

Call to Action: Better Care of Older Adults in Emergency Departments. A Much-Needed Collaboration Between Emergency Medicine Physicians and Geriatricians

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Adults aged greater than 65 have the highest Emergency Department (ED) use rates in the United States and worldwide¹. This population often suffers from multiple co-morbid diseases and has a high incidence of polypharmacy, mobility disorders, and cognitive impairment². Many of these older adults also have poor social support and utilize the ED as their primary source of health care delivery³. Repetitive ER visits and frequent hospitalizations in medically complex older adults often results in a decline in cognitive and functional status⁴. Furthermore, the fluctuating course of COVID-19 pandemic has uniformly stressed our ED's capacity to function and with limited resources, dramatically amplified the challenges of caring for older adults to an all-time high⁵. Resources are needed to identify, assess, follow and transition high-risk older adults to an appropriate level of care in high acuity and high volume ED's. However, this task very challenging, and it leaves our Emergency Medicine colleagues a binary choice: to admit or discharge. This process often results in hospitalizations, which contribute to the vicious cycle of unaddressed geriatric syndromes⁴. How then, as geriatricians, can we better support our ED colleagues as they continue the remarkable work of caring for this group of patients?

Geriatricians are well aware of the challenges faced by older adults in the in ED, the related adverse outcomes they contend with (due to altered mentation, falls, polypharmacy, poor social support, inability to care for themselves), and the stress ED providers manage while providing care to this patient population. We are also well versed in understanding and untangling geriatric syndromes to guide the complex care of older adults with multidisciplinary team as complex older adults engage with the health care system. Looking forward, we could play an active role in supporting our local EDs to improve care for such patients by bringing in similar multidisciplinary team approach by joining hands not only with ED physicians but also working with ED nursing, case management, social work, physical therapy and pharmacist.

Thoughtful solutions are required for the following questions:

- Do geriatricians have resources to work alongside ED Physicians where the length of stay is reduced to minutes and throughput is the measure of success?
- Can Comprehensive Geriatric Assessment (CGA) be performed in minutes rather than hours?⁶ Even if it can, which patients would most benefit from such intervention?
- If an intervention is performed, how would we measure our success?
- Should we limit ourselves to geriatric patient-specific ED policy instead of active patient evaluation?

Where then, might we find a solution? Major academic Emergency Medicine (EM) societies like the American College of Emergency Physicians (ACEP) and the Society of Academic Emergency Medicine (SAEM) have done an excellent job in carving out a space for education and research around geriatric patients in ED's by creating special interest groups^{7,8}. There are also a number of leading voices in EM whose work has laid the foundation for Geriatric EM care by garnering funding from the NIH and philanthropic organizations. The ACEP, for example, launched their Geriatric Emergency Department Accreditation (GEDA)⁷ Program in May 2018 with the support of the Gary and Mary West Health Institute and The John A. Hartford Foundation in the USA. As of 2021, the ACEP has accredited 258 Geriatric ED's in the US, Europe, and South America. Many other organizations including the Geriatric Emergency Department Collaborative (GEDC)⁹, Geriatric Emergency Care Applied Research (GEAR)¹⁰Network, and a number of Geriatric Emergency Medicine Fellowship programs are growing in various institutions led by our EM colleagues¹¹.

Outside of the EM environment, American Geriatric Society (AGS) have supported development of Geri-EM guideline¹² and recently created Geriatric ED Special Interest Group¹³ is a good step forward in bringing together both Geriatric Medicine and Emergency Medicine expertise. The Institute for Healthcare Improvement (IHI) Age-Friendly Health System Initiative has created clinical framework for addressing geriatric care in the ED and focuses on the 4Ms (Mobility, Mentation, Medication, Matters most)¹⁴. There are more than 2500 Age-Friendly Health System participants, but only 17 ED's are participating in this initiative at this time¹⁵.

Can geriatricians step up our game to match the initiative shown by our EM colleagues? Can we team up with our EDs in a meaningful way to improve the care provided to society's most vulnerable citizens, conduct research, and create multidisciplinary care paths that identify cost-saving strategies while improving our contribution to national and international societies?

Emerging evidence says yes. Comprehensive initiatives to detect and manage geriatric syndromes in the ED have started to demonstrate improved outcomes and cost savings¹⁶. Identifying delirium early as possible¹⁷, engaging physical therapy in ED¹⁸, addressing polypharmacy¹⁹, identifying cognitive impairment²⁰, optimizing transitions of care²¹, and increasing patient and caregiver satisfaction are some of the areas of success. A partnership between Geriatricians and EM physicians can achieve all of this and more.

As such, I call upon all of my geriatric medicine colleagues, regardless of where you are (community /academic) or what spectrum of the older patient you care for (primary care, in-patient consult, long term care, post-acute care, memory care, administrative or medical directorship) to have a conversation with our local EM colleagues and to participate in national efforts to achieve our shared goal - "To improve the care provided to our most vulnerable patients in our community when they are in our emergency departments."

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Geriatrics, emergency medicine

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