



## **GEM Section Meeting ACEP20 Minutes October 27, 2020**

Section leadership participants: Lauren Southerland, MD, FACEP; Kevin Biese, MD, FACEP; Maura Kennedy, MD; Danya Khoujah, MBBS; Chris Carpenter MD, FACEP; Shan Liu MD, FACEP, Luna Ragsdale, MD, FACEP; Phillip Magidson, MD; Nicole Tidwell; 42 GEMS members

Two- hour meeting covered:

1. Introduction of board, new positions, GEMS advocate and education review
2. Presentation: View from Ground Zero: changes to SNFs during the pandemic
3. Panel discussion: Care of older adults during the pandemic: presentation of COVID in older patients, visitors in the ED, ED to palliative care/hospice transitions
4. Proposed changes to the bylaws, add resident and fellows; agreed upon changes
5. Updates on GED projects and opportunities for 2021 JGEM
6. Summary and conclusion

Meeting start time – 12:33pm CST

**Lauren:** Introduction of newest GEMS Section Board for 2020-2022:  
Lauren Southerland, MD, FACEP – Chair  
Luna Ragsdale, MD, FACEP – Secretary  
Maura Kennedy, MD – Chair-elect  
Shan Liu, MD, FACEP – Counsellor  
Phil Magidson, MD, MPH – Alternate Counsellor  
Nicole Tidwell – GEDA Program and GEMS Section Manager

Mentioned Kevin Biese as the exiting Chair, thanked him for being Chair for past two years for passionate work performed, certificate in mail from Team and Mark Rosenberg for leading

Mentioned great achievements in 2020; Tess's GEDC work and team launched geriatric journal club work on informative publications; GEDA group worked hard; GEMS and Palliative medicine for section grant was funded for developing online CU modules for paramedics for training in geriatrics and Palliative medicine for hospice patients/end of life and will pilot them and EMS institutions to make them accredited and available nationally; GEMS newsletters (Phil keeping Team up-to-date); thanks to Maura and Luna for putting together educational accomplishment; GEDA pre-conference for ACEP – thanks to Maura and Luna for leading and keeping on-task – 265 people attend

**Shan:** Mentioned 30% was Luna and Maura, and 70% was Nicole on GEDA pre-conference

**Lauren:** Mentioned Nicole's hard work on managing ACEP GEDA in all aspects; grateful for working with great Team; all of GEMS is welcome to call-in on monthly meetings for assistance and to present ideas, Team is there to support all

What did not go well was:

- Submitted a full geriatric track series for ACEP, amount of education that would qualify under the eight domains of geriatric EM training for CME hours, GEDA accreditation is very light at ACEP, 1) put in a proposal to make things searchable by geriatrics, and 2) list of topics and speakers – no to both; however, geriatric track was added to JUNO; will continue to push for more geriatric educational tracks at ACEP and encourages to check out abstracts and research forums

**Kevin:** Mentioned that geriatric executive reached out to group on work done at the conference, and with Mark coming on as President shows that times are changing and everyone is realizing the impact that holistic medicine is having on geriatrics; remarkable progress is being made; continued perseverance is the reason

**Maura:** 270 people showed up on a Sunday shows interest; good when EM colleagues come to you and ask what to do with older adults

**Michael:** (Presentation) “View from Ground Zero: changes to SNFs during the pandemic”  
As a geriatrician for close to 35-years, comprehension is meaningful it is to hear you all talk and the work that is being done, and at any time you want me to participate I am there; this is outstanding

Talk about how SNIPS evolved during the COVID pandemic and things that is being done; will be telling his story via Twitter and please follow him on Twitter via @wassdoc; Twitter has proven to be a powerful connector amongst those within the field and follows those in geriatrics and aging and Twitter has provided a wonderful avenue for this; one colleague on NBC news tonight who met on Twitter at the beginning of COVID

Disclosures: on philanthropic boards, one is on positive aging; another ageism; and, SONOLA – stethoscopes to hear sounds outside of the human ear which might be helpful in the future

