

Navigating Care Transitions for Older Adults in the Emergency Department When a Social Worker is Unavailable

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BACKGROUND

Older patients often have multiple comorbid illnesses, leading to greater acuity and complexity of needs.¹ As such, the care they receive in the Emergency Department (ED) frequently requires more time and resources. For many older adults, a safe discharge plan hinges on care transitions and accessing community resources. The International Federation for Emergency Medicine (IFEM) outlined 8 minimum standards for the care of older persons in the ED, one of which is the provision of “strategies for the safe and effective transitions of care of older people with support from community and hospital-based services.”² The IFEM further states that care of older patients in the ED requires an interdisciplinary and multispecialty approach due to their multiple and often interconnected medical, social, functional, cognitive, and behavioral issues.² So, in addition to high quality medical diagnosis and care, complex social services support is also required.

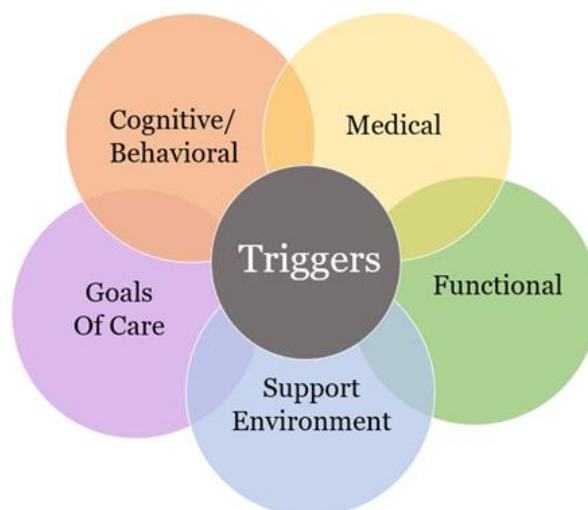
The challenge, particularly for rural or small community EDs, is that there is not always dedicated Social Work (SW) or Case Management (CM) support. Additionally, in the context of COVID-19 and national healthcare staffing shortages, EDs that had support for complex discharge planning may no longer have those resources. The ED clinicians are tasked with creating safe discharge plans while balancing the competing demands of a busy ED. Due to absent SW support, ED clinicians may promote patient safety by rapidly identifying triggers (elevated risk of injury and/or ED return). These triggers inform bundles of risk mitigation steps subsequently performed by the ED team. Similar triggers/bundles have been used in the ED for the evaluation and management of sepsis. Likewise, IHI used a similar method in their work³ and we have adapted this to the care of the older adults in the ED when SW support is not available.

TRIGGERS (IDENTIFY HIGH-RISK PATIENTS)

Rapid multi-domain assessment to identify older adults who would benefit from SW evaluation:

Cognitive/Behavioral

- Does this patient have medical decision-making capacity?⁴
- Does this patient have dementia and/or delirium?⁵
- Does this patient have a substance-use disorder?
- Does this patient have a mental health concern? (e.g., depression, anxiety, mood disorder.)



Medical

- Does this patient have a skilled need, such as IV medications or wound care? (Consider home care or outpatient services.)
- Does this patient need durable medical equipment (DME)? (e.g., a walker, a cane, a wheelchair.)

Functional

- Does this patient need help with self-care or have they experienced a recent decline in the ability to perform self-care? (Consider Timed Up and Go (TUG) Test.)⁶
- Is this patient at risk for rapid return to the ED due to inability to function in their home setting?
- Consider the use of the Identification of Seniors at Risk tool. (ISAR©)⁷

Support Environment

- Does this patient have a caregiver? Are they able and willing to provide care? Is caregiver burnout suspected? (Screen using the Zarit 4-item burden interview.)⁸
- Does the patient consider that they are able to safely perform self-care activities given their home environment (steps/space) and support environment? Does the patient have any services in the home presently?
- Does this patient have a safe and stable home environment? Questions to help guide determination, including, but not limited to: Can you make your own meals? Do you have enough food in your house to last 3-5 days? Do you have heating/air-conditioning? Do you have any friends or neighbors that can help you? How have things been going at home? Do you feel safe at home? Do you have any concerns about your medications?
- Is there concern for elder mistreatment or neglect? (Consider skin exam and hygiene.)

Goals of Care

- What matters most to the patient?
- Consider screening for unmet palliative care needs, including uncertain goals of care in patients with life-limiting illnesses and/or multiple recent ED admissions? (Align goals with plan of care.)

BUNDLES (RISK MITIGATION ACTIONS)

Provide support for older adults with unmet needs who are sent home from the ED when SW/CM are unavailable:

Communicate

- Connect with the primary care provider (PCP) while the patient is in the ED. The ED physician may facilitate discussion between PCP and patient while the patient is in the ED. If communication is not possible while the patient is still in the ED, connect via EMR note or secured communication to ensure the PCP



knows that their patient was in the ED and express any concerns that the ED team has at that time.

- Communicate with the patient and caregiver. For patients with unmet palliative care needs and/or multiple recent admissions, consider rapid prognostication and goals of care discussion with patient and caregiver to help guide treatment plan and align care plan with patient's wishes.⁹
- Provide medication for the patient before they are discharged home. If paper prescriptions are provided, ensure that the patient can get the medications from the pharmacy. (Consider transportation and co-pays.)
- Raise concerns related to polypharmacy, medication reactions, fall risk, etc.

Orders

- Consider utilizing a home-based service such as community paramedicine or visiting nurses to increase the probability that someone will see this patient timely.
- Order home care services, such as home nursing, home PT/OT, or home safety evaluation. Order outpatient PT/OT if they do not meet homebound criteria.
 - If unfamiliar with placing these orders, develop partnerships with Clinical Informatics, Home Care Liaisons, and Area Agency on Aging Liaisons to assist in making tip sheets.

Follow-Up

- Work with hospital staff and administration to develop a process for SW assistance for high-risk patients discharged from the ED. If there are concerns related to caregiver burnout, dementia/delirium, unmet palliative care needs, and/or home safety, urgent SW follow-up should be initiated.
- Set up critical follow-up with SW/CM to connect with the patient after they leave the ED.
- Schedule a follow-up appointment with the PCP/primary care team before the patient is discharged from the ED.

Resources

- Provide the patient and/or caregiver with a list of appropriate community support and resources such as Area Agency on Aging, Meals on Wheels, Veteran's outreach programs, caregiver support programs, and statewide resource networks.
- Partner with your Inpatient SW/CM to ensure ED clinicians have access to resource lists for those being discharged from the ED.¹⁰
- Determine if substance abuse support services are needed. Consider a behavioral health/AODA counseling referral. Provide a resource handout.
- Determine if financial resources are needed. Perhaps a list of free clinics in the area would be helpful.

Advocate

- Continue to advocate for more robust SW/CM support in the ED by tracking the needs of older adults. Use metrics, such as avoidable hospitalizations, length of stay, ED readmits and patient stories.
- Consider virtual SW support from another facility in the hospital system.

KEYWORDS

Care Transitions, Vulnerable Older Adults, Emergency Care, Social Work, Coordination of Care

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