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An Inflection Point to Improve the Emergency Care of Older Adults

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The following manuscript is an Editorial to accompany this published JGEM Review Article.

In the JGEM article linked above, Gerson et al[1] describe the history and journey of geriatric emergency medicine to the present day. As they clearly illustrate, today's champions of improved emergency care for older adults are standing on the shoulders of giants who over the last several decades have demonstrated that older adults needing emergency care are at risk for adverse health outcomes. They use emergency services at higher rates and require more resources.[2] These initial studies that revealed the complexity of caring for older adults in the ED, founded the field of geriatric emergency medicine to catalyze research and education to refine the care of older adults in the Emergency Department.

Sadly, the COVID pandemic has only made it clearer that despite the amazing heroes who work in emergency departments around the globe, the physical structures and care processes of emergency departments are poorly matched to the needs of many vulnerable older adults. The challenges to improve the care of older adults with multimorbidity with complex medical and psychosocial concerns in fast-paced and chaotic emergency department remains. **Table 1** below highlights the challenges of older adults who receive care in the emergency department. Fortunately, due to the efforts of many for decades, we may be at an inflection point of substantial and sustainable improved emergency care for older adults.

Table 1: Challenges in the Care of Older Adults in the Emergency Departments
1. Medical complexity of older adults receiving care e.g., multimorbidity, immunotherapy for advanced cancers, polypharmacy
2. Complex social needs in situations of suspected elder abuse, self-neglect, and lack of social support
3. Unmet psychological needs for patients with Dementia, behavioral disturbances in dementia, mental health problems, and mood disorders
4. Shortage of staff/workforce with knowledge in principles of geriatric care
5. Opportunities to disseminate or optimize geriatric emergency care
6. Crowding and boarding of older adults
7. Coordinating the care transitions beyond the emergency department

Today's Geriatric Emergency Medicine champions, including clinicians around the globe, the West Heath Institute and John A Hartford Foundation, and collaborating patient advocate groups are working towards the same goal: evolved standards of emergency care for older adults. Like the giants before us, we continue to focus on education and research to advance the standards of emergency care for older adults. This joint endeavor is accelerating geriatric emergency department accreditation, alignment with payment reform, and advocacy. In the next 10 years, we seek to ensure that the standard of care for emergency departments evolves to include the central tenants of geriatric emergency care. The focus is three-fold:

1. ensuring that ED visits are therapeutic rather than inadvertently iatrogenic
2. emergency care for older adults address both the immediate concern and relevant underlying geriatric syndromes
3. that geriatric principles of care are incorporated in telehealth programs in order to efficiently treat patients in the home setting when clinically appropriate.

The evolvement of this work would create emergency departments and providers capable to attend to the unique needs of geriatric patients. For example, when an older adult with a history of dementia with behavioral and psychological symptoms presents to an ED after a fall, the ED team both ensures a therapeutic setting and appropriate nonpharmacologic strategies to prevent delirium or deploy interventions that will prevent the escalation of difficult behaviors. Holistic care takes advantage of the unfortunate opportunity the fall presents to ensure that contributing factors to the fall (polypharmacy, debilitation, home safety, and caregiver support) are addressed to the best of the ED team's ability - with referrals for further support made whenever possible and appropriate. This example also creates an opportunity to strengthen telehealth programs and evaluate if there is a clear indication to bring the patient to the ED. In situations where a patient with dementia with behavioral disturbances and caregiver burden is a concern, telehealth programs can determine the need for resources to improve the home environment to prevent future falls and provide caregiver education to address difficult behaviors such as wandering, verbal disruptions, irritability, or sleep disturbances that sometimes can be the sole reason that triggers the visit to the ED.

We seek that it becomes the ED standard of care to identify geriatrics syndromes such as delirium, cognitive impairment, recurrent falls, hearing loss, and behavioral disturbances in dementia among others. The goal is to deploy evidence-based strategies tailored to the unique needs of this vulnerable population. This approach should be directed to reconcile medications, improve safe mobility after the patient leaves the ED and hospital setting, identify elder abuse and mistreatment, optimize care transitions, and, most importantly, focus all efforts on what matters to the patients and their loved ones. Please refer to **Table 2** below. Today we are recognizing these improved care processes through Geriatric Emergency Department (GED) accreditation and, within 10 years, strive to have this care be a standard part of care; similar to obtaining an electrocardiogram on a patient with chest pain. To do less would be to fail to meet the needs of the millions of older adults who need emergency care each year.

