Building the 21st Century Geriatric Emergency Department Around the World

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Washington University in St. Louis
March 10, 2014
Disclosure of Relationships

- Editor Academic Emergency Medicine and ACP Journal Club
- Chair, ACEP Geriatric Section
- Chair, SAEM Evidence Based Medicine group
- No commercial relationships, including no
  - Advisory boards/consulting
  - Officer or Board Member
  - Shareholder
  - Speaker’s Bureau
  - Intellectual property/patents pending
  - Other relationships
Objectives

- Define the “silver tsunami” related demographic challenges facing contemporary emergency medicine
- Illustrate effective clinical, educational, and research collaboration and cross-pollination around the world
- Explore concept of disruptive innovation within context of implementation science and generational learners
- Provide ideas and opportunities to extend geriatric acute care educational and research collaborations around the world
The 20th IAGG World Congress of Gerontology and Geriatrics
June 23-27, 2013 Coex, Seoul, Korea

Digital Ageing: A New Horizon for Health Care and Active Ageing
Historic and Projected Population Growth

To add the next 1 billion people:
- 8 Billion in 2024
- 7 Billion in 2011
- 6 Billion in 1999
- 5 Billion in 1987
- 4 Billion in 1974
- 3 Billion in 1960
- 2 Billion in 1930
- 1 Billion in 1800

SOURCES: CARL HAUB, POPULATION REFERENCE BUREAU (PRB), 2010; U.N. POPULATION DIVISION (UNPD), 2011
Baby Boomer Demographic Imperative ("Silver Tsunami")

**Developing Countries 2010**

**Developed Countries 2010**

*SOURCE: UNPD, 2011*
ED Geriatric Admission Rates Across the World

<table>
<thead>
<tr>
<th>Symptom</th>
<th>More time-consuming</th>
<th>More resources</th>
<th>More difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal pain</td>
<td>86</td>
<td>81</td>
<td>78</td>
</tr>
<tr>
<td>Fever without source</td>
<td>66</td>
<td>71</td>
<td>45</td>
</tr>
<tr>
<td>Altered mental status</td>
<td>70</td>
<td>76</td>
<td>59</td>
</tr>
<tr>
<td>Headache</td>
<td>67</td>
<td>64</td>
<td>47</td>
</tr>
<tr>
<td>Chest pain</td>
<td>58</td>
<td>57</td>
<td>45</td>
</tr>
<tr>
<td>Multisystem trauma</td>
<td>72</td>
<td>71</td>
<td>72</td>
</tr>
<tr>
<td>Dizziness/vertigo</td>
<td>80</td>
<td>76</td>
<td>64</td>
</tr>
</tbody>
</table>

**Figure 1–5** Evaluation of clinical symptoms in older compared to younger adult patients. (Numbers represent percent [%] of affirmative responses.) (Adapted from McNamara RM, Rousseau E, Sanders AB: Geriatric emergency medicine: a survey of practicing emergency physicians. *Ann Emerg Med.* July 1992;21:796–801.)
Current ED Screening Practice

Western J Emerg Med 2011; 12: 489-495
Proportion Abnormal MMSE, Documented Normal

![Bar chart showing the proportion of abnormal MMSE for different categories: ED Nurses, ED MDs, and Admit MDs. The κ values are provided for each category: κ 0.404, κ 0.597, and κ 0.688.](chart.png)
Okay, But I Work in the ED! So What?

- Why is caring for geriatric adults different than any other adult population?
- Why should I care?
- Do actionable solutions exist?
Step 1: Education

**EDUCATIONAL ADVANCE**

Development of Geriatric Competencies for Emergency Medicine Residents Using an Expert Consensus Process

Teresita M. Hogan, MD, Eve D. Losman, MD, Christopher R. Carpenter, MD, Karen Sauvigne, MA, Cheryl Irmiter, PhD, Linda Emanuel, MD, PhD, and Rosanne M. Leipzig, MD

*Acad Emerg Med* 2010; 17: 316-324
Development of Geriatric Competencies for Emergency Medicine Residents Using an Expert Consensus Process

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III. Cognitive and behavioral disorders

with the rules of the state and institution.

