Addressing the Public Health Crisis of Boarding of Older Adults in America

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Where discoveries are delivered.℠

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Learning Objectives

01

Describe the unique context and challenges of emergency care of older adults who are acutely ill or injured.

02

Describe evidence-based approaches to improve emergency care for older adults.

03

Describe next steps in bringing excellent emergency care to all older Americans.

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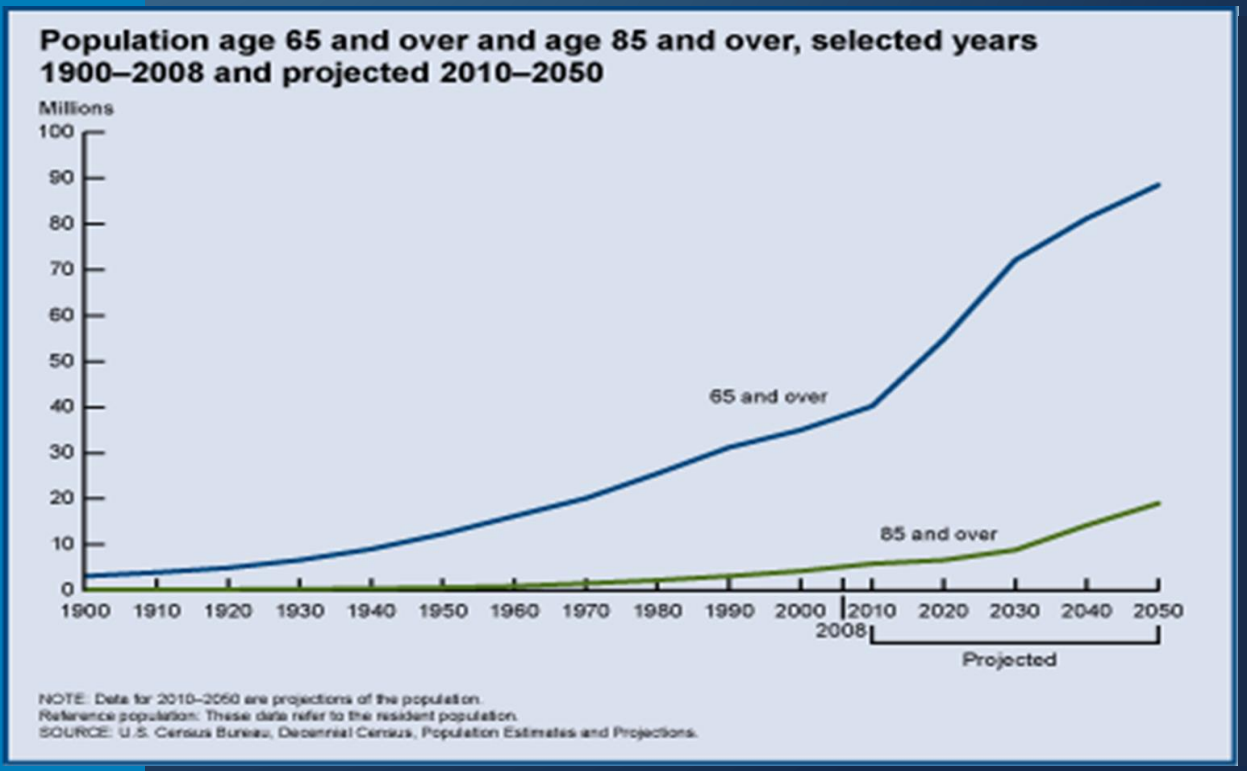
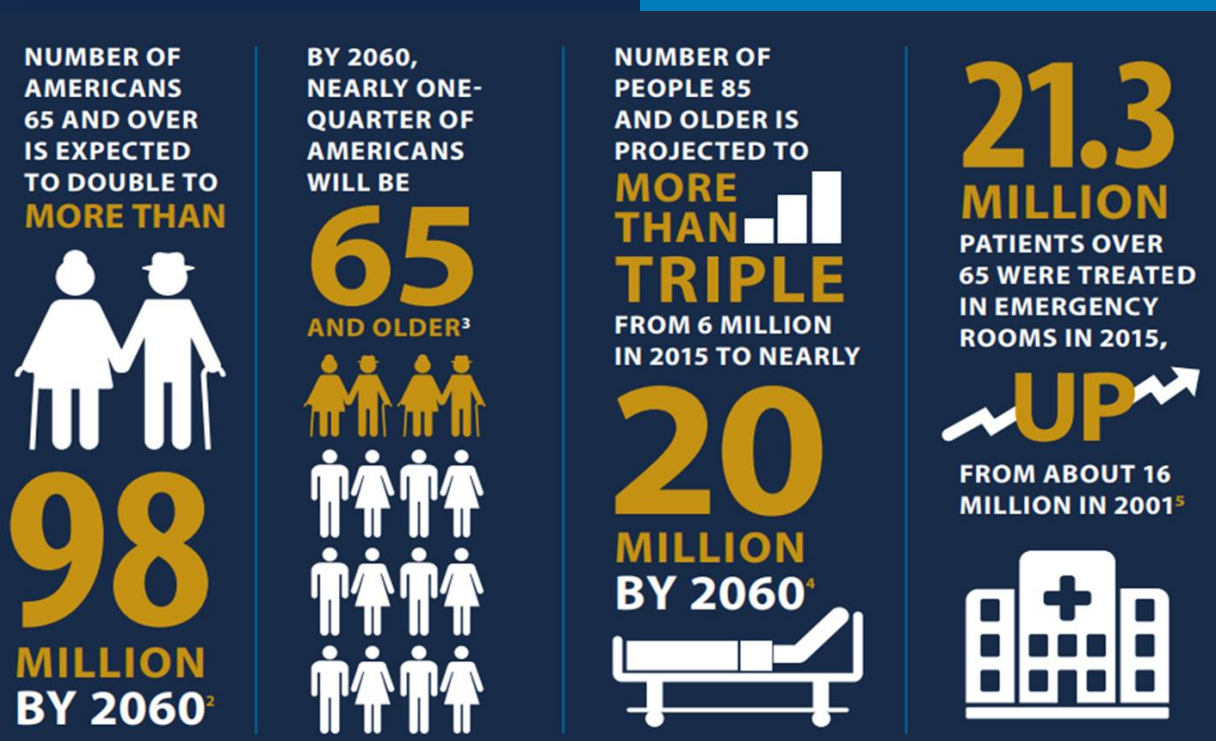
The Population is Getting Older…





