine/Emergency Department Chair, Chief Medical Officer, and/or Chief Executive Officer.

To garner executive support, create a business case which clearly addresses the top priorities facing your executive-level leaders (ie: "C-suite") and how GEDs are a tactic to support system-level strategies. Articulate how good geriatric emergency care translates to a broader vision (such as alignment with value-based care, improving quality metrics, reducing readmissions or enhancing the patient experience) and can solve pain points that your hospital or health system are currently experiencing. For example, GEDs can help optimize your hospital's census management. If your hospital's beds are full, GEDs can help direct patients to outpatient care settings, avoiding hospitalizations and thus freeing up space for higher-acuity and higher revenue-generating patients.

Make sure to provide data to back up your ideas in your business case. Articulate the need for a GED to serve your hyper-local patient population with census data on older adult patients, such as: total ED Visits for those 65+, average length of stay (LOS), 72 Hour Return Visits, 30 Day Return Visits, and ED Admissions for those 65+. For example, Northwell Health built a dashboard to show year-over-year, year-to-date, volume of ED visits per hospital for those aged 65+ when working with their executive leadership team to determine where and how best to prioritize implementation of GEDs across their system (Fig. 1).

Showcase impact of GEDs in your business case. There is a growing body of literature that supports the outcomes of GEDs to lower cost, improve quality and improve the patient experience:

- Up to 16.5% reduced risk of hospital admission[6]
- Up to 17.3% reduced risk of hospital re-admission[7]
- $3,202 savings per Medicare beneficiary after 60 days[8]
- Decreased odds of 30 and 60 day fall-related ED revisit with PT services[9]

- 87.3% satisfaction with the clarity of discharge information and perceived wellbeing[10]
- 21 studies showcasing improved experience across a variety of interventions[11]
- 25 hour decrease in length of stay for admitted patients[16]

Finally, understand the financial impact of your proposal and the resources that will be required. Make sure your business case and elevator pitch are in language that executive leadership will understand. For additional recommendations about how to make your case to an executive sponsor, check out this toolkit.

Step #2 - Build an Interdisciplinary and Cross-Site Team(s)

At a systems level, successful GED implementation is often led by an executive committee of multiple leaders responsible for implementation across the system. These groups often function as the administrative sponsors. For example, Northwell Health used a service-line approach with standardized policies and created a committee and partnership between the Emergency Medicine service line and Division of Geriatrics and Palliative Medicine, called the Geriatric Emergency Medicine (GEM) Committee (Fig. 2). The primary goal of the Committee was to ensure successful system-wide GED accreditation, but many other goals were a part of the Committee's oversight (Fig. 3).

At an individual level, successful GEDs include: a physician champion or medical director and an identified nurse case manager or transitional care nurse. Physicians and nurses receive additional education in geriatrics that provides added expertise in the emergency care of older adults. GEDs are often overseen by a physician while the day-to-day operations of the GED are executed by a registered nurse or nurse practitioner, frequently referred to as a "nurse champion." Successful GEDs also include multiple members of an interdisciplinary geriatric assessment team (intermediate care technicians, physiotherapy, occupational therapy, social work, pharmacy, gerontology).

In addition to an executive/administrative lead/sponsor, a physician champion/medical director, nurse champion, and multiple members of the interdisciplinary geriatric assessment team, successful interdisciplinary and cross-site teams also include a project manager and a data analyst. How you ultimately create interdisciplinary and cross-site teams will depend largely on the structure of your system, your local context and available resources.

Step #3 - Generate Buy-In

Creating buy-in is ultimately about influencing others to align with your vision and it will be important to generate buy-in with your executive leadership team, interdisciplinary team (including nurses and the larger clinical team) and external funders (if applicable).

Harvard Business School professor John Kotter is regarded by many as the authority on generating guy-in and managing wide-scale change. His 8-steps for leading change provides an easy-to-use and understand framework to begin thinking about generating buy-in amongst your stakeholders and ultimately leading the change of implementing geriatric emergency care throughout your system.

