

ENA Topic Brief

Collaborative Care for the Older Adult

Key Information

Urinary tract infections, sepsis, dehydration, bacterial pneumonia, and chronic obstructive pulmonary disease are considered to be some of the conditions that lead to potentially avoidable hospitalizations of nursing home residents.¹

Under the Patient Protection and Affordable Care Act, hospitals with higher-than-expected 30-day readmission rates may be subject to Centers for Medicare and Medicaid payment penalties.²

Collaboration with the older adult includes discharge education that is an ongoing dialogue between patient and caregiver throughout the time of care.³

A Geriatric Emergency Department is comprehensive and includes educational, staff composition, and physical considerations that interact to provide safe practice and safe care that address the specific needs of the older adult.⁴

Each older adult has specific physiological, psychosocial, and well-being needs and therefore requires an individualized, age-based approach.⁵

Purpose

Every year, over twenty percent of older adults arrive in United States emergency care facilities.⁶ The percentage of these patients from nursing homes and skilled nursing facilities increases with age, with patients age 85 and older accounting for up to 21.9% of ED visits.⁷ Many of these patients are vulnerable to gaps in health care communication and are unable to advocate for their own health care and living needs.⁸ It is widely acknowledged that best practice is collaborative.³ The purpose of this topic brief is to recognize potential pitfalls in the care of the older adult and outline methods to pursue collaborative efforts between skilled nursing facilities, patients/caregivers, and emergency department nurses to best advocate for the geriatric patient (those over the age of 65), as consistent with the Geriatric Emergency Department Guidelines.⁴

Overview

The population of older Americans is growing more rapidly than any other age group. Older Americans represented 13% of the population in 2010 and are expected to make up one fifth of the population by the year 2030.^{9,10} Many of these people will need to access the emergency care system at some time, with visits increasing with age.^{6,7} In addition to high rates of emergency department visits, older adults are more likely to have multiple providers, chronic medical problems, polypharmacy, social and medical factors contributing to communication, and barriers to health care continuity.^{1,8} These factors equate to increased care transitions for the older adult, with each transition holding the potential for information to be lost, possibly leading to patient harm and hospital readmission. More effective communication during care transitions can result in improved patient care, follow up, and quality of life.⁸

Levels of care and types of care facilities

Patients arriving to, or being discharged from the emergency department, may have come from one of a variety of facilities or from individual homes. The level of care from which patients came may not be appropriate for them upon discharge. Once the decision has been made to discharge a patient from the emergency department, there are a number of options available for those needing more assistance, such as:¹¹

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1. Independent living
2. Assisted living
3. Memory care
4. Skilled nursing
5. Home care
6. Adult day care

Admissions/readmissions

In 2011, reported use of emergency departments was highest in people aged 75 and older (27%) compared with other age groups.¹² People 65 years and older had a 40.8% admission or transfer rate to a hospital from the emergency department.¹² This evidence confirms that a large number of geriatric patients visit emergency departments and many are consequently admitted.¹²

Just over 18% of Americans enrolled in Medicare are readmitted to the hospital within thirty days of discharge.¹³ The most common diagnoses for readmission are congestive heart failure, acute myocardial infarction, and pneumonia.¹⁴ Many of the readmissions have been attributed to gaps in communication, discharge planning, coordination between hospital and community clinicians, and the lack of continuity of care. Identifying high-risk patients can enable a facility to focus efforts on prevention and early intervention before readmission becomes necessary. Strategies to help reduce readmissions include the use of multidisciplinary care teams, comprehensive and accurate medication reconciliation processes, and improved discharge instructions that emphasize disease- or condition-specific symptoms and red-flagging of potential problems.^{1,14,15}

While there are multiple factors that contribute to readmission, many are preventable. Understanding these factors can be a joint venture between the skilled nursing facility and the hospital. There are numerous resources and tools that can be used to track readmissions, such as INTERACT.¹⁶ Because readmissions can be related to gaps in the transition of care and/or education, there is the potential to team with the skilled nursing facility in tracking readmissions. Rather than focusing on one specific method, successes in reducing hospital readmissions have used multiple methods to close communication and care gaps. In a study out of Yale, success reducing readmissions increased with each additional intervention employed.¹⁷ Interventions included partnering with community physicians/physician groups and local hospitals, nurses performing medication reconciliation, arranging for follow-up appointments after discharge, having a process in place for sending discharge summaries directly to the patient's primary care physician, and assigning staff to follow up on test results that return after a patient is discharged.¹⁷ While these interventions are directed to the hospital inpatient being discharged, many of these are also being used in emergency department settings and can continue to be implemented as routine patient care.