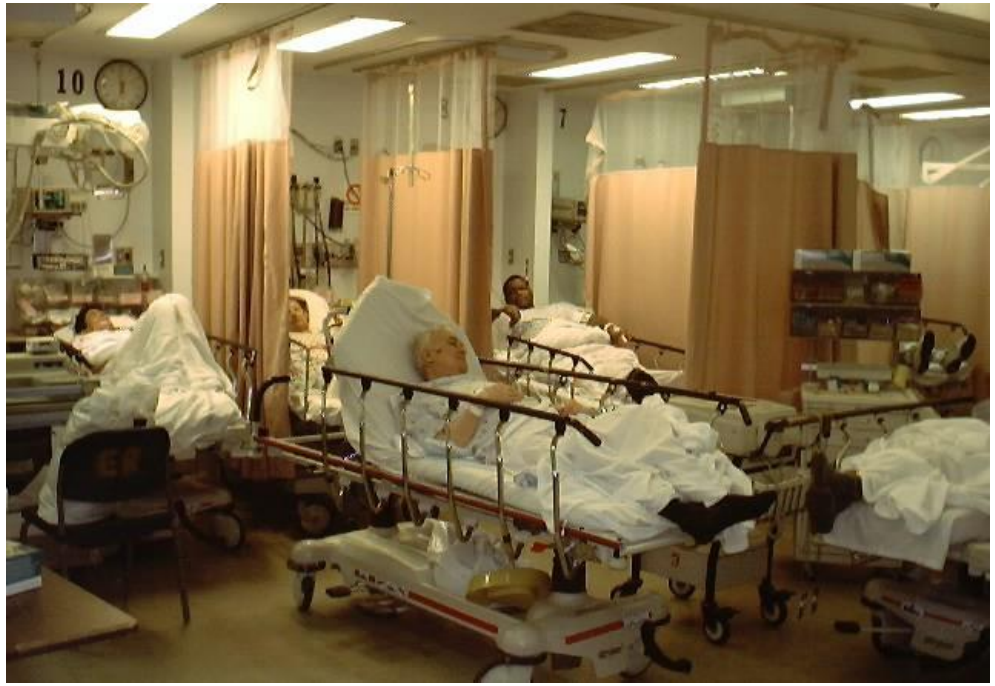
Quick facts about older adults…

- 10,000 people turn 65 every day
- 46% of all Emergency Department visits resulting in hospitalization are seniors
- Patients >75 yrs represent the second highest group of emergency department users (following only those 1-4 years old)
- The growing number of seniors with increased medical needs will place a non-sustainable cost burden on the current U.S. Healthcare System

Quick facts about Emergency Care…

- By 2060, nearly one quarter of Americans will be 65
- Number of people 85 and older is projected to more than triple from 6 million to nearly 20 million in 2060
- 21.3 Million patients over 65 were treated in Emergency Rooms in 2015. Up from about 16 Million in 2001
- Healthcare Spending is projected to increase to nearly 20% of the Gross Domestic Product (GDP) by 2024

Disconnect Between EDs and Older Adults…



Space designed for ED priorities of rapid patient evaluation and turnover, privacy forsaken for maximal use of space, crowding of narrow beds, shiny linoleum floors for quick cleanup…

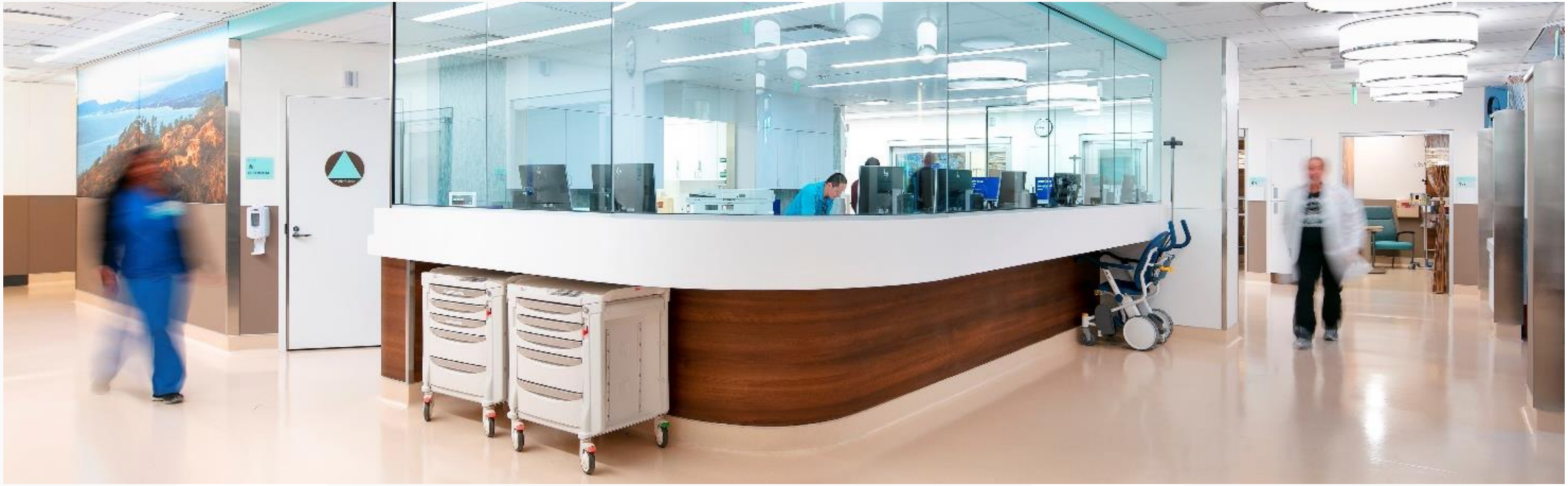
Literature Suggests

1) An ED visit is a sentinel event and marks early functional decline, leading to poor health outcomes, higher health care utilization and higher cost of care.

2) **Transitions of Care** are key points wherein physicians and care teams have the ability to impact the trajectory of patients and improve quality of care and decrease the cost of care.

Friedmann PD, et.al. Am J Emerg Med 2001
Aminzadeh F, et.al. Ann Emerg Med 2002
Coleman EA, et.al. Med Care 2005
Hastings SN, et.al. Med Care 2008

Senior Emergency Care is Different



The Need:

