

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-19.¹ Specific considerations regarding the presentation and treatment of COVID-19 in older adults have previously been outlined.² 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.³⁻⁵ 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.⁶ The absence of care partners at bedside is associated with decreased availability of collateral information,⁷ decreased patient comfort, and an increase in rate of inpatient falls with hip fractures.⁸ 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.⁹

- 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.¹⁰ 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.¹¹ 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.¹²
- 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.^{13,14}

- 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.¹⁵
- 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.¹⁶
- 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.^{17,18} Examples of alternatives to admission include home hospital programs,¹⁹ telemedicine follow-up, or virtually monitored interventions carried out by nurses and/or paramedics. When these pathways are unavailable,

consider focused pre-discharge risk stratification²⁰ and shared decision-making revolving around holistic care of the most vulnerable older adults.^{21,22}

SYMPTOM CONTROL AND SOCIAL CONNECTION AT THE END OF LIFE

EDs increasingly provide end-of-life care.²³ 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.²⁴
- Work with geriatrics and palliative medicine specialists to develop protocols for symptom management, consultation in the ED, and referrals to hospice.²⁵
- Utilize audio-visual platforms to conference with care partners and relatives at the end of life.²⁶

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

Anita Chary MD, PhD	Section of Health Services Research, Dept. of Medicine; Dept. of Emergency Medicine; Center for Innovations in Quality, Effectiveness and Safety; Baylor College of Medicine
Shan W. Liu MD, ScD	Dept. of Emergency Medicine, Massachusetts General Hospital, Harvard Medical School
Lauren Southerland MD	Department of Emergency Medicine, Ohio State University
Lauren Cameron-Comasco MD, FACEP	Dept. of Emergency Medicine, Beaumont Hospital-Royal Oak, Oakland University William Beaumont School of Medicine
Kei Ouchi MD, MPH	Department of Emergency Medicine, Brigham and Women’s Hospital, Dana Farber Cancer Institute
Christopher R. Carpenter MD, MSc	Department of Emergency Medicine, Barnes Jewish Hospital, Washington University School of Medicine
Edward W. Boyer MD, PhD	Department of Emergency Medicine, Ohio State University, Harvard Medical School
Aanand D. Naik MD	Department of Management, Policy, and Community Health, UT School of Public Health and UT Health Consortium on Aging
Maura Kennedy MD, MPH	Dept. of Emergency Medicine, Massachusetts General Hospital, Harvard Medical School

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

1. Centers for Disease Control and Prevention. COVID Data Tracker. Centers for Disease Control and Prevention. Published March 28, 2020. Accessed April 21, 2022. <https://covid.cdc.gov/covid-data-tracker>
2. Malone ML, Hogan TM, Bonner A, Biese K, Pagel P, Unroe K. COVID-19 in Older Adults- A Practical Review for Emergency Providers in 2022. *J Geriatr Emerg Med.* 2022;3(1):19.
3. Fareed N, Southerland LT, Rao BM, Sieck CJ. Geriatric assistive devices improve older patient engagement and clinical care in an emergency department. *Am J Emerg Med.* Published online August 2020. doi:10.1016/j.ajem.2020.07.073
4. Lichen IM, Berning MJ, Bower SM, et al. Non-pharmacologic interventions improve comfort and experience among older adults in the Emergency Department. *Am J Emerg Med.* 2021;39:15-20. doi:10.1016/j.ajem.2020.04.089
5. Chodosh J, Goldfeld K, Weinstein BE, et al. The HEAR-VA Pilot Study: Hearing Assistance Provided to Older Adults in the Emergency Department. *J Am Geriatr Soc.* 2021;69(4):1071-1078. doi:10.1111/jgs.17037
6. Lo AX, Wedel LK, Liu SW, et al. COVID-19 hospital and emergency department visitor policies in the United States: Impact on persons with cognitive or physical impairment or receiving end-of-life care. *J Am Coll Emerg Physicians Open.* 2022;3(1):e12622. doi:10.1002/emp2.12622
7. Chary AN, Castilla-Ojo N, Joshi C, et al. Evaluating older adults with cognitive dysfunction: A qualitative study with emergency clinicians. *J Am Geriatr Soc.* Published online November 18, 2021. doi:10.1111/jgs.17581
8. Silvera GA, Wolf JA, Stanowski A, Studer Q. The influence of COVID-19 visitation restrictions on patient experience and safety outcomes: A critical role for subjective advocates. *Patient Exp J.* 2021;8(1):30-39. doi:10.35680/2372-0247.1596
9. Fiest KM, Krewulak KD, Sept BG, et al. A study protocol for a randomized controlled trial of family-partnered delirium prevention, detection, and management in critically ill adults: the ACTIVATE study. *BMC Health Serv Res.* 2020;20(1):453. doi:10.1186/s12913-020-05281-8
10. Kelen GD, Wolfe R, D'Onofrio G, et al. Emergency Department Crowding: The Canary in the Health Care System. *NEJM Catal Innov Care Deliv.* Published online September 28, 2021. Accessed April 26, 2022. <https://catalyst.nejm.org/doi/full/10.1056/CAT.21.0217>
11. Ginsburg AD, Oliveira J E Silva L, Mullan A, et al. Should age be incorporated into the adult triage algorithm in the emergency department? *Am J Emerg Med.* 2021;46:508-514. doi:10.1016/j.ajem.2020.10.075