March 1<sup>st</sup> COVID was found in a nursing home in Kirkland, WA and AMDA was already beginning their FAQs, those in geriatrics and long-term medicine, colleagues via Twitter knew what they were seeing in their nursing homes in March; those in field were already talking about need for testing nursing home staff and residents; the nursing home industry said ‘we didn’t know’ because they didn’t engage the geriatric experts; EM medicine needs to reach out to geriatric network; on March 10<sup>th</sup> quoted on NBC news that nursing homes would be greatly affected by COVID; made statement that nursing homes were in need of infection preventionists

This recommendation was made since running the largest nursing homes in California before leaving a year and a half ago; typically, the infection preventionist in a nursing home has 10-12 other tasks and is pulled multiple directions; making this person full-time, giving them no other work to do checks a lot of boxes during a pandemic; in March AMDA said that hospitals should not send anyone to nursing homes during a pandemic; as we know what happened in New York and almost all of California, and with more surges, hospitals are filling up, how do nursing homes handle the influx of COVID in nursing homes; still one problem, nursing homes do not have the capacity and wherewithal to deal with the additional influx, even if systems are in place and the knowledge is there, there isn’t enough staff or the resources, this becomes the challenge

March 20 in California we told the nursing homes that every infection preventionist should become full-time; pushed in March crisis management, emergency preparedness, the concept of incident command; the book ‘5 Days at Memorial’ is an incredible read for emergency preparedness and it will teach you a lot about what not to do during an emergency

April 4<sup>th</sup> policies issues were discussed, whether you are a 5-star or 1-star nursing home you are going to get hit by COVID, but there are factors that will influence how to respond to COVID

By mid-April the organization put together a long-term aid response to COVID, and now, after 8 months since the onset of all of this our quadruple aim is not only for nursing homes, it is spot on in all emergency areas: 1) sufficient PPE, if nursing homes do not have sufficient PPE they will lose the battle to COVID – if staff do not have the proper equipment, masks, etc., the virus gets in; the frustration, there are still nursing homes that are struggling to have sufficient PPE, there isn't enough even if the government or local government say that there is enough, all has to have abundant PPE; still nursing homes running out of PPE; twice a week calls with health department in California regarding nursing homes, if there is a hint of running out of PPE, health department must make available; this is almost 1), 2), and 3), without PPE this virus can decimate a nursing home

The 2) is readily available testing; testing of all staff and residents; the hardest thing is what to do with staff that have the virus, test staff and make readily available and frequency; stellar prevention is still at the heart of this; still going back and forth on how this virus can be transmitted – fluid engineers use aerosol, airborne, etc., still uncomfortable about the use of these terms; we know that this virus can be transmitted through the air and that is why we wear masks, but it also can be transmitted through touching; infection protection is still critical on multiple fronts by wearing masks, hygiene and effective use of PPE; colleague shared working in nursing home and staffing lunching without their masks on in a small breakroom; COVID is so insidious that 100% has to be aimed for, really have to have stellar infection prevention and that is everywhere – hospitals, ERs, etc.;

3) Emergency preparedness mode aspect of it; I ran multi-million dollar nursing home chains during fires in California, need to understand what it means to be in emergency preparedness mode, and any organization knows the critical aspect of being in this mode and command; and, if you are in emergency preparedness mode, probably have excellent leadership commanding the facility or organization; good emergency preparedness mode is a proxy for excellent leadership; if you don't have good leadership, along with sufficient PPE and testing, there is highly likely that you are going to run out of PPE; your staff most likely will not be doing stellar infection prevention, so it comes down to leadership

CALTCM, February and March, before the pandemic hit, I wrote about the Delphi process, and those in geriatrics medicine for a long time have used a Delphi process coming to consensus about recommendations; there aren't a lot of writings on nursing homes on frail, vulnerable adults, so what's left is the need to pull experts together with clinical expertise and come up with recommendations; in April, when it was recognized that there needs to be testing in nursing homes, colleagues found that testing was being discouraged by nursing home chains and health departments for a variety of reasons, decided to put together an organization of experts from around the country to develop recommendations for testing