Table 2: Eight Critical Actions to Make a Meaningful Difference in the Emergency Care of Older Adults
1. Train and educate caregivers in the ED to effectively screen and assess the unique needs of older adults in the Emergency Department.
2. Work "upstream" from the Emergency Department to guide the care for older persons to avoid the need for emergency care, e.g., primary care, urgent care center, and EMS.
3. Develop care systems to support patients and families in crisis. For example, enhance primary care strategies to assist patients with multimorbidity early in their course of illness.
4. Enhance systems to support vulnerable older adults at risk for self-neglect and elder mistreatment.
5. Enhance community-wide public health approaches for fall prevention.
6. Develop safe and effective alternatives to hospitalization which can be integrated into emergency department care, e.g., hospital at home, advanced home health.
7. Develop systems to support and integrate family caregivers in the emergency department, particularly for those who have cognitive impairment.
8. Expand healthcare literacy that addresses the needs of older adults and family caregivers to prevent non-urgent visits to the emergency department.

Fortunately, a number of confluent forces from the provider, payer, and, most importantly, patient perspectives are coming together to make the best standard of care not only possible but preferable. Provider organizations are in the midst of a profound labor shortage resulting in an in-patient bed shortage. Hospitals need to optimize census management by utilizing in-patient beds for those who need interventions that are only available in the hospital. GEDs have demonstrated to reduce unneeded inpatient admissions, readmissions, ED revisits, and hospital length of stay. Therefore, GEDs are a critically important tool for managing the in-patient census.[3-7]

The mandate to optimize the in-patient census is true within a fee-for-service reimbursement structure. An unnecessary hospital admission results in the hospital likely losing money on a Medicare-funded admission as well as the profound opportunity cost of not being able to accommodate patients needing surgeries and other more highly compensated interventions. This mandate to improve census management is doubly true within risk-based contracting/value-based care arrangements (such as Accountable Care Organizations) where provider organizations suffer financial penalties for increased expenses in addition to the low reimbursement and opportunity costs they lose in their fee-for-service contracts.

Payers also benefit from the enhanced census management capabilities of GEDs. Hospital care accounts for over one-third of the total healthcare cost in our country.[8] Decreased admissions mean decreased total cost of care. If payers and provider organizations that contract with payers, fail to support GEDs, they will miss a tremendous opportunity to help ensure that only patients that need and will benefit from in-patient admissions are admitted to the hospital. Furthermore, CMS has shown an ever-increasing focus on the quality of care for Medicare recipients, and the GED movement improves the quality of care for these patients.

Finally, patients and patient advocacy groups are demanding enhanced emergency care for older adults. During the initial periods of the COVID pandemic, patients, especially older adults, avoided the ED out of fear of catching COVID. The resulting excess deaths were a true tragedy of COVID. Not only were people dying from COVID, but they were also dying from fear of being treated for other emergency conditions.[9] Now during the prolonged COVID pandemic and the resulting staffing shortage, waiting times and boarding times in EDs around the country have dramatically increased thereby increasing the risks of iatrogenesis while in the ED.[10] Partially, as a result of these multiple system stressors, patients and their advocates have been increasingly demanding enhanced geriatric emergency care. AARP, the Alzheimer Association as well as the state governments of California and New York all support rapid dissemination of geriatric emergency care. Patient advocate groups are striving to ensure that this improved patient care is available to all older adults needing emergency care.

In order to make geriatric emergency care the new standard of care, continued research is needed to ensure that advocated care processes are having the intended impact and that the best care processes are indeed being advocated for. While we cannot wait for all needed research on GED care processes to be complete before catalyzing a change, we need to continue to study the impact of GED care processes so as to continue to course correct. With the support of the National Institute for Aging as well as the previously mentioned West Health Institute and John A Hartford Foundation, the Geriatric Emergency Care Applied Research (GEAR) program now leads geriatric emergency medicine research projects around the country.[11]

Today's champions of geriatric emergency care are well-positioned to evolve the standards of emergency care for older adults. This is an opportunity we cannot afford to miss. The dissemination of GEDs across our country will require us to lead at this inflection point. Leaders will need to think big and have a vision that is beyond our current strategies to write the future history of GEDs. Together we will work to make this a reality.

