

JOURNAL OF GERIATRIC EMERGENCY MEDICINE

Winter 2022-2023 | Volume 3 | Issue 4

Article 4 | Collective Wisdom: Editorial

JGEM | The Journal of Geriatric
Emergency Medicine



The Geriatric Emergency Departments as Laboratories for Innovation

Brian W. Patterson, MD, MPH, Manish Shah, MD, MPH

The following manuscript is an Editorial to accompany this published [JGEM article](#).

Increasing numbers of emergency department (ED) visits are being made by older adults. Unfortunately, there is widespread recognition that current ED systems are poorly designed to serve this population's unique needs, both in terms of addressing acute illnesses and injuries and managing complex medical and psychosocial issues. One strategy to address these needs is to create geriatric EDs with a specific focus on caring for older adults. To this end, the American College of Emergency Physicians (ACEP) created the Geriatric Emergency Department Accreditation (GEDA) Program, accrediting institutions as Geriatric EDs (GEDs) based on their ability to assess and intervene to improve geriatric emergency care by meeting certain criteria. During accreditation, EDs apply to become level 1, 2, or 3 facilities based on resources available and policies and processes in place to adhere to best practices in geriatric emergency care. To achieve level 1 status, GEDs must have protocols or policies for 20 of the 27 GED guidelines, with 10 of the 27 being necessary for level 2 status. Furthermore, individual GEDs may specify how they address each individual policy or process.

This article by Santangelo et. al. analyzes the application materials for all level 1 and 2 GEDs accredited in a roughly three-year period.¹ The authors summarize the inclusion of and approach to five important GED care processes by abstracting the applications of 35 of the 36 approved GEDs that met their inclusion criteria. The study identified significant heterogeneity as to which of the five care processes were included, as well as how the processes were achieved. Results ranged from fall prevention, for which 89% of studied GEDs used one of 13 different screening protocols, to dementia, for which 49% of studied GEDs screened at least some patients, using one of seven different screening protocols. The authors noted similar heterogeneity among the responses to positive screens and the personnel carrying out screening.

This study has a few key limitations to consider: Data was only collected from the applications for accreditation, which may or may not reflect sustained practices in the included GEDs. After multiple years of experience, the topics of focus may have changed. Additionally, in many cases, GEDs report screening "subsets" of older adult patients. While identifying appropriate subsets of older adults for specific interventions and workflows is an important goal in creating feasible and effective workflows,² details regarding how the subsets are chosen and identified are unavailable. For example, a subset of patients could be screened for falls based on preselected risk factors or based on the availability of an additional nurse who performed screening. Finally, while care processes have face validity, limited data support their effectiveness. Thus, we do not actually know if the presence of the majority of these processes leads to a measurable impact on patient-centered outcomes.

Despite these limitations, this study provides an excellent overview of the initial activities planned for accredited level 1 and 2 GEDs. The variation between accredited sites may be seen both as

a strength and weakness of the GEDA Program. During the study period, only 36 level 1 and 2 GEDs were accredited. Current ACEP data shows 69 GEDs are currently accredited or pending accreditation as level 1 or level 2 centers and 319 centers have achieved the lower level 3 accreditation. This data confirms that this program is still in its relative infancy. At this stage, we can conceive of individual level 1 and level 2 GEDs as laboratories for innovation, where best practices continue to emerge to improve care for older adults. In this sense, the heterogeneity of care practices uncovered in this study is a major strength. For instance, individual GEDs use 13 different screening protocols for fall risk because one has not yet emerged that is superior to the others in terms of accuracy and feasibility. Unfortunately, variation in workflows between accredited centers can also be a weakness, as accreditation is less meaningful if it does not clearly communicate a set of expected practices to both patients and providers.