7. Institute appropriate early monitoring and testing with the understanding that elders may present with muted signs and symptoms (e.g., absent pain and neurologic changes) and are at risk for occult shock.

8. Assess whether an elder is able to give an accurate history, participate in determining the plan of care, and understand discharge instructions.

9. Assess and document current mental status and any change from baseline in every elder, with special attention to determining if delirium exists or has been superimposed on dementia.

10. Emergently evaluate and formulate an age-specific differential diagnosis for elders with new cognitive or behavioral impairment, including self-neglect; initiate a diagnostic workup to determine the etiology; and initiate treatment.
The Participants

American Geriatrics Society

- Founded in 1942
- 6000 health professionals
- Vision = providing every older American with high quality, patient-centered care
The Participants

American College of Emergency Physicians

- Founded in 1968
- 32,000 emergency physicians globally
- Vision = providing every older American with high quality, patient-centered care
The Participants

Society for Academic Emergency Medicine

- Founded in 1989
- 5000 academic emergency physicians
- Vision = create & promote discovery and advance education for clinicians, educators, and researchers
Meet Generation Y

- A closer sphere of influence
- Team Oriented
- Structure
- Pressured to succeed
- Multi-taskers
- Tech Savvy
Generation Y Learning Characteristics

- K.I.S.S.
- Prefer interaction with colleagues
- Use Technology
- Want learning to be entertaining and fun
- Visual, Nonlinear and Virtual Learners

“There aren’t any icons to click. It’s a chalk board.”
Education

Special Announcement: Online Course Now Available

How often do you encounter older patients in the emergency department with abdominal pain? Do you find it difficult to communicate with them? Is treatment challenging?

Learn how to interact with, diagnose, and treat older adults more effectively through this interactive online training tool titled "Abdominal Pain in the Older Adult."

FREE for non-CME participants; or $95 for 6 AMA PRA Category 1 Credits™.

This program is brought to you by the SAEM Academy of Geriatric Emergency Medicine (AGEM) and is funded through the generous support of the Retirement Research Foundation.

** See accreditation and disclosure policy statements below

→ Course 1: Abdominal Pain in the Older Adult

http://www.saem.org/login/
Sign Up!

Click on the button below to register now. Registration gives you access to interactive exercises, discussion boards, and much more. Register today.

http://geri-em.com/
Innovative Curriculum: POGOe
http://www.pogoe.org/
UC Irvine Medical Center

Geriatric Emergency Medicine
Online Curriculum (GEM-OC)

This curriculum presents a series of case studies with patient information, interactions with medical staff, analysis, diagnosis and care recommendations. It is designed to build knowledge and skills in geriatric competencies and to test your knowledge proficiency levels.

http://www.pogoe.org/productid/20771
Geriatric Emergency Medicine Online Curriculum

Welcome to the Cleveland Clinic's online curriculum for Geriatric Emergency Medicine. The curriculum includes basic and advanced courses. The basic courses are designed to improve your knowledge of the basic principles of geriatric emergency care with an emphasis on quality of care issues. The content is presented through questions, most of which are case-based. Questions include a brief discussion in the feedback for each answer chosen as well as suggested readings.

The curriculum consists of the following five courses:

- Altered Mental Status
- Geriatric Abdominal Pain
- Geriatric Trauma and Elder Abuse
- Inappropriate Prescribing and Adverse Drug Events
- Pain Management and Procedural Sedation

The advanced courses provide the opportunity to apply what you have learned in the basic courses to case simulations in which you work through historical information and physical examination findings, choose appropriate diagnostic testing and therapeutic interventions, and decide on correct diagnoses and dispositions. Each decision includes feedback regarding appropriateness of care.

