Mount Sinai’s Geriatric ED Advances the Patient Experience for Older Adults

By Audrey Doyle

Patient centeredness is one of the characteristics of high-quality health care. According to Dr. Denise Nassisi, it was also the impetus for developing the geriatric emergency department at Mount Sinai Hospital.

“Older adults who are seen in an emergency department typically have special care needs that are different from those of adults under age 65,” said Dr. Nassisi, who is the director of Geriatric Emergency Medicine, the director of Emergency Medicine Clinical Research, and an associate professor in the departments of Emergency Medicine and Medicine at the Icahn School of Medicine at Mount Sinai.

“With our geriatric ED we’re providing a physical space that’s safer and more geriatric-friendly,” she said. “We’re also following protocols and procedures designed to meet older adults’ emergency care needs and improve their health outcomes and quality of care to ensure that they have a positive patient experience.”

How Traditional EDs Can Fall Short

Located in Manhattan, Mount Sinai is a 1,183-bed general medical and surgical facility that’s part of the Mount Sinai Health System, which, along with the Icahn School of Medicine, also includes six additional hospital campuses in the New York metropolitan area. The facility opened its geriatric ED (GED) in February 2012 to cater to the growing number of patients age 65 and older who otherwise would be treated in its main ED.

“It’s an extremely busy and crowded place,” Dr. Nassisi said of the hospital’s main ED, which saw more than 108,000 patients last year. “A trip to the emergency department, especially one as hectic as ours, can be tough for anyone. But for older adults, it can be especially difficult.”

That’s because traditional EDs usually don’t provide the physical layout or delivery of care that’s best suited to the elderly. For example, to facilitate fast patient assessment and turnover, beds are placed close together and are separated by curtains rather than walls. While this makes the most use of a limited amount of space and enables physicians and nurses to maneuver among patients quickly and easily, it forsakes privacy and increases the noise level, which can increase the stress and anxiety levels of elderly patients and predispose them to delirium.

In addition, floors are made of linoleum, vinyl or a similarly slick and shiny composite material, which can facilitate cleanup but may create a possible safety hazard for older adults, especially those who have difficulty walking. Meanwhile, constant noise and glaring fluorescent lights can exacerbate an already chaotic and uninviting environment for geriatric patients who may have hearing, vision or cognitive impairments such as dementia or delirium.

In terms of care delivery, the rapid triage and diagnosis that’s characteristic of traditional EDs isn’t optimal—and in many cases is impossible to attain—when treating elderly patients, in whom multiple chronic medical conditions, polypharmacy and atypical presentation of disease are common.

“A patient with seven comorbidities who’s on eight different medications may present with shortness of breath or dizziness but may actually be having a heart attack,” Dr. Nassisi said. “Because their symptoms can be different from [those in] younger adults, and because they might not be able to clearly describe their symptoms or give an accurate account of their medical history, you can’t diagnose conditions quickly and easily in older adults the same way you might be able to in younger ones.”
A Better Way to Treat Elderly Patients

Mount Sinai considered all of these factors when planning the design and care delivery model for its GED. During the planning phase, which occurred throughout 2011, a multidisciplinary group of Mount Sinai leaders and staff met several times to discuss how to best meet the special needs of geriatric patients in order to improve their care experience.

“We wanted to take a comprehensive team approach to staffing the geriatric ED, so ED leaders, physicians and nurses were part of the group, along with representatives from other departments who would be involved in caring for these patients,” Dr. Nassisi said. These included social workers, pharmacists, home-care coordinators, geriatricians and members of the ED’s CARE (Care and Respect for Elders) volunteer program.

In terms of design and layout, the resultant GED is a separate unit located next to the hospital’s main ED. Able to accommodate up to 20 patients, it features nonslip, nonglare floors; nonglare lighting; raised toilet seats; ambulation-assist handrails in the halls; contrasting but soothing wall and floor colors; signage and instructions printed in a large font; curtains with plastic rather than metal rings to reduce noise; and walls and ceilings that absorb sound. Cushioned chairs with high backs and nonslip legs are available for patients who don’t want or need to lie down on a gurney, and for patients who do need to lie down, gurneys have thick mattresses to prevent bedsores and skin breakdown. CARE volunteers interact with patients, particularly those who have arrived without a family member or caregiver, and hand out stress balls, magazines, puzzles, reading glasses and hearing-assist devices to keep them engaged and oriented.

All of these changes have resulted in a quieter, less chaotic, more comfortable space in which to diagnose and treat older adults. In order to deliver in that space the type of care that’s best suited to these patients, all of the staff who would be working in the GED were given geriatrics-specific training and education.

As Dr. Nassisi explained, the GED is staffed by care providers who alternate shifts between the GED and the main ED. Therefore, everybody employed in the main ED, including clerical staff, received ageism training. In addition, disciplinary-specific training was given to ED nurses, ED techs, pharmacists, physician assistants, residents and attending physicians.

The additional education for the nursing staff included training in the use of the Identification of Seniors at Risk (ISAR) tool, which is designed to provide early identification in the ED of seniors at increased risk of adverse outcomes who could benefit from a more detailed clinical evaluation and specific intervention. Nurses also were trained in the Confusion Assessment Method (CAM), a quick screen for delirium; and the Get Up and Go test, a quick evaluation of mobility that can help identify patients at risk for a fall.

