# An Approach to the Older Patient in the Emergency Department

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**KEYWORDS**

- Geriatric emergency department • Cognitive impairment • Atypical presentation
- Functional assessment • Geriatric medication reconciliation
- Emergency department palliative care

**KEY POINTS**

- Older adults are a rapidly growing, high-risk, unique emergency department (ED) patient population. ED provider perspectives and ED processes must evolve to better serve their complex care requirements.
- A more comprehensive approach to older ED patients requires routine, standardized assessment of cognitive impairment, atypical presentations, functional impairment, medication management, trauma, and end-of-life issues.
- A senior-friendly approach enhances patient safety, quality of care, and patient, caregiver and provider satisfaction.

## INTRODUCTION

Most emergency physicians (EPs) would agree that during a busy shift of trauma presentations, resuscitations, breaking bad news, multitasking, and constant interruptions, the most challenging part of the shift can be providing care to older patients. Here is the issue: older individuals in an emergency department (ED) often present with multiple acute and chronic problems and sometimes cognitive impairment, accompanied by either no or many carers, often with many health care professionals

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involved in their care, and rarely with one simple solution or endpoint to their care.[1] Providing care to this rapidly growing population can seem overwhelming unless EPs have some core skills, knowledge, and attitudes that inform an approach. This article outlines the unique needs of older adults and approaches to address those needs. Many of the topics are addressed in detail in additional chapters of this issue.

Older adults are particularly vulnerable when they are acutely ill: they are more likely to experience adverse health outcomes due to depleted physiologic reserves; to have multiple comorbidities; and to be at risk for adverse events related to medications. The early identification of this particular vulnerability and awareness of geriatric syndromes, such as frailty, cognitive impairment, falls, delirium, sensory impairment, and polypharmacy, is crucial. Addressing the unique needs of older adults earlier while in an ED allows appropriate care for this vulnerable population.

High-risk ED presentations, such as trauma, sepsis, and cardiac arrest, trigger a standardized bundle of diagnostic and therapeutic interventions. Older adults in the ED are also a high-risk cohort and benefit from a similar comprehensive approach. A standardized approach to the unique vulnerabilities of older adults will have a significant impact on both the quality of care a patient receives and the efficiency of EPs and department work flow. This article outlines 6 key commonalities among older patients and demonstrates how increased geriatric awareness shapes an approach to older ED patients.

## COGNITIVE IMPAIRMENT

An overriding issue for older ED patients is assessment of mental status and cognitive impairment. Dementia is the most common disease of old age and affects as many as 25% of people over age 80. Furthermore, dementia is the principal risk factor for delirium, often the principal presenting symptom of serious life-threatening disease in older ED patients. EPs must have a clear approach to both of these issues.

Ideally each ED system will develop a process of care for delirium management that involves standardized screening and a protocol-driven approach to investigation and treatment of its cause(s), once identified, and symptoms. Various screening tools have been developed for the identification of delirium. They are all some modified version of the Confusion Assessment Method[2] and incorporate the principal features of delirium:

- Acute and fluctuating course
- The presence of inattention
- Either disorganized thinking and/or altered level of consciousness (hyperalert or hypoalert)

Han and colleagues[3] have proposed a 2-step process that can be built into the ED work flow of nurses and doctors and is time-efficient enough to recommend completing on all patients over a specified age. It uses a highly sensitive and simple screen—the Delirium Triage Screen—to rule out delirium followed by a highly specific 4-question tool—the brief Confusion Assessment Method—to rule it in. The Delirium Triage Screen consists of establishing a Richmond Agitation and Sedation Scale number, a familiar ED tool routinely used for intubated patients and in conscious sedation. If that number is anything other than zero (alert and normal), then a simple test of attention (eg, spell "LUNCH" backwards) is used. If the patient rules in on this screen, completed in approximately 15 seconds, then the protocol proceeds to a series of standard questions assessing the 4 domains of delirium. This process can be completed by a nurse or potentially a nonclinician (because it involves limited clinical ability) and is integrated into the electronic health record to trigger a delirium

investigation pathway. Establishing if acute confusion is present or absent must be one of the first steps in an EP's approach to the assessment of older patients.