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Potentially avoidable hospitalizations

Many hospitalizations, like readmissions, are potentially avoidable. It is common for nursing home residents to develop conditions such as heart failure, electrolyte imbalance, sepsis, urinary tract infections, and respiratory infections, all of which may be prevented with improved nursing education and effective nursing care in conjunction with evidence-based, institution-wide infection control policies.^{1,18} Initiatives to prevent potentially avoidable hospitalizations can be approached collaboratively by hospitals, emergency departments, and skilled nursing facilities. Joint education on the recognition of symptoms and integration of evidence-based care paths for nursing home residents can lead to early recognition of symptoms, diagnosis and treatment, avoiding the need for many emergency department visits and subsequent hospitalizations.^{1,16}

Transitions of care

Transitions of care have been identified throughout the health care community as a key factor in safe and effective patient care.¹⁹⁻²¹ Multidisciplinary collaboration and clear communication are required for high quality transitions of care. Poor transitions in care can result in delayed patient treatment, unnecessary health care expenditures, and increased rates of readmission.⁸ There are several potential barriers to safe transitions in care. These frequently result from variations in forms and patient-hand-off report tools between health care facilities. This leads to gaps in communication of key patient information, such as resuscitation orders, allergies, reason for emergency department visit, caregiver contact information, patient baseline and mental status, and full listing of medical/surgical history and medications. Fortunately, interfacility collaboration can lead to use of standardized communication and handoff tools that improve transitions in care.^{22,23}

Communication gaps in transitions of care can happen at any point, and may be the result of a single missing item or piece of information, such as a *Do Not Resuscitate* form, medication allergy, baseline mental status, functional goals, or complete medication reconciliation list. Safe transitions of care are critical and require effective two-way communication at both admission/intake to and disposition from the emergency department. These transitions are equally important for emergency departments, emergency medical services, and skilled nursing facilities.

Collaboration with nursing homes

Nursing homes play a vital role in the care of the geriatric patient. By establishing a rapport and open dialogue between nursing home and emergency department personnel, unique opportunities arise for improved patient care, handoffs, and outcomes. In areas where there are geriatric specialists or hospital liaisons, meetings between facility administrators can start a dialogue, assess support needs, and initiate collaboration. The emergency department manager, medical director, social worker, geriatric-care coordinator, or geriatric liaison can also serve as the hospital's contact person. Identifying agencies and facilities in the hospital's service area enables collaborations with those involved in care transitions.

Staff from skilled nursing facilities, emergency medical services, and the emergency department can work together to build or choose transitions of care tools that best provide the communications appropriate for their patients. These tools range from a simple SBAR (situation, background, assessment, recommendation) hand-off report, to the INTERACT quality improvement program, which has multiple tools, including those for transition of care communications.^{16,24}

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Establishing open communication is paramount and can help solidify working relationships between the nursing home and the emergency department. This strategy may also be useful in helping identify additional considerations for early intervention and additional proactive measures that might help reduce future hospital readmissions.

Geriatric Emergency Department

In recognition of the high rate of emergency department use among older adults⁸ and that they are a specific patient population, with their own complex physiologic, social, and functional needs, many hospitals are developing geriatric emergency departments, or *senior emergency departments*.^{4,15,25} These emergency departments have design enhancements that best address physical needs of older adults, while providing specialized education in geriatric emergency care for the staff and geriatric liaisons/geriatric-care coordinators, and giving special attention to transitions of care for the older adult.^{4,15,25} Common characteristics of the successful management of geriatric patients in the emergency setting include interprofessional partnerships within and between the hospital system and the community, an evidence-based practice model, a focused geriatric assessment, high risk screening, early initiation of discharge education, post-discharge follow-up, involvement of nurses in the interdisciplinary delivery team, and evaluation of patient outcomes from the processes implemented in the emergency department.¹⁵

Geriatric-Care Coordinator

Use of a geriatric-care coordinator or geriatric-case manager in the emergency department has been shown to be a successful way to ensure follow-up and improve patient outcomes.¹⁵ Geriatric-care managers are considered a component of a geriatric emergency department^{4,5} and may be a social worker or registered nurse. This position oversees the care and follow-up of the older adult patient.⁴ A geriatric-care coordinator or care liaison, can contribute to smooth transitions of care for patients being discharged into the community and decrease the potential for loss of follow-up care.¹⁵

Role of the emergency department nurse

Actions can be taken in the emergency department to improve care for the older adult. Working towards having a *Geriatric Emergency Department* improves the knowledge, staffing composition, and physical attributes that best serve the specific needs of the geriatric patient.⁴ Education of staff can include journal clubs specializing in geriatric care updates, maintaining specific geriatric educational training (such as with the Geriatric Emergency Nursing Education course [GENE]), and having a Geriatric Nurse Specialist. Teaming up with emergency medical services and skilled nursing facilities can lead to use of standardized transfer forms that include information determined to be essential by all stakeholders.^{14,19} Joint education programs for the skilled nursing facilities and the emergency department may lead to improved communication and professionalism as well as increasing the knowledge base of both specialties. In areas where they are available, it might be helpful to include community paramedics in these discussions and joint education practices.

