EMERGENCY DEPARTMENT GериАТРИЧЕСКИЕ УСЛУГИ

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St Joseph’s Healthcare System
St Joseph’s Regional Medical Center
Paterson, NJ

Chairman, Geriatric Emergency Medicine Section
American College Emergency Physicians

Spring 2011
Disclosures

- Nothing to Disclose
Lecture Design

- Experience at St Joseph’s Regional Medical Center
- Discussions with Dozens of Hospitals
- Not a Lecture on Geriatric EM
- My Hope .... This is a How To.... Guide
- End of Life Case Presentations
St Joseph’s Regional Medical Center

- 641 Bed Tertiary Care Teaching Hospital
- Paterson NJ
- Emergency Department
  - 130,000 Total Visit/Year
    - 41,000 Pediatric Emergency Department
    - 38,000 Geriatric Emergency Department (April 2009)
    - 200 Emergency Department Palliative Medicine (Jan 2010)
- Comprehensive Stroke Center
- Trauma Center
- Resuscitation Center
- Heart Failure Center
- Toxicology Reference Center
Geriatric Emergency Department Development

- **Why?**
- **People**
  - Coordinator
  - Nurses
  - Physicians
- **Clinical Quality and Practice**
  - Education
  - Triage
  - Patient Management and Safety
  - Patient Follow up
- **Facilities**
- **Community and EMS Outreach**
- **Disease Management**
  - Frailty
  - Organ Failure
  - Terminal Illness
WHY?
Why?

- 79 Million Baby Boomers become 65
- Age 65 and over have increased healthcare needs
- ED Utilization of Seniors
- Contributing Factors
- Outcomes
- Paradigm Shift
Geriatric Utilization Rates

- 15-20% of all Patients
- 7 x More Usage of ED Services
- 43% of all Admissions
- 48% of all Critical Care Admissions
- 20% Longer Length of Stay
- 50% more Lab
- 50% more Radiology
- 400% more Social Service Interventions
Contributing Factors

1. Shrinking Primary Care Pool
   - Deficit of 25,000 Gerontologists by 2030
     - FP Residents Decreased by 50%
     - IM Residents Into Primary Care Dropped from 54% to 22%

2. Lack of Financial Incentives
   - Medicare Is Primary Insurance of the Elderly
   - Medicare Pays 25-31% less than private insurers

3. Complexity of Care
   - Multiple Chronic Diseases compounded by Social Issues
   - Outpatient Management Issues
     - Cognition
     - Mobility
     - Transportation
     - Subspecialist Availability Difficult

4. ED Most Appropriate Venue
   - One Stop Shopping
     - Labs; X-ray; Specialist
     - Not More Expensive
Current Model: Poorer Outcomes for Seniors

1. Delay in Dx and Tx
   - Acute MI
   - Sepsis
   - Appendicitis
   - Ischemic Bowel

2. Unsuspecting Dx
   - Delirium
   - Depression
   - Cognitive Impairment
   - Drug and Alcohol
   - Elder Abuse
   - Polypharmacy

3. Under treatment
   - Low Rate of PCI in MI
   - TPA in Stroke
   - Less Surgical Intervention
   - Inadequate Pain Management

4. Overtreatment
   - High Rate of Foley Cath
   - Adverse Drug Events
   - Overuse of Sedation
Two Paradigms

ED

- Single complaint
- Acute
- Diagnose and treat
- Rapid disposition

Geriatrics

- Multiple problems
  - Medical
  - Functional
  - Social
- Acute on chronic, subacute
- Control symptoms, Maximize function, Enhance quality of life
- Continuity of care
Call for Action: A New Model of ED Care

- Organized Emergency Medicine Has Responded Before and Will Respond Again
  - Pediatrics ED’s
  - Trauma Care
  - Chest Pain Centers

- The Time is Now:
  “The Geriatric Emergency Department”
PEOPLE
People

- Program Coordinator
- Nurses
- Physicians
- Support Staff
Program Coordinator

- Nurse, Physician vs. Administrative Type
- Responsible for Program Operations
- Possible
  - Separate Position
  - Nurse Manager
  - Administrative Director
  - ED Medical Director
Nurses

- Must Have Geriatric Skill Set
- Several Options
  - Geriatric Nurses
  - ED Nurses with Geriatric Education
  - Geriatric Nurse Practitioner
Physicians

- Must Have Geriatric Skill Set
- Several Options
  - ED Boarded with Geriatric Education
    - Geriatric Nurse Practitioner
  - ED with Geriatric Fellowship
  - ED with Internal Medicine
  - ED with Family Practice
Support Staff