The management of the syndrome of delirium is the identification and treatment of its cause(s). As such, EPs should have a standardized approach to identifying its cause(s). There are many mnemonics for this purpose (DELIRIUM, I WATCH DEATH, and DIMES), but this efficient approach covers them all well (Rockwood Ken, personal communication, 2017):

- Drugs, drugs, drugs (for prescribed, over-the-counter and recreational) – either addition, withdrawal or misadventure)
- Infection
- Metabolic (hypometabolic or hypermetabolic: K, Na, Ca, thyroid, glucose, ketones, and so forth)
- Something in the head or heart
- Something else (think broadly)
- Some *combination* of the above five possibilities

This approach could be built into ED processes of care by means of an order set or prompts in the EHR. Even with extensive investigation in the ED, it may not be possible to identify the cause of delirium. If that is the case, then admission for further investigation and for the patient's safety is indicated.

A particularly troubling situation for many EPs is management of the agitation that sometimes accompanies geriatric delirium. It requires management if it is putting the patient or others at risk of harm or is interfering with care. (It is important to state also that hypoactive delirium is both more common and equally dangerous because it leaves a patient immobile, dehydrated, undernourished, and unable to participate in care.) It cannot be stated enough that nonpharmacologic strategies are often successful in reducing agitation. They should be the first-line approach to hyperactive delirium before reaching for pharmacologic and physical restraints. These include

- Addressing comfort (food, drink, and warmth)
- Addressing physiologic needs (toileting and mobility)
- Providing frequent orientation
- Correcting sensory impairments (glasses and hearing aids)
- Providing meaningful conversation, pleasant sensory stimulation, and family presence

Physical restraints should be avoided, because they are unlikely to be successful and are dangerous. If pharmacologic strategies are required, options include haloperidol (if no Parkinsonism/Lew body dementia) or most atypical antipsychotics – but usually at doses of as little as one-tenth of standard doses. Benzodiazepines are recommended only when delirium is due to alcohol or benzodiazepine withdrawal or stimulant toxicity.

Once delirium—which can be considered acute brain failure—has been ruled out, it is important to have an approach to identifying dementia—chronic brain failure. Although patients are rarely in the ED *because* of dementia, they are often in the ED for some other reason *with* dementia. Identifying the chronic cognitive impairment has an impact on multiple parts of an ED visit, that is, a clinician's ability

- To obtain an accurate history from patient and to seek collateral information
- To engage the patient in treatment
- To establish capacity and goals of care

- To coordinate disposition and establish a safe discharge plan
- To improve patient and caregiver satisfaction

There are multiple brief screening tools available to identify the presence of cognitive impairment.[4] None is unequivocally superior to another. The Ottawa 3DY meets the ED standards of brevity and simplicity and 94% sensitivity:

- What is the *D*ay of the week?
- What is the *D*ate?
- Spell WORL*D* backwards.
- What is the *Y*ear?

If dementia is identified during an ED visit, it needs to be included in disposition planning, particularly as it relates to a patient's understanding of postdischarge care and safety for discharge. The EP should communicate that finding or impression to some down-stream provider (family doctor or primary care provider) to ensure that further investigation and management are initiated. In short, a screening in the ED should be followed by an assessment in the context of an individual's primary care.

## ATYPICAL PRESENTATIONS OF DISEASE

Accurate, timely diagnosis of acute illness is more difficult in older adults owing to the increased likelihood of atypical presentations, defined as "no signs or symptoms or unusual signs and symptoms unrelated or even opposite of what is expected." Atypical presentation describes common geriatric nonspecific symptoms of weakness, dizziness, falls, accelerated functional decline, and a change in mental status. It also describes the misleading signs and diagnostic information complicating detection of serious acute illness in older adults. In the hectic, single complaint–oriented ED setting, atypical presentations lead to missed or delayed diagnoses with adverse effects on morbidity, mortality, and resource utilization.[5]

Traditional markers of serious illness, such as vital sign changes, physical examination findings, and laboratory and imaging abnormalities, are often absent in older adults. "Failure to mount a fever with an infectious disease" is the most common atypical ED, followed by "absence of pain with a painful condition."[5] Nonmedical factors, such as patient underreporting and provider discomfort with older adults, increase risk of missed or delayed diagnosis. Systematic ED undertriage of older adults, which affects 23% of older adults, further challenges timely diagnosis while creating diagnostic momentum toward less acutely significant diagnoses.[6,7]

Acute pathology of any organ system in older adults may present atypically. Exploration of 3 common high-risk presentations—infections, abdominal pain, and chest pain—illustrates the nuance of evaluating atypical presentations.