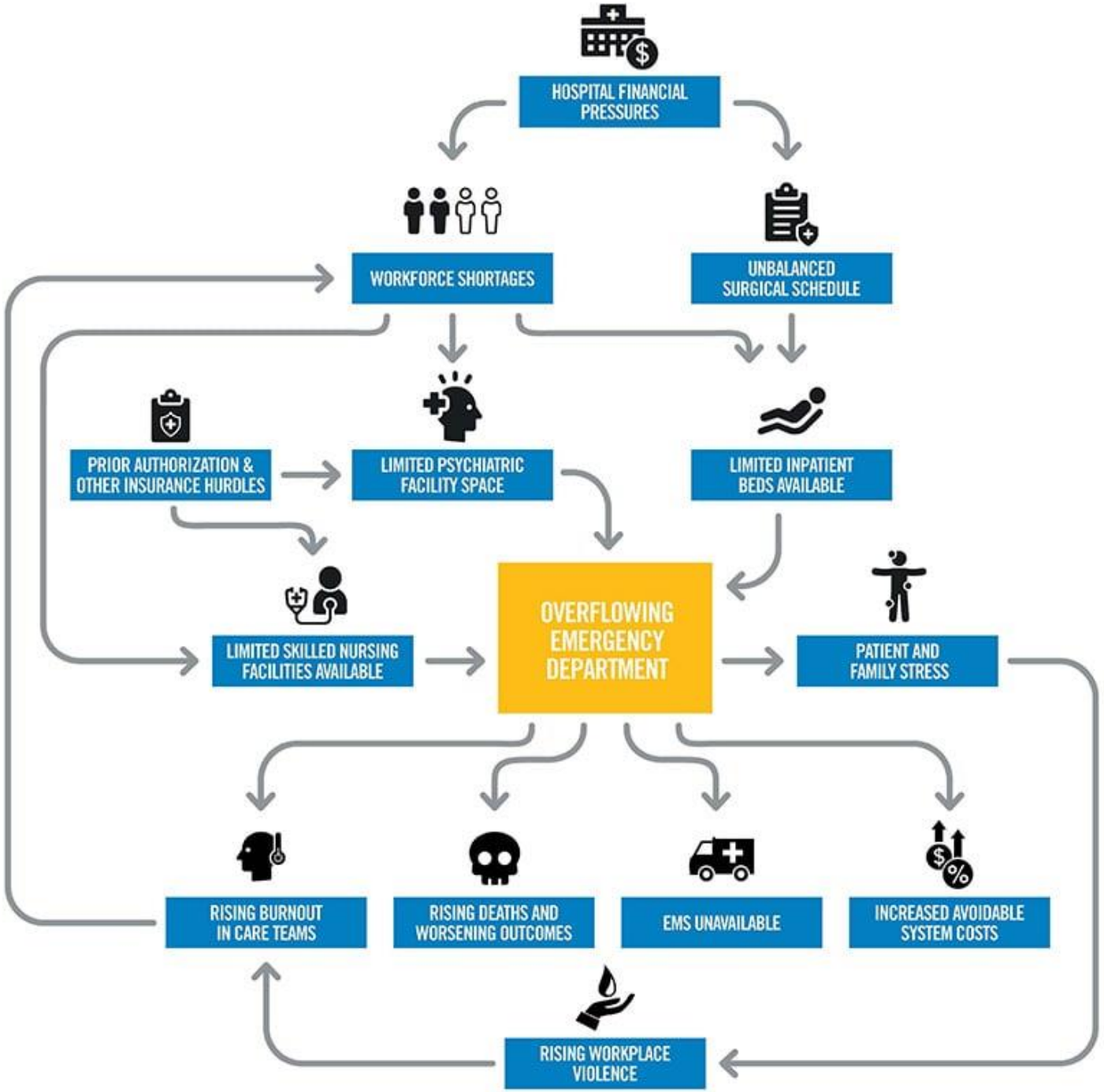
Needs of our senior population are different from other populations.

Social, Family, functional, patient centered goals

Senior Emergency Care is Different

How do we know this?

- Repeatedly, a growing body of data from existing models of geriatric emergency care, which promote best clinical practices for seniors and create a more positive and sensitive physical environment, demonstrate the **potential to improve patient outcomes and their transitions of care, while lowering costs.**



ACEP Boarding and Crowding 2023 Summit

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ED Boarding – GEDC roundtable April 2024

True Cost of Boarding: What we know…It's Bad

ED Boarding Harms Older Adults

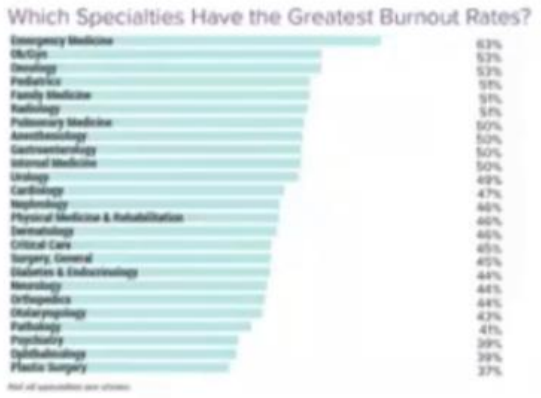
- More likely to
  - experience boarding
  - board for prolonged durations
- Deadly
- Results in
  - Immobility & Hospital Acquired Disability
  - Delirium
  - Restraints
- One overnight in the ED
  - 1.39 aRR death
  - 1 extra inpatient day

Boarding Begets Boarding

- High volume → higher likelihood of admission
  - OR 1.007/ per additional patient in the ED

It's a Workforce Issue

- Burnout
- Moral injury
- Violence



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Factors impacting Boarding

Throughput

- Decision to admit
- Consult times
- Study and procedure timing
- Discharge planning

Output

- Transport delays
- Bed availability
- Care transition plan

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Journal of Clinical Medicine

MDPI

Systematic Review

Association between Boarding of Frail Individuals in the Emergency Department and Mortality: A Systematic Review

Pasquale Iozzo [1,*], Noemi Spina [2], Giovanna Cannizzaro [2], Valentina Gambino [2], Agostina Patinella [2], Stefano Bambi [3], Ercole Vellone [1,4], Rosaria Alvaro [1] and Roberto Latina [5]

- Systematic review published early 2024
- Boarding and adverse outcomes
- Numerous studies: association of longer boarding of higher frailty patients with adverse outcomes
- Frail patients have more co-morbidities, require more time due to management complexities, and have longer LOS

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Original Investigation

November 6, 2023

Overnight Stay in the Emergency Department and Mortality in Older Patients

Melanie Roussel, MD[1]; Dorian Teissandier, MD[2]; Youri Yordanov, MD, PhD[3,4]; et al

» Author Affiliations

JAMA Intern Med. 2023;183(12):1378-1385. doi:10.1001/jamainternmed.2023.5961

- Prospective cohort study
- Higher mortality and morbidity for older patients, especially those with limited autonomy (need more help with ADLs)
- Need for prioritization for hospital ward bed

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Approaches to Improve Care for Seniors in the ED

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What is a GED?

Culture of care tailored to the specific needs of seniors in the ED

Improve clinical outcomes and reduce unnecessary hospitalizations, ED revisits, and readmissions.

May consist of varying components

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Why have a Geriatric ED

The Need:

Senior Emergency Care is Different

- The needs of our senior population are different from other populations.
- Social, Family, Functional, Patient Centered Goals

