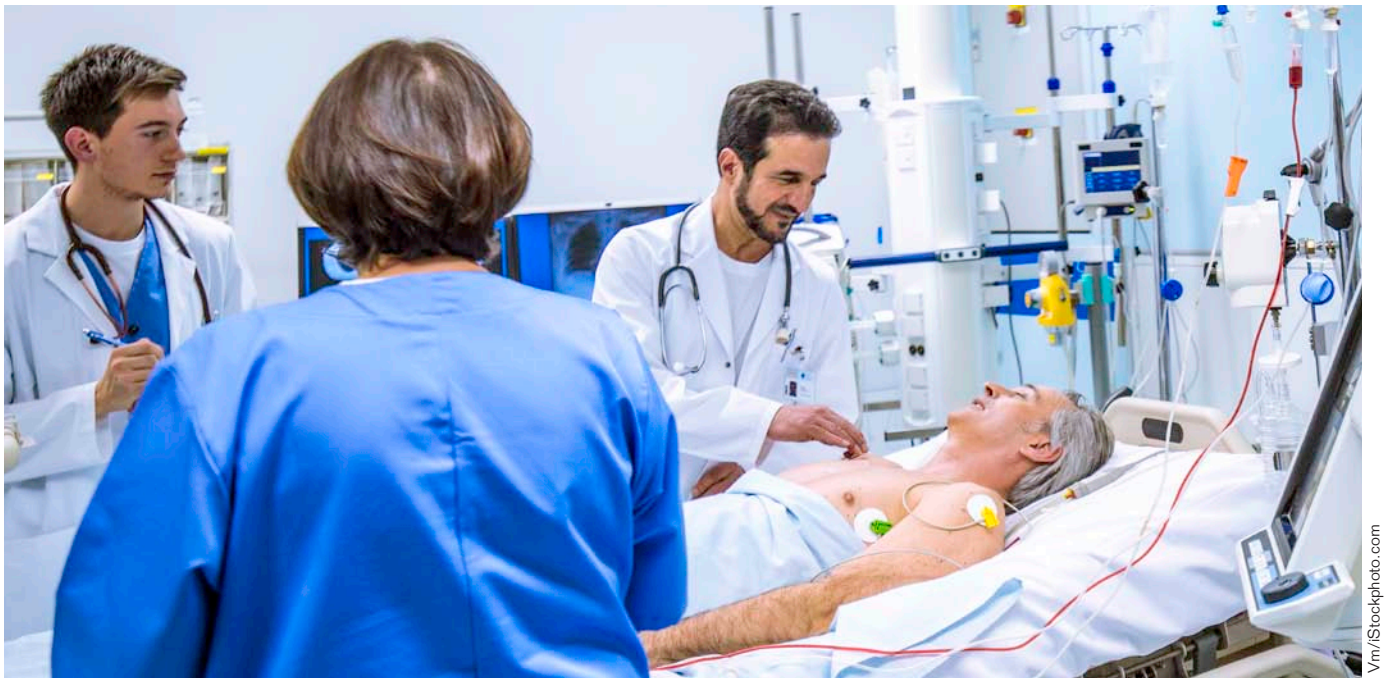
EM's Next Priority: Geriatric ED Care

BY GINA SHAW



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Eight years after the Geriatric Emergency Department Guidelines were published, the vast majority of U.S. emergency departments still do not provide the level of service they recommend, leaving older patients vulnerable depending on where they receive care.

The guidelines were endorsed by the American College of Emergency Physicians, the American Geriatrics Society, the Emergency Nurses Association, and the Society for Academic Emergency Medicine (http://bit.ly/3WWYYqg), which should be imprimatur enough for their adoption, but the guidelines, which characterize the complex needs of older ED patients and current best practices, should be considered only "aspirational" at this time, according to an article written after a panel discussion by emergency physicians and geriatricians at the 2021 American Academy of Emergency Medicine Scientific Assembly and published in the *Journal of Emergency Medicine* and the *Journal of the American Geriatrics Society*. (*J Emerg Med*. 2022;62[5]:585.)