Serious acute infectious disease is both more common and deadly in older adults, because 65% of ED patients diagnosed with sepsis are over 65 years old and septic shock has 30% to 50% higher mortality in older adults.[8] Age-related physiologic changes, immune senescence, medications, cognitive impairment, and preexisting conditions complicate rapid detection of both the presence and source of infection. In older adults identified with bacteremia, the classic findings of fever, respiratory or urinary tract symptoms, vital sign abnormalities, and increased white blood cell count are not reliably present. Infectious source is not identified in one-third of the older patients.

Urinary tract infection (UTI) is frequently diagnosed in older adults with nonspecific complaints. Representing 5% of ED older adult visits, UTI is difficult to diagnose accurately in the ED due to frequent absence of urinary symptoms, poor urinalysis test characteristics, and the high prevalence of asymptomatic bacteriuria.[9] Frail older adults with significant UTIs, especially those from nursing facilities, are more likely to present with delirium than urinary symptoms. The additional challenge in this setting is avoiding unnecessary use of antibiotics in those older patients who simply have asymptomatic bacteriuria.

ED providers may avoid delayed diagnosis and treatment in older adults with suspected infection by initiating treatment of a likely source early, while continuing the search for alternate infectious or noninfectious etiologies. A broad approach to suspected sepsis often includes advanced imaging, admission or observation, and collecting ancillary history from caregivers.

Intra-abdominal emergencies are notoriously subtle. There is a weak correlation of vital signs, pain description, and abdominal examination findings with disease severity in older adults. Examples include

- Among patients over 60 years old with endoscopically proved peptic ulcer disease, 35% report no abdominal pain.
- Among older adults with appendicitis, 25% have no right lower quadrant pain.
- Fewer than 50% of older patients with ruptured abdominal aortic aneurysm present with the classic combination of hypotension, abdominal pain, and palpable abdominal mass.[10,11]

Diagnostic information is also less reliable in older adults. White blood cell counts are not elevated in 30% of older adults with acute surgical abdominal etiology, and liver function tests are often normal in older adults with acute hepatobiliary disease. Imaging results may confuse diagnosis by identifying asymptomatic chronic conditions, as in the presence of gallstones in 50%, diverticulosis in 50% to 70%, and abdominal aortic aneurysms in 5% to 10% of older adults.

A conscientious approach to older adults with abdominal pain includes a high index of suspicion for severe disease, a broad differential, risk stratification based on severity of presentation and acute change from baseline, and consideration of factors conferring increased risk. Repeated evaluations are necessary, because peritonitis is more subtle and rapidly progressive in older adults. Early resuscitation, antibiotics, advanced imaging, and surgical consultation are often indicated.

Chest pain is the most common chief complaint among older adults in the ED.[12] As with abdominal pain, this complaint may represent serious disease without classic signs and symptoms or diagnostic information.

Symptoms are often unreliable with acute myocardial infarction; only 50% of patients 65 years old to 75 years old and 40% over 80 years old complain of chest pain. Instead, older adults present with shortness of breath (49%), diaphoresis (26%), nausea and vomiting (24%), syncope (19%), and delirium (5%).[13] Diagnostic tests are insensitive and nonspecific due to chronic electrocardiogram abnormalities and nonischemic elevations of cardiac biomarkers.[12]

Other conditions in the chest pain differential also present atypically in older adults. Pulmonary embolus, for example, is less likely to present with shortness of breath or pleuritic chest pain. Furthermore, the specificity of D-dimer drops significantly with age, to less than 5% over 80 years old. Secondary spontaneous pneumothorax mimics symptoms of underlying chronic obstructive pulmonary disease (COPD), and rapid diagnosis with physical examination and radiography is complicated by chronic fibrous and bullous changes.[12]

## FUNCTIONAL ASSESSMENT AND TRANSITIONS OF CARE

When faced with a complex older person, ED clinicians need to develop an approach that moves beyond the purely medical paradigm. Successful assessment and disposition of older patients require more than establishing a diagnosis and a treatment plan. If there is to be an optimal outcome for older patients, the EP must also consider a person's physical, mental, and social function before coming to the ED and the impact that the ED visit will have on those areas of function.

