

Elderly Populations in Disasters: Hospital Guidelines for Geriatric Preparedness

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Introduction

- **September 11, 2001**
 - Homebound patients were affected, unable to receive services
- **2003 Blackout in NYC**
 - Most hospital admissions were elderly
- **2005 Hurricane Katrina**
 - 74% of deaths were in individuals over age 60 years and 50% of in those over age 75 years



Why Concentrate on Geriatrics?

- Loss of physiologic reserve in a disaster
- Social factors affecting this population – lowest average income of all age groups, language barriers
- Existing health care shortages/national shortages of geriatricians – greatest impact on elderly
 - Elderly have highest number of patients coming to hospitals via ambulance
 - Elderly have highest hospitalization rate
 - Elderly use a disproportionate share of hospital resources for virtually all medical illnesses

Lessons Learned from Recent Disasters

- Difficulty locating and tracking seniors
- Tendency for frail elderly to become more vulnerable in chaotic situations (heightened confusion and agitation)
- Limited number of geriatric specialists to care for frail elderly patients

Lessons Learned from Recent Disasters (Cont'd)

- Need to foster communication between community-based and citywide agencies with geriatric expertise
- Need to address post-disaster, long-term needs – housing, basic services, access to entitlement programs

Difficulty Locating and Tracking Seniors



Astrodome, Houston, TX September 2006

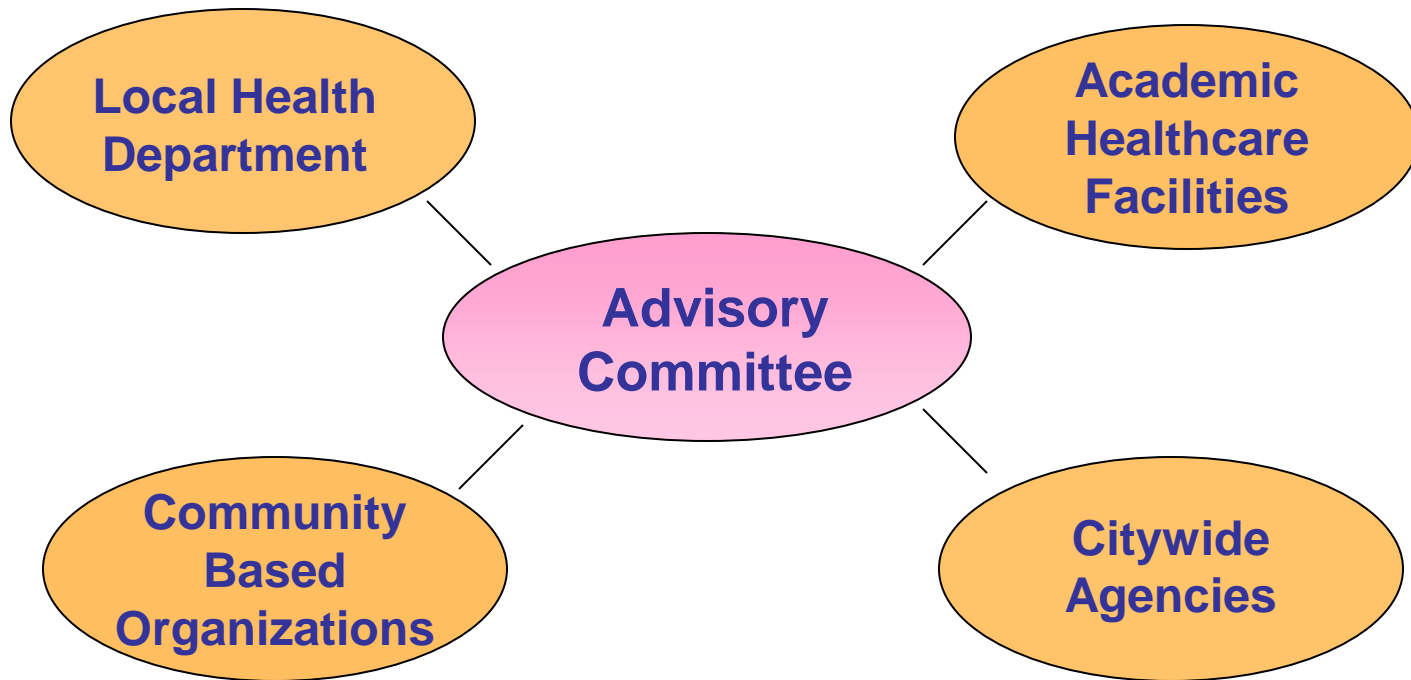
What is the Geriatric Toolkit?