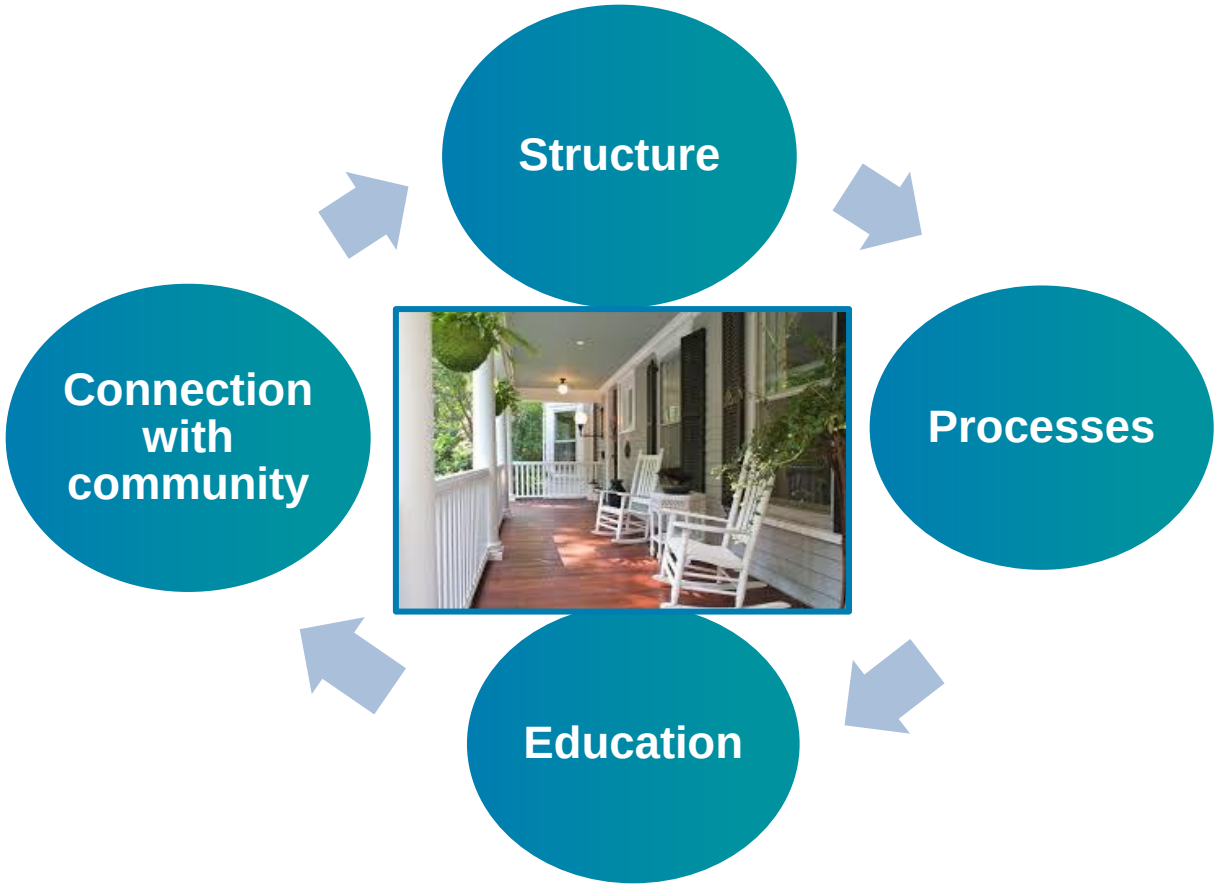
The Opportunity:

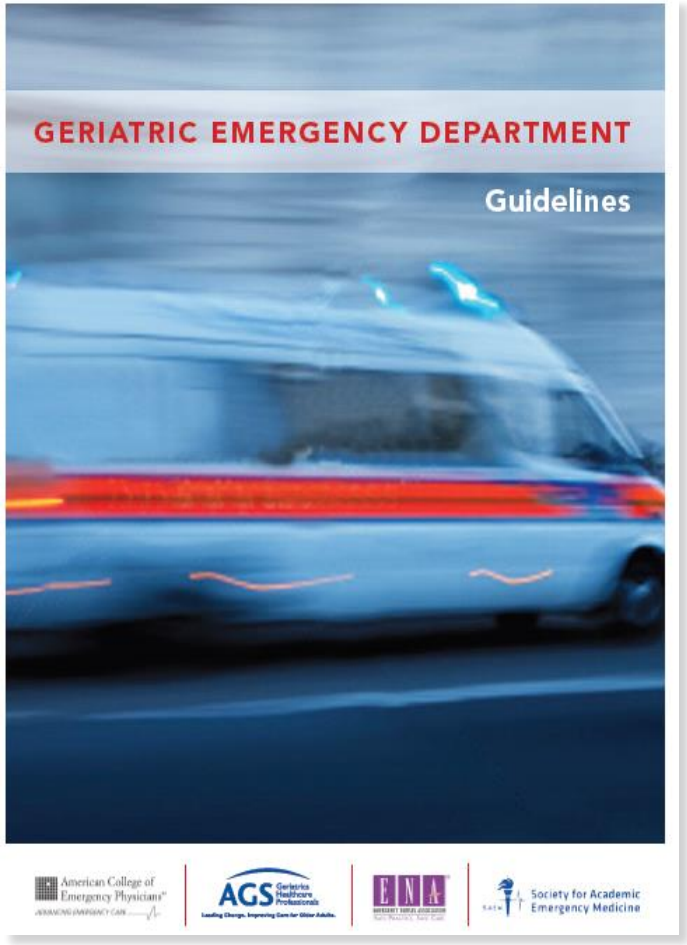
Geriatric Emergency Department will offer the necessary services specialized for this population

- Health & wellness acute care screening
- Geriatric medicine consultation
- Case management
- Pharmacy
- NICHE trained nurses
- Technician staff to assist patients
- Specialized equipment, lighting, and experience
- Social and psychiatric services

Geriatric ED Guidelines:

Four Critical Components of a Geriatric-Appropriate ED





Geriatric ED Guidelines 2014

ACEP Geriatric
Emergency Department Accreditation

Levels 1 and 2 are designed to reflect an increasing commitment to senior-specific care in the Emergency Department.

Level 3 is designed to be within reach of every hospital

GEDA is created in partnership with the Gary and Mary West Health Institute and The John A. Hartford Foundation.

