GERIATRICS AND THE IOM: DID REPORT FORGET THE ELDERLY?

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In June, the Institute of Medicine released 3 lengthy reports titled *The Future of Emergency Care*, highlighting the problems facing emergency medicine and making a number of recommendations to safeguard the vital system’s future. The reports totaled 1,184 pages, including 684 pages of text, more than 3 years of work prepared by 40 committee and subcommittee members that examined 4,300 references, commissioned 11 papers, held 17 meetings and listened to 62 expert presentations. Yet they contained hardly a word about the elderly.

Geriatrics received only 2 paragraphs in an appendix to one of the reports, and passing mention elsewhere. That might not have been such a glaring omission had 1 of the 3 IOM reports, *Emergency Care for Children: Growing Pains*, been devoted entirely to pediatric emergency care.

“I have to admit that I am a little surprised that they didn’t address geriatric issues head on,” said Carmel Bitondo Dyer, MD, an associate professor of Medicine at Baylor College of Medicine in Houston, and director of the Harris County Hospital District’s Geriatrics Program.

A GROWING GRAYING POPULATION

According to the 2003 National Hospital Ambulatory Medical Care Survey, the emergency department (ED) visitation rate for the 65-and-older age group increased by 26% from 1993 to 2003, more than any other demographic group. And if that trend continues among a graying population, as much as one-third of all ED visits will come from this group by the year 2030. Geriatrics patients also put more strain on the system: more are admitted than the general population, more require workups, imaging and lab tests, and they spend more time in the ED.

Concern about these demographics and the lack of geriatrics mentioned in the IOM reports prompted the Society for Academic Emergency Medicine (SAEM) to commission its own position paper on geriatric emergency medicine. By asking its Geriatrics Task Force to produce the report, the SAEM sought to inject geriatrics into the discussion among health care providers and policymakers that has followed the release of the IOM reports.

“While I don’t think this necessarily reflects a deficiency of the IOM reports, we felt that it was important that geriatrics receive some play here,” said James Hoekstra, MD, the SAEM’s President and Chairman of the Department of Emergency Medicine at Wake Forest University. “We wanted to carry this discussion beyond the IOM reports.”

A LACK OF GERIATRIC SPONSORS

Arthur Kellerman, MD, MPH, a member of the IOM committee and Chairman of the Department of Emergency Medicine at Emory University School of Medicine, noted that the IOM’s role is to address questions posed by the sponsors of its reports—whether that is Congress, one or more federal agencies, or a foundation. The focus of the 3 IOM emergency care reports was dictated by the sponsors, not the IOM, he said.

Initial support for what eventually became the 3 *Future of Emergency Care* reports came from the Josiah Macy Foundation, which funded an earlier report that promoted the development of emergency medicine and the creation of academic departments of emergency medicine in American medical schools. Additional funding subsequently was secured from the Agency for Healthcare Research and Quality, which provided enough funds to begin the process. Initially, a single committee was convened, Kellerman said,
but after more financial support came from the US Centers for Disease Control and Prevention (CDC), the Maternal and Child Health Bureau and the National Highway Traffic Safety Administration, the scope of the work was expanded. At that point, Kellerman said, the pediatrics and emergency medical services reports were added to the hospital-based emergency care report.

“The reason why there’s not a specific geriatric emergency care report like the pediatric emergency care report is because it wasn’t requested by the sponsors,” Kellerman said. “I do regret that some people feel like the committee didn’t provide adequate focus on the issue of geriatrics, but, if you read the reports, you will see that geriatric care issues are addressed throughout the hospital and EMS volumes.

“The fact of the matter is, no matter how many pages were written, no matter how much work done, some people are going to come out and say we didn’t address their particular issue. Throughout the process, there was a back-and-forth among the participants over how many issues one committee, or even 3 subcommittees, realistically could tackle and still engage the public. There never was a point when someone said, ‘You know what? Geriatrics issues don’t matter.’ To address everything, instead of writing 600 pages, we would have had to write 6,000 pages. But would anyone have read that? I doubt it.”

Kellerman also added that response to the reports has been substantial and that reaction to them has not been a “one-day wonder,” meaning there’s still time to comment on the reports and include geriatrics in that discussion.

THE TASK FORCE RECOMMENDATIONS

That’s precisely what the SAEM task force’s report is designed to do. Completed just a couple of months after the IOM Future of Emergency Care series was published, the report makes several recommendations. Among them:

- The emergency care system of the future should be one in which all participants fully coordinate their activities and integrate communications. This coordination and communication should be extended to nursing and rehabilitation facilities to improve the care of older patients. The federal government can directly effect this through Centers for Medicare and Medicaid Services (CMS) regulations.
- CMS should explore alternatives to inpatient hospitalization, such as home hospitalization and direct admission to skilled nursing facilities for older patients, to reduce the demand for inpatient beds.
- Federal agencies should target additional research funding to pre-hospital emergency care services, pediatric emergency care and geriatric care.
- EMS education should include training in the unique needs of older patients.
- Geriatric concerns should be explicit in disaster planning.

“The purpose of the task force report is not to highlight any omissions,” said Teresita Hogan, MD, a member of the SAEM Geriatrics Task Force and an emergency physician at Resurrection Medical Center in Chicago. “What we’re hoping to do is reach the policymakers and make them aware of the situation so they themselves can make the decisions. We need to keep elders in mind when we do all of this future planning because they’re going to be a large part of the future of emergency medicine. If we ignore them, we are simply not planning correctly.”

