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 a strained health care system. In response, geriatric emergency medicine clinicians, educators, and researchers collaborated with the American College of Emergency Physicians (ACEP), American Geriatrics Society (AGS), Emergency Nurses Association (ENA), and Society for Academic Emergency Medicine (SAEM) 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 attribute of the geriatric ED and received formal approval from the board of directors for each of the 4 societies in 2013 and 2014. This article is intended to introduce emergency medicine and geriatric health care providers to the guidelines while providing proposals for educational dissemination, refinement through formal effectiveness evaluations and cost-effectiveness studies, and institutional credentialing.

Three decades have passed since the landmark SAEM Task Force completed its work on the care of older patients in the ED. The task force was supported with funding by 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 adopt an alternative care model recognizing the special needs of older patients. They called for increased education and research in recommending that "[t]he 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."[1]

At that time, the JAHF and the 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 among medical specialists. Emergency medicine was selected as one of the original 5 (later 10) specialties to participate in the Geriatrics-for-Specialists Initiative. The initiative 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 Geriatrics-for-Specialists Initiative. The progress is measurable. By our rudimentary electronic search of PubMed, 321 articles in emergency medicine were published in the 5 years before the SAEM Task Force was created, with a patient age limit of older than 65 years. In contrast, the last 5 years (2008 to 2013) show 4,588 articles. In addition, competencies for residents were developed in conjunction with the American Medical Association, Council of Emergency Medicine Residency Directors, Emergency Medicine Residents' Association, ACEP, SAEM, and AGS.[2] Emergency medicine opinion leaders also defined priorities for quality improvement[3] and research[4,5] to accelerate the growth of geriatric emergency care. Both ACEP and SAEM have supported and grown organizations with members interested in improving geriatric emergency medicine.

During the past decade, geriatric and geriatric-friendly EDs have been described and implemented as a response to the challenge of caring for older adults.[6,7] However, 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. At present, we have enough information in the literature to develop evidence-based guidelines for the organization and care of elder patients. Therefore, the ACEP Geriatric Emergency Medicine Section, AGS, ENA, and 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://www.acep.org/geriEDguidelines/ and this essay is a general introduction to these new guidelines.

WHY A MULTIDISCIPLINARY GUIDELINE?

AGS and the JAHF recognized that optimal geriatric care in contemporary health care delivery models would require a multispecialty and multidisciplinary approach. The number of board-certified geriatricians is insufficient to meet the needs of an aging society. In addition, specialty physicians and other health professionals provide additional knowledge and skill sets. 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 health care providers who typically do not proactively develop such documents.[8] Acute management of geriatric adult emergencies requires reliable communication between primary care, inpatient and outpatient medical and surgical specialists, rehabilitation medicine, case managers, social work, pharmacy, and nursing professionals. In fact, 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.[8] 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 with colleagues outside 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 article participated in these calls and were split into 2 working groups: "structural and staffing" (M.B., A.C., L.W.G., U.H., W.L.L., B.M., M.R., S.W.) and "clinical/operational" (M.B., C.R.C., J.M.C., J.G., D.P.J., T.F.P.-M., L.R., M.R.). 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. The boards of directors of 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 6 general categories: staffing, transitions of care, education, quality improvement, equipment/supplies, and policies/procedures/protocols. Staffing includes recommendations for the medical director, 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 training by readily available self-learning modules or group didactics. We also recommend geriatric emergency medicine continuing medical education criteria with topic-specific content tailored to the individual department needs. The quality improvement recommendations provide a sample spreadsheet of prominent 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 an individual department. 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 increased risk for 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, and these are not a mandate for every geriatric-friendly ED to develop and sustain all of these elements. Instead, these principles should be tailored for each ED according to patient needs and available resources.

NEXT STEPS

Our 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 Web site. We plan 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 we realize most members of each organization cannot attend their organization's meetings each year, we are also seeking funding and support to develop a "geriatric ED boot camp" experience that is distinct from the annual meeting and geographically easier for busy health care providers to attend. We envision 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 institutions. The toolbox could include geriatric dementia, delirium, fall-risk, functional assessment, and prognostic screening instruments in an electronic

platform (Web site, Smartphone), as well as a community of mentors and colleagues with whom to collaborate on future research and quality improvement projects. We anticipate that we will draw on existing educational and clinical resources such as the Geriatrics-for-Specialty Residents toolbox of educational products and resources from ACEP, AGS, ENA, and SAEM.

Our 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 by a dedicated task force composed of experts across multiple fields and attained approval by the board of directors from each organization. We acknowledge that the science on which we built our recommendations is imperfect and that this remains an active area of research. As we enhance our understanding of effective geriatric ED models of care through future research,[4,5] key details of future geriatric ED guidelines will undoubtedly evolve.[9,10] More important, as clinicians identify barriers to implementing the geriatric ED guidelines within their respective hospitals and health care settings, we will seek their input for pragmatic solutions that still seek to optimize the value of emergency care for older adults. To attain this second objective, it is essential that we develop and maintain an open stream of communication with attendees at geriatric ED boot camp events, which is another reason to develop and fund new models to disseminate these guidelines.

Our third objective is to develop a credentialing system similar to the American College of Surgeons trauma center criteria to acknowledge health care systems that attain minimal levels of proficiency with these guidelines. The political and pragmatic ramifications of credentialing certain EDs according to consensus recommendations of multiple organizations will require open discussion, transparent evaluations of efficacy, and formal economic evaluations. We project 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 geriatric emergency patients for future generations.

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