Level 1 GED: Gary and Mary West Emergency Department at UC San Diego Health

Fast Facts

Annual ED Volume: 40,000

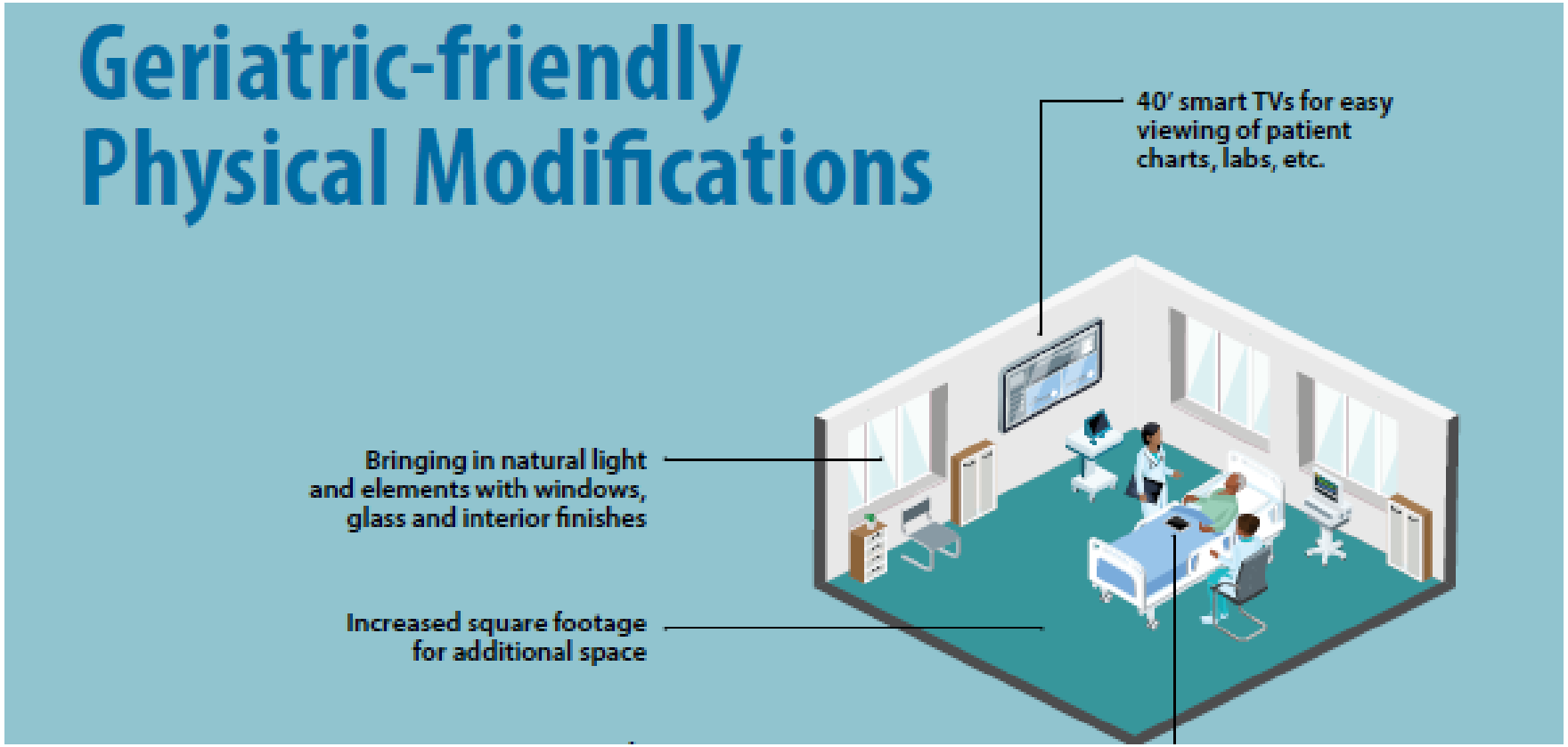
ED Visits by Seniors: 32%

Half of all ED admissions (patients >65)

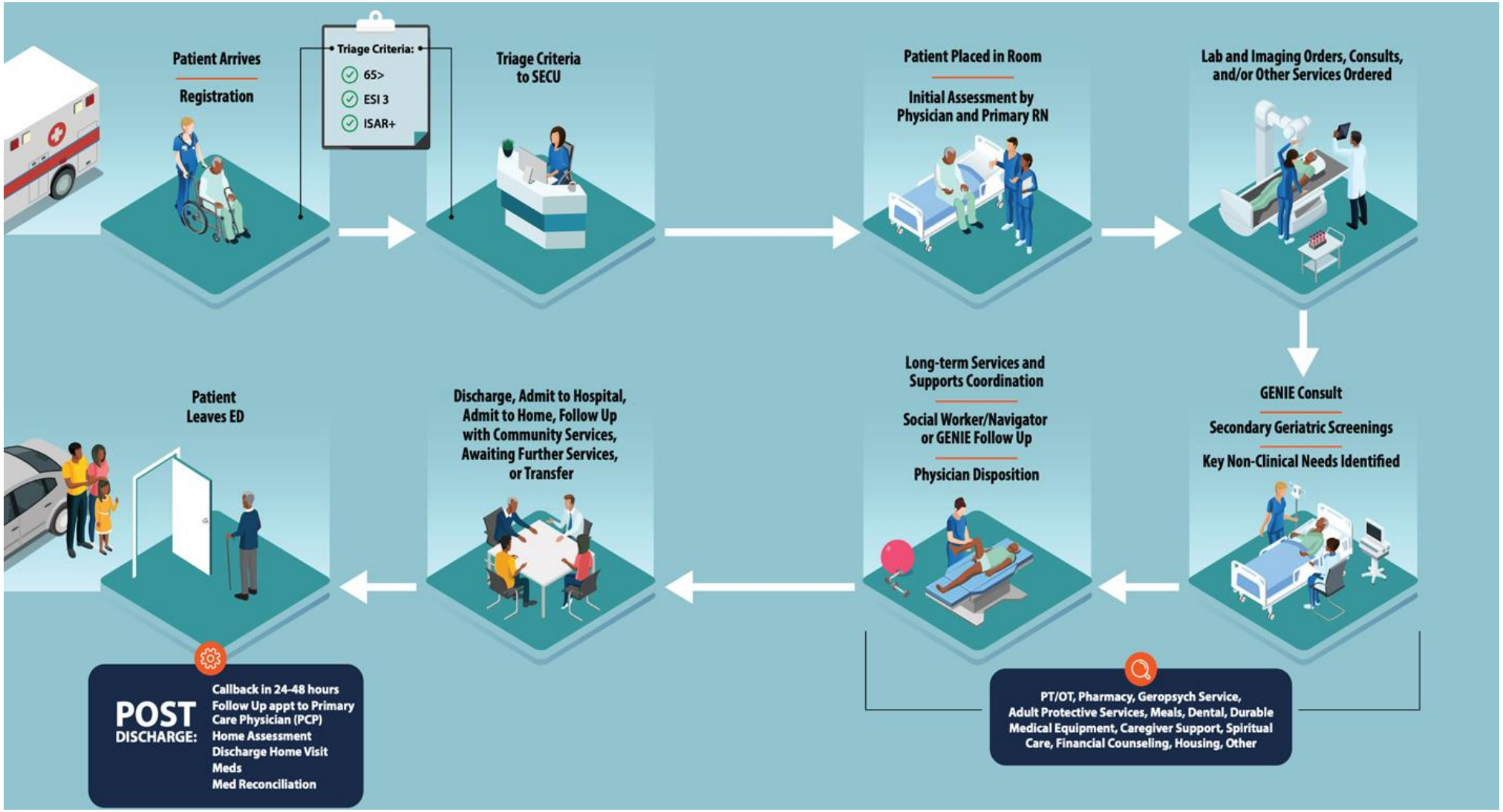
GED Outcomes

- Reduced admissions from the ED
- Provide targeted referrals & services
- Reduced total costs for patients discharged to Acute Care at Home
- First Level 1 GED in CA

Modifications



Patient Movement through the SECU



Consult Services

APS
Caregiver Support
Dental
DME
Financial Counseling
Geriatric-Medicine
Geriatric-psychiatry
Housing
Meals
Nutrition
PT/OT
Pharmacy
Spiritual Care
Transportation

