COMMENTARIES

Geriatric Care in the Emergency Department

We are all growing old. What can we expect for ourselves a few years from now, as we retire? With the aging of the population, the stresses on health care resources are increasing, especially with ongoing cutbacks. We know some of the outcomes, including an increased risk of infectious disease in the emergency department (ED),[1] increasingly poor care, lower staff morale and retention, and deconditioning of ED-admitted patients.[2]

This is the time to mobilize resources and focus research on the geriatric patient in the ED. A number of papers published in the last several years have attempted to identify patients at triage who will require more support in the ED and beyond.[3,4] As described by Siebens[5] in this issue of *Academic Emergency Medicine*, the Domain Management Model (DMM) provides an easy way to memorize the categories covered by these tools. Beyond identification of such patients, we need to look at enhanced communication with our partners and patients regarding the needs of elders, as well as improve ED utilization of resources, so that maximal benefit can be attained. In fact, a recent quality improvement project in Hamilton, Ontario, successfully partnered 26 extended care facilities (ECFs) and multiple hospitals, using the Juran model[6] to identify the communication and utilization initiatives most needed in both the community and hospital settings. The improved understanding has already produced one benefit: a commitment to ongoing collaborative work so that the effort does not die.

An important aspect of communication is the transfer of information from the ECF to the hospital, and vice versa. Indeed, initial data collection in Hamilton suggested that more than 60% of transfer forms from our community did not make it back to the ECF from the hospital. Thus, the paper by Terrell et al.[7] in this issue of the journal is a vital step in the enhancement of this communication. A simple data form that is used by everyone ensures that one does not need to search many documents for important information, especially when time is of the essence. As we move to a paperless environment, this communication will be easier electronically if the necessary first steps have occurred, i.e., common use of a simple form that captures necessary data elements. This paper highlights two concerns. First, reciprocal communication by the ED to the ECF was not addressed. Second, the majority of postintervention transfers did not include the transfer form, suggesting an avenue for improvement. In the end, however, this study is an important step in a continuing effort at seamless communication regarding the needs of the geriatric patient.

The other aim in the care of the elder patient is resource utilization. There are many aspects to this, including appropriateness, effectiveness, and safety. Patient-centered care and patient safety are both highlighted in the paper by Wilber et al.[8] in this issue. This paper demonstrates that use of a reclining chair improves patient satisfaction and reduces pain compared with use of a gurney. Sitting in one position for protracted periods can be uncomfortable, if not painful (as anyone who has been on an airplane recently can attest). Maintenance of a ''straight-leg raising'' position could even be considered uncaring. Wilber et al. have elegantly demonstrated that simple alternatives can be provided that affirm patient dignity. This study considered the primary limitations and followed through, confirming the data with the intention-to-treat principle, as well as based on actual participation. One other piece of information further supports the authors' efforts. A 1997 paper[2] suggests that for every day of deconditioning, significant physiologic effects may result, including loss of muscle mass and bone density, with higher subsequent risk for injury. Pain reduction, as shown by Wilber et al., is an important first step to reduce the need for longer hospital stays as a result of deconditioning.

Finally, the paper by Siebens[5] highlights many of these issues and points out others through the DMM. Again, communication and utilization are an essential part of the equation. Siebens' paper demonstrates how a better focus on advance directives and on paramedic and primary care provider communication, as an example, can reduce the number of ED visits and hospital admissions that might otherwise be considered inappropriate. While most communities have adopted advance directives, the significant variance can ultimately obstruct patient care. For instance, in Ontario, paramedics will not honor ECF advance directives if they do not use the same form as the emergency medical services system. Hence, patients may be intubated in the field despite wishes to the contrary. Again, a quality improvement initiative using a DMM approach (where quality = reduced variance[6,9]) would support a patient-centered focus that enhances appropriateness, effectiveness, and patient and health care worker satisfaction.

What do these three important papers suggest? They demonstrate that emergency medicine as a mature specialty can continue its active role in geriatric care, education, and research. Support for this work is critical. The John A. Hartford Foundation, as an example, has supported many of these efforts, through opportunities such as the Jahnigen Program, which

develops new leaders and disseminates information about geriatrics; the Geriatrics Education for Specialty Residents Program; the availability of discretionary grants; and an initiative to develop an up-to-date bibliography of relevant literature. The three senior authors of the papers discussed here are involved in one way or another with this project. It is only through this ongoing relationship that we will be able to produce quality research as published in this issue of *Academic Emergency Medicine*.—**Christopher M. B. Fernandes, MD** (christopher_fernandes@sympatico.ca), *McMaster University/Hamilton Health Sciences, Hamilton, Ontario, Canada*
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