Disseminating and Sustaining Emergency Department Innovations for Older Adults: Good Ideas Deserve Better Policies

Older adults often visit the emergency department (ED) with chief complaints that understate or detract from their true complex health care needs.[1,2] These needs are frequently missed because addressing them requires a time-consuming effort that is antithetical to the (necessarily) rapid, complaint-specific protocols of the ED.[2] Key ED performance indices (e.g., length of stay, throughput) also create a disincentive against undertaking comprehensive geriatric assessments when not clearly germane to the chief complaint. However, ignoring these complex care issues can contribute to poor health outcomes.[2] These visits often serve as sentinel events in the patient's health trajectory, which irreversibly hastens loss of independence.[3] Such encounters will only increase as the population ages.[3,4]

One common response is to hospitalize these "complex" patients.[4] While this can provide an opportunity to address the complicated social support needs and underlying clinical conditions, this strategy is problematic because: 1) unnecessary hospitalizations are associated with adverse health outcomes,[4] 2) these patients often do not see a geriatrician,[5] and 3) hospitalizations result in unsustainable costs and quality of care is often poor.[4] Delegating complex care issues to outpatient providers is ideal when possible; however, in most cases, optimal care transitions from ED to community resources are severely limited, and uncoordinated outpatient follow-up after ED discharge is poor (20%–37%).[6]

Southerland's innovative geriatric ED observation unit (EDOU) program offers a promising solution. Their preliminary results showing no increase in hospital admissions, ED recidivism, or EDOU length of stay have important ramifications: The EDOU model can address complex geriatric care issues without compromising performance metrics or throughput by shifting the complex geriatric care process from the main ED service line to the EDOU, thereby freeing ED beds. Institutions with existing observation units wishing to implement geriatric ED (GED) guidelines, but lack the human or financial capital to develop new GED programs, can now improve their GED capabilities by adopting Southerland's program. Further research on the efficacy of comprehensive and focused geriatric assessments, and interdisciplinary interventions, will be critical to sustaining any GED advances.

Two cautionary points: First, EDs adopting geriatric EDOU programs must not stop pursuing improvements in overall geriatric care processes, including ED to community care transitions. Second, the majority of Medicare beneficiaries possessing Medicare Part B face a 20% copay for any EDOU care; the 5 million beneficiaries without part B are responsible for the entire cost unless they have adequate supplemental insurance.[7] This latter group will incur higher direct costs for observation status care than if admitted (under justifiable reasons) as inpatients. Addressing these barriers to the optimal utilization of EDOU programs will be critical to empowering acute care systems to optimize care for older adults while maximizing financial sustainability.

Southerland's model joins current geriatric acute care innovations—the Centers for Medicare and Medicaid funded Geriatric ED Innovations[8] and the jointly

The authors have no relevant financial information or potential conflicts of interest to disclose.
A related article appears on page XXX.

doi: 10.1111/acem.13339
ISSN 1069-6563
PII ISSN 1069-6563583

funded West Health Institute and John A. Hartford Foundation GED Collaborative[9]—in having the conceptual basis to positively impact population health. However, widespread implementation cannot flourish without policy innovations to safeguard the financial well-being of patients and institutions.

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