Emergency Department Policies to Improve Care Experiences for Older Adults During the COVID-19 Pandemic

Anita Chary MD PhD, Shan W. Liu MD SD, Lauren Southerland MD, Lauren Cameron-Comasco MD, Kei Ouchi MD MPH, Christopher R. Carpenter MD MSc, Edward W. Boyer MD PhD, Aanand D. Naik MD, Maura Kennedy MD MPH

INTRODUCTION

The COVID-19 pandemic has greatly affected the emergency care of older adults. Older adults (aged 65 and older) are the most likely age group to be hospitalized for and die from COVID-19. Specific considerations regarding the presentation and treatment of COVID-19 in older adults have previously been outlined. In this topic supplement, we focus on the additional ways that older adults are vulnerable to specific changes in emergency department (ED) environments that have resulted from the pandemic. Challenges in communication, crowding and boarding, and end-of-life care have been exacerbated by the COVID-19 pandemic and are likely to impact our older patients for years to come. Policies to mitigate pandemic-related challenges can promote equitable care for older adults in the ED. Recommendations herein derive from existing literature and consensus among the authors, who are experts in geriatric emergency medicine, geriatrics, and healthcare improvement.

CHALLENGES IN COMMUNICATION

Important and necessary infection control measures, such as masking and visitor restriction policies, have led to challenges in communication with older adults. Masking, which muffles speech, hinders lip-reading, and physically displaces hearing aids, can negatively impact communication with patients with hearing impairment.

- Stock masks that tie in the back and offer them to patients who use hearing aids.
- For patients with hearing impairment who are accustomed to lip reading, have healthcare team members use clear view window masks.
- Offer patients hearing assist devices during their ED stay. In the pre-COVID era, this intervention was associated with improved patient and clinician communication and satisfaction. Disposable hearing amplifiers are available for approximately $15/unit. For example, at Massachusetts General Hospital, which has an annual visit volume of adults >65 years old of approximately 25,000, about 10 hearing amplifiers are used monthly. A modest annual cost of $1,800 may make this intervention relatively affordable in EDs with similar volumes.

DIFFERENTIATING CARE PARTNERS AND VISITORS

Hospital visitor restriction policies generally do not adequately distinguish visitors for social reasons from the integral care partners who help older adults navigate the health care system and engage with care teams. A recent nationwide survey of over 350 hospitals in the United States revealed that the
majority did not provide exceptions for care partners to be present at bedside, even for patients with cognitive or physical impairment or for patients at the end of life. The absence of care partners at bedside is associated with decreased availability of collateral information, decreased patient comfort, and an increase in rate of inpatient falls with hip fractures. When present at bedside, care partners can assist with orientation and hydration while promoting patient comfort, which has potential to reduce the incidence of delirium.

- Modify visitor policies to treat care partners as a distinct category of people who are allowed at bedside when asymptomatic and adhering to masking mandates.
- Assess care partners for caregiver burden and ask about any home health resources, or medical equipment needs at home that could lessen their burden.

**TRIAGE, HALLWAY CARE, AND BOARDING**

While overall ED volumes decreased dramatically with the onset of the pandemic in the United States, subsequent COVID surges have often overwhelmed EDs and hospital systems. This has been due to increased number of visits for COVID-related complaints with the simultaneous return of patients who had deferred their medical care. Healthcare staff shortages have resulted in decreased availability of ED, hospital, and rehabilitation and nursing facility beds. Together, these problems have led to prolonged boarding of inpatients in EDs and increasing numbers of ED care encounters occurring in waiting rooms and hallways rather than in rooms. Long wait times for a complete evaluation and difficulties examining patients in chairs while fully clothed and surrounded by other patients can put older adults at risk of missed diagnoses and clinical decompensation.

- Develop triage protocols that recognize the potential for under-triage in older adults. For example, in health systems where clinicians assign an emergency severity index (ESI) for each encounter to help guide downstream clinicians in prioritizing evaluations, work with triage clinicians to assign higher acuity scores to older adults with specific chief complaints associated with high morbidity and mortality (e.g. “abdominal pain,” “altered mental status”). Incorporating assessment of frailty into triage algorithms (e.g. Clinical Frailty Score) may improve predictions of resource utilization and clinical acuity and prioritize triage and disposition decisions for this high-risk group.

- When dealing with crowding in waiting rooms, educate ED staff about prioritizing evaluation and reassessment of older adults to avoid risks of dehydration, delirium, and clinical decompensation.

Boarding in a bright, loud, and overcrowded ED environment with minimal opportunities for hydration, eating, mobility, and toileting as well as missed daily medications can contribute to delirium in older adults.