12. Rueegg M, Nissen SK, Brabrand M, et al. The clinical frailty scale predicts 1-year mortality in emergency department patients aged 65 years and older. *Acad Emerg Med*. n/a(n/a). doi:10.1111/acem.14460
13. van Loveren K, Singla A, Sinvani L, et al. Increased Emergency Department Hallway Length of Stay is Associated with Development of Delirium. *West J Emerg Med*. 2021;22(3):726-735. doi:10.5811/westjem.2021.1.49320
14. Moura Junior V, Westover MB, Li F, et al. Hospital complications among older adults: Better processes could reduce the risk of delirium. *Health Serv Manage Res*. Published online July 11, 2021;9514848211028708. doi:10.1177/09514848211028707
15. Wilber ST, Burger B, Gerson LW, Blanda M. Reclining chairs reduce pain from gurneys in older emergency department patients: a randomized controlled trial. *Acad Emerg Med Off J Soc Acad Emerg Med*. 2005;12(2):119-123. doi:10.1197/j.aem.2004.10.016
16. Liu SW, Chang Y, Weissman JS, et al. An Empirical Assessment of Boarding and Quality of Care: Delays in Care Among Chest Pain, Pneumonia, and Cellulitis Patients. *Acad Emerg Med*. 2011;18(12):1339-1348. doi:10.1111/j.1553-2712.2011.01082.x
17. Biese K. "What Matters" beyond the MOLST. In: *ACEP21 Geriatric Pre-Conference: The 4Ms and Geriatric Emergency Care*. ; 2021.
18. Tinetti ME. Condensed-Conversation-Guide-for-Identifying-Patient-Priorities-The-One-Thing-ED-version.pdf. Condensed Conversation Guide for Identifying Patient Priorities (The One Thing) Emergency Department version. Published 2020. Accessed April 21, 2022. <https://patientprioritiescare.org/wp-content/uploads/2020/03/Condensed-Conversation-Guide-for-Identifying-Patient-Priorities-The-One-Thing-ED-version.pdf>
19. Ouchi K, Liu S, Tonellato D, Keschner YG, Kennedy M, Levine DM. Home hospital as a disposition for older adults from the emergency department: Benefits and opportunities. *J Am Coll Emerg Physicians Open*. 2021;2(4):e12517. doi:10.1002/emp2.12517
20. Southerland LT, Pearson S, Hullick C, Carpenter CR, Arendts G. Safe to send home? Discharge risk assessment in the emergency department. *Emerg Med Australas*. 2019;31(2):266-270. doi:10.1111/1742-6723.13250
21. Yiadom MYAB, Scheulen J, McWade CM, Augustine JJ. Implementing Data Definition Consistency for Emergency Department Operations Benchmarking and Research. *Acad Emerg Med*. 2016;23(7):796-802. doi:10.1111/acem.12988
22. Shared Decision Making to Improve the Emergency Care of Older Adults: A Research Agenda - Hogan - 2016 - Academic Emergency Medicine - Wiley Online Library. Accessed April 28, 2022. <https://onlinelibrary.wiley.com/doi/10.1111/acem.13074>
23. Arendts G, Carpenter CR, Hullick C, Burkett E, Nagaraj G, Rogers IR. Approach to death in the older emergency department patient. *Emerg Med Australas*. 2016;28(6):730-734. doi:10.1111/1742-6723.12678
24. Ouchi K, Lawton AJ, Bowman J, Bernacki R, George N. Managing Code Status Conversations for Seriously Ill Older Adults in Respiratory Failure. *Ann Emerg Med*. 2020;76(6):751-756. doi:10.1016/j.annemergmed.2020.05.039
25. O'Mara L, Streiter S, Orkaby A, Ouchi K, Bernacki R. A Framework to Triage Older Adults with Covid-19 to Provide Patient-Centered Care. *NEJM Catal Innov Care Deliv*. Published online November 5, 2020. Accessed May 5, 2022. <https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0552>
26. Landry A, Ouchi K. Story of human connection. *Emerg Med J EMJ*. 2020;37(8):526. doi:10.1136/emered-2020-209987