Much can also be learned from leading healthcare systems currently undergoing the effort to accredit all of their emergency departments as geriatric-friendly. The Veterans Administration shared some key elements to gaining widespread buy-in across a large system:

1. Engage leadership and frontline staff
2. Be mission-driven
3. Listen to what matters and address it
4. Create education focused on the audience in the time and formats they want (Fig. 4)
5. Recruit and engage champions
6. Provide constant engagement by offering continued guidance, check-ins, examples and resources
7. Recognition of team members that is personalized and congratulatory towards their accomplishments (Fig. 5)

Another key element of generating buy-in amongst your teams is by participating in shared decision-making. For example, anecdotally, Mount Sinai engaged with nurses about selecting the specific delirium screening tool to use, which led to higher levels of screen completion.

Step #4 - Integrate Older Adult Triage, Screening and Treatment Tools within Standard Workflows and Electronic Health Records (EHRs)

GEDA guidelines require "evidence of a geriatric emergency care initiative" or between 10-20 "policies, guidelines and procedures" to improve the care for older adults in the emergency department. An outsized emphasis is placed on triage and screening protocols. Working with a physician champion or medical director, a nurse case manager or transitional care nurse, the larger interdisciplinary team and an EHR engineer, to implement triage, screening and treatment tools within your standard clinical workflows and EHRs is required for GED accreditation.

Enhanced screening processes are important because they can quickly uncover physical or mental health risks that are more common in older adults. For example, screening tools uncover geriatric syndromes (like falls, polypharmacy, delirium, dementia) as well as social vulnerabilities (like food insecurity or elder mistreatment).

There are a variety of older adult triage, screening and treatment tools to choose from:

- A standardized delirium screening process (DTS; CAM; 4AT)
- A standardized dementia screening process (Ottawa 3DY; Mini Cog; SIS; Short Blessed Test)
- A standardized assessment of function and functional decline (ISAR; PRISMA-7; interRAI Screener)
  - For additional information on screening tools for delirium, dementia and functional decline please view this article.

- A standardized [fall assessment](#) protocol (including mobility assessment, e.g. Timed Up and Go)
- An approach to identification of [elder abuse](#) (EASI)

"Implementing consistent screening and assessment requires careful planning, resource allocation, and modification of existing work practices to achieve its intended benefits."[12] When you begin the process of implementing consistent triage, screening and treatment tools, there may be resistance that adding steps to the clinical workflow will seem overwhelming and time consuming. However, a 2021 study showed that "performing three geriatric screening tools took approximately three minutes of real clinical time" and that "performing screenings is feasible in a busy ED setting."[13] An important first step to implementing a consistent screening and assessment approach is to create a clinical flow process map. For additional detailed steps on how to implement a consistent screening and assessment approach for geriatric care in your ED, please view [this article](#).

Once you have successfully implemented consistent triage, screening and treatment tools, you may find that adherence wanes over time. This was the experience of the Mayo Clinic as they sought to implement delirium screening across their GEDs sites. To solve this problem, the Mayo Clinic conducted a process analysis (Fig. 6), which showcased that a variety of environment, patient and people causes were affecting the completion of the delirium screening assessment. Then, the Mayo Clinic utilized the [Institute for Healthcare Improvement's Plan-Do-Study-Act (PDSA) Cycles](#) to improve education and ultimately, adherence (Fig. 7).

Step #5 - Begin and Complete the Geriatric Emergency Department Accreditation (GEDA) Application Process

The [Geriatric Emergency Department Accreditation (GEDA) Program](#) was developed by the [American College of Emergency Physicians (ACEP)](#) to ensure that our older patients receive well-coordinated, quality care at the appropriate level at every ED encounter. The accreditation process has four phases:

1. Pre-Application
2. Online Application
3. Site Visit
4. Award

During the Pre-Application phase, determine the appropriate accreditation level for your institution and prepare your supporting documents for the online application.

Similar to the categorization of Trauma Centers, a Level 1 GED is the top level of accreditation and thus has the highest level of interdisciplinary and specially trained staff, policies, guidelines and procedures for geriatric emergency care. Level 1 GEDs must have at least 20 initiatives chosen from models of care that benefit older adults (e.g., a urinary catheter utilization policy) and quality improvement components, 5 outcome measures, availability of 10 equipment and supplies specific to older adults, and enhancements to the physical environment.