Planning guide for use by hospitals, their clinical providers and emergency managers in preparing for the care of geriatric patients during an emergency

Purpose

- To determine key planning issues surrounding the care of geriatric patients during emergencies
- To fill gaps pertaining to the care of geriatric patients in emergency plans
- To identify special needs of individuals during disasters, especially those of frail elderly

Creation of the Geriatrics Disaster Preparedness Advisory Committee



Composition of the Geriatrics Disaster Preparedness Advisory Committee

- Geriatric Medicine
- Emergency Medicine
- Emergency Management
- Pharmacy
- Nursing
- Administration
- Palliative and Hospice Care
- Ambulatory Care
- Social Work
- Long-Term Care
- Medical Ethics & Law
- Mental Health

Development of the Toolkit

- Literature review
- Interviews
- Reviewed initiatives at community organizations and alliances
- Day-long review of toolkit with medical, public health and community colleagues

Overview of Toolkit

- Executive Summary
- Triage and Ongoing Risk Assessment
- Soft Care Area
- Clinical Care of Acutely Ill Elderly Individuals
- Medications: Prescribing and Dispensing
- Mental Health Issues
- Ethical and Legal Issues
- Palliative Care

Chapter Format

- Purpose
- Background
- Planning Guidelines
- Tools
- References

Section 1: Triage and Ongoing Risk Assessment

- Identify facility staff with geriatric expertise and include them on the facility's Emergency Preparedness Committee
- Provide basic geriatric assessment training to emergency department staff and other triage personnel as a component of disaster preparedness education
 - Medical, functional and mental status
- Determine how to operationalize relevant guidelines that have been developed for use in disasters (NY State Task Force on Life and the Law Draft Guidelines for ventilator access; methods of credentialing and deploying unaffiliated clinical providers)

Seniors Without Families Triage (SWiFT) Tool*

Swift Level	Explanation	Post-Disaster Actions
1	Cannot perform at least one basic ADL (activities of daily living: eating, bathing, dressing, toileting, walking, continence) without assistance	Immediate transfer to a location that can provide skilled or personal care (i.e., assisted living facility, nursing home)
2	Trouble with instrumental activities of daily living (finances, benefits management, assessing resources)	Connect with a local aging services case manager
3	Minimal assistance with ADL and instrumental activities of daily living	Needs to be connected with a rescue organization service (i.e., Red Cross)