Hilary Siebens[14] proposed the Domain Management Model for ED assessment of an older person by dividing it into 4 domains: medical and surgical, mental status and coping, physical function, and physical and social environment. It is clear that physicians typically focus on the medical/surgical components and are usually adept at assessing them. The other 3 domains may require a more comprehensive, coordinated, and often interdisciplinary approach; although there is no reason that a nurse or physician cannot assess cognition and ask about activities of daily living (ADLs) or instrumental ADLs or social supports. Something as simple as a physician-observed walk test or a more standardized Timed Get Up and Go test may be a simple place to start assessing how well a patient is going to function once back home.[15]

This approach should start early in a patient's ED stay, with standardized screening for baseline function, which can be implemented at triage or as part of a primary nursing assessment. A widely used tool is the Identification of Seniors at Risk tool,[16] a 6-item risk screen to assess care needs at home regularly and currently, hospitalizations, sensory or cognitive impairments, and medications. The Triage Risk Screening Tool[17] is a 5-item tool that includes questions about mobility and falls, social isolation, and clinician impression. A more recent addition to the toolkit is an app-based tool, the interRAI ED Screener,[18] which uses an algorithm focused on responses to questions about

- Bathing
- Hygiene
- Dressing
- Decisional ability
- Mobility
- Self-rated health
- Dyspnea
- Depression
- Caregiver stress

The interRAI ED Screener is used to identify the need for further involvement of inpatient or outpatient geriatric services.[18] A theme for all these tools is the recognition that a person's baseline function, as much as the severity of the medical diagnosis, has an impact on management and disposition. Examples are a person who has a wrist fracture whose mobility in a 2-level house depends on a cane and a person who presents with mild diarrhea and vomiting but is reliant for most ADLs on a burnt-out caregiver. All these screening tools can be completed in less than 2 minutes and can be easily built into either nurse or doctor work flow. Although the specific utility and outcomes for any given tool are widely debated,[19,20] one benefit of implementing any of them is that it focuses the whole ED team early on issues that will have an effect on assessment and disposition planning.

Adequate assessment of any complex clinical situation is best managed not by a single health care provider. This applies equally to older people in the ED. The approach to functional assessment is best shared with an interdisciplinary team. A

high-functioning ED that sees older people will have a mechanism for ensuring in-department assessment, as needed, by a social worker, physiotherapist, occupational therapist, pharmacist, and/or discharge coordinator/community liaison.[21] Although extending the scope of the assessment may prolong ED length of stay, it is reasonable that a more robust assessment will produce fewer hospital admissions, more durable ED discharges, and greater patient satisfaction.

Attention to transitions of care, rarely considered in younger ED patients, is a component of this more extended assessment. The assessment and disposition of a vulnerable older person is complex. Older patients can be cognitively or functionally impaired, with a new or poorly understood condition, sometimes with 3 or more care providers, and a significant change in function, cognition, or social situation. Because older people may have many different health care providers—multiple specialists, family doctor, informal and formal caregivers—involved in their care, it is essential that there be some communication between the ED provider and that care network. This may involve using the health system's electronic health record to notify everyone involved of the ED visit, the new findings, and treatment plans. Or it may involve something as old-fashioned as a phone call by one of the ED team to the primary care provider or long-term care home.