Level 2 GEDs provide many of the same enhancements as a Level 1, but on a smaller scale (e.g. only requires 10 geriatric emergency care initiatives) and often with fewer interdisciplinary and specially trained staff.

Level 3 GEDs require physician oversight, a nurse champion, and evidence of at least one geriatric emergency medicine care initiative. Oftentimes, hospitals begin the accreditation journey at a Level 3 and then "level up" as they build their infrastructure and gain core competencies in the operational and clinical requirements necessary to implement higher levels of geriatric specific emergency medical care.

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

During the second phase, create a login and complete the online application via the online application portal, as well as submitting the application fee. Submitted applications will be reviewed for completeness by ACEP GEDA staff first, followed by a comprehensive evaluation by a team of ACEP-appointed physician reviewers. Next, ACEP will assign a reviewer to conduct a site visit. Finally, in the Award phase, applications will be notified of the final accreditation decision (Fig. 8)[14]. The GEDA program managers are phenomenal resources to assist in your application preparation and submission. They can be reached at:

- Nicole Tidwell, GEDA program manager at: ntidwell@acep.org | 469-499-0149
- Bonita Marek, GEDA program coordinator at: bmarek@acep.org

Additionally, the Geriatric Emergency Department Collaborative (GEDC) offers consulting engagements to hospitals and health systems beginning their accreditation journey, or those seeking to achieve a higher level of accreditation. If you are interested in learning more about how the GEDC can assist you, please contact the GEDC.

Your strategy for applying for system-wide GED accreditation will depend largely on the structure of your system, your local context and available resources. For example, Northwell Health accredited all 17 GEDs as Level 3 at once. After Northwell Health decided to accredit all 17 EDs at once, they created and followed a standardized internal application process[15]. A needs assessment guide was used by each ED leadership team to formulate their applications. The system-wide Geriatric Emergency Medicine (GEM) committee reviewed these applications for both individual merit and to ensure appropriate standardization across all applications submitted by the system.

For example, Northwell's needs assessment revealed that "there were many policies and programs implemented to support the care of older adults, but much of this work was "siloed" within individual sites.[15]" Then, Northwell decided to "aggregate all of the process improvement projects that were already ongoing within the EDs and assess which projects were most relatable to all EDs and which projects were more likely to be measurable using data from the electronic medical record (EMR).[15]" As a result, Northwell highlighted their catheterization policy and catheter associated urinary tract infection reduction strategy for all GEDA applications.

Finally, Northwell's GEM committee partnered with ACEP leadership to match all applications to the existing GEDA guidelines and created a feedback loop for incorporating ACEP feedback into each batch of applications.

The Veterans Administration (VA) took a different approach to accreditation across their system. The VA developed a cohort strategy where accreditation has been rolled-out over time based on geographical service areas known as Veterans Integrated Services Networks (VISNs) (Fig. 9 & 10), due to the pre-existing administrative and leadership structures embedded within those service networks.

Step #6 - Create Standardized Outcome Metrics and Management Dashboards

The creation of standardized outcome metrics and other data management dashboards are important to understand success, opportunities, trends, and outcomes of treating older adults in your ED. It is important to assess progress in implementing older adult triage, screening and treatment tools within standard workflows and electronic health records (EHRs) that you instituted in step #4 in order to make any ongoing adjustments. Some standard metrics to consider tracking on your dashboard could include:

- % Completion of specific triage, screening and treatment tool(s)
- Older adult ED visits
- Length of Stay
- Admissions Rate
- Return ED visits
- Other metrics important to your health system or hospital, such as the patient experience

For an in-depth example of a GED Dashboard, please view this information session on the West Health GED Dashboard and how you can participate.

Oftentimes, a data analyst and/or an EHR engineer (in conjunction with a project manager) works in tandem with your physician and nurse champions to create these dashboards. Data analysts often use visualization tools (such as Tableau*) to create dashboards with data extracted from your EHR. The Mayo Clinic utilizes an extensive dashboard that tracks many metrics over time (Fig. 11 & 12), which serves as a great example to get you started thinking about what your dashboard could look like.

