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Addressing America's Greatest Challenges in Emergency Care for Older Adults

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Acute Care for Elders 2024 Virtual Conference

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Disclosures

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John A. Hartford Foundation (GEDC)

West Health Institute (GEDC, GEAR pilots)

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Emergency Medicine Foundation
(GEAR 2.0 pilots)

Dolby Family Foundation
(SF GED Phase 1, SF GED Phase 2-3)

Objectives

1. Understand the role of the ED (crossroads of healthcare) and intersection with older adults and Age-Friendly Healthcare
2. Opportunity and challenges when *detecting conditions, improving care, preventing poor outcomes*

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Why Geriatric Emergency Medicine?

EDs are challenging and ….

The New York Times

SUBSC

Well

DOCTOR AND PATIENT | MARCH 13, 2014, 12:01 AM | 137 Comments

Emergency Rooms Are No Place for the Elderly

By PAULINE W. CHEN, M.D.

Why is Geriatric Emergency Medicine a Challenge?
Different patient care paradigm

Non-geriatric ED Patient	Geriatric ED Patient
Single complaint	Multiple problems • Medical • Functional • Social
Acute	Acute on chronic
Diagnose and treat	***Control symptoms, Maximize function, Restore quality of life***
Rapid Disposition	Continuity of Care

Rosenberg 2013

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Older adults and the ED…

High risk of hospitalization & iatrogenesis

Poor outcomes if discharged to the community

Undetected delirium

Adverse drug events

Higher rates of functional decline, disability, nursing home admission and mortality (Nagurney Ann Emerg Med 2017)

Disability risk worsened by greater age, frailty, lower-extremity weakness, and being unmarried post ED discharge (Nagurney Acad Emerg Med 2020)

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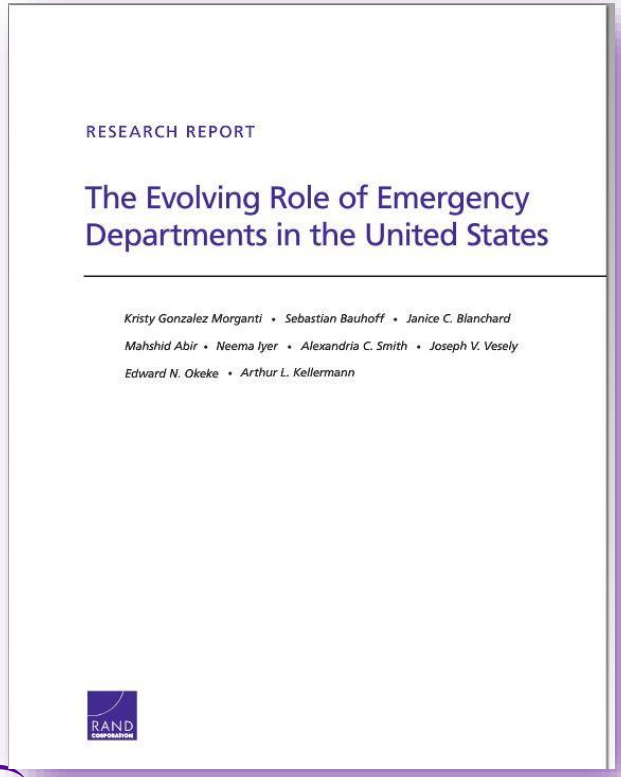
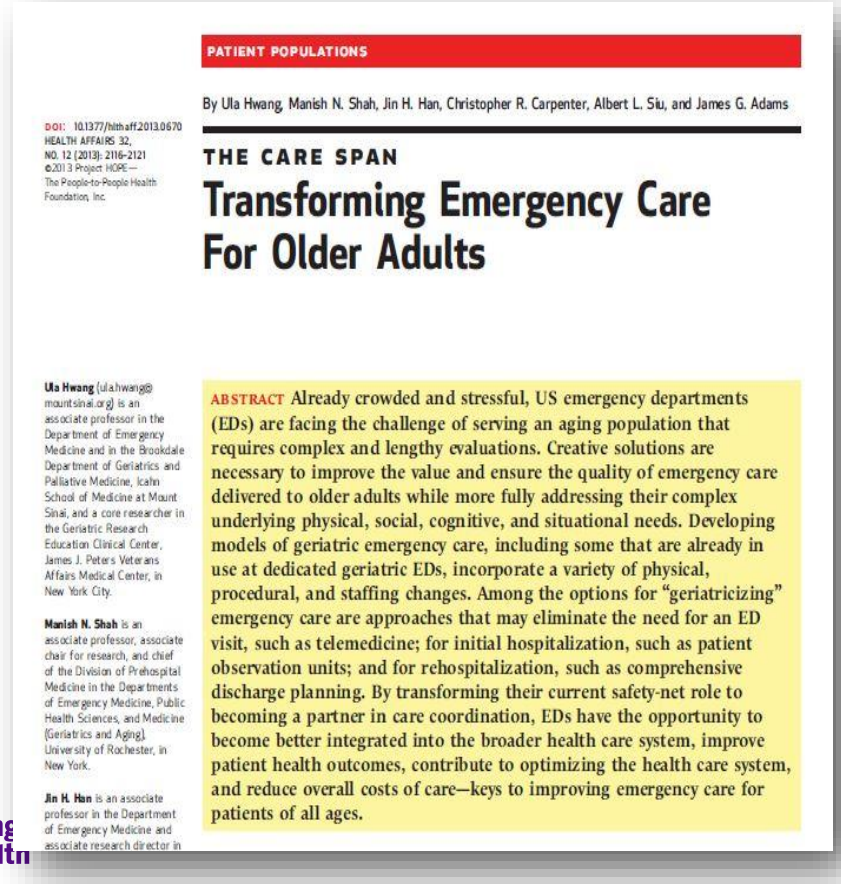
May 2013 RAND report



