

Geriatric emergency medicine: Research priorities to respond to “The Silver Boom”

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With this issue, *CJEM* devotes an entire section to research in the field of geriatric emergency medicine (EM), that subspecialty of EM that focuses on the needs of older patients and the opportunities for providing optimal care to them. I salute the editors for devoting this much space to work by researchers in an area that some practitioners still don't even identify as “a thing”; while those of us identify it as “the thing that is going to have the largest impact on the practice of EM for the next 30 years.”

Even 10 years ago, focus on the care of older emergency department (ED) patients seemed like a niche interest. Ten years later, demographic realities have made the importance of that focus clear to anyone working in an ED. It is not necessary to review tedious demographic statistics. One look at any street or shopping mall or doctor's waiting room in the Western world reveals that the shape and structure of society are changing. The population pyramid has been inverted, and, for the next several decades, there will be increasingly more people over age 65 than under age 30 in most societies in the world. Those people will be the main consumers of ED care. EM has always prided itself on its ability to respond to urgent social realities (AIDS, severe acute respiratory syndrome [SARS], gun violence, the opioid epidemic, etc.). As the policy statement from the International Federation of Emergency Medicine points out, the field of EM must embrace the reality that older people are among our core users and that their care needs are among our *raison d'être*.¹ Now is the time for EM to champion a system change to ensure optimal care to older patients – and to provide the research that supports and drives that change.

In 2013, a consensus group of emergency physicians, nurses, and geriatricians published the Geriatric ED Guidelines.² Those guidelines outline opportunities for improvement that can be implemented in any general ED, related to the following:

- Staffing – the addition of nurse-led geriatric case management and interdisciplinary teams to provide additional assessments
- Education – the addition of continuing professional development to enhance skills knowledge and attitudes about geriatric issues and their impact on ED care
- Processes of care – the addition of standardized protocols and procedures around screening, investigation, and management of conditions and presentations (from hip fractures to functional decline to frailty to unmet social needs) that are often present in older patients
- Transitions of care – the addition of strategies to integrate ED care with the continuum of the patient's care (recognizing that the ED is not just the front door to the hospital but also a “front porch” before a return to the community^{3,4})
- Physical environment of the ED – the addition of features that extend from a thorough re-build using senior-friendly features to ensuring the presence of the most basic features essential to caring for vulnerable older people (the presence of canes, walkers, warm blankets, and food!)

Since then, EDs have implemented quality improvement projects informed by these guidelines. Many EDs are committed to a thorough overhaul of

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their staffing and processes in the interest of senior-friendly change. In fact, the American College of Emergency Physicians has just launched an accreditation process for those hospitals that want to be identified as a Level One Geriatric ED – with the same rigorous standards and metrics as it takes to be identified as a Trauma Centre or a Burn Unit.

Unfortunately, some of these changes are lacking an attribute of quality improvement – evidence. As its paradoxically youngest subspecialty, geriatric EM has the same shallow research base that plagued EM during its first decades (the '70s and '80s) – when everyone just thought that “the golden hour” seemed like a good idea and that a Broselow tape probably changed outcomes. But no one had proven it with high-quality research. In the past 30 years, EM researchers have contributed a vast amount to our knowledge of these basic components of ED care. However, as Eagles et al. found, even with a question as self-evident as: Does an ED-based mobility assessment of an older patient lead to improved outcomes? – the answer is not “yes” or “no” but rather “we don’t know” – highlighting “the large gap in knowledge in the care of this vulnerable patient population.”⁵ It turns out that for almost any question asked in this field – What is the best approach to pain management? Does early ED identification of delirium reduce length of stay (LOS)? Does implementing an interdisciplinary team cost more or less money? Drive or reduce admissions? – you get the same answer: We don’t know.

The opportunities for research activities are nearly endless and of great impact, given that the results will affect as many as one-third of all ED patients. There have been several efforts to establish an agenda of research within geriatric EM^{6,7} that have focused mostly on the basics: screening for delirium and functional decline and abuse, medication reconciliation, falls assessment. Certainly, more work is needed in all of these fields. But there are even more challenging research questions to be asked, as follows:

- What are the characteristics of quality ED care of older patients? How can we measure them?
- How can frailty and complexity and vulnerability be identified in the ED? What impact does that identification have on outcomes?
- What are outcome measures that matter to older patients? Why do we keep using institution-centred

outcomes (LOS, return to ED, admission rates) if we don’t know that they matter to patient well-being?

- What situations are most amenable to shared-decision-making, especially when we have such an insufficient research base? How and with whom can we use shared-decision-making to improve outcomes?
- What interventions are most effective at changing provider behaviour to improve patient outcomes?

In short, *more research is necessary – much more.* Geriatric EM research is the niche that has become a gaping chasm. There are fascinating questions to ask and answer about a complex ever-present population. If EM research is willing to take on these questions, we will improve our own work experience and the life experience of the next generations of older patients . . . including my own.

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