JOURNAL OF GERIATRIC EMERGENCY MEDICINE

Fall 2022 | Volume 3 | Issue 3 Article 7 | Collective Wisdom: Editorial

JGEM | The Journal of Geriatric Emergency Medicine

The Geriatric Emergency Department at the University of California San Francisco: Structures, Roles, and Lessons Learned

Todd James, MD

The University of San Francisco (UCSF) is responding to changing demographics with the development of an accredited Geriatric Emergency Department (GED). This manuscript will discuss the formation of the UCSF GED, describing how a collaboration of clinician leaders moved us forward and including a description of challenges and lessons learned for successful GED implementations.

BACKGROUND AND RATIONALE

The University of California (UC) includes six regional academic medical centers, twenty health professional schools, and systemwide services such as the Center for Health Quality and Innovation. UCSF and three other UC academic medical centers (UC San Diego, UC Davis, and UC Irvine) currently have Level 1 GEDs accreditation from the American College of Emergency Physicians (ACEP).

UCSF has multiple programs that are focused on the needs of older adults and UCSF has been recognized by the Institute for Health Care Improvement (IHI) as an Age-Friendly Health System. Locally, we found that the use of the word "geriatrics" in our ED was not consistent with messaging of our Age-Friendly Health System activities, and thus we changed our GED program name to the Age-Friendly ED (AFED).

The UCSF ED receives approximately 36,000 visits annually and has 35 acute beds and 10 observation beds. Adults who are age 65 and older account for 32% of visits. This is much higher than the national average of 17.9% reported in 2018 by the National Hospital Ambulatory Medical Care Survey.[1] These statistics indicated the increasing importance of addressing the unique needs of older adults and launched a collaborative effort to create a GED program.

For the AFED, the Department of Emergency Medicine (DEM) leadership sought input from the Division of Geriatrics, the Department of Neurology, and the Department of Psychiatry as well as pharmacy, social work, chaplaincy, and physical therapy teams. Geriatrics is well-versed in quality and value improvement programs and was already working with the DEM for the development of the UCSF Hip Fracture Protocol Care Pathway and the Safe Mobilization program. These programs bring together multiple disciplines to promote new consensus and practice change for older adults. DEM faculty identified that a collaborative approach with geriatrics would strengthen the AFED program, expand program outcomes, and modulate practice change in the ED. Geriatrics expertise regarding older adult medicine, care transitions and multiple models and settings of care was seen as vital to creating value and sustainability.

STRUCTURE AND ROLES

The AFED program structure at UCSF was driven by the ACEP GED Level 1 accreditation requirements. Many GEDs created programs that depend on nursing staff for implementation. We followed the lead of an advanced practice provider (APP) model GED at Bridgeport Hospital of Yale New Haven Health.

Our AFED staffing model includes not only APPs but a dedicated social worker and a dedicated pharmacist. We provide training in geriatrics principles. The medical director of the program is an ED physician. Nonetheless, the APPs are hired through the Division of Geriatrics, and this enables them to function as a consulting service for independent service billing. We project that this arrangement will enhance sustainability within our health system. To harmonize with other geriatrics programs in the health system and to provide feedback and consistency, geriatricians review AFED notes and are given protected time to share feedback. The AFED has 27 unique care pathway protocols, including likely one of the first protocols for caregiver assessment, which includes the Kingston Caregiver Stress Scale.

Many in geriatrics view older adults through a lens that recognizes many stages of aging, such as described by Louise Aronson in her book *Elderhood*, and this insight generates benefits to the AFED. We conduct a modified comprehensive geriatric assessment to identify vulnerabilities and areas of resiliency. Each older adult is unique, and we adapt our assessments and recommendations accordingly.

Utilizing geriatric expertise leads to improved outcomes for older adults. Nationally and locally, geriatricians have developed and promoted new models of care such as GRACE,[2] ACE,[3] Geriatrics-Orthopedics programs,[4] UCSF Care Support,[5] and house calls medicine to bring the benefits of a geriatrics focus into new settings. This has frequently resulted in higher quality of care, lower costs, and improved patient experiences. In a similar manner, pursuing ACEP GED accreditation has led to the creation of a new care program for older adults within the ED and we anticipate similar quality improvements, such as reduced recidivism.

CHALLENGES AND LESSONS LEARNED

As with any new program, the UCSF AFED has faced challenges. From our progress, we can offer four lessons learned while leading change. See **Table 1**.

Table 1: GED Development: Four Lessons Learned
1. Embrace complexity.
2. Engage champions.
3. Utilize clinical protocols.
4. Establish interprofessional education through a geriatrics lens.

First, it is helpful to have fortitude and a sense of adventure when managing health system complexity. Obstacles cannot be fully anticipated in complex systems.[6] We have found that program obstacles are frequent, such as needing a new billing entity for geriatrics in the ED setting or creating a process for an effective consult order. Other obstacles are obscure such as permitting the social worker to access geriatric assessments in the nursing template rather than duplicating the assessment elsewhere. Indeed, even having a physical item such as a clock placed in a patient space can take months to accomplish. There are many competing priorities and limitations in healthcare settings. Yet, even small changes begin to have an impact on older adults, which increases engagement and morale for teams in the ED. For example, we saw a patient with dementia who exhausted their caregivers. The AFED team was able to organize placement into an appropriate congregate living facility without hospital admission.