- 2003 – 2009:
  - ↓admissions (vs. population)
  - driven by unscheduled ED visits (17% ↑)
- ↑referrals of PCPs to ED care:
  - Overflow, afterhours / weekend
  - **Complex diagnostic w/u
- 2006 – 2014 (Lin et.al JAMA Int Med 2018)
  - ↑20% ED visits
- Tension of admissions & hospital revenue
- **ED as an expensive decision maker [even more so, post COVID]**

Transforming Emergency Care for Older Adults



PATIENT POPULATIONS

DOI: 10.1377/hlthaff.2013.0670
HEALTH AFFAIRS 32,
NO. 12 (2013): 2116–2121

By Ula Hwang, Manish N. Shah, Jin H. Han, Christopher R. Carpenter, Albert L. Siu, and James G. Adams

THE CARE SPAN

Transforming Emergency Care For Older Adults

Ula Hwang (ula.hwang@mountsinai.org) is an associate professor in the Department of Emergency Medicine and in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai, and a core researcher in the Geriatric Research Education Clinical Center, James J. Peters Veterans Affairs Medical Center, in New York City.

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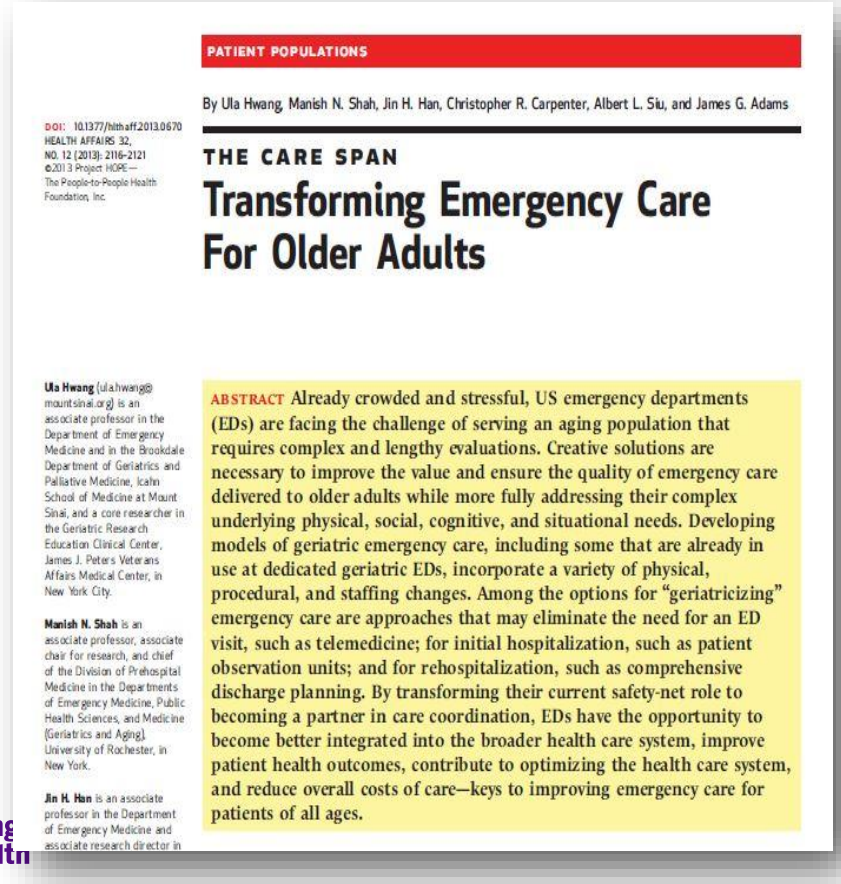
ABSTRACT Already crowded and stressful, US emergency departments (EDs) are facing the challenge of serving an aging population that requires complex and lengthy evaluations. Creative solutions are necessary to improve the value and ensure the quality of emergency care delivered to older adults while more fully addressing their complex underlying physical, social, cognitive, and situational needs. Developing models of geriatric emergency care, including some that are already in use at dedicated geriatric EDs, incorporate a variety of physical, procedural, and staffing changes. Among the options for "geriatricizing" emergency care are approaches that may eliminate the need for an ED visit, such as telemedicine; for initial hospitalization, such as patient observation units; and for rehospitalization, such as comprehensive discharge planning. By transforming their current safety-net role to becoming a partner in care coordination, EDs have the opportunity to become better integrated into the broader health care system, improve patient health outcomes, contribute to optimizing the health care system, and reduce overall costs of care—keys to improving emergency care for patients of all ages.

- "Front Door"

Transforming Emergency Care for Older Adults



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- "Front Door"
  → **"Front Porch"**

- "Safety net role" …
  AND
  Partner in care coordination

MODELS OF GERIATRIC CARE, QUALITY IMPROVEMENT, AND PROGRAM DISSEMINATION

The Geriatric Emergency Department

Ula Hwang, MD, MPH,† and R. Sean Morrison, MD*†‡

With the aging of the population and the demographic shift of older adults in the healthcare system, the emergency department (ED) will be increasingly challenged with complexities of providing care to geriatric patients. The special care needs of older adults unfortunately may not be aligned with the priorities for how ED physical design and care is rendered. Rapid triage and diagnosis may be impossible in the older patient with multiple comorbidities, polypharmacy, and functional and cognitive impairments who often presents with subtle clinical signs and symptoms of acute illness. The use of Geriatric Emergency Department Interventions, structural and process of care modifications ad-

may help to address these challenges and thereby improve the quality of care of elderly people in the ED.

OLDER ADULTS AND THE ED

Although the aging population will affect all areas of health care, the ED is likely to be disproportionately affected. In 2002, approximately 58% of 75-year-olds had at least one visit to an ED, as compared to 39% of those of all ages, and ED use increased with increasing age.[3] Once in the ED, older patients are more likely to have an emergent or urgent condition, be hospitalized, and be admitted to a critical care

- Paradigm shift of ED physical design and care (Pediatric, Psychiatric EDs)
- Geriatric ED Interventions (GEDIs)
  - Structural modifications: lighting, flooring, hearing assist devices, clocks
  - Process of care modifications: screening for cognitive function, delirium, adverse health outcomes (e.g., ISAR, TRST, BRIGHT), nursing discharge coordinator
- No “Geriatric EDs” or “Senior EDs” at time of press – Journal of the American Geriatrics Society, 2007