Conclusion

Many healthcare systems have begun to place a wide-scale, strategic emphasis on caring for older adults through achieving geriatric emergency department accreditation. Early adopters of this strategy have followed a similar six-step journey from which others can learn.

For more information on how you can become a Geriatric Emergency Department, please contact the Geriatric Emergency Department Collaborative.
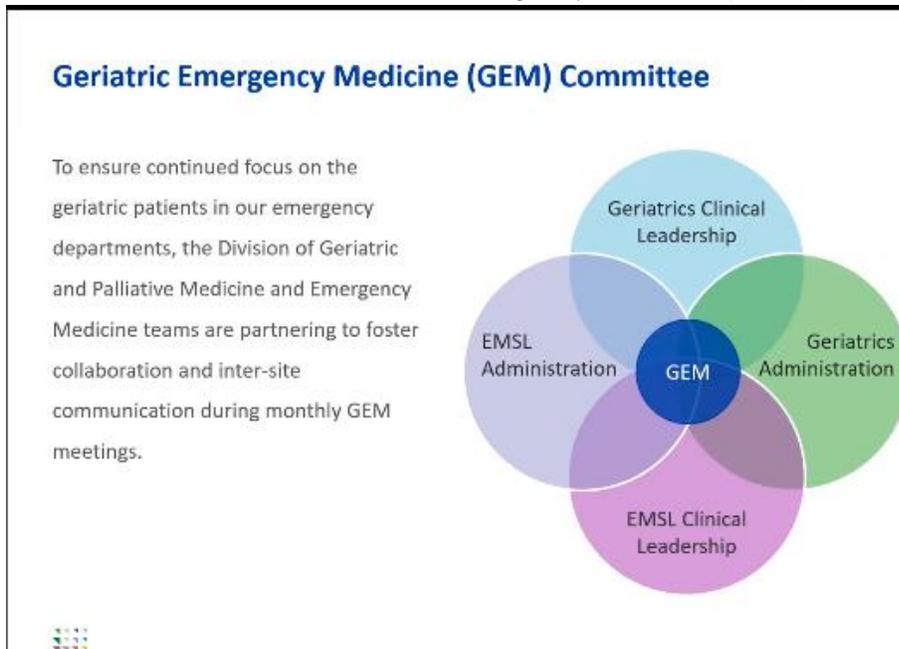
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*Any mention of products or tools does not represent endorsement by the Geriatric Emergency Department Collaborative and is instead merely reflective of what hospitals and health systems have mentioned that they use.

Figures

1. Northwell Health 65+ ED Volume Data Dashboard

2. Northwell Health Geriatric Emergency Medicine (GEM) Committee Structure

3. Northwell Health Geriatric Emergency Medicine (GEM) Committee Goals

GEM Committee Goals

- Review geriatric cases; address quality of geriatric care in the ED
- Learn about best practices for older adults from geriatricians, geriatric EM physicians, and other clinicians:
  - The four Ms
  - Drug interactions and dosages
  - Community-based resources
  - End-of-life care decisions and forms
- Provide Champions with tools to teach their teams/peers about clinical practices
- Share policy implementation strategies and recommendations
- Support EDs that want to increase their ACEP Geriatric ED Accreditation Level

4. Veterans Administration Approach to Continual & Consistent Education as a Way to Generate Buy-In

Continual & Consistent Education

1. Offer CEs for the multidisciplinary teams in the field
   1. Nursing, Physician, Social Work, Pharmacy, Physical Therapy and Occupational Therapy

3. Engage champions to present insight and best practices

4. Bring experts to discuss geriatric emergency care on education platforms
   3. Office Hours
   4. Webinars
   5. Summits
   6. Education Bootcamps

5. Continually adapt and change to field needs through lessons learned/surveys

1st VA Geriatric Emergency Department Booster!