After speaking to a number of geriatrics experts, a similar refrain kept popping up: as America ages it will have a profound effect on the ED and emergency medical services.

DISASTERS ILLUSTRATE THE ISSUE

Two major US hurricanes in 2005, Katrina and Rita, certainly highlight that fact and make the case for the SAEM recommendation to explicitly include geriatrics concerns in disaster planning.

According to the Louisiana Department of Health and Hospitals, at the post-Katrina temporary morgues established at St. Gabriel and Carville, 46% of the identified victims were older than 75 years, and 70% were older than 60. Before Rita made landfall in western Louisiana and eastern Texas, 23 seniors died on a nursing home bus on a freeway between Houston and Dallas, engulfed in flames. And according to a medical examiner’s report, 22 of the county’s other 35 evacuation deaths involved senior citizens.

Evacuations favor those who can help themselves. People who own a car can buy gasoline and obtain temporary lodging in a distant city. But, as Rita and Katrina made abundantly clear, in many places across the country where a disaster might strike, hundreds of thousands of residents, from home-bound seniors to bed-bound patients in a nursing home, cannot help themselves.

“Many elderly require caregivers. You just can’t herd the elderly into a shelter like you can with a younger adult, and say ‘There’s your bed and some food, take care of yourself,’” Hogan said. “They’re going to need extra assistance.”

Because emergency medical services and EDs will be involved in evacuations and patient treatment during disasters, they must be involved in the planning, said Brent King, MD, chairman of the Department of Emergency Medicine at the University of Texas Medical School at Houston.

“You’ve got all these frail, elderly people in a home-care environment in a Category-4 or Category-5 hurricane evacuation zone, what do you do for that person? Where do you take them? If they require fairly exhaustive care at home, and could get sick en route, how do you get them there?” King asked.
STATE OF CONFUSION IN NURSING HOMES

One clear lesson from Rita: too many nursing homes evacuated because their owners weren’t sure if they were in the flood zones and were concerned about liability. States, public health officials said, need to give those taking care of the elderly specific guidance on whether to go or not, because evacuations are so difficult and, for a frail population, dangerous.

A primary focus of the IOM reports was that demand for care in the ED was growing—by 26% between 1993 and 2003—while the total number of EDs declined by 425 during that time, and the number of hospital beds shrank by 198,000.

Some geriatrics experts believe one way to relieve this crowding is to make senior care during an initial visit to the ED more comprehensive, thereby reducing the need for follow-up visits.

Geriatric visits to the emergency department are often characterized by delirium, said Dyer, of Baylor College of Medicine. Emergency physicians may not be trained to look for delirium, which can be difficult to diagnose, but discharging patients without addressing all of a patient’s health issues, including delirium, can be deadly.

A 2003 study in the Journal of the American Geriatrics Society found a statistically significant association between delirium and mortality 6 months after discharge. Patients whose delirium was not detected in the ED had a mortality of 31%, while patients whose delirium was detected in the ED was only 12%.

Since then, follow-up research has found that taking a broader approach toward geriatric patients can be beneficial, Dyer said. Instead of just sending an emergency physician to treat a patient’s acute condition, a geriatric review team might find that a patient isn’t taking his or her medicine, or needs a cane, or needs meals delivered to their home.

A FOCUSED APPROACH TO THE ELDERLY

In Houston, Dyer said Ben Taub Hospital, one of the county’s 2 public hospitals, has put forth a proposal to have a trained geriatric nurse practitioner see geriatric patients in the ED, work from protocols and refer the patients to a geriatrics clinic if necessary.

“We’re confident that by taking a more holistic view, rather than a medical view, we will have fewer subsequent visits to the emergency department,” Dyer said.

A review study of geriatric interventions, published this year in the Journal of Gerontology: Medical Sciences, found that such interventions in outpatient and primary care settings were most effective in reducing ED usage. And results from the DEED II study, published in 2004 in the Journal of the American Geriatrics Society, found that a comprehensive geriatric assessment during an ED visit significantly lowered the rate of ED re-admissions in the subsequent 18 months (44% for those who had an intervention, 54% for those who did not).

The SAEM task force also recommended such alternatives as “Hospitals at Home” programs to relieve some of the geriatric patient contributions to ED crowding.

Ultimately, however, many geriatric issues are similar to those of other special needs populations in the ED. Hogan said that for many of the findings and recommendations in the IOM pediatrics report, it would be entirely appropriate to substitute “geriatric” for “pediatric,” and “seniors” for “children.”

Arthur Sanders, MD, professor of emergency medicine at the University of Arizona and a geriatric issues expert, agreed. He said the way to address geriatrics issues in the emergency department is to address the overall problems.

“If we take steps toward solving the major emergency department problems, we would address the geriatrics issues by the nature of it,” Sanders said. “The major issue right now is that the system is overwhelmed.”

PAUSE FOR POLICY MAKERS

Still, Sanders acknowledged that even a cursory review of the demographics of seniors and their increasing use of the ED should give pause to any policymakers reviewing the problems with emergency medicine. The fastest growing group of ED users is not children or immigrants, but senior citizens, who require more time and resources.

“Planning is the key,” Sanders said. “As a society we need to recognize where the demographics are going, and realize that whatever problems we have in the system now are going to get worse as the population ages.”

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