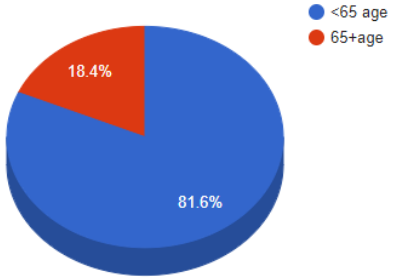
Intersection of Geriatrics + Emergency Medicine

2019 NHAMCS Data:

27 Million ED visits (**18.4%**) by 65+

One in Two *older adults 65+ will make an ED visit*

(1:1.85)



5,200 EDs in the US:

Today, **517 (~10%) US EDs are GED Accredited in last 6 years**

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Total Today:

517 Total Accredited Sites

U.S. across 48 States

6 International

- Spain, Level 3
- Thailand, level 3
- Brazil, Level 3
- Canada, Level 2 and Level 3
- Dubai, Level 2
- Switzerland, Level 1

30

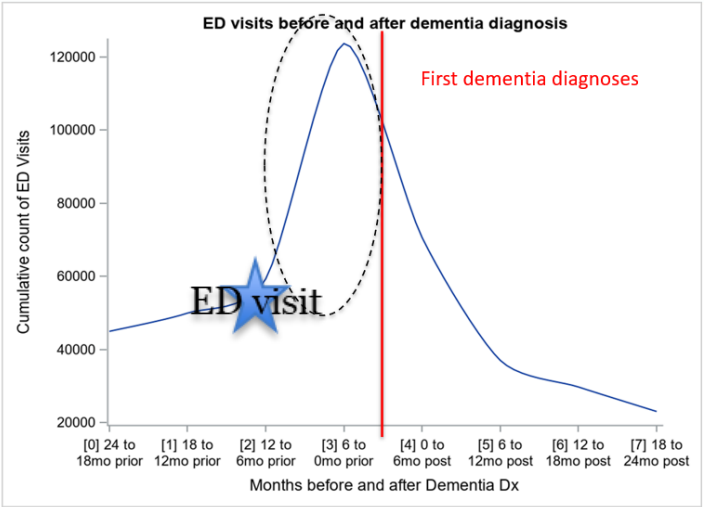
66

421

GEDC

Intersection of Geriatrics + Emergency Medicine + Dementia

- **ED use by patients with dementia diagnosis double those without (Odd ratio 2.29)** (LaMantia 2017 Alz Dis Assoc Disord)
- **Cognitive impairment missed 57-83% of the time because it is not routinely assessed** (Naughton 1995 Ann Emerg Med, Hustey 2002/2003 Ann Emerg Med)
- **ED use surges in months prior to ADRD diagnoses** (Seidenfeld 2023 AEM)