Because polypharmacy is a common problem among older adults, the ED’s pharmacy staff received training in geriatric pharmacy, including training in the use of the Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. Compiled by the American Geriatrics Society, the Beers Criteria is a list of drugs that may potentially be inappropriate for use in elderly patients due to the drugs’ side effects and drug-drug interactions.

Physician assistants, residents and attending physicians, meanwhile, went to conferences and sessions focused on geriatrics. The geriatrics-specific training and education didn’t end when the GED opened, according to Dr. Nassisi. “It’s an ongoing process for everyone,” she said. “Plus, during grand rounds, our residents and attendings get to see how atypical presentation of disease is common with geriatric patients,” she explained, adding that atypical presentation can include vague presentation of illness, altered presentation of illness (e.g., pneumonia presenting as confusion) or nonpresentation of illness. “They also get to see how geriatric patients can present with vague or subtle conditions—for example, saying their chief complaint is that they’re dizzy or they don’t feel well—as opposed to something much more specific that can help us pinpoint a diagnosis.”

As noted earlier, one reason the entire ED staff received geriatric training was because the GED is staffed by care providers who alternate shifts between the GED and the main ED. Another reason is because not all geriatric patients are guaranteed to be seen in the GED. “Patients who qualify to be seen in the GED at times when the GED is full will be seen in the main ED,” explained Dr. Nassisi. “All ED patients who are critically ill and medically unstable are first evaluated and treated in the ED’s five-bed resuscitation area. Once they are stabilized, patients who are over age 65 can be moved to the GED.”

Besides providing geriatrics-specific training, Dr. Nassisi said it was also important to staff the GED with additional personnel who would play a role in the department’s comprehensive team approach to care delivery. Therefore, the GED team also comprises social workers, whose many responsibilities include interacting with family members, assisting with home safety assessments and accessing community-based resources such as Meals on Wheels delivery; physical therapists; and home-care coordinators who can organize home attendant or visiting nurse assistance. Additionally, members of the hospital’s palliative care team are available to address palliative care and end-of-life issues.
Because elderly patients have such complex medical needs, the team also created a new position, that of geriatric nurse/nurse practitioner, whose responsibilities include providing additional cognitive and functional patient screenings and helping to educate patients and family members.

Importantly, the geriatric nurse/nurse practitioner also conducts follow-up calls post-discharge. “We want to make sure the patient is doing well, they understand their discharge instructions, they got their medication and are taking it, they’ve made a follow-up appointment with their physician and they’re following through on a specialty referral if necessary. If the patient doesn’t have someone already established who we can easily hand off their care to, the geriatric nurse/nurse practitioner can make further follow-up calls until the patient handoff is made,” Dr. Nassisi said.

**Preliminary Outcomes Show Promise**

According to Dr. Nassisi, the GED at Mount Sinai has been successful in several areas. Because multiple variables were changed over time with the opening of the GED and the implementation of several initiatives, specific metrics weren’t available for dissemination at press time. However, she did note that the hospital has “definitely reduced the percentage of patients 65 and older who are admitted from the ED, decreased the rate of falls within the ED, decreased the incidence of delirium and agitation, increased the screening of patients for potentially inappropriate medications, increased the screening of seniors at risk of adverse outcomes and delirium using the ISAR score and CAM tool, and increased the satisfaction of patients, family members/caregivers and referring providers.”

Regarding the reduction in unnecessary hospital admissions in particular, Dr. Nassisi said that providing an environment and care delivery model conducive to the specific needs of older adults has resulted in a culture shift throughout the ED.

“The inclination in the past was to admit an older patient whose medical condition combined with their psychosocial and functional status was too complex to fully address in the emergency department, and to have the hospital staff handle the transition back to the community from the inpatient service,” she explained. “But now our geriatrics-trained multidisciplinary team can screen, diagnose and treat that patient, and in many cases we can send them home. Or if they’re on pain meds because of a fall and it would be unsafe to send them home, we can get a PT consult and send them directly to subacute rehab, which we weren’t able to do before.

“Elderly patients who are admitted to the hospital often have a difficult time returning to activities of daily living, or they become delirious, catch nosocomial infections or suffer some other form of iatrogenic complication,” she added. “If we can safely discharge them home or to secondary care, it is better for the patient and the patient usually prefers it.”

Importantly, this culture shift hasn’t occurred only in the GED. Through Mount Sinai’s interdisciplinary care delivery model called TracED, the team is expanding from the geriatric population to all adults younger than age 65 who are seen in the main ED with complex medical and perhaps psychosocial conditions that require complex care coordination.

TracED, which stands for Transitions of Care in the Emergency Department, targets high-risk ED patients with the same integrated set of services and innovations as those in the GED. “As a result, we can do more thorough screenings in cases of polypharmacy or comorbidity, prevent unnecessary admissions, coordinate services for these patients at home—give all adults in the ED who have complex conditions that follow-through and transition of care that we’re giving to our geriatric patients,” Dr. Nassisi said.

“As health care providers, we want to take better care of everybody,” she concluded. “It’s our goal, and it’s what patient-centered care is all about.”

Dr. Nassisi and Dr. Gallane Dabela Abraham, GED associate director, will share additional insight on how the Mount Sinai GED is addressing the needs of the elderly in a webinar to be held on Wednesday, Feb. 1, from 3 to 4 p.m. ET. Click here to reserve your spot for “Meeting the Unique Needs of an Aging Population: Mount Sinai’s Geriatric ED.”