"The GED Guidelines make specific recommendations regarding evaluation protocols, nurse and physician education, emergency department infrastructure, quality improvement dashboard metrics, optimal staffing, and follow-up care," said Richard Shih, MD, a professor of emergency medicine at the Florida Atlantic University Charles E. Schmidt College of Medicine and Delray Medical Center and a senior author of the article. "The recommendations are extensive, and most emergency departments before the guidelines as well as now have neither the resources nor hospital administrative support to provide this best practice type of care."

The article focuses on delirium, falls, and polypharmacy, three high-impact geriatric clinical conditions frequently seen in the ED. Delirium, which occurs in seven to 20 percent of older ED patients and is an independent predictor of death and accelerated cognitive and functional decline, is not only common but often missed in older patients in the emergency department, the authors said.

Approximately one in three community-dwelling adults over 65 suffers falls, and older adults who present to an ED after a fall have an approximately 30 percent greater risk of functional decline and depression at six months after the event. The GED Guidelines for fall prevention reflect best practices, but they are not typically completed in most ED cases. Polypharmacy is also common among older adults and has been associated with adverse drug reactions, but rapidly identifying medication issues is difficult to accomplish in the ED, as is deprescribing.

"The guideline recommendations on these and other areas of geriatric emergency care all make sense, but most emergency departments don't come close to operating that way," Dr. Shih said.

Challenges to Implementation

Geriatric emergency medicine has not been top of mind for leaders in emergency medicine on the national or local front, said Maura Kennedy, MD, the chief of geriatric emergency medicine at Massachusetts General Hospital. She said EDs are in the process of improving care for geriatric ED patients, just not in the time frame they had hoped for when the guidelines came out.

"Change takes time, and the reality is also that there have been a lot of competing priorities," she said. "The COVID-19 pandemic and our boarding crisis have appropriately consumed the attention of a lot of our leadership and taken away some of our local ability to address other issues, including geriatric ED care. With finite resources and time, our leaders have had to make difficult decisions about what to focus on."

An epidemic in geriatric emergency care is coming, and EPs need to prepare for it

Other challenges also prevented wider adoption of the geriatric emergency department guidelines, Dr. Kennedy said, including a tendency to overestimate how well the institution is already doing on these issues. "Among ED leadership and individual clinicians, there remains a lack of knowledge about how good we are or are not at caring for older individuals in the ED," she said. "In a survey we conducted, we found that the vast majority of respondents said they were advanced or expert in detecting delirium among older ED patients, but other studies clearly show that delirium is commonly missed in the ED. There's a lack of recognition that we have a lot of work to do this area."

The health care staffing shortage is another major barrier, Dr. Kennedy said, noting that EDs need physician and nurse champions to be a geriatric ED. "And nurses are being asked to do more and more—suicide screenings, domestic violence screenings, and other required best practices—with more patients boarding in the ED and fewer nurses," she said. "Maintaining quality with one more initiative in the setting of a major nursing shortage is difficult."

EDs can pursue Level 1, 2, or 3 accreditation, with Level 1 being the most rigorous, said Dr. Kennedy, a member of the accreditation team for ACEP's Geriatric Emergency Department Accreditation program (GEDA) that was launched in 2018 and is based on the GED guidelines. "Although adoption of best practices may not be where we want it to be, as of today we have over 350 accredited GEDAs," she said. "It takes a lot of work to get your application through the review process and get it approved, and it costs money with no reimbursement from Medicare or Medicaid, and yet over 350 EDs have received accreditation and we have about 200 in various stages of submission. More importantly, people are coming back and renewing and upgrading. More than 50 sites have

renewed their accreditation, and 13 of those have upgraded from Level 3 to 2 or 2 to 1."

Adoption of GED principles has been particularly challenging in rural hospitals. A 2021 study assessing the reach and adoption of GEDA by Dr. Kennedy and colleagues found that only nine of 225 accredited geriatric EDs at the time were in rural regions. (*Ann Emerg Med*. 2022;79[4]:367; http://bit.ly/3Et19dW.)