Collaboration in care and patient advocacy extends to the patient's quality of life. For example, functional status of the older adult can be maintained during the emergency department visit. This includes encouraging and assisting in movement when possible and appropriate (such as for walking to the bathroom or standing for a urinal), assisting with dietary needs or modifications when patients are permitted oral intake, preserving patient dignity through

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compassionate nursing care, and advocating for patients as well as engaging with them through conversation, touch, and participation in their health care decisions.

The emergency nurse can engage in educating the patient and/or family/caregiver throughout the emergency department visit. Effective education involves knowledge checks, such as using the teach-back method to confirm patient and/or family/caregiver understanding. Inappropriately communicated discharge education can increase adverse health outcomes for the older adult, emphasizing the need for rigor and attention to detail in patient education. Through continuing diligence and attention to education and compassionate nursing care, emergency nurses can have a positive impact on geriatric patients and their loved ones.

Educational tools for geriatric emergency nursing:

ENA has developed a comprehensive geriatric nursing education course on the provision of safe practice and safe care for the older adult in the emergency setting. (The Geriatric Emergency Nursing Education Course [GENE]: <http://www.ena.org/education/education/GENE/Pages/default.aspx>)

BEERS list addresses the unique physiology of the older adult in regards to medications: http://www.americangeriatrics.org/health_care_professionals/clinical_practice/clinical_guidelines_recommendations/2012

The following are the Geriatric Emergency Department Guidelines put forth as a joint effort by the American College of Emergency Physicians, American Geriatric Society, Emergency Nurses Association, and the Society for Academic Emergency Medicine: http://www.ena.org/about/media/PressReleases/Documents/Geri_ED_Guidelines.pdf

Tools and resources for transitions of care:

INTERACT has multiple tools for transitions of care, readmissions tracking, and care paths for skilled nursing facilities: INTERACT, http://interact2.net/tools_v3.aspx

The Joint Commission, <http://www.jointcommission.org/toc.aspx>

AHRQ, <http://psnet.ahrq.gov/resource.aspx?resourceID=24737>

RARE Campaign, <http://www.rarereadmissions.org/>

CMS Partnership for Patients, <http://partnershipforpatients.cms.gov>

Hospital Engagement Network, Preventable Readmission Change Package - 2014, http://www.hret-hen.org/index.php?option=com_content&view=article&id=11&Itemid=135

National Transitions of Care Coalition, http://www.ntocc.org/Portals/0/PDF/Resources/ImplementationPlan_EDToHome.pdf

Centers for Health Care Research and Transformation, <http://www.chrt.org/assets/policy-papers/CHRT-Care-Transitions-Best-Practices-and-Evidence-based-Programs.pdf>

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Future

Older adults are a patient population that is increasingly coming to the emergency department for care. To safely and appropriately care for these patients in the emergency department, there is a growing movement towards community efforts and multidisciplinary collaboration, with procedures in place for transitions in care. Care transition is an endorsed performance measure of the National Quality Forum.²⁶ There are a growing number of senior emergency departments in the United States, and in 2014 the first consensus-based geriatric emergency department guidelines were published. These are clear indications that attention to the needs of the geriatric patient is an emerging trend and educational necessity in the profession of emergency nursing.⁴

Conclusion

A change in environment, such as an emergency department visit, can be extremely stressful for the older adult.²⁷ Immediate nursing care in the emergency department can include accommodating the needs and comfort of the older adult, while long-term nursing goals can include collaboration for safer transitions of care and reduced avoidable hospitalizations. Along with necessary medical information, transition of care forms can include known sources of comfort, dietary considerations, and functional status, with all being implemented in emergency nursing care of the nursing home resident. Through these collaborative advocacy efforts, safe practice and safe care can be achieved for the older adult patient population.

Definitions of Terms

Transitions in care: All actions involved in ensuring the coordination and continuity of care of patients between settings, such as hospital to home, nursing homes, and other care settings, with the goal of safe and effective patient care.

Independent living: This is a category of senior housing for those who are primarily functionally independent. Occasionally, a home health aide may be needed at this level.

Assisted living: An adult who is mostly independent is a candidate to live in this type of facility. The older adult who requires some additional care can pay for services such as medication reminders or assistance with bathing or dressing.

Memory care: This is typically a closed unit within a skilled nursing facility that caters specifically for the safety and functional and cognitive needs of residents with dementia.

Skilled nursing facility: This type of facility provides care around the clock that includes special activities, meals, and nursing and medical care for individuals who are unable to care for themselves.

Home care: This is care provided in the patient's home that permits him or her to continue living there. The degree depends on the patient's needs, and can vary from help with meals and personal care to assistance with medications.

Adult day care: A location that provides interactive daytime care for adults by interdisciplinary staff in a safe and secure environment, with the older adult returning to a home in the community at night, accompanied by a caregiver.

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