Cohort #1

National Geriatric ED Core Team
*Tuesday September 21, 2021*
1:00pm – 3:30 pm EST

Optimizing ED Environment for Geriatric Care & Sensory Impairments
VA Geriatric ED Webinar Supporting Cohort #1 and #2 !
National Geriatric ED Council and Core Team
Tuesday July 13, 2021
3pm- 4:15pm EST

Mobility Risk Recognition, Intervention & Prevention
VA Geriatric ED Webinar Supporting Cohort #1 and #2 !
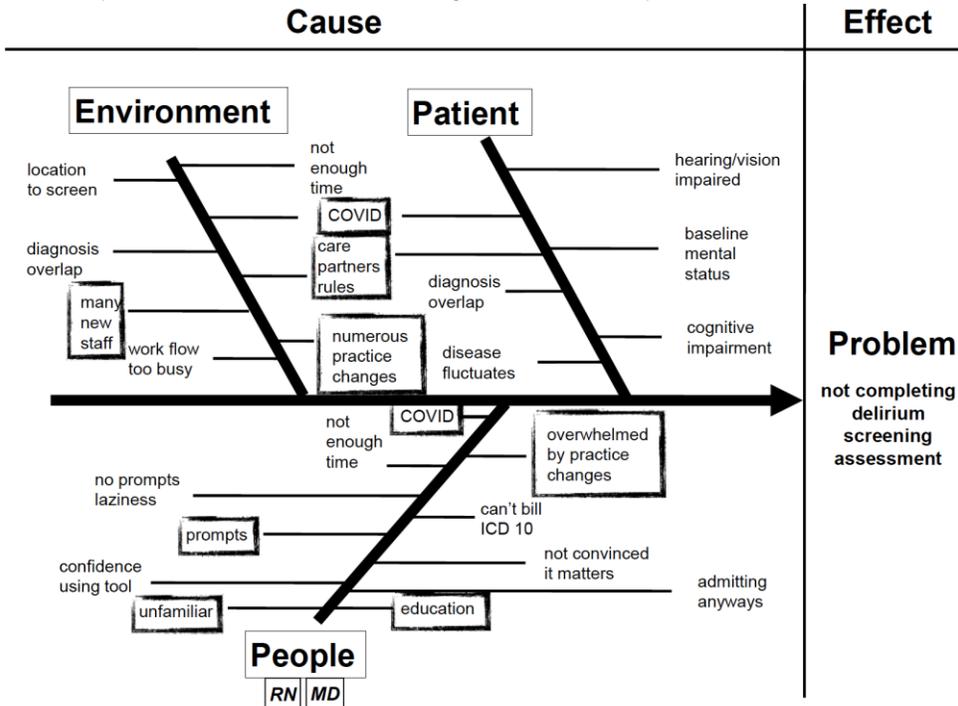*National Geriatric ED Core Team and GEDC*
Tuesday July 27, 2021
3pm – 4pm EST

VA | U.S. Department of Veterans Affairs | 21

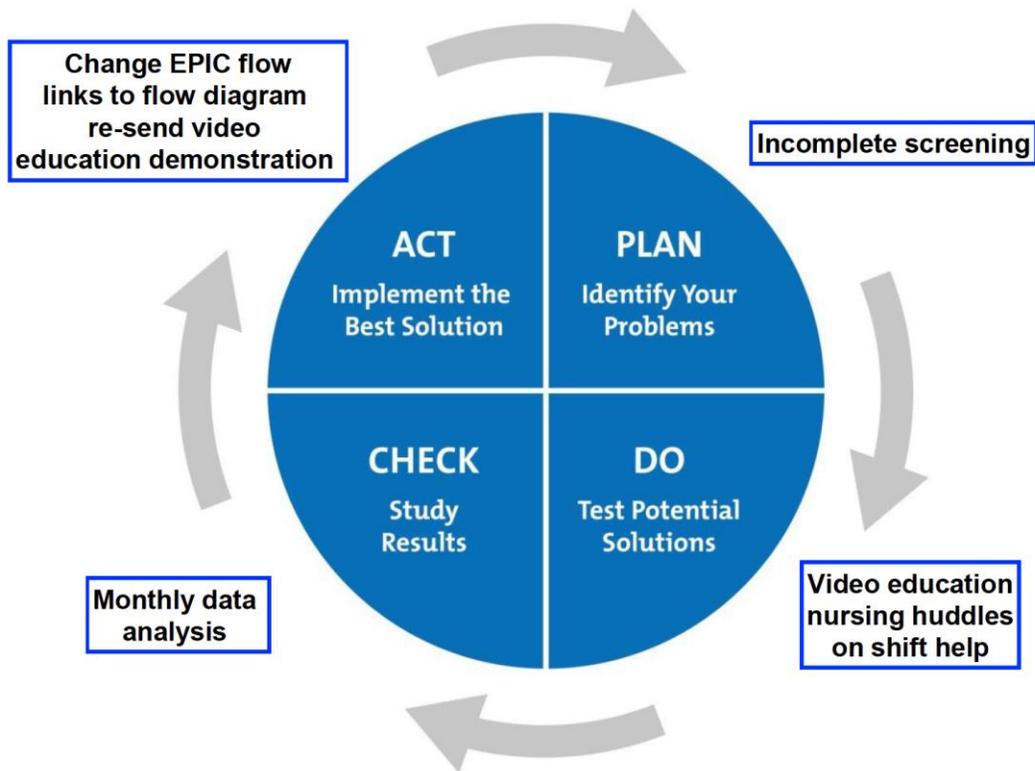5. Veterans Administration Approach to Recognition as a Way to Generate Buy-In
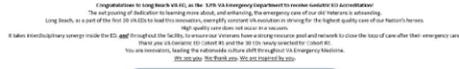
6. Mayo Clinic Delirium Screening Process Analysis