KEYWORDS

Geriatric Emergency Department, Older Adult

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CONFLICTS OF INTEREST

- Kevin Biese, MD - discloses that he serves as the Chair of the Board of Governors for the American College of Emergency Physicians Geriatric Emergency Department Accreditation program, serves as PI for the geriatric emergency department collaborative (GEDC,) and advisor for Third Eye Health, a telehealth provider for skilled nursing facility residents.
- Michael L. Malone, MD - discloses he owns stock in Abbott Labs and AbbVie.
- Jonny Macias Tejada, MD - has no conflicts to report.

REFERENCES

1. Gerson L, Hogan T, Sanders, A . The History of Geriatric Emergency Medicine
2. Aminzadeh F, Dalziel WB. Older adults in the emergency department: a systematic review of patterns of use, adverse outcomes, and effectiveness of interventions. Ann Emerg Med. 2002 Mar;39(3):238-47. doi: 10.1067/mem.2002.121523. PMID: 11867975.
3. Hwang U, Dresden SM, Rosenberg MS, Garrido MM, Loo G, Sze J, Gravenor S, Courtney DM, Kang R, Zhu CW, Vargas-Torres C, Grudzen CR, Richardson LD; GEDI WISE Investigators. Geriatric Emergency Department Innovations: Transitional Care Nurses and Hospital Use. J Am Geriatr Soc. 2018 Mar;66(3):459-466. doi: 10.1111/jgs.15235. Epub 2018 Jan 10. PMID: 29318583; PMCID: PMC6764445.
4. Dresden SM, Hwang U, Garrido MM, Sze J, Kang R, Vargas-Torres C, Courtney DM, Loo G, Rosenberg M, Richardson L. Geriatric Emergency Department Innovations: The Impact of Transitional Care Nurses on 30-day Readmissions for Older Adults. Acad Emerg Med. 2020 Jan;27(1):43-53. doi: 10.1111/acem.13880. Epub 2019 Dec 1. PMID: 31663245.
5. Lesser A, Israni J, Kent T, Ko KJ. Association Between Physical Therapy in the Emergency Department and Emergency Department Revisits for Older Adult Fallers: A Nationally Representative Analysis. J Am Geriatr Soc. 2018 Nov;66(11):2205-2212. doi: 10.1111/jgs.15469. Epub 2018 Aug 21. PMID: 30132800.
6. Simpson M, Sergi C, Malsch A, Ryer S, Rubach C, Singh M. Association of Geriatric Emergency Department post-discharge referral order and follow-up with healthcare utilization. J Am Geriatr Soc. 2022 Dec 1. doi: 10.1111/jgs.18137. Epub ahead of print. PMID: 36455283.
7. Keene SE, Cameron-Comasco L. Implementation of a geriatric emergency medicine assessment team decreases hospital length of stay. Am J Emerg Med. 2022 May;55:45-50. doi: 10.1016/j.ajem.2022.02.027. Epub 2022 Feb 21. PMID: 35276545.
8. https://www.cdc.gov/nchs/hus/topics/health-care-expenditures.htm Accessed March,12, 2023.
9. COVID-19 Excess Mortality Collaborators. Estimating excess mortality due to the COVID-19 pandemic: a systematic analysis of COVID-19-related mortality, 2020-21. Lancet. 2022 Apr 16;399(10334):1513-1536. doi: 10.1016/S0140-6736(21)02796-3. Epub 2022 Mar 10. Erratum in: Lancet. 2022 Apr 16;399(10334):1468. PMID: 35279232; PMCID: PMC8912932.
10. https://www.acep.org/globalassets/new-pdfs/advocacy/emergency-department-boarding-crisis-sign-on-letter-11.07.22.pdf Accessed March,12, 2023.
11. Hwang U, Carpenter C, Dresden S, et al. The Geriatric Emergency Care Applied Research (GEAR) network approach: a protocol to advance stakeholder consensus and research priorities in geriatrics and dementia care in the emergency department. BMJ Open. 2022;12(4):e060974. Published 2022 Apr 22. doi:10.1136/bmjopen-2022-060974