Second, it is essential to have champions. Champions are those individuals dedicated to the vision and the culture change that is needed to enable successful programs for older adults. Champions are needed at multiple levels for a program to succeed, including within front-line teams, the institution, and the community. When champions have system knowledge, contacts, and dedication to the needs of the program, it is possible for a program such as AFED to respond to older adults with expanded capacity and effectiveness. The UCSF AFED depends on champions in each of these areas. One AFED clinician was a champion when he focused on the development of a unique clinical note template. With determination, perseverance, and institutional connections, he succeeded.

Third, standardized protocols increase and reinforce new activities. Protocols for older adults recognize how their needs are different from other patient populations. Protocols drive behavior change and develop relationships and pathways for interacting across programs, health systems, and institutions. Geriatricians in the UCSF AFED were able to use experience and knowledge to advocate for older adults and create protocols that emphasized their unique needs in the ED.

Fourth, interprofessional education through a geriatric lens is needed to build the knowledge, skills, and attitudes which are effective for working with older adults and their caregivers.[7] Systematic geriatric approaches allow for patient-centered care. This care requires outreach to build teams and community connections that benefit patients beyond the ED setting. Indeed, multiple health professionals working and learning together are vital for older adult programs. We have developed novel referral pathways across programs to ease the workload in primary care and extend continuity of care beyond the walls of the ED. Referral pathways that engage the community currently include:

- UCSF Osher Center for Integrative Health's AGE SELF CARE Group Visit Program
- Memory and Aging Center Referral for Cognitive Evaluation Pathway
- On Lok Connected Care Pathway for care coordination

CONCLUSION

In summary, the UCSF AFED is responding to increasing numbers of older adults with a targeted geriatric program, and the AFED is one of four Level 1 GEDs at UC academic medical centers. Our broad group of clinician leaders brings greater effectiveness to this new program implementation. By deploying a team of health professionals in a systematic and collaborative way, the AFED supports patients and caregivers and expands the reach of the AFED through community partnerships. In addition, we believe GEDs are enhanced by directly engaging complexity, identifying champions, developing protocols, and interprofessional education through a geriatric lens.

KEYWORDS

GED, Geriatrics, Age-Friendly, Lessons, Interprofessional, Protocols

AFFILIATIONS

Todd James, MD	University of California, San Francisco

CORRESPONDING AUTHOR

Todd James, MD
Todd.james@ucsf.edu

ACKNOWLEDGMENTS

Sponsor Role: There were no sponsors for this work.

Funding: There was no funding for this work.

CONFLICTS OF INTEREST

The author has no conflicts to report.

REFERENCES

1. Cairns C, Kang K, Santo L. National Hospital Ambulatory Medical Care Survey: 2018 emergency department summary tables. Available from: https://www.cdc.gov/nchs/data/nhamcs/web_tables/2018_ed_web_tables-508.pdf.
2. Counsell SR, Callahan CM, Tu W, Stump TE, Arling GW. Cost analysis of the Geriatric Resources for Assessment and Care of Elders care management intervention. J Am Geriatr Soc. 2009 Aug;57(8):1420-6. doi: 10.1111/j.1532-5415.2009.02383.x. PMID: 19691149; PMCID: PMC3874584

3. Rogers SE, Flood KL, Kuang QY, Harrison JD, Malone ML, Cremer J, Palmer RM. The current landscape of Acute Care for Elders units in the United States. J Am Geriatr Soc. 2022 Jun 6. doi: 10.1111/jgs.17892. Epub ahead of print. PMID: 35666631
4. Rogers SE, Ko JS, McNicoll L, Mendelson DA. The Diverse Implementation of Geriatrics-Orthopedics Comanagement Programs in the United States. Journal of the American Geriatrics Society. 2020 Aug;68(8):1714-1719. DOI: 10.1111/jgs.16677. PMID: 32632949
5. Ritchie C, Andersen R, Eng J, Garrigues SK, Intinarelli G, Kao H, Kawahara S, Patel K, Sapiro L, Thibault A, Tunick E, Barnes DE. Implementation of an Interdisciplinary, Team-Based Complex Care Support Health Care Model at an Academic Medical Center: Impact on Health Care Utilization and Quality of Life. PLoS One. 2016 Feb 12;11(2):e0148096. doi: 10.1371/journal.pone.0148096. PMID: 26871704; PMCID: PMC4752211.
6. Martin CM. Complex adaptive systems approaches in health care-A slow but real emergence? J Eval Clin Pract. 2018 Feb;24(1):266-268. doi: 10.1111/jep.12878. PMID: 29589876.
7. Kottek, A., Bates, T., Spetz, J. (2017). The Roles and Value of Geriatricians in Health Care Teams: A Landscape Analysis. San Francisco, CA: UCSF Health Workforce Research Center on Long-Term Care.