7. Mayo Clinic PDSA Cycle to Improve Delirium Screening Education & Adherence

ACT
Implement the Best Solution

PLAN
Identify Your Problems

CHECK
Study Results

DO
Test Potential Solutions

Change EPIC flow links to flow diagram re-send video education demonstration

Incomplete screening

Monthly data analysis

Video education nursing huddles on shift help

8. Geriatric Emergency Department Accreditation (GEDA) Application Process

What to expect during the application process

(Note: criteria and process are subject to annual revisions.)

Pre-Application

Determine appropriate accreditation level for your institution

Prepare documents for online application (see sample documents tab in FAQs)

Online Application

Create a login and complete application via online application portal

Submit application fee

Site Visit

ACEP will assign a reviewer for the site visit

Level 1: Mandatory

Level 2: Discretionary site visit, required phone conversation post application

Award

Level 1 applicants will be notified of decision within 8 weeks after site visit has been conducted.

Level 2 and 3 applicants will be notified of decision within 16 to 18 weeks after online application is submitted.

9. Veterans Administration's Veterans Integrated Services Networks (VISNs)

Veterans Integrated Services Networks (VISNs)

Veterans Integrated Services Network: The U.S. is divided into 18 Veterans Integrated Service Networks, or VISNs — regional systems of care working together to better meet local health care needs and provides greater access to care.
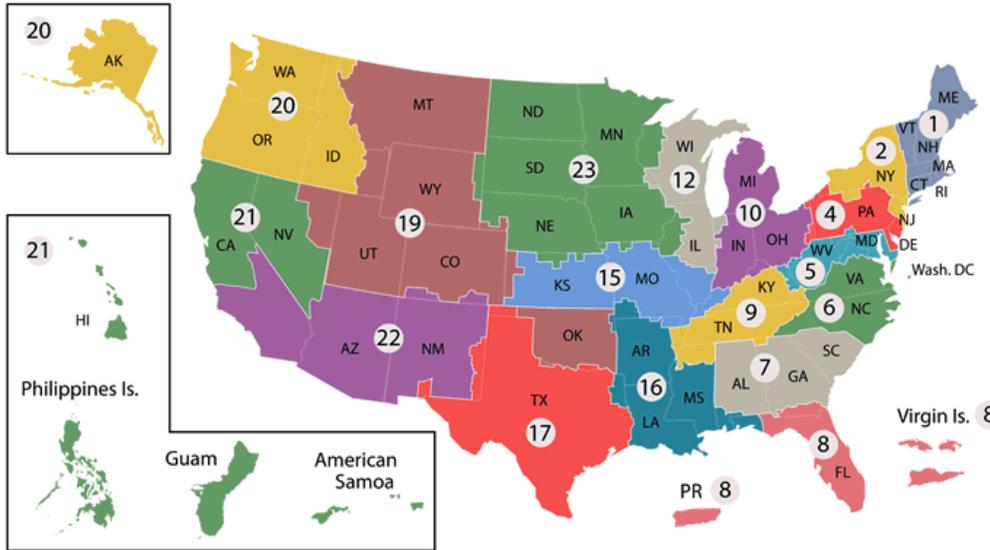
10. Veterans Administration Cohort Strategy for System-Wide Geriatric Emergency Department Accreditation

