

## COMMENTARIES

### A New Model for Emergency Care of Geriatric Patients

The special challenges of geriatric patients in the emergency department (ED) have been discussed for several decades.<sup>1</sup> The unique nature of older patients and the notable challenges of caring for them have been described.<sup>2</sup> Teaching curricula have even been developed for emergency medicine residents and practicing physicians to address these challenges and to optimize quality of care.<sup>3-5</sup> The importance of optimizing care for elder patients in the ED does not need to be debated. What can be questioned, however, is whether there is evidence that the nation's emergency caregivers are meeting these challenges. Are patients being better served? Are emergency physicians more at ease, and less frustrated? It is likely that EDs still have a long way to go. The specialty's leaders must continue to clarify the challenges and devise ways to implement the lessons learned.

In this issue of Academic Emergency Medicine, four articles provide further insight into geriatric issues in emergency medicine.<sup>6-9</sup> Although each provides important new information, none disputes what we have known for a long time. The older patient in the ED, with impaired functional status, need for assistance at home, comorbid conditions, and physiologic differences, offers challenges to the caregiving system and the caregivers themselves.

It is important to recognize the insights offered in these articles, but it is equally important to recognize that emergency physicians are not easily able to deal with the information. Whether it is a call for implementation of screening tools or a need to deal with geriatric patients who are not equally referred to trauma centers, we are mostly left wondering what to do. As we analyze these articles, maybe we should also analyze our systems of care. We might have to conceive of innovative delivery systems to decrease our frustration and optimize geriatric ED care. Perhaps then we can make more progress in the coming decade than we have in the past.

We must first recognize important information, and challenges, presented in this issue of the journal. Lane and colleagues<sup>6</sup> report that seriously injured older patients are less likely to be taken to a trauma center than are younger patients with the same severity of injury. McCusker et al<sup>7</sup> in Montreal demonstrate the benefit of a brief screen in planning care after discharge. Meldon and colleagues<sup>8</sup> in Cleveland show the value of a brief screen in identifying patients likely

to use expensive health services within four months of their ED visit.

The aims of the Montreal and Cleveland studies are similar. Both authors report results of secondary analyses from randomized trials to evaluate the effect of an ED case-finding program. They both use a brief screen followed by a more detailed evaluation and referral to clinical services. The two studies use six-item screens that might look different, but are really quite similar. Both screens question independence, health care use, functional impairment, cognitive impairment, and polypharmacy.

These papers have another commonality that they share with data presented from the Pennsylvania trauma registry. All three papers raise important questions about improving processes of emergency care for older patients. This is the cardinal research question raised by the Research Agenda Setting Process (RASP), summarized in the forth geriatric emergency medicine paper in this issue of AEM.<sup>9</sup> RASP is a project convened by the American Geriatrics Society with support from the John A. Hartford Foundation. The goal was to set a geriatric research agenda for ten surgical and related medical specialties. The highest-priority research question is "Can alterations in the process of ED care. . . improve the outcomes of older ED patients? These processes of care, as demonstrated by the three studies, include out-of-hospital care, care in the ED, and linkages with providers after discharge. The studies reported in this issue are early in a research path leading to improved outcomes for older patients. We must answer the questions RASP raised and incorporate the results as best practices to improve care of and outcomes for older patients.

#### IS IT REALLY POSSIBLE TO IMPROVE ED CARE FOR OLDER PEOPLE?

While this research agenda is important, it is also daunting. For already overburdened emergency physicians, there may be limited energy to devote to this challenge. After all, emergency caregivers have known for many years that older people are not optimally served in modern EDs. It has been clear for decades that elders who seek emergency services have special needs.<sup>10,11</sup> In order to improve care that older patients receive, it has already been suggested that emergency physicians should inquire about functional status, adequacy of help at home, and comorbid conditions, to target those at greatest risk of

poor recovery to improve care that older patients receive.<sup>12</sup> It is known that older persons use ED services more frequently, are admitted more often, stay a longer time in the ED (sometimes 50% longer), and are readmitted to the ED after discharge twice as often.<sup>13</sup> The real benefit of the articles presented in this issue of the journal is the continued recognition that existing systems do not serve well the oldest of our patients. The screening tools and the information presented in these articles provide both useful information and useful provocation, challenging us to think about new methods of care delivery for geriatric patients.

