

EDITORIAL

Geriatrics

Implementing geriatric emergency departments across a large hospital system: operational considerations and the evidence gap

The projected growth of U.S. older adults,¹ the shrinking workforce of fellowship-trained geriatricians,² and the increasing demand for care by older adults with complex care needs³ frequently thrust the emergency department (ED) into the non-traditional role of addressing these unmet needs for many older adults, whether related to their health care or to social needs.^{3,4} In recognition of and response to this demand, there has been an exponential growth of the subspecialty of geriatric emergency medicine over the past 3 decades that is highlighted by 2 landmark events: the 2014 publication of the geriatric emergency department (GED) consensus guidelines^{5,6} and launch of the American College of Emergency Physicians (ACEP) tiered Geriatric ED Accreditation (GEDA) process for EDs (www.acep.org/geda) to catalyze, objectively qualify, and formally acknowledge improvements in care processes and outcomes for older adults.

In this issue, Liberman et al described their approach in attaining GEDA accreditation and offer an exemplary framework and key lessons for the standardized implementation of geriatric emergency department best practices across an entire healthcare system comprising 17 separate EDs. Although recognizing that there were numerous factors needed for this hospital system to navigate and address the intricate requirements to achieve accreditation for one site, let alone 17, their experience highlights 4 important observations that may be useful to other hospitals seeking similar system-wide accreditation.

First, this hospital system has a singular and uniform care platform that facilitated the adoption and dissemination of geriatric emergency department practices. The Emergency Medicine Service Line (EMSL) is a unique operational entity within their health system that is responsible for overseeing all clinical, financial, operational, and qualitative elements of the 17 individual EDs. With this centralized oversight, the group was able to standardize processes across member EDs of varying operational size and scope as well as consolidate administrative tasks. This latter feature proved particularly useful in streamlining and facilitating the GEDA application processes for all sites. The ED team was also able to leverage the EMSL structure to develop a system-wide partnership with the geriatrics and palliative care teams, who also served as subject matter experts to facilitate the development of operational processes and educational programs in concordance with best

practices in geriatrics and palliative care. Although there are numerous healthcare systems that oversee multiple EDs, some of them may not have the same degree of central management and system integration comparable to the EMSL infrastructure described in the article. In the absence of such an efficient system-wide operational integration, it may be more challenging to implement and coordinate similar care programs across a diverse health system.

Second, the decision to develop an accredited geriatric emergency department program was an institutional response to a growing patient population in the communities they serve. As the authors pointed out, the state of New York has the fourth largest population of older adults 65-years and older, and the New York Metropolitan area saw a nearly 20% increase in this specific population in the preceding 10 years. This classical supply and demand argument appeared to be a significant contributor to this healthcare system's decision to develop and implement a special care program to meet the needs of their aging community. Nevertheless, not all healthcare systems share these same pressures and other organizations may not appreciate the value in developing a geriatric emergency department program. Although there are data describing the return on investment (ROI) for specific single-site geriatric emergency department programs,⁷ the literature has limited data overall on the economics of geriatric emergency departments. The economic decision for any individual organization to pursue a geriatric emergency department program is multifactorial, and the multifaceted considerations beyond the financial ROI are complex and highly variable across different organizations, underscoring the challenges in formulating a robust and generalizable economic argument in favor of geriatric emergency departments.⁸ With this in mind, to support the advancement of geriatric emergency medicine, additional evidence further defining potential financial, operational, or qualitative ROI must be developed in order to inform institutional decisions to invest in geriatric emergency departments.

Third, this article underscores the fact that leadership engagement—leadership from multiple stakeholder areas—is essential to the success of any geriatric emergency department initiative. There have been numerous GED models described⁴ since the geriatric emergency department consensus guidelines were first published in 2014.⁵

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The expected variation in the operational characteristics and scope of programs, as well as the leadership structures, all emphasize the need for flexibility based on institutional needs and strategies. Although geriatric emergency departments intuitively have the potential to provide patients with high-quality care, the economic justification for geriatric emergency department programs remains unclear for many EDs.⁴ Even within a single hospital system, the value of a geriatric emergency department can vary across its member EDs. For example, although there may be a clear ROI at one ED, it may not necessarily be true for all EDs across the same system. The presence of engaged and enthusiastic leadership at the departmental, and particularly at the organizational or system level, will be critical to the development of a geriatric emergency department program at one ED site. This leadership engagement will be ever more critical in a system where there is variation in service platforms, patient populations, institutional resources, and financial profiles across the EDs. Leadership engagement will allow geriatric emergency department champions to navigate these factors and will prove crucial when coordinating against operational challenges such as those described in the article: developing policies, standardizing education, and creating and updating data dashboards.

Fourth, for any hospital system considering the implementation of a geriatric emergency department program at multiple ED sites, Liberman et al demonstrate the value in standardizing data and education across the system. Standardization allows initiatives to be streamlined across sites and promotes consistency. In particular, system-wide dashboards and data-sharing creates transparency and helps illuminate operational areas of need. Producing data-driven and educational initiatives across a diverse group of EDs also fosters collaboration, which further promoted this healthcare system's strategy of integration and in turn may provide a platform that allows the organization to standardize other initiatives such as marketing and branding campaigns.

Based on these observations, it is evident that the most important catalysts critical to the continued growth of geriatric emergency medicine are data. However, the current limited evidence base on geriatric emergency care, particularly for topics related to the impact on patients and ED metrics, is a significant impediment to a wider acceptance of geriatric emergency department guidelines and care innovations.⁹ With this hospital system's remarkable achievement with their successful geriatric emergency department program implementation, it joins the ever-growing ranks of U.S. geriatric emergency departments with the means and opportunity to add to the evidence base and advance the science of geriatric emergency care. For example, one interesting question that arose from this article is: in a hospital system without an ESML or where there is a known financial ROI for only one or a few sites, is it more beneficial for that institution to implement a geriatric emergency department program only at those particular sites or across the entire system? To address these and other questions, the field will need data on how different geriatric emergency department models of care affect patient-centered outcomes; data on how different geriatric emergency department models of care affect established ED metrics and operational factors (eg, patient flow, length of stay, wait times); data on screening tools to identify which patients

are at increased risk for poor outcomes; data to clarify which outcomes are most meaningful to older adults; data on how the geriatric emergency department influences potentially avoidable hospitalizations or ED recidivism; and data on the revenue and ROI related to each site's geriatric emergency department program. Perhaps, as more individual EDs or hospital systems with multiple EDs achieve accreditation, data to inform these decisions will be forthcoming in order to guide other organizations in the future.

Geriatric emergency medicine is still a nascent field, and a concomitantly expanding evidence base for geriatric emergency departments and their new models of care will be necessary to foster the continued maturation of this field. Each geriatric emergency department has the ability to raise the quality of care for seniors, and with this power as agents of change comes the responsibility to support and sustain geriatric emergency care by contributing data, sharing best practices, and disseminating knowledge.

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