The curriculum consists of the following course:

- A Case of Geriatric Abdominal Pain
- A Case of Altered Mental Status
- A Case of Geriatric Trauma

The entire curriculum provides links to key references in PubMed.

http://www.pogoe.org/productid/20457
The patient, Mrs. Jane Simon, arrives in the ED of the 200-bed community hospital via ambulance. She is brought to the triage area on a stretcher.

Triage vital signs: BP 170/105; HR 136 & irregular; RR 22; Temp. 96°F; pulse ox 99% on non-rebreather

Triage nurse assigns Emergency Severity Index (ESI) of 1 based on hypoxia.

http://www.rowan.edu/som/njisa/students-residents/
Framework for Enhancing the Value of Research for Dissemination and Implementation

Planning
- Clinical, Health System, or Public Health Intervention
  - Evidence Base
  - Program Logic
  - Mechanisms of change
- Context
  - Setting characteristics, Resources constraints, Culture, Capacity & Readiness
- Implementation Strategy
  - Evaluability
  - Scalability
- Partnership
- D&I Study Design

Delivery
- Reach
- Adoption
- Evolution of intervention and implementation strategy to fit context
- Implementation
  - Fidelity, Dose & Adaptation
- Implementation Costs and Resources Expended

Evaluation/Results Reporting
- Effectiveness
  - Primary outcome
  - Broader consequences (e.g., other benefits and harms)
- External Validity of findings, including explicit description of setting and setting change
  - Robustness
  - Pragmatic Criteria (PRECIS)

Long-Term Outcomes
- Sustainability
  - Evolvability
  - Transportability
- Replication & Uptake:
  - Conditions under which findings hold
  - Economic evaluation (e.g., cost-benefit/effectiveness, budget impact, replication/implementation cost)

GOALS
- Improvements in population health, health equity, social well-being, and health system efficiency

Cross-Cutting Issues:
- Multi-level context (including history, policy climate, and incentives)
- Multiple Stakeholders Perspectives
- Costs of intervention, implementation and replication

* underused
** lacking
The Care Span
Transforming Emergency Care For Older Adults
Step 2: Clinical Guidelines

http://www.acep.org/geriEDguidelines/
New Guidelines Enhance Care Standards for Elderly Patients in the ED
Recommendations cover staffing, education, equipment, procedures, follow-up tips, and performance improvement measures for geriatric emergency care

Silver Book

http://tinyurl.com/c48ytyc
Step 3: Research Prioritization

3

GERIATRIC EMERGENCY MEDICINE

Christopher R. Carpenter, MD, MSc, FACEP; Lowell W. Gerson, PhD*

The American Geriatric Society (AGS) project “Increasing Geriatric Expertise in Surgical and Related Medical Specialties” sponsored an effort to summarize the existing evidence and to identify priorities for future research in geriatrics aspects of several surgical and related medical fields. Ultimately, each specialty’s research agenda was disseminated in a book (hereinafter referred to as New Frontiers)¹ and a Web site (http://www.frycomm.com/ags/rasp), and many were also disseminated in professional journals, as was, for example, the agenda for emergency medicine.² In 2005, the AGS initiated a review of each specialty’s recommendations to analyze any progress made and evaluate whether any agenda items should be discarded or new ones added.

http://newfrontiers.americangeriatrics.org/
High Yield Research Opportunities in Geriatric Emergency Medicine: Prehospital Care, Delirium, Adverse Drug Events, and Falls

Christopher R. Carpenter,1 Manish N. Shah,2 Fredric M. Hustey,3 Kennon Heard,4,5 Lowell W. Gerson,6,7 and Douglas K. Miller8,9

Research Priorities for High-quality Geriatric Emergency Care: Medication Management, Screening, and Prevention and Functional Assessment

Christopher R. Carpenter, MD, MS, Kennon Heard, MD, Scott Wilber, MD, MPH, Adit A. Ginde, MD, MPH, Kirk Stiffler, MD, Lowell W. Gerson, PhD, Neal S. Wenger, MD, MPH, and Douglas K. Miller, MD, on behalf of the Society for Academic Emergency Medicine (SAEM) Geriatric Task Force