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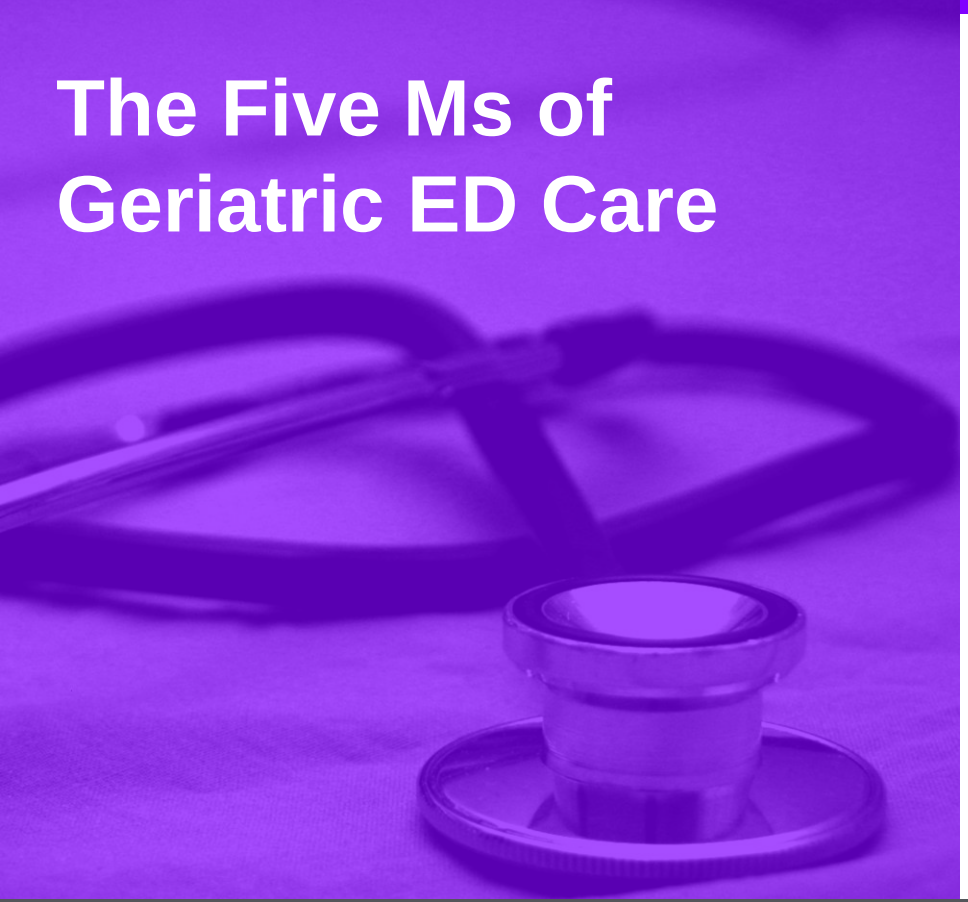
What is a Geriatric ED?

…Better care and transitions to and from the ED for older adults

What is a Geriatric ED?

…Better care and transitions to and from the ED for ALL patients

The Five Ms of Geriatric ED Care