## MEDICATION MANAGEMENT

Older adults are more likely to have multiple prescriptions. Polypharmacy is common in older adults and prevalence of polypharmacy increases with advanced age. Older adults are particularly more vulnerable to polypharmacy and adverse drug effects due to multiple comorbidities and reduced physiologic reserves. Adverse drug events are associated with increased patient morbidity, mortality, and resource utilization.[22,23]

Accurate, timely ED medication reconciliation is critical to diagnosis, treatment, and patient safety. It is much more complicated in older adults, who often take multiple medications from multiple pharmacies and providers in addition to over-the-counter, vitamin, and herbal preparations. A systematic approach to medication reconciliation that describes both what is prescribed and how medications are actually taken is a foundational element of the ED evaluation of older adults.

When evaluating and treating patients in the ED, it is imperative to understand pharmacodynamics, pharmacokinetics, risks, benefits, and potential adverse events in older patients. Pharmacodynamics (what a drug does to the body) and pharmacokinetics (absorption, distribution, metabolism, and excretion, ie, what the body does to a drug) are both altered in older adults. These concepts are essential to keep in mind because older adults have multiple age-related physiologic changes (decreased renal and hepatic clearance) that can potentially affect the pharmacologic process of certain medications. There is little change in drug absorption with aging. The reduction in lean body mass and increased body fat with aging can affect volume of distribution and prolonged clearance rates of certain drugs, such as some benzodiazepines. Metabolism is also affected with aging. Reduced oxidative metabolism by cytochrome P450 enzymes in the liver decrease with age, potentially affecting drug metabolism. Finally, elimination of many drug therapies occurs through kidney clearance and renal function is generally reduced in older adults. These age-related physiologic changes are important to understand when prescribing to older adults.

It is also important to consider high-risk medications in older adults. The Beers Criteria for potentially inappropriate medication is a simple, rapid instrument that

may be used in the ED to improve medication selection, reduce adverse drug events, and educate clinicians and patients.

The 2015 updated Beers Criteria reinforce avoiding antipsychotics in older adults. The rationale was modified to "avoid antipsychotics for behavioral problems unless nonpharmacologic options have failed or are not possible, and the older adult is threatening substantial harm to self or others." Beers Criteria encourage the use of nonpharmacologic interventions in older adults with delirium or dementia.

Drugs with strong anticholinergic properties, such as diphenhydramine, cyclobenzaprine, olanzapine, doxepin, and nortriptyline, should be avoided in older adults because they are associated with impaired physical and cognitive function and increased risk for dementia in older adults.

## TRAUMA AND FALLS

Trauma management is one of the key domains of emergency medicine. It is easy to forget that the most common and often the most devastating source of trauma in older people is a fall from standing height.[24] EPs need an approach to the injured older person, whether from a fall or other mechanism, which is perhaps broader than the usual resuscitate-and-refer approach and which addresses the expanded competencies of geriatric care. An alternative model falls into 4 parts:

1. Assess the cause of the fall.
2. Assess the consequences of the fall.
3. Assess and ensure safety for discharge.
4. Implement strategies for prevention.

This model, focusing principally on standing-level falls, incorporates an awareness of the unique physiologic, physical, social, and functional differences between older and younger patients presenting with traumatic injuries.

Geriatric-focused EPs spend considerable time assessing multiple factors in the etiology of a fall for any given older patient. The much overused and poorly understood term, *mechanical fall*, implies a fall exclusively caused by an extrinsic factor (a pot hole, a curb on a dark street, or an electric cord) which would have happened regardless of age or disease factors. As such, almost no fall in older people is *mechanical*, and the term should be used with caution—or abandoned. Fall assessment starts with a careful search for causative factors, including cognitive impairment (either baseline dementia or acute delirium); visual, hearing, tactile, or proprioceptive impairment; gait impairment because of joint disease, pain, or mobility disorders (eg, Parkinson's disease); muscular weakness because of deconditioning or general frailty; cardiac arrhythmias; and, most importantly, medications. The medication list provides a wealth of possible etiologies of falls:

- Decreased postural response due to $\beta$-blockers and $\alpha$-blockers
- Hypovolemia due to diuretics
- Hypotension due to antihypertensives
- Precipitous hypoglycemia due to sulfonylureas and other oral hypoglycemics
- Decreased reaction time and mental slowing due to benzodiazepines, opioids, and other sedatives

A falls assessment should include a thorough understanding of all a patient's medications—prescribed, over-the-counter, recreational, and homeopathic—including how, when, and if the patient is taking them.