J Gerontol Med Sci 2011

Acad Emerg Med 2011
High Quality Clinically Relevant Evidence

Awareness
- Tort reform
- Interdisciplin ary education
- Balanced commercials

Acceptance
- Original research description of evidence use at dissimilar clinical settings

Applicable
- Increased pragmatic clinical trials
- Clear description of demographics

Able
- PDA or computer order entry prompts
- Community EBM education
- Anticipate counterarguments

Act On
- Evidence-based discharge summaries

Agree

Adhere
- Information Overload,
  Literature Search Deficiency,
  Inadequate Time,
  Inefficient Strategies
- Uncertain Interpretation,
  Uncertain Local Demographics,
  Clinically Significant Differences from Study Population
- Hectic ED Environment,
  Frequent Distractions,
  Competing Mandates
- Patient Compliance,
  Forgetfulness

Resource Constraints
- Skill Competence

Competing Influences,
- Marketing
- Authoritarian Doctrine
- Contradictory Experience
- Poorly Differentiated Health versus Unhealthy Skepticism

Information Overload,
- Competing Influences

Optimal Patient Outcomes Based Upon Best Evidence
25 screening instruments described
Most required > 10-minutes
None validated in ED settings
The Six-item Screener to Detect Cognitive Impairment in Older Emergency Department Patients

Scott T. Wilber, MD, MPH, Christopher R. Carpenter, MD, MS, Fredric M. Hustey, MD

The Six-Item Screener and AD8 for the Detection of Cognitive Impairment in Geriatric Emergency Department Patients

Christopher R. Carpenter, MD, MS, Bobby DesPain, BS, Travis N. Keeling, BS, Mansi Shah, BS, Morgan Rothenberger, MSOT, OTR/L

From the Division of Emergency Medicine (Carpenter, DesPain, Keeling, Shah) and the Division of Occupational Therapy (Rothenberger), Washington University in St. Louis School of Medicine, St. Louis, MO.

Four Sensitive Screening Tools to Detect Cognitive Dysfunction in Geriatric Emergency Department Patients: Brief Alzheimer’s Screen, Short Blessed Test, Ottawa 3DY, and the Caregiver-completed AD8

Christopher R. Carpenter, MD, MS, Elizabeth R. Bassett, Grant M. Fischer, Jonathan Shirshhekan, James E. Galvin, MD, MPH, and John C. Morris, MD
## Diagnostic Test Characteristics

<table>
<thead>
<tr>
<th></th>
<th>Sen</th>
<th>Spec</th>
<th>Pos-LR</th>
<th>Neg-LR</th>
<th>AUC</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAS</td>
<td>95</td>
<td>52</td>
<td>2.0</td>
<td>0.10</td>
<td>0.934</td>
</tr>
<tr>
<td>SBT</td>
<td>95</td>
<td>65</td>
<td>2.7</td>
<td>0.08</td>
<td>0.930</td>
</tr>
<tr>
<td>O3DY</td>
<td>95</td>
<td>51</td>
<td>2.0</td>
<td>0.10</td>
<td></td>
</tr>
<tr>
<td>cAD8</td>
<td>83</td>
<td>63</td>
<td>2.2</td>
<td>0.27</td>
<td>0.816</td>
</tr>
</tbody>
</table>
CHAPTER 73

Dementia and the Rural Emergency Department

http://www.jorem.org/index.php/jorem
Short Screen all patients over age 65-years for cognitive dysfunction
- Six Item Screener
- Short Blessed Test
- Ottawa 3DY

Abnormal

Secondary screens for cognitive dysfunction
- MMSE
- Montreal Cognitive Assessment

Abnormal

If new diagnosis
1. Consider initiation of work-up for reversible dementia.
2. Consider referral to primary care physician or specialist in neurodegenerative disorders.