11. Mayo Clinic Data Dashboard Part 1

ED Visits - Age 65+ years
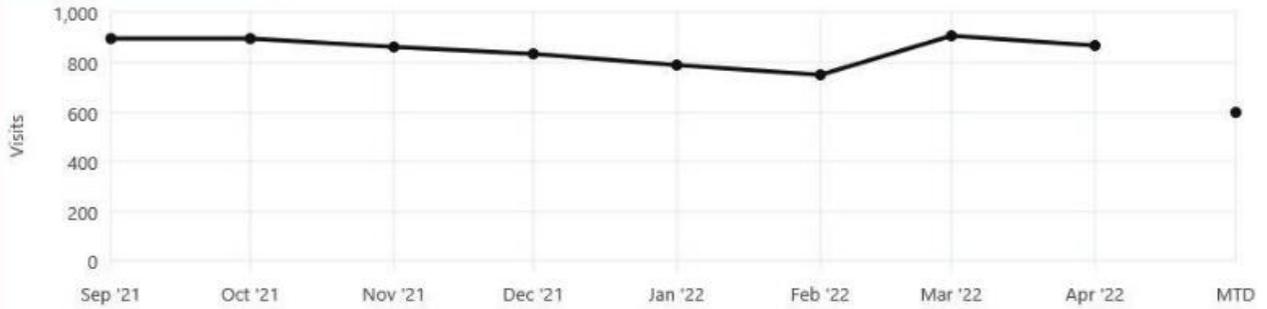
Global Metric Percentages

	Sep 21	Oct 21	Nov 21	Dec 21	Jan	Feb	Mar	Apr	MTD
Age 65+ years	28.6 %	28.8 %	29.9 %	29.8 %	27.8 %	30.3 %	31.3 %	32.7 %	33.8 %
ED Admitted: % Age 65+	53.1 %	49.9 %	50.7 %	55.4 %	52.8 %	52.5 %	54.9 %	55.0 %	58.1 %
GERI: % Admitted	39.6 %	37.8 %	39.2 %	42.4 %	42.5 %	44.1 %	42.7 %	41.2 %	38.1 %
GERI Admitted: Upgraded Level of Care	4.2 %	3.8 %	4.7 %	5.1 %	5.4 %	4.5 %	6.2 %	5.9 %	3.5 %
GERI Admitted: Expired	3.4 %	4.7 %	4.1 %	3.9 %	6.0 %	2.7 %	4.4 %	3.4 %	1.3 %
GERI: Expired in ED	0.33 %	0.33 %	0.46 %	0.24 %	0.25 %	0.13 %	0.11 %	0.00 %	0.00 %
Suspected Abuse Yes ⓘ	0.3 %	0.4 %	0.3 %	0.0 %	0.1 %	0.1 %	0.1 %	0.3 %	0.2 %
Suspected Abuse Enc	0.0 %	0.0 %	0.0 %	0.0 %	0.0 %	0.0 %	0.0 %	0.1 %	0.0 %
Return to ED - 72 Hours	5.8 %	6.1 %	5.1 %	5.5 %	6.1 %	4.1 %	7.1 %	5.3 %	5.5 %
Return to ED - 30 Days	9.7 %	9.0 %	8.6 %	9.3 %	6.6 %	10.1 %	7.7 %	8.4 %	3.8 %
GERI: % Transferred	2.0 %	1.9 %	1.2 %	0.6 %	1.3 %	0.9 %	0.9 %	1.2 %	0.5 %