1. Mobility
2. Mentation
3. Medication
4. What Matters
5. Elder Mistreatment

https://www.healthinaging.org/sites/default/files/media/pdf/HIA-TipSheet%20Geriatric%205Ms.July20_0.pdf

Mobility

Clinical Pearl

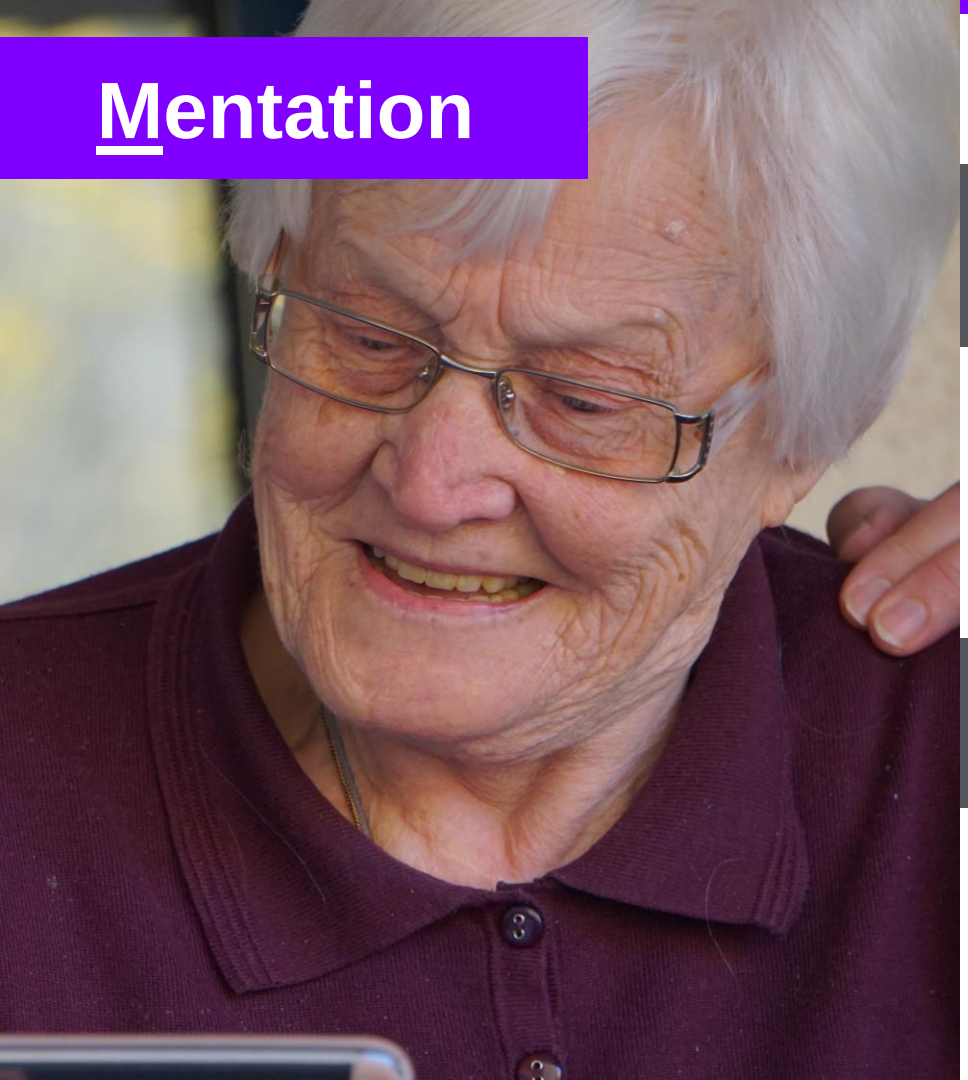
How many falls have you had in the last three months?