Normal

Perform CAM to detect delirium
Abnormal

Search for underlying cause of delirium
- Infection
- Medications
- Trauma

No further cognitive evaluation necessary

Normal
Self-Administration of eMoCA

1. Instructions from the tablet based on recorded voice of actor give clear, consistent instructions uniformly across all participants.

2. The participant either responds verbally or uses stylus to draw on the tablet to complete cognitive assessment.

3. The tablet repeats instructions if time-out waiting for a response occurs.

4. The researcher scores participants recorded responses.

This version of the eMoCA was developed by the authors of this poster.
Welcome...

Welcome to the website for the Charles F. and Joanne Knight Alzheimer's Disease Research Center (Knight ADRC), in the Department of Neurology, at Washington University School of Medicine in St. Louis, Missouri, USA. The Washington University Knight ADRC is one of 28 centers funded or otherwise supported by the National Institute on Aging with the collective aim of facilitating advanced research on clinical, genetic, neuropathological, neuroanatomical, biomedical, psychosocial, and neuropsychological aspects of Alzheimer’s disease and related brain disorders. Our Center and its clinical research arm - the Memory and Aging Project along with the Memory and Aging Project Satellite (MAPS) - are at the forefront of a worldwide effort to uncover key causal factors in the development of Alzheimer’s disease, with a goal of developing more effective treatments and an eventual cure.

For patient clinical care please visit the website for the Memory Diagnostic Center.

http://alzheimer.wustl.edu/
Physician and Nurse Acceptance of Technicians to Screen for Geriatric Syndromes in the Emergency Department

Christopher R. Carpenter, MD, MSc*
Richard T. Griffey, MD, MPH*
Susan Stark, PhD, OTR/L†
Craig M. Coopersmith, MD‡
Brian F. Gage, MD, MSc§

*Washington University School of Medicine, Division of Emergency Medicine, St Louis, Missouri
†Washington University School of Medicine, Division of Occupational Therapy, St Louis, Missouri
‡Emory University School of Medicine, Division of Critical Care, Atlanta, Georgia
§Washington University School of Medicine, Division of General Medical Sciences, St Louis, Missouri

Western J Emerg Med 2011
2011 National Institutes of Health Research Funding, in Millions

- Cancer: $6,036
- Heart Disease: $4,179
- HIV: $3,184
- Alzheimer's Disease: $480
Currently, AD is the 5th leading cause of death in people ≥ 65 yo

Unlike other major diseases, which caused fewer deaths in 2008 than in 2000, AD deaths rose by 66%
Step 4: Reaching Out

http://www.iceg.info/node/11
The Challenge
Cross-disciplinary Publications

Emergency Orthogeriatrics: Concepts and Therapeutic Alternatives

Christopher R. Carpenter, MD, MSc a,*, Michael E. Stern, MD b

Evolving Prehospital, Emergency Department, and “Inpatient” Management Models for Geriatric Emergencies

Christopher R. Carpenter, MD, MSc a,*, Timothy F. Platts-Mills, MD b
Fig. 1. Underlying causes of dizziness in the elderly. Conditions requiring rapid diagnosis in the ED are shown in bold italic type.

Fig. 2. Ambier grid of a patient with age-related macular degeneration.
Barriers to Collaboration
Cross-Disciplinary, Multi-National

- Awareness
  - Key professional organizations
  - Opinion leaders within each professional organization

- Language

- Geography

- Shrinking CME finances

- Burgeoning medical literature

- Lack of *quid pro quo*
Quid Pro Quo
One Idea to Enhance Membership

Information Explosion

Medical Articles per Day

- Trials
- Medline
- Biomedical
BMJ Medscape Student BMJ

JGIM Journal of General Internal Medicine

Cleveland Clinic Journal of Medicine

nature.com

JACC

JASN

Clinical Infectious Diseases

Reuters

MJA The Medical Journal of Australia

THE WALL STREET JOURNAL

Los Angeles Times
Negative results

- 18% Dickersin, 1987
- 46% Koren, 1989
- 35% Balas, 1995
- 50% Poynard, 1985

Lack of numbers

It takes 17 years to turn 14 per cent of original research to the benefit of patient care