There needed to be testing of front line nursing home staff, as well as residents and by embargo leaked their paper to the CDC and the California Department of Public Health and hopefully that worked to get guidance out around testing that has subsequently been made and Delphi had to deal with planning of testing in nursing homes as guidance

Most recent Delphi publication had to deal with visitations, and recently published in Journal of American Medical Association made these recommendations for nursing homes: social isolation of vulnerable older adults – loved ones, family – still see strong infection prevention and control, use indoor and outdoor visits, and also, limited physical contact, use of appropriate precautions; there

are still benefits and risks to all this (used the scenario of visiting his parents with family two weeks ago since March – use of masks, distancing, and other safety measures)

Risks of social isolation is huge, more literature being published now; cannot treat nursing home residents as prisoners, they have rights, autonomy and dignity, there has to be a balance in all of this because COVID is not going away in the coming months

Finally, honored to have been on the National Academies Committee that made recommendations about the coronavirus vaccine; recommended that the nursing homes' staff receives Phase 1A receive the first vaccinations; remember who brings the virus into the nursing homes and transmits it to the patients – staff; staff needs to be vaccinated, but the problem is they do not want to be worked on by the state and federal health organizations; huge problems with vaccine hesitancy in front line staff, having a very high number of communities of color, which brings a high number of vaccine hesitancy; in California, maybe 20% of staff will be willing to be vaccinated; problem is if nursing home staff is not vaccinating staff, and a vaccine comes out people will think that 'we can put our guard down', we could be faced with a double-whammy, even if assuming that vaccines are safe and effective, if people don't get them, we won't have what is needed in the nursing homes and is combined with people letting their guards down further there will be resurges, as in the country right now, things could get a lot worse

Bringing geriatrics into the medical field is a battle, a war; use of Twitter with experts is critical; find your allies among nursing, emergency groups that feel the same as you on matters of geriatric care; combine efforts for assistance; bring a cohesive message to the front both in the media and legislatively to stop the separateness between medical fields outside of hospice, nursing homes; work together

Interest in ACEP GEDA for inclusion of getting the word out about older adults since there are strong relationships with the hospitals, avoiding the separateness and inability to be heard; get into the room for sustainability

**Kevin:** (Panel Presentation) Care of Older Adults during the pandemic: presentation of COVID in older patients, visitors in the ED, ED to palliative care/hospice transitions

Introduction of three outstanding panelist for discussion:

Maura Kennedy, MGH; Amer Aldeen, USCS; and Adam Perry, GEDC - Rural PA/LA

Q1: Greatest challenge for caring for older adults during COVID, care of older adults gone wrong?

Maura: Answering from a state of emotion vs administratively, focus on caregivers until COVID hit; didn't know about testing, didn't know about asymptomatic spreading, and didn't know if PPE would last. As a result, MGH made important decisions of visitor restrictions that were really harsh, didn't allow visitors unless end of life. Visitors of older adults were being told that they had to leave; patients that couldn't provide histories for themselves; being alone, frightened and scared; distancing from older adults. Recycled and sterilized PPE to be sure there was enough to work with. Difficult on staff, patients, and caregivers.

Amer: Two biggest things found was: 1) ability to share information rapidly throughout the different sites and centers, and countering the misinformation that was coming in to all right at the beginning – the shoulds and shouldn'ts, lots of changes and the ability to pivot quickly, 2) the not seeing the other problems entering the ED for other non-COVID related ED visits, decreases in MIs, gall bladder

disorders, appendicitis, due to COVID. Challenges of barrage of information, misinformation. Patients were not coming in due to COVID.

Kevin: Saw the amount of deaths due to non-COVID related patients/visits to ED. How to make visits to the ER safe for critical issues.