For the strengths of the current variation to be realized, GEDs must not only develop workflows to effectively meet GEDA Program requirements but must demonstrate the feasibility and effectiveness of these workflows and promote dissemination. GEDs may be leading a movement towards improved care for older adults, but given these few centers see only a tiny fraction of older adult ED patients, this mission can only be realized by identifying interventions that are seen as worth implementing more broadly. EDs already face challenges to maintain basic emergency services in the current environment of high volumes, inpatient boarding, low staffing, and uncertain reimbursement. Thus, only interventions that provide clear benefits without undue provider burden are likely to achieve widespread uptake. There are several reasons to be hopeful that such interventions are possible. Some programs are taking advantage of existing payment structures to provide older ED patients with needed services.³ New programs to improve care transitions have the potential to enable higher quality care while lowering costs.³ Excitingly, advances in artificial intelligence and automation are enabling the identification of at-risk ED patients without burdening ED clinicians.⁴ At this stage in the development of geriatric emergency medicine, one of the critical steps in surfacing best practices is a rigorous evaluation of the outcomes as centers innovate. Professional societies and research networks such as GEAR 1.0⁵ and 2.0⁶ can help to identify research priorities and spotlight promising programs, however individual centers need to commit to evaluation and publication so that their efforts are noticed and applied beyond single institutions.

This study should be seen as a call to action to expand efforts in delineating best practices based on achievable workflows with proven results. As the GEDA Program continues to mature and the best ED practices are defined, variation between GEDs as identified in this article will become increasingly harmful to the long-term goal of accreditation: improving patient care. Just as with trauma, stroke, or STEMI centers, a set of clear standards of care will be needed to define the core capabilities of GEDs to meet the expectations of patients and providers. ACEP accreditation guidelines will need to evolve to better specify which components of care are no longer optional for a GED. Ideally, this will occur because centers are currently free to innovate and experiment to produce high-quality evidence which will lead to an accreditation process focused on meeting proven metrics to improve outcomes. In the absence of such evidence, standardization of arbitrary workflows risks damaging the legitimacy and usefulness of the accreditation process.

KEYWORDS

Geriatric Emergency Department

AFFILIATIONS

Brian W. Patterson, MD, MPH	BerbeeWalsh Department of Emergency Medicine, University of Wisconsin-Madison School of Medicine and Public Health Department of Biostatistics and Medical Informatics, University of Wisconsin-Madison School of Medicine and Public Health Department of Industrial and Systems Engineering, University of Wisconsin-Madison
Manish N. Shah, MD, MPH	BerbeeWalsh Department of Emergency Medicine, University of Wisconsin-Madison School of Medicine and Public Health Department of Medicine, Division of Geriatrics and Gerontology, University of Wisconsin-Madison School of Medicine and Public Health Department of Population Health Sciences, University of Wisconsin-Madison School of Medicine and Public Health

CORRESPONDING AUTHOR

Brian Patterson, MD, MPH
bpatter@medicine.wisc.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. Santangelo I, Ahmad S, Liu S, et al. Examination of geriatric care processes implemented in level 1 and level 2 geriatric emergency departments. Accepted at *Journal of Geriatric Emergency Medicine*. 2023.
2. Carpenter C, Mooijaart S. Geriatric Screeners 2.0: Time for a Paradigm Shift in Emergency Department Vulnerability Research. *J Am Geriatr Soc*. 2020;68(7):1402-1405.
3. Shah MN, Hollander MM, Jones CMc, et al. Improving the ED-to-Home Transition: The Community Paramedic-Delivered Care Transitions Intervention-Preliminary Findings. *Journal of the American Geriatrics Society*. 2018 Nov 2018;66(11) doi:10.1111/jgs.15475
4. Jacobsohn G, Leaf M, Liao F, et al. Collaborative design and implementation of a clinical decision support system for automated fall-risk identification and referrals in emergency departments. *Healthcare (Amsterdam, Netherlands)*. 2022 Mar 2022;10(1):100598. PMID: PMC8881336.
5. Geriatric Emergency care Applied Research Network (GEAR). Gear 1.0 Research Priorities. <https://gearnetwork.org/about-gear-1/research-priorities-gear1/>
6. Geriatric Emergency care Applied Research Network (GEAR). GEAR 2.0 Research Priorities. <https://gearnetwork.org/about-gear-2/research-priorities-gear2/>