The part of this approach with which most EPs feel most comfortable is assessing the consequences of a fall, but here too an older patient poses some specific challenges. Vital signs must be judiciously assessed in the light of medication history (β-blockers and other antihypertensives blunt tachycardia, and chronic pain medications, such as opioids, alter pain response). The presence of chronic neurodegenerative conditions like dementia, Parkinson's disease, and diabetes pose challenges in assessing mental status changes, mobility, and sensation. Other chronic conditions, such as COPD and kidney failure, may mean that trivial effects (eg, an isolated rib fracture or a brief episode of hypotension) can have calamitous consequences.

Although older people can suffer all the effects of trauma of a younger person, there are certain patterns of injury that require special attention. Because of the atrophic brain, fragile stretched bridging veins, and frequent presence of anticoagulant or antiplatelet medications, older people are at much greater risk of acute or delayed development of subdural hemorrhage after even minor trauma. Both NEXUS II[25] and the Canadian Head CT Rule[26] exclude patients over 65 and, therefore, provide no guidance, but early and even repeat CT imaging are probably prudent. In addition, early reversal of anticoagulation and stopping antiplatelet medication should be considered, weighing the risks and benefits. Because of age-related cervical stenosis, degenerative disk disease, osteoporosis, and osteoarthritis, minimal traumatic energy to the cervical spine can cause fracture and even cord injury without fracture. The physician should maintain a high index of suspicion for cervical cord or spine injury after a fall in the presence or absence of neck pain, especially if there are any upper limb sensory or motor findings. Again, early CT imaging of the spine is probably indicated.

Osteoporotic ribs and decreased chest wall compliance mean that multiple rib fractures can occur from a minimal injury. Additionally, chest wall contusion or lung and pleural contusion can be sufficiently painful to significantly impact respiratory function with the risk of pneumonia or COPD decompensation. There are few differences in assessment of intra-abdominal traumatic injuries in older people, other than bleeding, that are likely to be more marked because of anticoagulation.

Turning to skeletal injuries, proximal femoral fractures are the most common and the most consequential with falls. Any older person who is non–weight-bearing because of hip pain and has a radiograph that appears normal requires advanced imaging because impacted or undisplaced fracture, particularly of the femoral neck, is not well seen on plain radiographs.

The third component of this approach is ensuring safe disposition planning for the injured older ED patient. This includes a careful consideration of whether a person is suitable for discharge—or requires admission to an inpatient trauma service. An older person who has a head injury, a humeral neck fracture, and a lung contusion does satisfy the criteria for polytrauma and may, even though stable, be best managed in a hospital. If injured patients are returning home, it is important to ensure that they are either at their functional baseline or have adequate supports in place to ensure safe function. This includes adequate analgesia, enquiring about social supports at home, and identifying and facilitating any assistive devices that may be necessary.

EPs also have a role to play in the prevention of future falls—which may be more injurious than the sentinel event. Especially if medications are believed to be causative, an EP should feel empowered to suggest changes that may prevent recurrent falls. Examples are as follows: (1) for a person who is clearly having postural orthostasis, recommending a reduction in diuretic or β-blockade medication will likely cause more benefit than harm; (2) in someone with morning unsteadiness, suggesting reducing or discontinuing night benzodiazepines is an evidence-based strategy for harm reduction; and (3) when adding a new medication (eg, an opioid for acute

pain), ensuring understanding of its potential for falls. Even if an EP feels inadequately qualified or informed to make such recommendations, it may be helpful to make a referral to a falls prevention clinic—as an EP would refer to a cardiologist for worsening heart failure or a nephrologist for changes in renal function.