- Social Workers
- Case Managers
- Pharmacists
- Administrative Support Staff
- PT and OT
- Home Care
- Toxicologist
CLINICAL QUALITY AND PRACTICE
Clinical Quality and Practice

- Define Your Goal
- Education
- Triage
- Practice Environment
- Patient Safety
- Follow-up
Define The Goal

- Define Your Population
- Better Emergency Care For Seniors
- Maintain Independence
- Decrease or Increase Admissions
- Marketing Strategy
Education – 10 Major Areas

1. **Physiological Changes of Aging**
   - Decrease Functional Reserve

2. **Abdominal Pain**
   - Always Bad

3. **Falls**
   - A Fractured Wrist is not a Fractured Wrist

4. **Infectious Disease**

5. **The Dizzy Patient**

6. **Poly-pharmacy**

7. **Chest Pain**
   - Cardiac USUALLY presents without Chest Pain

8. **Delirium vs. Dementia**

9. **General Assessment**

10. **End of Life Issues**
Triage

- Be Aware of Vague Complaints
- Normal Vitals
  - Normal BP in a Hypertensive
- “I Just Don’t Feel Well”
- Presentation of Ischemic Heart Disease
- Abdominal Pain

Strategies
- ESI Triage Levels Increase
- Prepare for the Worst......
Practice Management

- The Environment
  - Beds
    - Thick Mattresses
    - Hospital Beds
  - Non Shiny/Non Slip Floors
  - Lighting
  - Hand Rails
  - Location
  - Blankets
  - Room For Family and Visitors
Practice Management

- Safety
  - Drug Interactions
    - 5 Meds = 70% chance of Drug Interactions
    - 7 Meds = 100% chance of Drug Interaction
  - Beers Criteria
    - Archives of Internal Medicine December 2003
    - Potentially Inappropriate Medication Use in Older Adults
  - Falls Assessment
    - Get up and Go Testing
  - Home Assessment
### Beers Criteria:

<table>
<thead>
<tr>
<th>Drug</th>
<th>Concern</th>
<th>Severity Rating</th>
</tr>
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<tbody>
<tr>
<td>Propafenone (Cavat) and combination products</td>
<td>Offers few advantages over standard agents but has the adverse effects of other class III agents. It is not available as an over-the-counter product. It is used in the treatment of atrial fibrillation and flutter.</td>
<td>High</td>
</tr>
<tr>
<td>Penicillin (sulfadiazine)</td>
<td>Aminoglycosides carry a higher risk of ototoxicity, nephrotoxicity, and hypomagnesemia. They are also less effective than vancomycin and other newer antibiotics.</td>
<td>High</td>
</tr>
<tr>
<td>Trimethoprim-sulfamethoxazole (TSU)</td>
<td>UTI is the most common adverse effect. It is also associated with skin rashes, gastrointestinal symptoms, and rarely, seizures.</td>
<td>High</td>
</tr>
<tr>
<td>Muscle relaxants and antipsychotics (neuroleptics)</td>
<td>Most muscle relaxants and antipsychotics are typically used for moderate to severe psychiatric disorders and are generally considered safe and effective.</td>
<td>High</td>
</tr>
<tr>
<td>Antihypertensive (Beta-blockers)</td>
<td>This benzodiazepine hypnotic has an extremely long half-life in elderly patients, often leading to prolonged sedation and increasing the incidence of falls and fractures. Medium- or short-acting benzodiazepines are preferred.</td>
<td>High</td>
</tr>
<tr>
<td>Oxaprozin (Naproxen)</td>
<td>This is a highly effective and widely used NSAID. These drugs are preferred for prolonged use as they may become addictive and may need to be withdrawn slowly.</td>
<td>High</td>
</tr>
<tr>
<td>Diazepam (Valium)</td>
<td>Because of increased antiemetic activity, these drugs are preferred for delayed gastric emptying. They are also less effective as antiemetics.</td>
<td>High</td>
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<td>Mesoridazine (Equithene)</td>
<td>These drugs have a long half-life in elderly patients, often leading to prolonged sedation and increasing the risk of falls and fractures. These drugs are less effective as antiemetics.</td>
<td>High</td>
</tr>
<tr>
<td>Digoxin (Lanoxin)</td>
<td>This is a highly effective and widely used diuretic. It is preferred for delayed gastric emptying. This drug may become addictive and may need to be withdrawn slowly.</td>
<td>High</td>
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<td>Digoxin (Lanoxin)</td>
<td>These drugs carry a higher risk of adverse effects. They are also less effective as antiemetics.</td>
<td>High</td>
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<td>Diltiazem (Cardizem)</td>
<td>This is a highly effective and widely used diuretic. It is preferred for delayed gastric emptying. This drug may become addictive and may need to be withdrawn slowly.</td>
<td>High</td>
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<tr>
<td>Lisinopril (Prinivil)</td>
<td>These drugs carry a higher risk of adverse effects. They are also less effective as antiemetics.</td>
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<td>Metoclopramide (Reglan)</td>
<td>These drugs carry a higher risk of adverse effects. They are also less effective as antiemetics.</td>
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<td>Propranolol (Inderal)</td>
<td>These drugs carry a higher risk of adverse effects. They are also less effective as antiemetics.</td>
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This table lists commonly prescribed medications that are not recommended for older adults due to their potential for adverse effects or lack of evidence for efficacy.
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<th>Alternative Treatment</th>
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<td><strong>Analgesics</strong></td>
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<tr>
<td>Ketorolac (Toradol) (B); long-term use (C)</td>
<td>GI bleeding&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Mild pain: APAP, short-acting NSAID (e.g., ibuprofen)</td>
</tr>
<tr>
<td>Meperidine&lt;sup&gt;4&lt;/sup&gt; (Demerol) (B); long-term use (C)</td>
<td>Not effective at commonly used oral doses; confusion, falls, factures, dependency, withdrawal&lt;sup&gt;1,5&lt;/sup&gt;</td>
<td>Moderate or severe pain: morphine, hydrocodone/APAP (Vicodin, etc), oxycodone (OxyContin, etc), oxycodone/APAP (Percocet, etc), fentanyl patch (Duregesic)&lt;sup&gt;10&lt;/sup&gt;</td>
</tr>
<tr>
<td>Pentazocine (Talwin) (B); long-term use (C)</td>
<td>More CNS effects (e.g., confusion, hallucinations) than other opioids; ceiling to analgesic effect&lt;sup&gt;5&lt;/sup&gt;</td>
<td>Topicals (neuropathic pain, arthritis): lidocaine (Lidoderm), capsaicin (Zostrix, etc)</td>
</tr>
<tr>
<td>Propoxyphene (e.g., Darvon, etc) (B)</td>
<td>No better than acetaminophen, but has narcotic AE&lt;sup&gt;3&lt;/sup&gt;</td>
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<tr>
<td><strong>Antidepressants</strong></td>
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<tr>
<td>Amitriptyline (Elavil) (B, C), doxepin (Sinequan, etc) (B), imipramine (Tofranil) (C)</td>
<td>Anticholinergic AE, sedation, urinary retention or incontinence, constipation, arrhythmias, falls&lt;sup&gt;5,15&lt;/sup&gt;</td>
<td>Tricyclic without active metabolites (Nortriptyline [Pamelor], desipramine [Norpramin])&lt;sup&gt;15&lt;/sup&gt;</td>
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<td>SSRI&lt;sup&gt;15&lt;/sup&gt;</td>
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<td>Bupropion (Wellbutrin) (for cardiac patient)&lt;sup&gt;19&lt;/sup&gt;</td>
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<tr>
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<td></td>
<td>Mirtazapine (Remeron) (for insomnia or anorexia)&lt;sup&gt;19&lt;/sup&gt;</td>
</tr>
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<td>Neuropathic pain: topicals (lidocaine [Lidoderm], capsaicin [Zostrix, etc])</td>
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</tr>
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<td>Bupropion (Wellbutrin), seizure disorder (B)</td>
<td>May cause seizure&lt;sup&gt;3&lt;/sup&gt;</td>
<td>SSRI with shorter half-life (e.g., escitalopram [Lexapro], sertraline [Zoloft])</td>
</tr>
<tr>
<td>Fluoxetine (Prozac) used daily (B)</td>
<td>Long half-life; agitation, insomnia, anorexia&lt;sup&gt;3&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>Tricyclic for depression in patient with postural hypotension, BPH, glaucoma, heart block (C)</td>
<td>Fall risk; urinary retention; worsening glaucoma, heart block&lt;sup&gt;15&lt;/sup&gt;</td>
<td>SSRI, with blood pressure monitoring&lt;sup&gt;15&lt;/sup&gt;</td>
</tr>
</tbody>
</table>
Get Up And Go Test...

Instructions:
Ask the patient to perform the following series of maneuvers:
1. Sit comfortably in a straight-backed chair.
2. Stand from the chair.
3. Walk a short distance (approximately 3 meters).
4. Turn around.
5. Walk back to the chair.
6. Sit in the chair.