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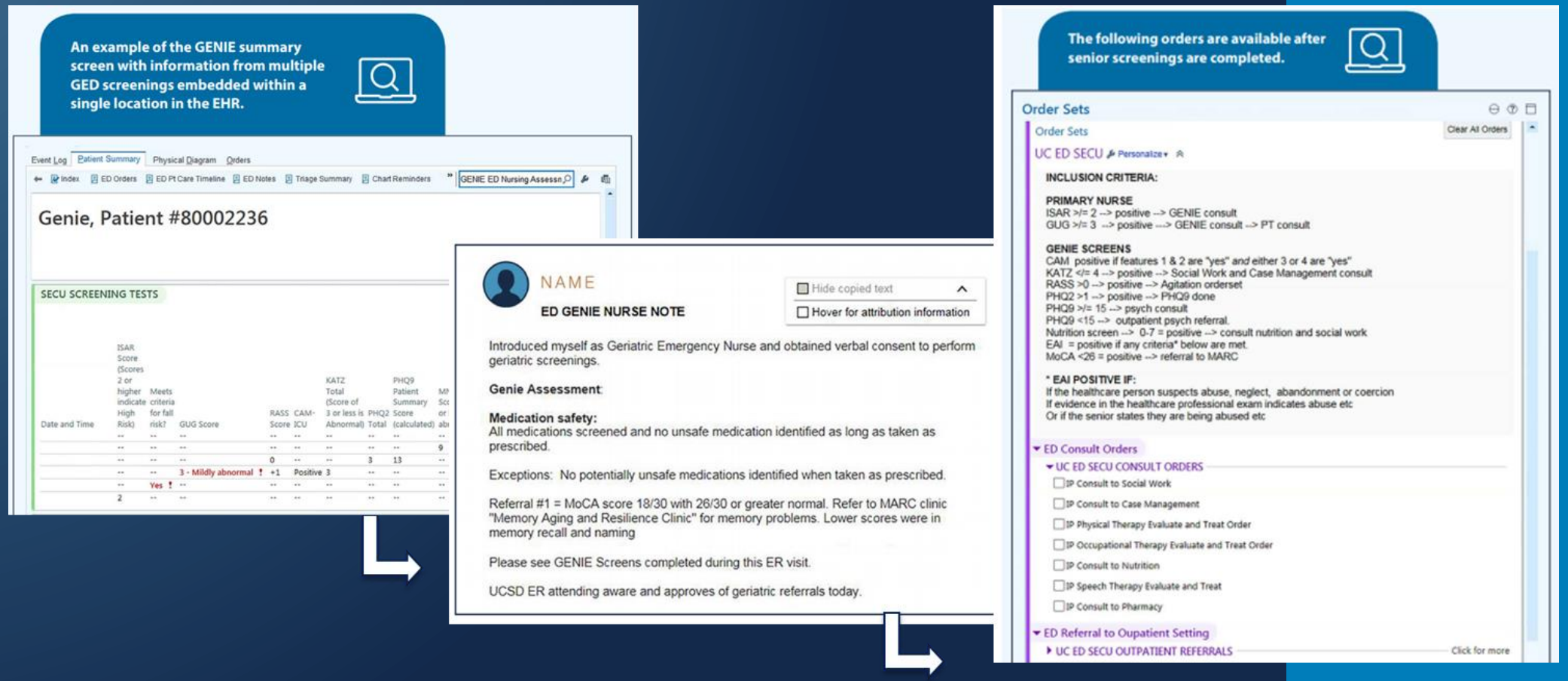
Role of the GENIE Nurse

GENIE REFERRALS TO UCSD CASE MANAGER AND UCSD SOCIAL WORK

- **GENIE:**
  - Psychiatry for Major Depression, SECU Pharmacy for Medication Safety, ER Attending for Delirium, UCSD Nutrition for malnutrition or food insecurity (MOW), IPPT, IPOT, IPST for swallowing or choking, Cognitive positive scores referral to UCSD MARC Clinic (Memory, Aging and Resilience Clinic).
- **UCSD Case Manager:**
  - All Home Health Referrals, Skilled Nursing Facility, Rehabilitation Facility, Memory Care Facility, Adult Day Care, Caregiver Resources.

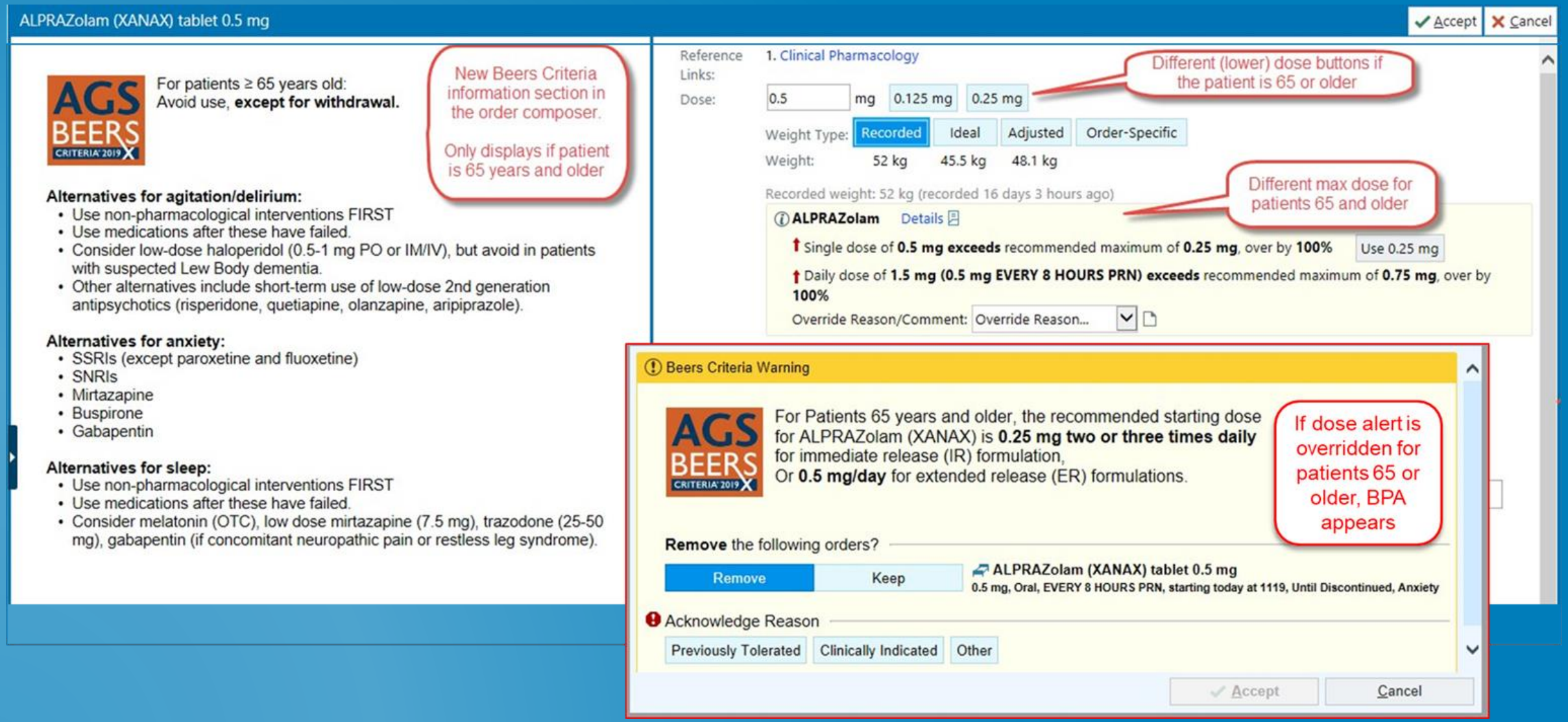
- **UCSD Social Work:**
  - Abuse and Neglect, Psychiatry for other than Major Depression, Caregiver Strain, Transportation,
  - Community Resources