### EDS ARE NOT DESIGNED FOR OLDER PEOPLE

It is worth noting that the current model of ED care was designed for the acutely ill and injured patient, not a medically complicated, slow-moving, functionally impaired geriatric patient. In fact, ED processes are usually inadequate and inhospitable for the older person. The rapid triage and care process is often unable to elicit a full understanding of the person to enable optimal care. The full breadth of medical conditions, a long list of medicines, communication challenges, and sometimes slowly evolving problems rather than clear and acute events all impair effective understanding of the patient's current need. The ambient environment, the noisy waiting room, the hard gurneys, the crowded department, the lack of pillows, the rushed history and physical examination, the harried caregivers, the separation from friends and family, and even the lack of effective information delivery systems all demonstrate a design that does not enable optimal care.

This is really no surprise when one considers that modern ED design still adheres to principles set forth by the Committee on Trauma of the American College of Surgeons in 1962.<sup>14</sup> This design was proposed for "any person who considers himself ill or injured" and establishes the model floor plan still most commonly used today. A central nurses and physician station enables maximal visibility of care rooms that surround it. The emphasis was, and remains, on rapid treatment of emergent and urgent needs. It does not enable thorough assessment and evaluation of a person whose needs are complex and whose care process is slow-moving. It is not a surprise that screening tools have not been implemented and few enduring changes are noted. The ED depends on rapid patient turnover. The goal is acute intervention and disposition. When a medically complex older person with impaired memory, impaired mobility, and impaired social supports presents, the system slows and frustration ensues. If frustration is to be reduced and quality optimized, perhaps a new model of emergency care is required. The special needs of trauma

patients were addressed through the establishment of trauma teams. An enormous range of hospital services cease all other functions to attend to the traumatized person, sometimes even to the detriment of more seriously ill elder patients in the ED. The special needs of people with important but less threatening disorders were addressed by establishing urgent care centers and fast tracks. Special needs of children were addressed by establishing pediatric emergency centers, where space, equipment, and the environment safely, even pleasantly, serve the younger ED visitors. Yet geriatric patients, sometimes the most complex of all, are left in to the usual chaos, despite widespread recognition of unmet needs. Perhaps a new model of care must be conceived.

### INNOVATIVE MODELS OF GERIATRIC EMERGENCY CARE

Some institutions have devised a geriatric ED. Nassau University Medical Center on Long Island developed a unit that is staffed not by emergency physicians, but by geriatricians. Mount Sinai Hospital in New York City has introduced geriatric nurse practitioners in the ED. They noted that 41% of patients 65 years and older were repeat visitors to the ED.<sup>15</sup> The geriatric nurse practitioners attempt to improve communication, assist with coordination across practice sites, reduce unnecessary utilization, assist with patient care, expedite admission, or assist with discharge planning. While we know of no scientific data available to show the effect of such approaches, perhaps the rest of us should still take note.