- Prioritize rooming older adults and taking them out of hallway beds as quickly as possible.
- Consider recliner chairs rather than gurneys for boarding patients, as these are more comfortable and encourages older adults to ambulate and interact socially.
- Educate staff and develop electronic health record-based reminders to administer patients’ crucial daily medications (e.g. for Parkinson’s disease) that might otherwise be missed as they board.
- Consider alternatives to inpatient admission when clinically appropriate or compatible with a patient’s care preferences, which can be elicited within three minutes using simple questions outlined by geriatricians and palliative care specialists. Examples of alternatives to admission include home hospital programs, telemedicine follow-up, or virtually monitored interventions carried out by nurses and/or paramedics. When these pathways are unavailable,
consider focused pre-discharge risk stratification and shared decision-making revolving around holistic care of the most vulnerable older adults.

**SYMPTOM CONTROL AND SOCIAL CONNECTION AT THE END OF LIFE**

EDs increasingly provide end-of-life care. However, ED clinicians and staff have variable training in end-of-life communication strategies and symptom management. Infection control measures may limit the number of loved ones at bedside at the end of life.

- Educate staff on how to have rapid value-based serious illness conversations. Rather than simply eliciting code status, these conversations determine a patient’s values and preferences for interventions that would allow them to live with a quality of life they find acceptable, and subsequently guide clinicians in making therapeutic recommendations that align with patients’ goals.
- Work with geriatrics and palliative medicine specialists to develop protocols for symptom management, consultation in the ED, and referrals to hospice.
- Utilize audio-visual platforms to conference with care partners and relatives at the end of life.

**CONCLUSION**

In summary, EDs can take several actions to address challenges posed by the COVID-19 pandemic in the emergency care experiences of older adults. We highlight communication, boarding, and end-of-life care as three key areas of healthcare improvement based on our experiences with ED operations and geriatric acute care innovations. Several of the strategies we offer require no or low cost but may require buy-in from ED administrators and leadership. Our authorship team includes physician leaders from both geriatric-accredited and non-accredited institutions. In our experience, even in EDs without dedicated geriatrics resources, a geriatrics champion who promotes efforts such as the above can motivate geriatric healthcare improvement.

**KEYWORDS**

Boarding, triage, disposition, communication, end-of-life care

**AFFILIATIONS**

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anita Chary MD, PhD</td>
<td>Section of Health Services Research, Dept. of Medicine; Dept. of Emergency Medicine; Center for Innovations in Quality, Effectiveness and Safety; Baylor College of Medicine</td>
</tr>
<tr>
<td>Shan W. Liu MD, ScD</td>
<td>Dept. of Emergency Medicine, Massachusetts General Hospital, Harvard Medical School</td>
</tr>
<tr>
<td>Lauren Southerland MD</td>
<td>Department of Emergency Medicine, Ohio State University</td>
</tr>
<tr>
<td>Lauren Cameron-Comasco MD, FACEP</td>
<td>Dept. of Emergency Medicine, Beaumont Hospital-Royal Oak, Oakland University William Beaumont School of Medicine</td>
</tr>
<tr>
<td>Kei Ouchi MD, MPH</td>
<td>Department of Emergency Medicine, Brigham and Women’s Hospital, Dana Farber Cancer Institute</td>
</tr>
<tr>
<td>Christopher R. Carpenter MD, MSc</td>
<td>Department of Emergency Medicine, Barnes Jewish Hospital, Washington University School of Medicine</td>
</tr>
<tr>
<td>Edward W. Boyer MD, PhD</td>
<td>Department of Emergency Medicine, Ohio State University, Harvard Medical School</td>
</tr>
<tr>
<td>Aanand D. Naik MD</td>
<td>Department of Management, Policy, and Community Health, UT School of Public Health and UT Health Consortium on Aging</td>
</tr>
<tr>
<td>Maura Kennedy MD, MPH</td>
<td>Dept. of Emergency Medicine, Massachusetts General Hospital, Harvard Medical School</td>
</tr>
</tbody>
</table>
CORRESPONDING AUTHOR
Anita Chary, MD PhD
2450 Holcombe Blvd., Suite 01Y
Center for Innovations in Quality, Effectiveness and Safety
Houston, TX 77021
anita.chary@bcm.edu

AUTHOR CONTRIBUTIONS
Both authors contributed to the conceptualization, writing, and revision of this article.

Sponsor Role: There were no sponsors of this work.

Funding: There was no funding for this work.

CONFLICTS OF INTEREST
Authors have no conflicts to report.

REFERENCES
doi:10.1111/acem.14460


doi:10.1177/09514848211028707