Adam: COVID vs geriatric continued care. 90% fatalities in PA were in nursing facilities, majority were never transferred to acute care centers. ER was not seeing a lot of very ill COVID cases. Did see the decrease in the ER capacity due to COVID. Decreased provider staffing, increase nursing staffing. Decrease in social work capacity, dietary, staffing. Disintegration of continued care. Home resources, care programs, etc. decreased. And in-home care. Forced to do more with less with complex older adults. Continuum of care took a hit.

Q2: Delirium in ED, how is delirium detected in the ED? Is there anything that we can do to decrease its impact? This is specifically for Maura. Is there anything during COVID that could be making delirium worse?

Maura: For older adults, remember clearly that one of our missed delirium cases was in the surge, an older adult in our memory care unit with advanced dementia, geri psych unit at MGH notice increased agitation and delirium and was admitted to unit for medication adjustment. No fever, no cough, no shortness of breath, no other symptoms and no other cases in that long-term care facility. Somewhere during he got a temp of 101 degrees and some medical experts may say that the temp is acceptable in long-term care facilities and could be different for older adults. These older adults may not mention being short of breath, and these symptoms may be acceptable in long-term care facilities for delirium. A study in France, 85+ age delirium patients may have this symptom at presentation at the ED. COVID has to be in your differential, now we know. Both that you are treating the patient correctly, and that you won't send them somewhere without testing to be sure that they are not affected. There is post IC delirium and there is delirium that don't end up in ED. They are seeing tremendous amounts of IC delirium. Hopefully we are seeing less of post-ventilator delirium. And our response had shifted because we are seeing patients with increased post ICU delirium since COVID began. This was very hard for colleagues to understand at that time. There are now ways we treat COVID and post-COVID delirium with cases. Mobility. We weren't to walk the patients down the hallways. We are to have family talk to them and support them, but we had visitor restrictions. What we used to do for delirium patients, we had to modify. If you go out on the health networks for delirium during COVID you will find ways to modify treatment. Mobilization in their rooms was one of the directives in a pamphlet for those that could read and MGH provided. Videos were set up so that they could pop in more frequently. Now we realize that visitors can be screened to keep protection control in place and by bedside and create some structure around that. Mobility, exercises, reorientation around the bedside, using tablets, calling the family, and other distractions while keeping them in the room.

Kevin: Eluding to the fact that caregivers are not visitors is one aspect of our campaign. Use CHAT on this call to see how mobilizing patients can be done. There are comments out there on how to mobilize delirium patients during COVID. There is logistical creativity needed. CHAT some thoughts on that.

Q3: Which will be for Amer...talk to us at a system-level. Coming up with medical approaches across over 170 sites and think about how you are delivering care. How do you equip your nurses, doctors, and other medical staff during COVID?

Amer: The barrage of information mentioned earlier. Immediate and seamless communication. Set up COVID task force for all of the medical directors and directors across the country has been a great

forum set up directly for that purpose. What all we came up with we could immediately spin out to folks. Out of 170 EDs we have clinical management tools we use for high-risk cases but also to maintain optimal quality for utilization. One was created for COVID and we edited that as more information came out, and then we shared the final version of our tool with EHA(?), with ACEP and with everyone. We normally don't share this information outside of the organization but with COVID we shared with everyone. The tool helped us to re-stratify our patients, mostly our geriatric patients to make sure we were caring for those patients. In addition to the clinical instruments, the PPE, we needed to protect our people. For a while I became a mass-sterilization specialist. Revisited that from the creator from 1995 to learn how to re-sterilize our equipment. Get those best practices out there, not only with our clinicians, but with our hospital partners. They are hungry for this knowledge as well. It is advantageous to take the lead where it comes to the ED and how that translates to the floor in the ICU. Urge all of you to share those best practices clinically if it hasn't already been done. High-risk is easy, low-risk is easy, it's really that middle that we've learned to re-stratify. It's pattern recognition alone. Please do get involved as ED-based professionals.

Kevin: Great idea. I have relationships with Tenet medical directors and am wondering why I have not done this as well. Start the dialogue for best practices. Some of our experiences we aren't sharing with the community.