Scoring:
Observe the patient's movements for any deviation from a confident, normal performance. Use the following scale:

Score 1 = Normal
Score 2 = Very slightly abnormal
Score 3 = Mildly abnormal
Score 4 = Moderately abnormal
Score 5 = Severely abnormal

Note: "Normal" indicates that the patient gave no evidence of being at risk of falling during the test or at any other time. "Severely abnormal" indicates that the patient appeared at risk of falling during the test. Intermediate grades reflect the presence of any of the following as indicators of the possibility of falling: undue slowness, dizziness, unsteadiness, tendency to sway, staggering, stumbling.
Follow up

- Role of Patient Call Backs
  - Five Concerns
    - Status
    - Meds
    - PMD
    - ADL
    - Support

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Two Step Emergency Department

- 40% of Geriatric ED Patients Have Functional Decline Within 30 Days of ED Discharge.
- The Two Step ED Process Prevents Functional Decline
- Screening Tool Identifies Patients at Risk
- Patients at Risk Have Full Complement of Hospital and Community Resources
Triage

EMS

Walk in

Triage

Registration

Age >65
ESI = 1 or 2

Stabilized Adult ED

Age >65
ESI = 3,4 or 5

Geriatric Emergency Dept

Age 55-65 and ED staff concerned
Two Step - Home Follow-up

- Called by Geriatric Team Within 24 Hours of ED Discharge
- Further Screening Tools Used
- Further Needs Identified
- Pharmacologist and Toxicologist Review
- Hospital and Community Resources Coordinated
- Primary Care Doctor Notified
Facility Options: Is it ..... 

- Process
- Separate Unit
- Functional
- Universal Design
Universal Design in the ED

- Staff
- Mattresses
- Lighting
- Floors
- Hand Rails
- Blankets
- Follow up Processes
Take Home Message

If you don’t have space for a Geriatric ED…. Make you entire ED a Geriatric ED.

If the ED is Designed for the Most Frail and Vulnerable ..... It will work for the Strongest.
Community and EMS Outreach

- Marketing
- Education
  - Nursing Homes
  - Assisted Living
  - SNF
  - LTAC
- Community Outreach
  - EMS
- DNR and Advance Directives
- Disaster Kits
  - “The Disaster Shoulder Bag” ©
    - Meds
    - DNR
    - Health History
Palliative Care in the ED or the Revolving Door
Elderly Disease Management: The ED Revolving Door

- Frailty
- Organ Failure
- Terminal Illness
Assessment of Illness Trajectory and Decline

![Proposed Trajectories of Dying](image)

**Figure 1.** Trajectories of dying. Reproduced with permission of Blackwell Publishing (Lunney JR, Lynne J, Hogan C. Profiles of older Medicare decedents. *JAGS.* 2002;50:1108-1112).
Trajectories of End-of-Life Care in the Emergency Department

Cara Bailey, PhD, RGN, Roger Murphy, PhD, BSc, Davina Porock, PhD, RGN

From the School of Nursing, Queens Medical Centre (Bailey, Porock), and the School of Education, Jubilee Campus (Murphy), The University of Nottingham, Nottingham, UK.

Dr. Bailey is currently affiliated with Nursing and Physiotherapy, Health and Population Sciences, University of Birmingham, Birmingham, UK.

Study objective: The emergency department (ED) is the gateway to the hospital setting. Despite the intentions from the end-of-life care strategy in the UK to improve care provision, the ED has increasingly become the access site for end-of-life support. Little attention has been given to this aspect of the work of the ED, even as the quality of end-of-life care in hospitals has become the subject of increasing concerns. We explore end-of-life care in the ED and provide an understanding of how care is delivered to the dying, deceased and bereaved in the emergency setting.

Methods: Observation was carried out in a large urban ED during 12 months. This was complemented by detailed interviews with emergency staff, patients diagnosed with a terminal condition, who had visited the ED in the previous 6 months, and their relatives. Data were analyzed thematically, following the normal conventions of ethnographic research.

Results: Two distinct trajectories of end-of-life care were identified in the ED: the spectacular and the subtacular. Patients and family members experiencing end-of-life care in the ED have distinctly different care because of the nature of these 2 trajectories, frequently resulting in dissatisfaction for staff and distress and frustration for patients and their relatives.

Conclusion: The ED is priority driven, focused on resuscitation and the prolongation of life. As a result of the consuming nature of the spectacular death, a reluctance to build relationships with the dying, and a lack of educational support, the care needs of patients in the subtacular trajectory are somewhat neglected. These trajectories can be used to identify the shortfalls in end-of-life care in the ED and raise serious concerns for policy in regard to staffing, resources, and professional development. [Ann Emerg Med. 2011;57:362–369.]