Falls are not an event, they are a syndrome

How do we help you not fall after leaving the ED?

- Medication reconciliation
- Community Paramedicine
- Physical therapy consults

Screening Test: Timed Get Up and Go Test



Mentation

Delirium

Clinical Pearl
Delirium is the vital sign of older adults.

Delirium is a change from baseline with inattention
Picture of sleeping older adult
Screening Tool: BCAM or 4AT

Dementia

Clinical Pearl
Family and caregivers are your friends.

Prevent delirium
Care transitions are key
Awareness
Referral for definitive diagnosis
Screening tool: Six-Item Screener

Medication

Clinical Pearl

First think drugs.
Are you taking any new medications?

Medication reconciliation is key (not just admitted!)
Deprescribing is Gedi level
Screening tool 1: Beers list
Screening tool 2: Pharmacist for polypharmacy

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what Matters

Elder Mistreatment

Clinical Pearl

We miss it all the time.

1:10
Need referral pathway to community services
Picture of scared older adult
Screening tool: Elder Abuse Suspicion Index and Elder Mistreatment ED Toolkit

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August 1, 2024

CMS Hospital Inpatient Quality Reporting Program: Age-Friendly Structural Measure beginning CY2025 / FY 2027 payment determination

For full CMS payments, hospital attestation of provision of clinical care addressing 5 Domains:

- **Domain 1:** Eliciting Patient Healthcare Goals
- **Domain 2:** Responsible Medication Management
- **Domain 3:** Frailty Screening and Intervention (i.e., Mobility, Mentation, and Malnutrition
- **Domain 4:** Social Vulnerability
- **Domain 5:** Age Friendly Care Leadership

MEASURE = **Numerator: # of Domains compliant**
Denominator: 5

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ED Crowding & Boarding

December 1, 2023 …

Research

JAMA Internal Medicine | Original Investigation

Overnight Stay in the Emergency Department and Mortality in Older Patients

Melanie Roussel, MD; Dorian Teissandier, MD; Youri Yordanov, MD, PhD; Frederic Balen, MD; Marc Noizet, MD; Karim Tazarourte, MD, PhD; Ben Bloom, MD, PhD; Pierre Catoire, MD; Laurence Berard, MD; Marine Cachanado, MSc; Tabassome Simon, MD, PhD; Said Laribi, MD, PhD; Yonathan Freund, MD, PhD; for the FHU IMPEC–IRU SFMU Collaborators

- Observational study over 2 days, 97 EDs in France in 2022
- 30D Mortality rates of patients 75+, admitted to hospital who:

  Went to Ward BEFORE midnight VS.