E.A. Balas, 2000
Information Overload

Consensus Conference Follow-up: Inter-rater Reliability Assessment of the Best Evidence

Best Evidence in Emergency Medicine (BEEM) Rater Scores Correlate With Publications’ Future Citations

Christopher R. Carpenter, MD, MSc, Cathy C. Sarli, MLS, Susan A. Fowler, MLIS, Kulamakan Kulasegaram, Teresa Valler, Pierre Lapaine, Grant Schalet, and Andrew Worster, MD, MSc

http://pmid.us/24127703
BEEM
Best Evidence in Emergency Medicine
http://tinyurl.com/WhatIsBEEM
AGEM Journal Club: The Step-by-Step Process

http://hiru.mcmaster.ca/hiru/HIRU_McMaster_PLUS_Projects.aspx
Step 1
Finding the Evidence

- Monthly Surveillance of Peer-Reviewed Publications with Medical-Librarian Assisted Search of PUBMED, EMBASE, CINAHL, & Cochrane Database
- Review of Secondary Peer Reviewed Sources including ACP Journal Club, EM Abstracts, Practical Reviews in Emergency Medicine, EM Journal Watch, Epocrates Doc Alerts, PEPID BEEM Alerts, and Best Evidence in Emergency Medicine

The Cochrane Collaboration
Working together to provide the best evidence for health care
Step 2
Rate the Evidence

Monthly Survey of AGEM and ACEP Geriatric Section List Serves providing volunteers with the manuscript title, author conclusions, and PMID number then asking them to rate each manuscript on a reliable, EM-specific rating instrument (BEEM Rater scale) over a range from 1-7 (↑ score = more clinically relevant)
AGEM Journal Club Process

20. Meet the needs of aging patients with a senior-friendly ED.
PMID: 21809699 [PubMed - indexed for MEDLINE]

Abstract
A growing number of medical centers are establishing separate senior EDs to take care of older patients who have different clinical and emotional needs than younger populations. Such units offer thicker mattresses, subdued lighting, pharmacological reviews, and screening exams for issues that frequently occur in senior populations. In addition, many are staffed with clinicians with at least some geriatric training. St. Joseph's Regional Medical Center in Paterson, NJ, has seen the rate within 30 days plummet from 20% to just over 1% since it opened a 14-bed geriatric unit two years ago, and all of the senior patients who have visited the unit over the main ED. Novi, MI-based Trinity Health is in the process of implementing senior EDs in all of its acute care hospitals after Holy Cross Hospital in Silverdale, MD, successfully piloted the idea in 2008. Experts stress that you don't have to develop a separate unit to offer senior-friendly care. Providing staff with some geriatric training can help them better understand the health care needs of older patients.

Assuming that the results of this article are valid, how much does this article impact EM clinical practice?

1. Useless information
2. Not really interesting, not really new, changes nothing...
3. Interesting and new but doesn't change practice
4. Interesting and new, has the potential to change practice
5. New and important: this would probably change practice for some EP.
6. New and important: this would change practice for most EP
7. This is a "must know" for Emergency Physicians.
AGEM Journal Club Process

Step 3
Appraise the Evidence

Content experts (all practicing EM clinicians) critically appraise manuscripts that AGEM raters grade as $\geq 5/7$

Step 4
Disseminate the Evidence & Critical Appraisal
Multidisciplinary Geriatrician-Guided Discharge Planning Effectively Reduces Readmissions

STUDY QUESTION
Does a multimodal inpatient discharge planning process reduce emergency readmissions or ED recidivism in geriatric adults?