These hospitals, often extremely resource-constricted, are particularly in need of incentives to pursue GEDA, but they don't always find them, said Christopher Carpenter, MD, a professor of emergency medicine at Washington University School of Medicine in St. Louis, a member of the GEDA advisory board, and an author of the recent commentary. He said he spoke last year with a colleague from a resource-limited rural hospital that had sought accreditation whose experience was eye-opening.

"They expected it would be highlighted by their institution and would help improve their market share in the region as the only hospital in the area to have geriatric-friendly care," Dr. Carpenter said, but none of that happened. "Their certificate was buried in a back hallway, no administrator drew attention to it or congratulated them, and payers didn't seem to care that they were the region's only geriatric ED."

Positive Feedback

But other rural geriatric EDs have been recognized and inspired their colleagues. Alice Peck Day Memorial Hospital, part of Dartmouth-Hitchcock Health, is a rural 25-bed critical access hospital serving a large geriatric population that achieved Level 2 GEDA certification in 2021.

One area of focus has been transitions of care where their callback program contacts all patients over 70 two to three days after ED discharge, said Jennifer V. Pope, MD, an assistant professor of medicine at Dartmouth's Geisel School of Medicine and the medical director of APD's GEDA program. "When someone is in the ED for an acute issue, they are often distracted, stressed, and in pain, so they may not keep up with the verbal and written instructions given to them by the physician and nurse when they are discharged. Reinforcing these instructions in a follow-up phone call, as well as examining any difficulties they may have understanding or filling prescriptions and barriers they may be finding in getting appointments with specialists or primary care doctors, is very important for our geriatric patients."

After Kristie Foster, RN, an APD ED nurse manager and clinical educator who spearheaded the GEDA program development, spoke at local geriatric meetings about the callback program, other hospitals in the area began following suit and implementing similar initiatives.

"Patients are so touched by our callbacks that they ask to convert over to Alice Peck Day for their primary care. In one month, we had 13 referrals to our primary care program. This is what patients are looking for," Ms. Foster said in a video about the program screened at the 2022 ACEP Scientific Assembly.

"One patient stands out in my memory, a woman in her 80s with back pain that was 10 out of 10," she said. "We sent her home with Tylenol and ibuprofen because there were no acute findings. When we called back, she was almost in tears. She'd tried to get a referral to a pain clinic and was told it would be months. She said, 'I guess I'm just going to have to live with this.' We told her that was not acceptable, and called our primary care service here and got her to see them that day and into the pain clinic that week. She was overcome with gratitude and told us she was a retired nurse, and that she would have been honored to work alongside people like us."

The Next Steps

State officials are also starting to pay attention to geriatric emergency care with initiatives like the one in Massachusetts, where the governor signed a law in 2018 focusing on care of those with Alzheimer's disease and related dementias. One aspect of that law requires hospitals to have an operational plan for caring for those with dementia in acute settings, Dr. Kennedy said. "It's really driving our local hospitals to think about dementia and delirium care in the ED," she said. "New Hampshire recently passed a similar law."

The GED guidelines as written in 2014 were based more on expert consensus than higher quality evidence from the medical literature, said Phillip Magidson, MD, an assistant professor of emergency medicine at Johns Hopkins University School of Medicine and the director of observation and geriatric emergency medicine at Johns Hopkins Bayview Medical Center. And they are now undergoing an exhaustive review and update process.

Dr. Carpenter said this will include a systematic review and meta-analysis for each question in which they walk through the GRADE-based Evidence-to-Decision framework, outlining and citing the scope of the problem and the direct and indirect evidence to support every intervention, diagnostic test, or prognostic test that is recommended. "The review will also quantify the desirable and undesirable effects and cost-effectiveness of the recommended tests or interventions, including health equity considerations," he said.

The effort is entirely unfunded, and the entire clinical team donates its time. Dr. Carpenter said they are starting with systematic reviews for delirium that they hope to publish by the end of the year. After that, they will tackle dementia.

"I believe that as the general population gets older, there is an epidemic in geriatric emergency care coming toward us, and we need to start preparing for it," Dr. Shih said. "More simple emergent conditions are being treated in urgent care centers, and in the ED, we are already seeing more and more complex older patients with a higher acuity rate. I think that trend is going to increase, and we need to start preparing for it now." **EMN**

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