As we continue on the inevitable journey to optimize the care of older patients in the ED, we can begin to establish a vision of best practices. Three main principles apply. We must first attempt to make patients familiar to the ED caregivers, rather than confronting each person as new. Most emergency physicians accept it as inevitable that every ED patient is a new patient. Yet many of the patients are repeat visitors. Why must the caregivers go through rediscovery of the patient's history? The promise of information technology will not be fully realized until this inefficient, even dangerous, challenge is diminished. We must also accept that care is enabled through effective team functioning, and be willing to increasingly rely on nurses and allied health personnel. Finally, a comforting environment should be created for the older patient. A comfortable place for the patient, family, doctor, and nurse should be provided, uniquely conceived, not based on the surgical model of care. Some of the operational implications of these suggestions are obvious:

- First, we must try to make the patient known. For example, the ED is often called by a primary physician about an incoming patient. Most EDs

consider such calls an intrusion and establish no effective means to take advantage of the information provided. Information technology theoretically enables a pre-registration function so that critical information can be captured. Such preparations would save time once the patient arrives. A pre-registration function also has the advantage of easing the triage nurse task, potentially eliminating waiting time.

- Second, as part of the pre-registration or usual registration, much information should be automatically downloaded from hospital databases and provided to the caregivers. Key information should populate any electronic ED record. For example, existing medical illnesses, results of recent imaging studies, recent laboratory studies, last known medications, allergies, dates of recent admissions, social history, and functional status all should be provided to the ED. Without such information, expert care is impeded. It is often not possible for any caregiver in the ED to do more than a cursory computer search, possibly overlooking key data about a complex patient. Time pressures are great and competing demands are distracting. Information technology holds great promise to impact the clinical operation and improve quality and efficiency for the geriatric patient, if applied as an active delivery tool rather than a database.
- Third, for older patients, it is more important than ever to work as a team. The core skills of the emergency physician are to expertly relate to the patient and family, synthesize critical information, formulate a diagnostic plan, and make therapeutic decisions. Emergency physicians become frustrated when circumstances interfere with these tasks. The geriatric patient represents such a challenge. Often unable to communicate complete or accurate information, the diagnostic and therapeutic direction might become difficult to establish. Other caregivers can help by spending the time to identify key information, clarify recent events, provide information about prior functional status, ensure an accurate medication list, etc. This requires emergency physicians to work as a team with the patient's primary physician, the ED nurses, and, potentially, geriatric nurse practitioners or physician assistants. A highly functional team could theoretically optimize quality, efficiency, and satisfaction, although little scientific data are yet available.
- Fourth, a comforting environment must be created. The high stress and fast pace of the typical ED are not easy for any patient, especially older people. Several years ago, one of us (JGA) quietly scoffed when a sweet 84-year-old woman asked him for "a cup of tea, with only one lump of sugar, please." He now has come to realize that maybe

we need a unit where this is possible. Thicker mattresses, warm blankets, a pillow, easy lighting, seats for family, and comfortable chair for the doctor (an incentive to stay and talk) should not be too much to ask. We have devised other specialized units to optimize efficiency and quality. Perhaps geriatric units are now needed, to provide space and comfort without high-stakes worries of throughput and length of stay. A hybridized ED and observation unit might optimize care for complex but stable older people in the midst of prolonged diagnostic workups. In this setting, an emergency caregiving team could function optimally, with less frustration. Other team members could carry out their tasks. In this environment, screening tools might not seem like such a burden.

- Finally, financial support and hospital commitment are required. Most EDs already lose money on elder patients, so adequate geriatric units are unlikely to be eagerly built. A strong business concept is required to ensure fair reimbursement. If leading departments have sufficient visibility, though, others will take note. If research data reveal optimized outcomes, decreased subsequent resource utilization, or other meaningful improvements, a trend could begin. Then we all will benefit.

The increasing numbers of older patients in the EDs of the United States should push us to consider innovations. Only by applying lessons known and by continuing important research efforts will we be able to make meaningful improvements for older patients. Improvements that benefit patients will inevitably benefit caregivers as well.—James G. Adams, MD (jadams@nmh.org), Division of Emergency Medicine, Northwestern University, Feinberg School of Medicine, Northwestern Memorial Hospital, Chicago, IL; and Lowell W. Gerson, PhD (lgerson@nesucom.edu), Division of Community Health Sciences, Northeastern Ohio Universities College of Emergency Medicine, Akron, OH.

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