## END-OF-LIFE ISSUES

EDs treat an increasing number of older adults with serious, advanced illness near the end of life. In the United States, 75% of older adults visit an ED in the last 6 months of life and 50% in the last month. Repeated ED visits in the last months of life are common.[27] ED management of patients with serious or incurable illness includes concurrent curative and symptomatic interventions. A common example may be an older adult with advanced dementia who is transferred from long-term care with recurrent pneumonia causing dyspnea, hypoxia, and delirium. Acute management includes treating the infection with early fluids and antibiotics while addressing the dyspnea and delirium. As this clinical scenario becomes more common, facility with trajectories of illness, rapid goals of care discussions, symptom management, and working with hospice patients have become core competencies for ED providers.

Identifying a patient's illness trajectory informs acute and subsequent care by placing the acute presentation in the context of the chronic illness. Older adults with a terminal illness trajectory often have rapidly progressive malignancy, brain or pancreatic, not amenable to curative intervention. The frailty trajectory describes patients with dementia and a more gradual, largely unalterable loss of function. The organ failure trajectory describes the course of end-stage heart, kidney, or lung failure with increasingly frequent exacerbations without return to previous health or functional status.

Patients without curative options come to the ED seeking care for distressing symptoms not adequately controlled in their current environment and/or with accelerated functional decline. Identifying ED patients with unmet palliative care needs guides emergent treatment and informs acute and ongoing goals of care discussions. Recommended criteria for ED palliative care assessment in patients with potentially life-limiting conditions include

- Multiple recent ED visits or hospitalizations for the same condition
- Difficulty controlling physical or psychological symptoms
- Significant and/or rapidly progressive functional dependence
- Complex care requirements, such as outpatient intravenous therapy or ventilator
- A negative response to the "surprise question": "Would you be surprised if this patient died within 1 year?"
- Very serious or end-stage diseases, such as advanced dementia, home oxygen, and out-of-hospital arrest[28]

ED goals-of-care discussions are challenged by symptom severity, time pressure, and limited historical and prognostic information. Because ED-based palliative care consultations are rarely available, ED providers may best serve patients near the end of life by developing the primary palliative skills of communicating prognosis, eliciting values, reconciling goals to the acute situation, and making recommendations. These discussions are valuable for the patient and family, because clear communication is identified as both uncommon and important at end-of-life.[27] In patients with severe acute symptoms and life-limiting illness, the ED discussion informs acute management, sets the trajectory for subsequent care, and facilitates subsequent discussion by introducing the patient and family to palliative approaches.

Older adults in the United States with Medicare Part A may choose the hospice benefit if they are expected to live 6 months or less, agree to forgo curative treatment of the hospice diagnosis, and sign a statement choosing hospice care over other Medicare-covered treatments for the terminal illness and related conditions. It is not necessary to choose a do-not-resuscitate directive to qualify for hospice. Hospice patients frequently seek emergency treatment due to inadequate symptom control, the inability to receive appropriate care in the current environment, a new condition not related to the hospice diagnosis (such as trauma), or a change in goals of care. An ED visit does not necessarily signal that a patient wishes to rescind the hospice benefit.

ED providers should develop an action plan when treating this unique population. This includes quickly contacting hospice personnel, because they understand a patient's ongoing care and can help guide emergency management. It is also imperative to rapidly determine the reason for the emergency visit in the context of the patient's ongoing illness as well as the patient's and family's goals for the ED visit. Initial evaluation should determine if a patient wishes to remain in hospice or pursue curative treatment. For patients remaining in hospice, decisions regarding diagnostic testing and transition to an inpatient setting or alternate outpatient setting are made through shared decision making with the patient, hospice personnel, outpatient providers, caregivers, and, if necessary, surrogate decision makers.

## SUMMARY

Older patients in the ED can be considered to represent a distinct population, one for whom the usual body-part and body-system approaches of emergency medicine do not produce a fulsome assessment. The usual 1 patient/1 problem approach frequently fails the clinician when faced with patients with several different active problems at the same time, including psychosocial and cognitive and functional problems, which have an impact on assessment and disposition. This article suggests a different approach, which acknowledges the principal domains of geriatric emergency medicine[29,30]—cognitive impairment, atypical presentations of disease, functional assessment, medication management, trauma and falls, and end-of-life care. Having a standardized, organized way to think about those commonalities—an approach—will have a significant impact on both the quality of care a patient receives and efficiency of the EP's and department's work flow.

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