ED Geriatrics - Other Metrics

	Sep 21	Oct 21	Nov 21	Dec 21	Jan	Feb	Mar	Apr	MTD
Procedural Sedation Used	1.2 %	0.9 %	1.2 %	1.4 %	0.4 %	0.5 %	1.2 %	0.6 %	0.8 %
Advance Directives on Chart	72.5 %	69.0 %	71.4 %	69.1 %	68.6 %	71.0 %	71.1 %	69.9 %	72.2 %

12. Mayo Clinic Data Dashboard Part 2

Delirium

	Sep 21	Oct 21	Nov 21	Dec 21	Jan	Feb	Mar	Apr	MTD
Delirium Screen Completed	78.2 %	81.5 %	84.1 %	85.1 %	84.2 %	86.7 %	80.5 %	83.0 %	84.2 %
Delirium Positive	14.9 %	13.1 %	12.3 %	13.2 %	12.5 %	13.1 %	10.2 %	8.2 %	12.5 %
Restraint Used	0.0 %	0.0 %	0.1 %	0.1 %	0.1 %	0.1 %	0.1 %	0.0 %	0.3 %
GERI Restraint: Danger to Self	0	0	0	0	0	0	0	0	0
GERI Restraint: Danger to Others	0	0	0	0	0	0	0	0	0

Falls

	Sep 21	Oct 21	Nov 21	Dec 21	Jan	Feb	Mar	Apr	MTD
% Chief Complaint Fall	14.4 %	13.4 %	15.6 %	16.0 %	14.3 %	12.1 %	15.8 %	15.8 %	13.5 %
Fall: % Injury	14.7 %	8.3 %	11.1 %	12.7 %	8.0 %	8.8 %	8.4 %	6.6 %	13.6 %
Fall: Fall Risk Completed	96.1 %	96.7 %	96.3 %	96.3 %	97.3 %	95.6 %	95.1 %	94.2 %	95.1 %
Fall or Alert: PT Ordered in ED	11.6 %	12.4 %	22.3 %	17.5 %	9.8 %	11.1 %	5.0 %	10.4 %	14.2 %
Fall or Alert Admitted: PT Ordered on Floor	60.4 %	61.1 %	51.0 %	49.2 %	64.5 %	62.1 %	70.7 %	58.2 %	58.3 %
Fall or Alert: % PT Follow Up Visit	9.0 %	5.4 %	8.4 %	5.4 %	6.3 %	7.4 %	6.1 %	4.3 %	0.0 %
Fall or Alert: % PT Follow Up Referral	2.6 %	2.7 %	2.3 %	2.0 %	1.6 %	1.1 %	2.7 %	0.7 %	1.0 %
Fall: % Expired in ED	0.0 %	0.8 %	0.0 %	0.0 %	0.0 %	0.0 %	0.0 %	0.0 %	0.0 %
Fall Admitted: % Expired	2.0 %	4.1 %	3.4 %	4.0 %	7.1 %	0.0 %	5.5 %	5.4 %	2.9 %
Fall Alert: % Expired	2.0 %	4.5 %	4.2 %	3.7 %	5.0 %	2.6 %	3.3 %	3.3 %	0.0 %
TUG Tested: TUG Failed	3.9 %	3.7 %	4.0 %	4.6 %	10.9 %	3.6 %	3.0 %	4.7 %	2.9 %
TUG Failed: PT Consult or Referral	0.0 %	0.0 %	0.0 %	0.0 %	3.2 %	0.0 %	0.0 %	12.5 %	0.0 %

Urinary Catheters

	Sep 21	Oct 21	Nov 21	Dec 21	Jan	Feb	Mar	Apr	MTD
Urinary Catheter Placed and Admitted	18	23	25	25	12	10	23	15	6
Urinary Catheter Placed	3.5 %	4.2 %	4.3 %	3.3 %	2.3 %	2.3 %	3.5 %	2.5 %	1.8 %
Urinary Cath: Bedrest	4	4	3	11	4	2	5	5	1
Urinary Cath: Chronic Indwelling	5	5	3	1	0	2	2	2	1
Urinary Cath: Comfort Cares	0	1	0	0	0	0	0	0	0
Urinary Cath: Impaired Level of Consciousness	1	0	3	1	1	0	2	2	1
Urinary Cath: Incontinence	0	0	0	1	0	0	0	0	0

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