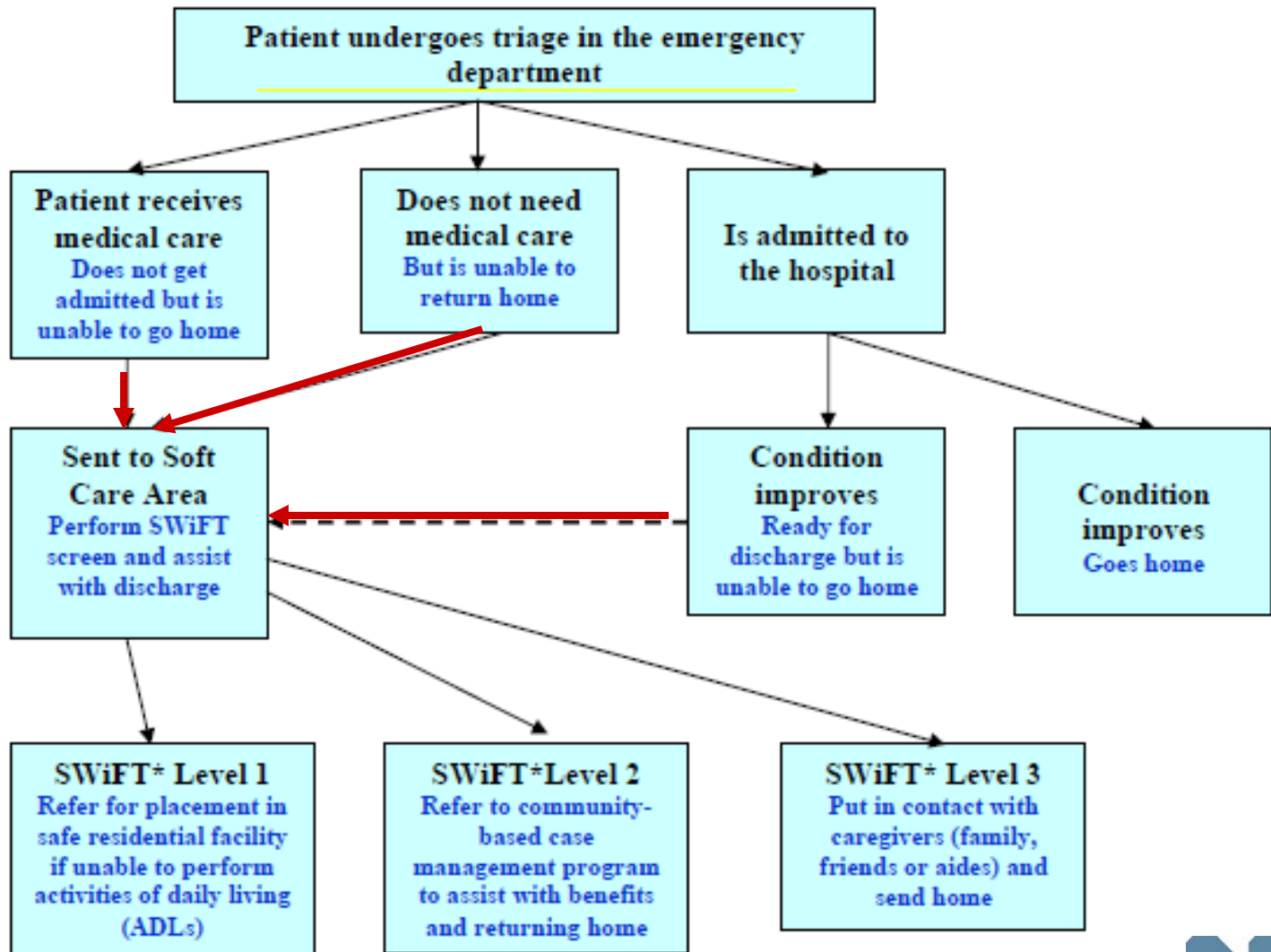
Section 2: Soft Care Area

- Provide a Soft Care Area - a **secure place in the hospital with clinical staff to treat medically stable, but frail elderly** and other vulnerable adults who cannot safely be discharged
- Identify institutional expertise in community-based social services and discharge planning
- Link to community-based senior service organizations to establish relationships and to coordinate disaster plans

Section 2: Soft Care Area (cont'd)

- Link Soft Care Area to Family Information and Support Center
 - Develop methods for identifying and tracking frail elderly individuals
 - Provide assistance for adults seeking missing adults
- Stock a minimum 4-day supply of commonly used outpatient medications