  Stayed in ED & overnight boarding

December 1, 2023 …

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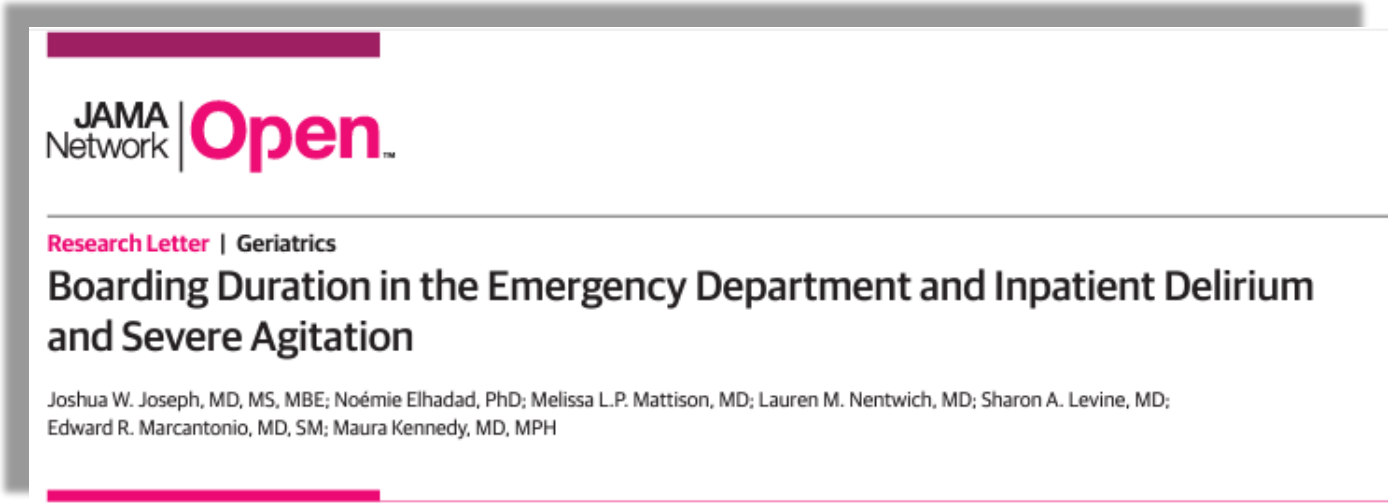
- Observational study over 2 days, 97 EDs in France in 2022
- 30D Mortality rates of patients 75+, admitted to hospital who:

Went to Ward BEFORE midnight VS.	11.1% mortality
Stayed in ED & overnight boarding	15.7% mortality

RR = 1.81 mortality boarding overnight

June 11, 2024



JAMA Network | Open

Research Letter | Geriatrics

Boarding Duration in the Emergency Department and Inpatient Delirium and Severe Agitation

Joshua W. Joseph, MD, MS, MBE; Noémie Elhadad, PhD; Melissa L.P. Mattison, MD; Lauren M. Nentwich, MD; Sharon A. Levine, MD; Edward R. Marcantonio, MD, SM; Maura Kennedy, MD, MPH

- Affirmation of ED hallway time increased risk of delirium for admitted patients
- Retrospective review 236,169 pateints; 7 EDs at MGB admitted patients (2018-2022)
- Predictors: boarding, age, dementia
- Outcome: DELIRIUM

Boarding	OR 1.02 (1.02,1.02) delirium	*50 yo boarding 2 hours vs.*
Age increase (each year)	OR 1.07 (1.05, 1.09)	*75 yo boarding 4 hr ➔ **2X** delirium risk*
Dementia	OR 2.04 (1.90, 2.19)	*75 & dementia & 8hr boarding ➔ **7X** risk*

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- **Domain 2:** Responsible Medication Management
- **Domain 3:** *Frailty Screening and Intervention (i.e., Mobility, Mentation, and Malnutrition)* – **older patients out within 8 hours of arrival and/or within 3 hours of the decision to admit**
- **Domain 4:** Social Vulnerability
- **Domain 5:** Age Friendly Care Leadership

MEASURE = Numerator: # of Domains compliant
Denominator: 5

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Why Geriatric Emergency Medicine?

…to turn little challenges into opportunities

…and give our older ED patients the best care, health, and outcomes possible

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Thank you

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