Amer: People usually ignore emails, but if you have cell phone numbers, put them in a group and start sending texts, I can guarantee that you'll get some great responses.

Kevin: Mentioned the benefits of GEDA program to the group to mobilize community. Make your ED better for older adults. Now is the time. Leverage GEDA to get your hospital to focus in the direction of combining your strength during COVID.

Q4: Next, for Adam. Work in small hospitals, critical care hospitals and/or rural hospitals. Unique situations of working in smaller hospitals and about folks with more resources may be able to collaborate with less resources.

Adam: COVID has decreased the capacity in decreasing the snowball effect on staffing. In rural and smaller communities, which are already lower resources environments. From the provider capacity it increases the necessity to do more with less. There exists a fear to coming to the ED in older adults resulting in ambiguity. Low resources, less resources and then COVID in cases of older adults. Means completing a broader scope with older adults from a provider responsibility. Assessing the capabilities of the older adults that have declined, and real specifics of functional status, how do you get your groceries, and if you go home how do you get your medicines? In rural and smaller communities, there is no case management for many in the COVID era. This responsibility may fall on the providers. Also it stresses the capabilities of the providers who do not have a means of palpable care or via tele-health. This broadens the scope for providers. In modern community settings or broader community settings, there is a reliance on transfers and more care. The smaller care facilities will be stressed and have challenges in the area of transfers. The risks of the transfers, treating in-house, falls on the community provider and one of the factors is multi-community providers are not there. When you have in-house and you cannot transfer, communication is really revolutionary for the provider. Especially in the middle of the night. One more point about care in lower community settings, when providers are tasked with this stress of evaluations, there's an importance on training. That is one of the guidelines of the accreditation process. This part of education and training was not existent years ago, there's an importance of training in the low risk sites and COVID.

Kevin: Stressed the importance of visits to the GEDA website for collaborative training and education, and GERIM(?) are two great resources for education. GEDA is really geriatric training and education and is passionately dedicating how to care for older adults in rural settings too.

Mentioned two hospitals communicated with earlier in the day where there is a development of two tele-health programs and how tele-health is sustainable for all communities to make the resources pharma, geri, etc. available in smaller settings.

Q5: For Adam, share about some of the work done as a geriatrician doctor in nursing facilities and EDs, how are you setting up communications between these emergency departments, whether the older adult lives at home or in long-term care facilities?

Adam: Transitioning a cognitive individual to a longer care setting. Spoke with Lauren earlier in the week regarding SNIPS. The individual may be in a SNIPS, or recently discharged or, they might be going home, which meets the definition of homebound, that's a larger percentage if you look at it. Talking to American Academy of Homecare, Florida Home Bound Association(?) and the excitement in the professional organizations, some discussion with the ER community is palpable. With the result of best practices, as we have illustrated, the pandemic has created the necessity of bringing the geriatric presence into the ER, and this is being one of those, and the risks and benefits of the decision of coming to the ER, being admitted to the ER, has changed. You may not get visitors if you are in the ER or hospital, you may increase the chances of getting an infection in the ER. The risks and benefits have really changed. Overall, the ED visit has become more of a consult, that is one part of the whole picture. With the associations across the continuum, the ER visit has become more of a consultation. How do you reframe that? With the regard to transfer policy, a best practice from an article we had with skilled nursing we had recently, is in the COVID area, if you are coming to the ER you've already assumed that risk. There is a two-part conversation strategy going into the ER and coming out. How do we set up safe alternatives? An important part of that the out-patient provider that's SNIPS is part of the care team or the family, who cannot be a part of the hospital. Communication is at a much higher premium. Work with each of the sites and at-home agencies is certainly much more important in this setting.

Q6: For Maura, talk about how MGH is incorporating palpable care into the ED, as well as any hopes of incorporating palpable care even if you don't choose MGH?