Approach


An example of the GENIE summary screen with information from multiple GED screenings embedded within a single location in the EHR.
Event Log
Patient Summary
Physical Diagram
Orders
ED Orders
ED Pt Care Timeline
ED Notes
Triage Summary
Chart Reminders
GENIE ED Nursing Assessn
Genie, Patient #80002236
SECU SCREENING TESTS
Date and Time
ISAR Score (Scores 2 or higher indicate High Risk)
Meets criteria for fall risk?
GUG Score
RASS Score
CAM-ICU
KATZ Total (Score of 3 or less is Abnormal)
PHQ2 Total
PHQ9 Patient Summary Score (calculated)
3 - Mildly abnormal
Yes
NAME
ED GENIE NURSE NOTE
Hide copied text
Hover for attribution information
Introduced myself as Geriatric Emergency Nurse and obtained verbal consent to perform geriatric screenings.
Genie Assessment:
Medication safety:
All medications screened and no unsafe medication identified as long as taken as prescribed.
Exceptions: No potentially unsafe medications identified when taken as prescribed.
Referral #1 = MoCA score 18/30 with 26/30 or greater normal. Refer to MARC clinic "Memory Aging and Resilience Clinic" for memory problems. Lower scores were in memory recall and naming
Please see GENIE Screens completed during this ER visit.
UCSD ER attending aware and approves of geriatric referrals today.
The following orders are available after senior screenings are completed.
Order Sets
Clear All Orders
UC ED SECU
Personalize
INCLUSION CRITERIA:
PRIMARY NURSE
ISAR >/= 2 --> positive --> GENIE consult
GUG >/= 3 --> positive --> GENIE consult --> PT consult
GENIE SCREENS
CAM positive if features 1 & 2 are "yes" and either 3 or 4 are "yes"
KATZ </= 4 --> positive --> Social Work and Case Management consult
RASS >0 --> positive --> Agitation orderset
PHQ2 >1 --> positive --> PHQ9 done
PHQ9 >/= 15 --> psych consult
PHQ9 <15 --> outpatient psych referral.
Nutrition screen --> 0-7 = positive --> consult nutrition and social work
EAI = positive if any criteria* below are met.
MoCA <26 = positive --> referral to MARC
* EAI POSITIVE IF:
If the healthcare person suspects abuse, neglect, abandonment or coercion
If evidence in the healthcare professional exam indicates abuse etc
Or if the senior states they are being abused etc
ED Consult Orders
UC ED SECU CONSULT ORDERS
IP Consult to Social Work
IP Consult to Case Management
IP Physical Therapy Evaluate and Treat Order
IP Occupational Therapy Evaluate and Treat Order
IP Consult to Nutrition
IP Speech Therapy Evaluate and Treat
IP Consult to Pharmacy
ED Referral to Oupatient Setting
UC ED SECU OUTPATIENT REFERRALS
Click for more

Geriatric-Specific Medication Alerts

FOR PATIENTS 65 YEARS AND OLDER, NEW GUIDANCE WILL APPEAR FOR MEDICATIONS ON THE BEERS CRITERIA



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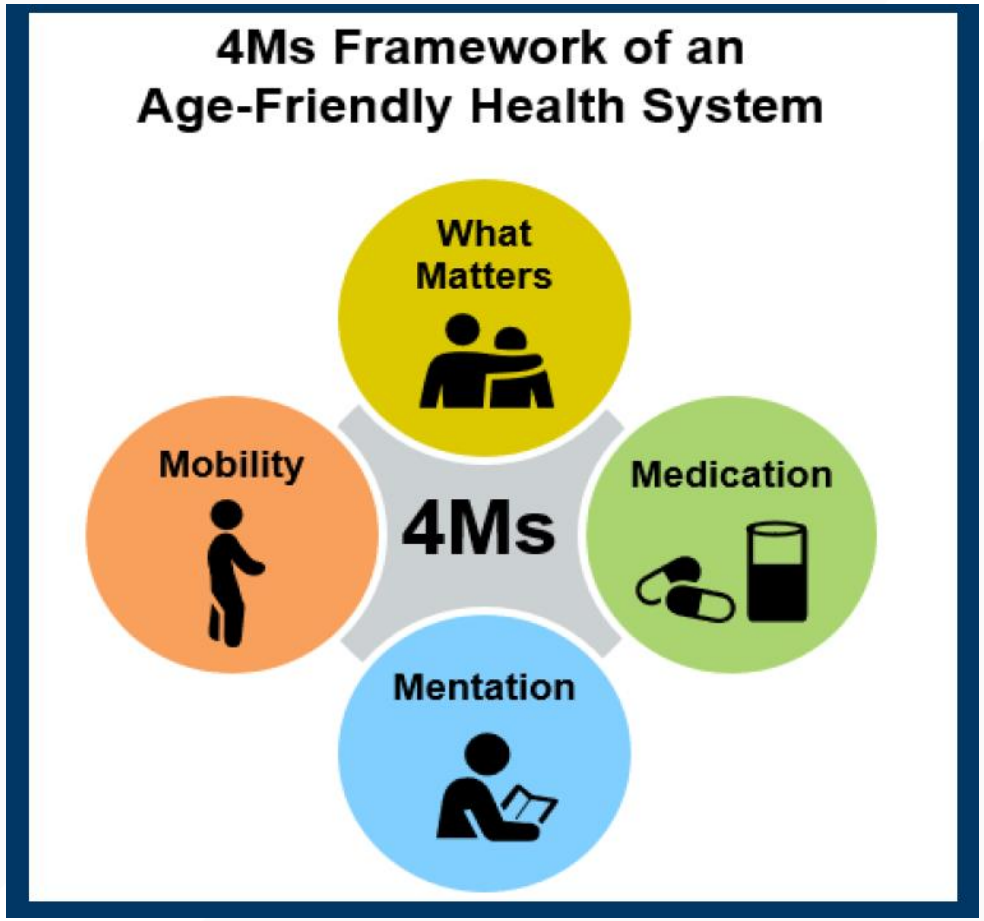
4Ms of Age-Friendly Care



what Matters

Know and align care with what Matters to each older adult

Medications

Deprescribe or do not prescribe high- risk meds considering what matters most

Mobility

Promote safe mobility to maintain function and do what matters most

Mind

Prevent, diagnosis, and manage delirium, depression, and dementia to enjoy what matters most