Psychosocial Triage in the Soft Care Area



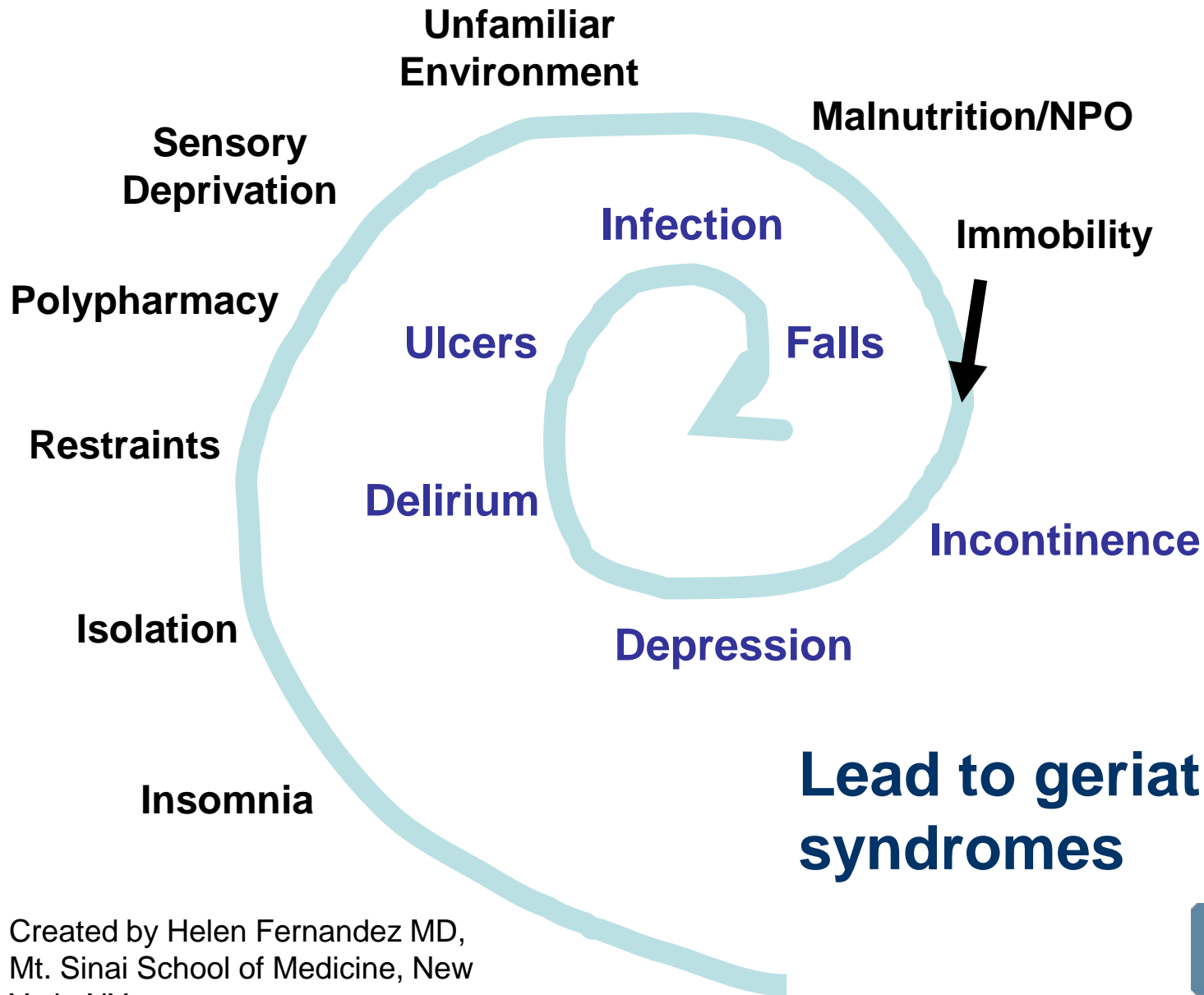
Section 3: Clinical Care of Acutely Ill, Elderly Patients

- Identify staff with geriatric expertise at the facility to provide staff education and to oversee geriatric care delivery during a disaster
- Determine the location and nature of geriatric care in the institution
 - Geriatric care area (**acute care for the elderly [ACE] unit**)
 - Multi-disciplinary care
 - Geriatric consultation service

Section 3: Clinical Care of Acutely Ill, Elderly Patients (Cont'd)

- Provide staff with tools and training in basic geriatric skills
 - Assessing activities of daily living and risk factors for falls
 - Determining causes of agitation
 - Diagnosing delirium
 - Recognizing altered presentations of disease
 - Understanding feeding techniques and nutritional requirements

Hazards of Hospitalizations



Created by Helen Fernandez MD,
Mt. Sinai School of Medicine, New
York, NY

Ten Commandments of Care for Hospitalized Elderly*

1. Get the patient moving
2. Simplify the drug regimen
3. Remove IV lines and catheters ASAP
4. Avoid restraints whenever possible
5. Assess and monitor mental status

Ten Commandments of Care for Hospitalized Elderly (Cont'd)

