Optimal Older Adult Emergency Care: Introducing Multidisciplinary Geriatric Emergency Department Guidelines from the American College of Emergency Physicians, American Geriatrics Society, Emergency Nurses Association, and Society for Academic Emergency Medicine

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In the United States and around the world, effective, efficient, and reliable strategies to provide emergency care to aging adults is challenging crowded emergency departments (EDs) and strained healthcare systems. In response, geriatric emergency medicine clinicians, educators, and researchers collaborated with the American College of Emergency Physicians, American Geriatrics Society, Emergency Nurses Association, and Society for Academic Emergency Medicine to develop guidelines intended to improve ED geriatric care by enhancing expertise, educational, and quality improvement expectations, equipment, policies, and protocols. These Geriatric Emergency Department Guidelines represent the first formal society-led attempt to characterize the essential attributes of the geriatric ED and received formal approval from the boards of directors of each of the four societies in 2013 and 2014. This article is intended to introduce emergency medicine and geriatric healthcare providers to the guidelines while providing recommendations for continued refinement of these proposals through educational dissemination, formal effectiveness evaluations, cost-effectiveness studies, and eventually institutional credentialing. **J Am Geriatr Soc 62:1360–1363, 2014.**

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A rapidly expanding geriatric population will challenge healthcare systems around the world in coming decades. Emergency departments (EDs) play a critical role in the care of older adults with acute illness and injury and serve as the safety net for those with limited access to primary care.[1,2] Healthcare leaders in emergency medicine now face the additional challenge of delivering effective

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care to this aging population within a cost-constrained environment and high consumer expectations.

Three decades have passed since the landmark Society for Academic Emergency Medicine (SAEM) Task Force completed its work on the care of older adults in the ED. The task force was supported with funding from The John A. Hartford Foundation (JAHF) to evaluate the state of care and to make recommendations for the future. The research led to recommendations that emergency medicine must adopt an alternative care model recognizing the special needs of older adults. They called for increased education and research in recommending that "The structure of emergency health care delivery for elderly patients must be evaluated and innovations explored. For example, the role of geriatric emergency health care centers analogous to trauma centers or pediatric centers should be investigated. The center concept might provide a mechanism for delivering specialized care and attending to the special needs of geriatric patients but may be practical in only some communities."[3]

At that time, the JAHF and the American Geriatrics Society (AGS) also recognized the rapid growth of the older population and the shortfall in the number of geriatricians to meet the need to care for this population. The solution was to increase expertise in geriatrics of medical specialists. Emergency medicine was selected as one of the original five (later 10) specialties to participate in the Geriatrics-for-Specialists Initiative (GSI). The GSI supported resident training opportunities and fostered a body of skilled and dedicated researchers. The Atlantic Philanthropies joined JAHF in funding the development of researchers through the GSI. The progress is measurable. PubMed had 321 articles in emergency medicine with an age of 65 and older published in the 5 years before the SAEM Task Force, whereas there were 4,588 articles from 2008 to 2013. In addition, competencies for residents were developed in conjunction with the American Medical Association, Council of Residency Directors, Emergency Medicine Residents' Association, American College of Emergency Physicians (ACEP), SAEM, and AGS.[4] Emergency medicine opinion leaders also defined priorities for quality improvement[5] and research[6,7] to accelerate the growth of geriatric emergency care. ACEP and SAEM have supported organizations with members interested in improving geriatric emergency medicine.

Over the past decade, geriatric and geriatric-friendly EDs have been described and implemented as a response to the challenge of caring for older adults,[8,9] but the existing literature and interest groups focusing on specific areas of need are insufficient to guide and adequately motivate emergency providers and administrators in the development of such EDs. There is enough information in the literature to develop evidence-based guidelines for the organization and care of elderly adults, so the ACEP Geriatric Emergency Medicine Section, the AGS, the Emergency Nurses Association (ENA), and the SAEM Academy of Geriatric Emergency Medicine formed a task force in 2011 to provide peer-reviewed guidelines for optimal geriatric ED staffing; transitions of care; continuing medical education; quality improvement metrics; essential equipment requirements; and recommended policies, procedures, and protocols. The product of this multidisciplinary task force is now available at http://geriatricscareonline.org/ProductAbstract/geriatric-emergency-department-guidelines/CL013, and this article is intended to serve as a general introduction to these new guidelines. The next step is modifying these guidelines based on research about their usefulness and the collective ability to implement them in an active ED. Eventually, this process of continuous quality improvement can lead to a system of certifying an ED that meets the requisite criteria as a geriatric emergency department.

WHY A MULTIDISCIPLINARY GUIDELINE?

The AGS and JAHF recognized that optimal geriatric care in contemporary healthcare delivery models would require a multispecialty, multidisciplinary approach because specialty physicians and other health professionals provide additional knowledge and skill sets, but the number of board-certified geriatricians is insufficient to meet the needs of an aging society. Compassionate, timely, efficient, and cost-effective geriatric care rests on collaborative protocols and reliable transitions of care that are developed and acceptable across a wide range of healthcare providers who typically do not proactively develop such documents.[2] Acute management of geriatric adult emergencies requires reliable communication between primary care, inpatient and outpatient medical and surgical specialists, rehabilitation medicine, case managers, social workers, pharmacists, and nursing professionals. The ED often serves as the front porch of the hospital, with one foot on the inpatient side and the other foot in the outpatient world.[2] Therefore, a comprehensive geriatric ED guideline document needs to reflect the requisite collaboration in care and the role that contemporary emergency medicine can and should reliably provide to colleagues outside of the ED.