STUDY DESIGN
Design: Pragmatic Zelen-method randomized controlled trial
Setting: Acute geriatric units (AGU) in one of five demographically diverse university hospitals or one private clinic in Paris from April 2007 to October 2008.
Patients: Consecutive patients over age 70-years admitted to the AGU in an emergency. Exclusion criteria included anticipated length of stay less than 5 days, unlikely survival beyond 3 months, palliative care, anticipated barriers to follow-up, or absence of health insurance.
Description of Intervention: Four intervention-dedicated geriatricians (IDG) with focused training on patient communication assessed AGU patients for three interrelated problems amenable to acute management: depression, protein-energy malnutrition, and medication management. The IDG was not part of the routine care team, but performed standardized reviews of all chronic diagnoses with their medication management for each participant and screened for depression or malnutrition. The IDG organized and ran four structured patient-centric educational sessions. Upon discharge, the IDG provided patients, caregivers, and outpatient physicians with a brief report letter. The control group received standardized care from the AGU that included comprehensive geriatric assessments without the IDG.

Outcomes: Emergency hospitalization or ED recidivism at 3- and 6-months.

MAIN RESULTS
The mean age of participants was 86 years and 92.7% of IDG participants received the intervention. In total, 70% of IDG participants had at least one major chronic drug modification recommended to the AGU team, while 43% and 78% were diagnosed with depression or malnutrition, respectively. The IDG participants had lower rates of emergency hospitalization or ED visits at 3-months (23% vs. 30.5%, NNT = 13) and 6-months (35.3% versus 40.8%, NNT = 18), though the latter was not statistically significant. The cost savings of the intervention was $635 per participant.

CONCLUSION
This intervention was effective in reducing rehospitalizations and ED visits for very elderly participants 3 but not 6 months after AGU discharge.

ABSTRACTED FROM

Source of funding: French Ministry of Health
Clinical Impact Rating: Geriatric Emergency Medicine 5/7

COMMENTARY by Chris Carpenter, MD, MSc (Washington University)
Readmissions and ED recidivism are major economic and quality improvement challenges to clinicians and hospital administrators and targeted care bundles are one effective solution.[1] Forty percent of geriatric ED patients return within three-months.[2] A hospital discharge process focused on effective transitions of care is one proven mechanism to prevent 30-day recidivism as is comprehensive geriatric assessment (CGA).[3, 4] However, the pragmatic reality is that most institutions lack a geriatrician with sufficient time to dedicate to CGA in the ED or even in the AGU, if the hospital has an AGU. While the effectiveness of this study is impressive, real-world application of this model is a challenge. Indeed, even the study authors had to stop data collection prematurely because the IDG were pulled away for more pressing clinical responsibilities. Nonetheless, clinicians must continue exploring efficient methods to restore health and avoid short-term recidivism.
<table>
<thead>
<tr>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Reduces information overload using reliable &amp; valid screening instrument</td>
<td>- Unfunded</td>
</tr>
<tr>
<td>- Shortens knowledge pipeline</td>
<td>- Effect size difficult to measure</td>
</tr>
<tr>
<td>- Enhances value of membership</td>
<td>- Pre-filtering search strategy of uncertain validity</td>
</tr>
<tr>
<td>- Free resource</td>
<td>- English-language bias</td>
</tr>
<tr>
<td>- Ownership of literature</td>
<td>- Health sciences bias</td>
</tr>
<tr>
<td></td>
<td>- Uncertain dissemination model</td>
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</table>
Opportunities Galore
Summary

- 21st Century emergency medicine has an unprecedented opportunity to care for geriatric adults
- Pragmatic clinical solutions exist
- Underfunded geriatric and emergency medicine research from the NIH is reflected in struggles to develop evidence basis
- Implementation trials of GED guidelines must extend beyond traditional publications and didactics to incorporate asynchronous web-based learning, Twitter, podcasts, & blogs
Acknowledgements

- Dr. John Morris, Director WU ADRC
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- Dr. Brent Ruoff, WU EM Division Head
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- Enola Proctor, PhD, Wash U DIRC
- Ross Brownson, PhD, Wash U DIRC
- Stephanie Herbers, MSW, MPH, Friedman Mgr
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Twitter1 @GeriEDNews Twitter2 @SAEMEBM