6. Delirium is a medical emergency
7. Do not over sedate
8. Watch for depression
9. Pay attention to nutritional status
10. Involve patient and family in decision-making and advanced directives

Section 4: Medications – Prescribing and Dispensing

- Create an inventory of essential **inpatient and outpatient** medications that serve the special needs of elderly patients – be sure to stock minimal-dosage tablets or special formulations of commonly used medications
- Ensure adherence to principles of geriatric prescribing and administration of medications



Section 5: Mental Health Issues

- Identify individuals with expertise in geriatric mental health and geriatric medicine to participate in disaster preparedness activities and to provide oversight for clinical care during a disaster
- Credential such professionals to volunteer in professional roles during a disaster
- Train and prepare staff to provide psychological first aid to patients arriving at the hospital

Section 6: Ethical and Legal Issues

- Informal age discrimination may occur in the clinical setting – ensure that emergency preparedness committee members recognize that chronological age is a poor indicator of biological wellness
- Provide training to staff on state laws governing life-sustaining treatment
 - **Health Care Proxy**: a designated agent who can make decisions with the physician if patient is unable to participate in decision making (New York State Law)
 - **Living Will or Medical Directive**: a written declaration that provides the patient's health care wishes

Section 6: Ethical and Legal Issues (Cont'd)

- Provide training on how to determine a patient's decisional capacity
- As many diseases present atypically in the elderly, it is especially important to base treatment/resource allocations decisions on sound diagnoses
- Consider use of non-clinical volunteers to ensure patients get adequate non-medical care (e.g. assistance with feeding/toileting)

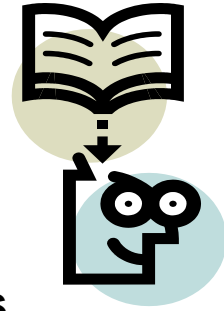
Section 7: Palliative Care

- Palliative care:
 - Involves **active management** to relieve physical and psychological suffering and is not intended to hasten death
 - Is an adjunct, but not an alternative, to conventional medical care
 - Is an intrinsic part of medical care, regardless of the patient's prognosis
 - Is care that is patient and family centered
- Identify institutional palliative care expertise and include on the Emergency Preparedness Committee
 - For facilities with little or no palliative care expertise, identify outside consultants during the planning process
 - Train staff on when and how to use the palliative care services

Section 7: Palliative Care (Cont'd)

- Train staff on basic palliative care skills and principles
- Ensure there are adequate supplies of medications and access to injectable morphine
- Work with city agencies to identify alternative care sites for patients in need of palliative care
- Encourage primary care providers to pre-identify individuals with terminal or life-threatening illness who do not wish to be hospitalized

What Are Your Next Steps?



- **Get to know the staff that care for the frail elderly (social workers, nurses, doctors). Invite them to join your disaster committee**
- **Consider planning for soft care area for frail elderly and vulnerable adults**
- **During an emergency remember the “hazards of hospitalization” and the corresponding 10 commandments to abide by**
- **Advise clinicians to work with their pharmacists in dosing medications and monitoring for adverse effects. Raise awareness for all clinical staff including doctors, nurses, physician’s assistants, nurse’s aides, students**
- **Advance directives and healthcare proxies ideally should be gotten before an emergency**
- **Add a palliative care specialist and/or hospice nurse to your disaster committee**

What Works in the Geriatric Toolkit

- Planning guidelines
- Geriatric assessment tools
- Preferred drugs and starting doses
- Thorough bibliography and well-cross referenced throughout document

How Can the Tool Assist Emergency Managers?



- Provides training materials
- Provides speaking points that can be used to engage other clinicians and administrators from various departments
- The clinical geriatric tools can be used to train medical volunteers
- A source of quick and reliable references
- Outlines potential problems and potential solutions

It is what it is.....

- Does not provide emergency-specific recommendations
- Not an operational manual
- Geared to hospitals and clinicians



Send Us Your Comments

- Geriatric Toolkit is open for comment
www.nyc.gov/health/bhpp
- Please send your comments to Dr. Bindy Crouch at bcrouch1@health.nyc.gov

Acknowledgements

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