WHAT CONSTITUTES THE GERIATRIC ED GUIDELINE AND HOW WAS IT DERIVED?

In 2011, the leadership of the ACEP Geriatric Section and SAEM Academy for Geriatric Emergency Medicine identified representatives from ACEP, AGS, ENA, and SAEM to participate in a series of teleconferences to develop geriatric ED guidelines. The 14 coauthors of this manuscript participated in these calls and were split into two working groups: (1) structural and staffing and (2) clinical and operational. Each working group reviewed the literature and provided best-evidence recommendations for essential geriatric emergency care. The leaders of the participating organizations reviewed the resulting guideline. ACEP, SAEM, AGS, and ENA officially approved the final guideline as a set of formal recommendations.

The geriatric ED guidelines document consists of 40 specific recommendations in six general categories: staffing; transitions of care; education; quality improvement; equipment, supplies; and policies, procedures, and protocols. Staffing includes recommendations for the medical director and nurse manager and accessibility to specialist ancillary services. Transitions of care include discharge processes and large-font instructions, as well as appropriate collaboration with home health services and home-safety assessments. Nurse and physician education includes front-end geriatric-specific educational materials

through readily available self-learning modules or group didactics. Criteria for geriatric emergency medicine continuing medical education are also recommended, with topic-specific content customized to the individual department needs. The quality improvement recommendations provide a sample spreadsheet of important older adult emergency care indicators and the frequency with which they should be monitored, including the prevalence of injurious falls and documentation of fall-risk assessment. The document includes a quality assessment matrix to track preventable adverse events within individual departments. The section on equipment and supplies describes some of the potential physical structure enhancements such as the use of reclining chairs and pressure-redistributing foam mattresses to reduce the incidence of pressure ulcers. A variety of policies, procedures, and protocols are provided to facilitate screening for older adults at risk of post-ED discharge functional decline, recidivism, or institutionalization, as well as validated and ED-feasible screening instruments for geriatric syndromes such as delirium, polypharmacy, falls, and dementia.

The geriatric ED guidelines represent recommendations for older adult emergency care; these are not a mandate for every geriatric-friendly ED to develop and sustain all of these elements. Instead, these principles should be customized for each ED based upon patient needs and available resources.

NEXT STEPS

The first step is to disseminate these guidelines across heterogeneous care settings: rural and urban, academic and community. This introduction is one mode of dissemination, and the guideline will be freely available on each organization's website. It is planned to distribute and review these guidelines at the annual meetings of the sponsoring organizations and to disseminate the guidelines to other organizations that may find them of interest. Because most members of each organization cannot attend their organization's meetings each year, funding and support is also being sought to develop a "geriatric ED boot camp" experience that is distinct from the annual meeting and geographically easier for busy healthcare providers to attend. A concentrated 3-day exposure to the guideline recommendations and providing attendees with a toolbox of resources to facilitate implementation of the geriatric ED guidelines at their home institution is envisioned. The toolbox could include geriatric dementia, delirium, fall risk, functional assessment, and prognostic screening instruments in an electronic platform (e.g., website, smartphone), as well as a community of mentors and colleagues with whom to collaborate on future research and quality improvement projects. It is anticipated that existing educational and clinical resources such as the Geriatrics-for-Specialty Residents toolbox of educational products, and resources from ACEP, AGS, ENA, and SAEM will be drawn on.

The second objective is to refine and improve these guidelines to address real-world barriers to operationalizing the current recommendations. The current guidelines resulted from more than 2 years of work of a dedicated task force composed of experts from multiple fields, and board of director approvals from each organization were attained. The science upon which the recommendations were built is imperfect, and this remains an active area of research. As understanding of effective geriatric ED models of care is enhanced through future research,[6,7] important details of future geriatric ED guidelines will undoubtedly evolve.[10,11] More importantly, as clinicians identify barriers to implementing the geriatric ED guidelines within their respective hospitals and healthcare settings, their input will be sought for pragmatic solutions to optimize the value of emergency care for older adults. To attain this second objective, it is essential that an open stream of communication with attendees at "geriatric ED boot camp" events be developed and maintained, which is another reason to develop and fund new models to disseminate these guidelines.

The third objective is to develop a credentialing system similar to the American College of Surgeons trauma center criteria to acknowledge healthcare systems that attain minimal levels of proficiency with these guidelines. The political and pragmatic ramifications of credentialing certain EDs based on consensus recommendations of multiple organizations will require open discussion, transparent evaluations of efficacy, and formal economic evaluations. It is thought that this objective will require a decade to attain.

SUMMARY

The geriatric ED guideline recommendations represent best-evidence- and best-practice-based research and consensus from the perspectives of ACEP, AGS, ENA, and SAEM. Three decades after the first SAEM Task Force recognized the challenges that an aging population would present to contemporary emergency medicine, these guidelines provide an opportunity to disseminate, adapt, and incorporate geriatric principles into the emergency medicine model of care. Effective implementation of these recommendations will positively influence the care of older adults in the ED for future generations.

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