GED interventions have been shown to…

- Improve ED utilization
  - Decrease in risk of hospital admission at index visit (Keene et al., 2022; Hwang et al., 2018)
  - Decrease ED revisits in high-risk populations (Huded et al., 2022; Lesser et al., 2018)
  - Decrease ED readmissions (Dresden et al., 2019)
  - Reduce length of stay inpatient post-ED (Keene et al., 2022)
- Reduce costs
  - Lower cost of care for older adults (~$2500-$2900 per Medicare beneficiary) in the 30 days following a GED visit (Hwang et al., 2021)
  - Estimated savings of $1.7 million per year as result of reduction in inpatient LOS (Keene et al., 2022)
- Connect patients to care outside of ED encounter
  - Increase referral rates to gerontology and home-based primary care (Huded et al., 2022)
- Increase staff satisfaction and patient experience (Guttman et al., 2005; Mion et al., 2003)

Future Steps

- Need established frailty assessment tool
- Identify goals of care (4 Ms)
- Focused screening
- Align outcomes of screenings with operational and flow priorities
- Models for care at home
- AI and LLM for earlier risk identification and stratification

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GEDC 2019 Boarding and Overcrowding Newsletter
Strategies to manage older adults boarding in the emergency department

- Develop a “safety and comfort” protocol for boarding older adults.
- Avoid catheters and NPO designation
- Early medication reconciliation to continue management of chronic conditions.
- Decrease risk of deconditioning by encouraging mobility and getting out of bed.
- Employ a delirium mitigation protocol for those older adults at increased risk, such as those with underlying dementia.
- Emphasize caregiver comfort and communication by frequent updates, nutrition, adequate seating, Wi-Fi, and parking assistance.
- Review the systems-based flow of patients with hospital leadership to improve the flow of patients. Look at patterns and practices to better address the needs of patients.
- Obtain Case Management and PT/OT evaluations onboarding patients who will need post-acute services.
- Work with the admitting services to clearly delineate responsibility for admitted patients boarding in the ED, including a protocol regarding rounding and orders for boarding patients.
- Develop a protocol to frequently review admission status for boarding patients to address

Fall 2023 | Volume 4 | Issue 4 Article 1 | Collective Wisdom: Editorial

JGEM The Journal of Geriatric Emergency Medicine

ADVOCATE HEALTH

GEDC

Prioritizing Care of Older Adults in Times of Emergency Department Overcrowding

April Ehrlich, MD, Mitchel Erickson, DNP, Esther S Oh, MD PhD, Todd James, MD, Saket Saxena, MD

- Health system preparedness
- Prioritize Care for Older Adults
- Transitions of Care
- Community Engagement
- National Engagement

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Strategies to Mitigate impact of Boarding on Older adults

- Prioritize access to outpatient care
- Improve virtual access to acute care
- Improved connections to behavioral and cognitive impairment services

- Geriatric ED initiatives
- Prioritize care for higher risk older adults
- Improve communication and transitions of care

- Begin care coordination and discharge planning in the ED
- Focus on WHAT MATTERS. Include caregivers and family in ongoing care decisions
- Community resources and care coordination for an ”enhanced” discharge

UCSD at Home

Patient Flow from ED to UCSD at Home

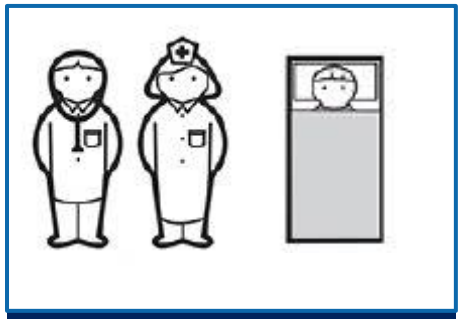
Patient is evaluated in the ED

ED Unit

ED OBS Unit

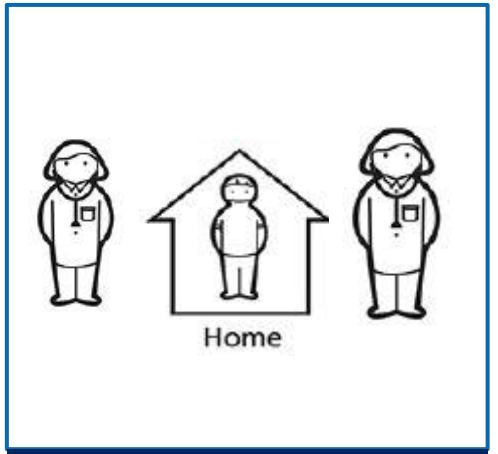
EDIP Unit

ED APP and ED Case Manager review patients who meet criteria for UCSD at Home Program



Patient is met at the bedside and discharge planning is completed including:

- Pharmacy discharge
- UCSD at Home Program scheduling
- Coordination with Accent Care



Patient is discharged home with the added support of UCSD at Home ED MD/NP
Accent Care Home Health
Digital Health Devices

1-24 hours → 12-24 hours → Day After Discharge

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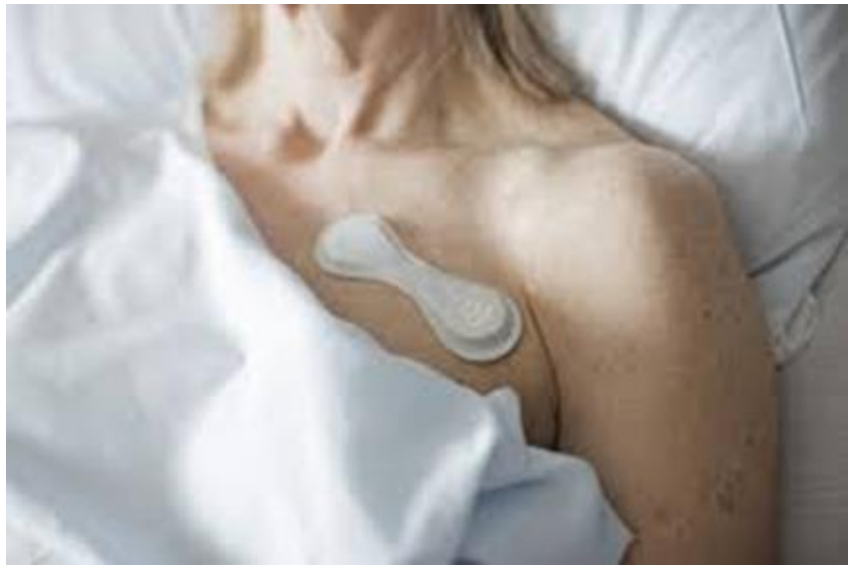
Remote Monitoring Care

Helps caregivers identify early signs of patient deterioration and detects falls to drive early intervention



Philips wearable biosensors for VS, falls, position

Data analytics and early notifications, automated alerts to staff for any change in status, or risks

Lasts for Average Patient Stay (3-4 Days)

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AI/Machine Learning/Predictive Analytics

Sepsis

Likelihood to occupy Bed

- Look for alternative care models

ED Flow Predictions / census mgmt.

- Forecasting, opening alternative sites (IC, UC, OR)

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Thank you!

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