ACEP
Geriatric Emergency Medicine Section

# NEWSLETTER

## Overview

MONDAY 5/12/2025



## Upcoming Events

- GED Feature in PBS Documentary: "Aging in America: Survive or Thrive" - Streaming **May 1, 2025**
- GEDC Healthcare Systems Roundtable: "Transforming EDs for Persons Living with Dementia and Their Care Partners" – **June 24, 2025** 1:00-2:00 PM EST
- GEDC Webinar: Medication Management and the CMS Hospital Measure – **July 14, 2025** 3:00-4:00 PM EST
- GEDC Healthcare Systems Roundtable: "Embedding Innovation: Using Technology to Transform Care Delivery" – **August 26, 2025** 1:00-2:00 PM EST
- GEMMSTAR Application Deadline: **October 2025**
- BMC Emergency Medicine – Geriatric Emergency Medicine Collection (2025) – Journal Call for Submissions: Submission Deadline: **December 18, 2025**
- For more events, see the ACEP Event Calendar

## Policy Updates

- **New CMS Model Launched:** In July 2024, CMS introduced the GUIDING an Improved Dementia Experience (GUIDE) Model, an eight-year initiative to improve dementia care and support unpaid caregivers through coordinated, person-centered services.
  - **EDs Not Explicitly Included:** While the model does not explicitly address emergency departments as a core part of dementia care, many persons living with dementia (PLWD) rely on the ED, especially during crises and care transitions.
  - **Policy Recommendations:** A recent perspective by Zikry et al., titled "Integrating Emergency Departments Into The CMS GUIDE Model For People Living With Dementia", offers suggestions for integrating EDs into GUIDE-aligned care, including enhanced care coordination, caregiver communication, and streamlined referrals.
- For more detailed information, visit the CMS GUIDE Model page.

## Member Publication Spotlight:

### *Addressing the Hidden Harms of ED Boarding in Older Adults*

A recent review by Joseph et al. examines the disproportionate risks that emergency department (ED) boarding poses for older adults. Boarding—defined as the prolonged stay of admitted patients in the ED due to unavailable inpatient beds—is associated with adverse outcomes for this population, including increased rates of delirium, hospital-acquired disability, and mortality.

The review outlines several structural contributors to ED boarding, including inpatient capacity constraints, discharge inefficiencies, and rising hospital occupancy. While the GUIDE model and similar federal initiatives focus on dementia care in community settings, they do not explicitly address the role of the ED in caring for persons living with dementia—a gap the authors acknowledge.

To mitigate harm, the authors highlight actionable strategies such as prioritizing high-risk older adults for inpatient transfer, implementing delirium prevention protocols during boarding, and considering alternatives to hospitalization, such as hospital-at-home models. The Geriatric Emergency Department Accreditation (GEDA) program is cited as a framework for improving the quality of care delivered to older adults during prolonged ED stays, including tracking boarding durations by age group.

The review emphasizes that boarding is not only a throughput issue but also a patient safety and quality concern, particularly for older adults with complex medical and cognitive needs.

### *Goals of Care Golden Hour*

A two-year retrospective analysis explored the impact of early goals of care (GOC) conversations initiated while patients were still physically located in the emergency department (ED). These conversations—whether conducted by ED or inpatient providers—were associated with a significantly shorter inpatient length of stay compared to those held after hospital admission. Early GOC discussions extended beyond code status to focus on what matters most to patients in the moment, such as returning home, managing symptoms, or attending a family event. Prioritizing these conversations during the ED's "golden hour" supports care that is more aligned with patient values and may prevent hospitalizations that do not match patient goals.

Importantly, the findings demonstrated that early GOC conversations are not just a patient-centered intervention but also a hospital flow strategy. Patients who had early GOC conversations contributed to improved throughput by shortening inpatient stays, which in turn helped alleviate ED boarding. Financial analysis showed these patients were associated with a higher contribution margin, and when scaled, the benefit exceeded the salary of an additional palliative care physician. These results informed the successful addition of a dedicated ED-based palliative care clinician, reinforcing early GOC conversations as a high-impact, value-aligned intervention that benefits patients, clinicians, and health systems alike.

**For questions/collaborations:** Payal Sud, MD
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## EM Insights: *Meeting Older Adults Where They Are: Lessons from the ED and Beyond*

Joella Byerley, University of Pennsylvania

Recruiting older adults into clinical research is never simple—and since COVID-19, it's only gotten harder. The National Institute on Aging has highlighted the persistent challenges of enrolling older adults, particularly those with cognitive impairment or from historically underrepresented backgrounds. These challenges extend beyond academic medical centers to community programs and social services, where systemic barriers and trust gaps often go unaddressed.

To enroll older adults successfully, the literature points to several best practices:

- Cultural humility and empathy to build trust with patients, families, and care partners
- Clear, respectful communication tailored to health literacy and cognitive needs
- Timing the approach—for example, after pain management but before discharge
- Addressing fears and misconceptions early and directly
- Providing appropriate incentives or minimizing perceived burden

I've come to understand these principles firsthand in my current role recruiting for Dr. Ari Friedman's ED-GAP and SAGE Cohort studies, where I approach older adults in the emergency department—an environment that is, by nature, chaotic and fast-moving. One afternoon, I approached a patient with abdominal pain. She seemed withdrawn, and her daughter was hesitant. Rather than diving into the study details, I paused. I acknowledged the stress of the moment, explained our goals plainly, and made space for questions. I waited until the patient was more comfortable—after receiving pain medication but before discharge—to revisit the conversation. I listened closely to her concerns, reassured her that participation was voluntary and low-burden, and gave her and her daughter time to talk it over. We enrolled her.

That outcome wasn't accidental. It drew on earlier roles, like recruiting for the Mayor's Commission on Aging's SCSEP employment program, where I learned how to navigate fragmented systems and build trust with older adults who had reason to be skeptical. As a CNA in a skilled nursing facility, I also learned to center dignity in every interaction, especially with those living with cognitive impairment.

These experiences shaped how I approach each encounter in the ED not just as a researcher, but as someone committed to equitable research. Research teams can't succeed without trust, and trust requires staff who can listen, adapt, and treat every encounter as a human one.

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