The GAP-ED Project: Improving Care for Frail and Elderly Patients Presenting to the Emergency Department

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BACKGROUND

• Older adults in the ED are a vulnerable population at risk of return visits, unnecessary hospitalization, and death. Currently in the U.S., more than 63% of persons older than 75 years of age are admitted to the ED each year and are at an increased risk of return visits, unneeded or repeat hospitalization(s), prolonged pain and suffering, and death.
• ED admissions data at Long Island Jewish Medical Center (LIJMC) revealed an elderly population with multiple revisits for non-emergency medical care.
• On November 2, 2015, the Geriatric and Palliative (GAP) Division and ED at LIJMC implemented a multidisciplinary GAP-ED Team, delivering geriatric and palliative expertise to the ED.

HYPOTHESIS

• We hypothesize this intervention will reduce 30-day ED revisit and 30-day hospitalization rates by at least 10%.
•As a secondary objective, we aim to improve patient and caregiver satisfaction and to improve care of older adults in the ED by providing comprehensive geriatric assessments, discussing advance directives and Goals of Care, linking patients to community resources, and coordinating care after discharge.

METHODS

• The GAP-ED Specialist, a geriatric social worker, identified ED patients who met criteria (≥65 years of age, community-dwelling, discharged home, had medical/ social co-morbidities increasing risk of recidivism.)
• The Specialist assessed medical conditions, medication reconciliation, psychosocial needs, and discussed Goals of Care. The Specialist connected patients to community-based resources and followed up by phone at 3, 7, and 30 days post-discharge.
• Five weeks post-intervention, a satisfaction survey was administered to patients or their family members.

DATA

510 patients have been seen to date

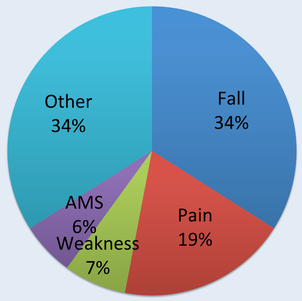
Advance Directives have been established for 96% of these patients

Of 157 patients or caregivers surveyed:

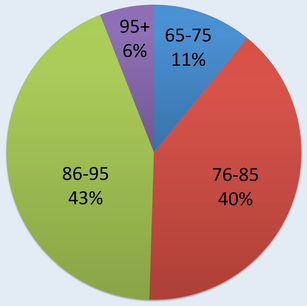
91% found the Specialist helpful in providing support and resources

86% believe all ED's should have this initiative

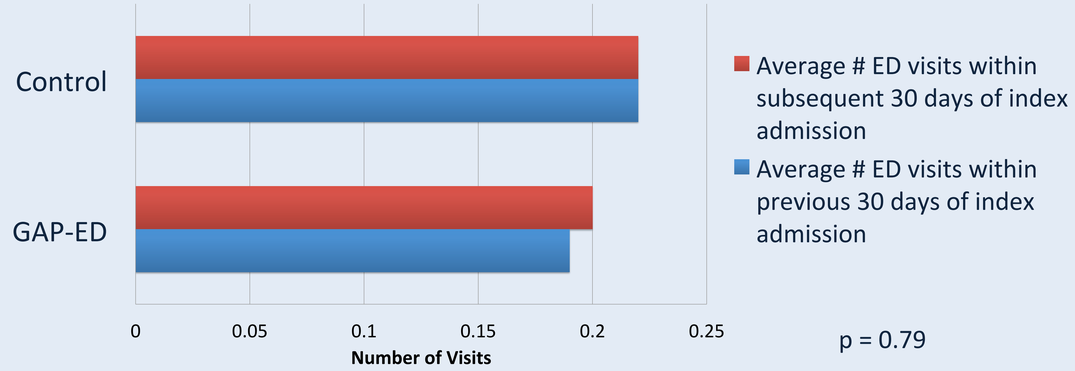
GAP-ED Patients: Chief Complaint



GAP-ED Patients: Age



ED Admission Data



RESULTS

- There was no significant reduction in 30-day ED revisits for GAP-ED patients
- Patient and caregiver feedback showed overwhelming support for the GAP-ED initiative
- Patients and families were extremely appreciative of the assistance and focus on their needs. Post-discharge, the GAP-ED Specialist improved communication and turnaround time in delivering services to patients.

CONCLUSION

- There are multiple possibilities explaining why the GAP-ED Intervention did not significantly affect 30-day ED revisit rates. The quality of resources to which the Specialist connected patients may not have been robust enough to decrease ED usage. Furthermore, only half of patients reported that they followed up with these community resources. It is also possible that the patients who would most benefit from increased support were resistant to outside help.
- Ongoing work includes analysis of GAP-ED patients who did follow up with community resources to see whether 30-day ED revisit rates differed from those who did not follow up
- Regardless of revisit rates, the presence of a Geriatric Social Worker in the LIJ ED was welcomed and appreciated. The emotional support provided to patients and their caregivers leaves a lasting impact and improves their healthcare experience, evident by the positive survey feedback.
- Future work should involve an in-depth analysis of characteristics that correlate with high rates of ED use in the older adult population as well as an analysis of the financial impact of the GAP-ED intervention on the LIJ ED, Northwell Health's community resources, and patients.