Please see page 363 for the Editor’s Capsule Summary of this article.
Hospice Care and the Emergency Department: Rules, Regulations, and Referrals

Sangeeta Lamba, MD, Tammie E. Quest, MD

From the Department of Emergency Medicine, University of Medicine and Dentistry of New Jersey, New Jersey Medical School, Newark, NJ (Lamba); and the Department of Emergency Medicine, Emory University School of Medicine, Atlanta, GA (Quest).

Emergency clinicians often care for patients with terminal illness who are receiving hospice care and many more patients who may be in need of such care. Hospice care has been shown to successfully address the multidimensional aspects of the end-of-life concerns of terminally ill patients: dying with dignity, dying without pain, reducing the burden on family and caregivers, and achieving a home death, when desired. Traditional emergency medicine training may fail to address hospice as a system of care. When they are unfamiliar with the hospice model, emergency clinicians, patients, and caregivers may find it difficult to properly use and interact with these care services. Potential poor outcomes include the propagation of misleading or inaccurate information about the hospice system and the failure to guide appropriate patient referrals. This article reviews the hospice care service model and benefits offered, who may qualify for hospice care, common emergency presentations in patients under hospice care, and a stepwise approach to initiating a hospice care referral in the emergency department. [Ann Emerg Med. 2011;57:282-290.]
Early Palliative Care Prolongs Quality Life and Mood

ABSTRACT

BACKGROUND
Patients with metastatic non–small-cell lung cancer have a substantial symptom burden and may receive aggressive care at the end of life. We examined the effect of introducing palliative care early after diagnosis on patient-reported outcomes and end-of-life care among ambulatory patients with newly diagnosed disease.

METHODS
We randomly assigned patients with newly diagnosed metastatic non–small-cell lung cancer to receive either early palliative care integrated with standard oncologic care or standard oncologic care alone. Quality of life and mood were assessed at baseline and at 12 weeks with the use of the Functional Assessment of Cancer Therapy–Lung (FACT-L) scale and the Hospital Anxiety and Depression Scale, respectively. The primary outcome was the change in the quality of life at 12 weeks. Data on end-of-life care were collected from electronic medical records.

RESULTS
Of the 151 patients who underwent randomization, 27 died by 12 weeks and 107 (86% of the remaining patients) completed assessments. Patients assigned to early palliative care had a better quality of life than did patients assigned to standard care (mean score on the FACT-L scale [in which scores range from 0 to 136, with higher scores indicating better quality of life], 98.0 vs. 91.5; P = 0.03). In addition, fewer patients in the palliative care group than in the standard care group had depressive symptoms (10% vs. 38%, P = 0.01). Despite the fact that fewer patients in the early palliative care group than in the standard care group received aggressive end-of-life care (33% vs. 54%, P = 0.05), median survival was longer among patients receiving early palliative care (11.6 months vs. 8.9 months, P = 0.02).

CONCLUSIONS
Among patients with metastatic non–small-cell lung cancer, early palliative care led to significant improvements in both quality of life and mood. As compared with patients receiving standard care, patients receiving early palliative care had less aggressive care at the end of life but longer survival. (Funded by an American Society of Clinical Oncology Career Development Award and philanthropic gifts; ClinicalTrials.gov number, NCT01038271.)
Palliative Care

WHO definition....

“The active total care of patients whose disease is not responsive to curative treatment” (1990).

Goals...

“To prevent and relieve suffering and to support the best possible quality of life for patients (all ages) and their families, regardless of the stage of the disease or the need for other therapies” (WHO, 1990).
THE BEGINNING OF PALLIATIVE CARE IS NOT THE END OF CONVENTIONAL MEDICAL CARE.
Hospice

- Branch of palliative care
- Less than 6 months to live
- Accepting death as a part of life
- No longer want to prolong nor hasten
Hospice and Palliative Care

World Health Organization, Cancer Pain & Palliative Care, 1990
A NEW MODEL OF PALLIATIVE CARE FOR ELDERS

Dichotomous model

Curative/disease-modifying treatment

Hospice/Palliative Care

Diagnosis

Death

Continuum-of-care model

Pain relief and palliative care

Diagnosis

Death

Family Bereavement

World Health Organization, Cancer Pain & Palliative Care, 1990
WHO(1994): Which Older Adults Need Palliative Care?

Important:
- Disease
- Diagnosis
- Co-morbidities
- Prognosis
- Trajectory

Cancer
Heart Failure
Dementia
Results

- Improved Care
- Less Functional Decline
- Decreased Return Visits
- Increased New Visits
- Improved Patient Satisfaction
- Improved Staff Satisfaction
- Prevents The Revolving Door
Putting it all Together

- Why?
- People
  - Coordinator
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Thank you

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