Maura: Obviously, we have incorporated palpable care across the country. We are seeing amazing things about palpable care. When things really started to accelerate in the Boston area in Massachusetts, we saw that it had taken a foothold in our long-term care facilities. We started seeing more of our dementia patients come in and our acute care unit was overrun with acutely cases of COVID, our palpable care colleagues, our palpable care physicians selected a group of them that was able to jump right in in our emergency care department. They came down and sat in our emergency care department, and importantly they did a lot of our case findings. Instead of us running our two high-Q(?) areas, they jumped right in and did our case findings and spoke with patients. They would often offer to call the family. Their goal was mainly around palpable care and would have those serious illness conversations. They dove in and helped us out.

It was hard to get people into to hospice in the beginning before testing but those earlier elder conversations kind of pivoted into home hospice and/or hospital admittance by the ER. One case, we had restrictions on visitors, but one daughter took her family member home instead for home hospice since she was disoriented, frightened but we did. It probably took 16 hours but we let her go with hospice. It was the right thing for the patient and for the family. It just took time to get those processes in place.

Training. Emergency physicians are good about asking if you want CPR, do you want to be shocked. We're not as good with saying what did your elder family member do two weeks ago. What does he or she value? It gave us an opportunity to learn from our palpable care colleague. One of the doctors gave us training and set up guidelines to help us through this. And I've learned from that, and just the other day I was with someone that was full code and came in with that and EMF said that all of the family is critically ill. And I told the daughter to tell me about your mother and she said that she was doing well about two months ago but let me tell you that over the past two weeks she stopped eating. So we had this very clear change within the past two weeks. She had had an acute change in her life and she was at a place where she was ready to let go and she would make statements around that. She'd say, "I've had a good life, I'm okay, I love you, but I've had a good life." We were able to transfer her to CMO because I'd opened the conversation with tell me about your mother. It's about improving our skillset.

Kevin: I couldn't agree more. So many more resources, like tele-health. Learning to talk like people about tough things. Asked Lauren to post some good resources about what Dr. Kennedy was just sharing.

Any final words from Amer or Maura about the balancing of good practices and letting it \_\_\_\_\_? Because unfortunately cases are going way up again and we'll be facing tough choices again.

Amer: With the consideration of time, I think Maura has a good academic view on this. I'll just say that much like pediatrics, geriatrics, caregivers. I'll just stop there.

Maura: I am academic but I am emotional. But thoughtful as well. Visitor restrictions. You don't refer to a parent as a visitor. And not to equate adults with children, but a lot of adults with cognitive and physical disabilities have needs that are physical, communication challenges that could be due to a stroke, or dementia, that caregiver is really important. And communication, whether that is dementia and they get agitated in an ED setting, with change, without being at home, or someone with advanced dementia that can say I need to eat or go to the bathroom, agitation is sort of that response. Understanding the distinction between a caregiver who does things like socialization and provides hands on care, is critical to communication and care transitions. And just remember how many people with dementia who do not carry documentation on their diagnosis or have the opportunity to be diagnosed, and remember how many times we miss deliria. So you miss delirium in a patient, they don't have a caregiver at bedside to discharge them, that is a recipe for disaster in terms of that patient discharge course. Trying to identify that person as if this a visitor is a nice thing to have but not a necessity. Or is this person capable of providing a caregiver element that is critical to the patient that is helpful and the care that we provide to them?

And the last thing that I will say is before we started enacting a plan for dementia we had one patient where the family was told that the patient was not end of life, and when she was alone she became agitated because she didn't know where she was. And in turn, that provided more of a provider exposure. We would go into the room more often, to wear more PPE, we would have a sitter sitting outside the room, but found that we had to go into the room. In that case we had a family member who was a person who totally understood and respectful to us, who could have probably minimized our exposure to COVID-19. On the flip side we have had more family or visitors that were more disruptive and don't follow instructions and you look at how many people don't mask when they are told to mask. You also have to be cognizant of the fact that there is someone who is not following the guidelines.

Kevin: We have 30 seconds left and I'm going to go with Amer, Adam, and Maura, what is something we've learned by responding to COVID that we should carry with us even after there is a distributed vaccine?



Amer: Communication is revolutionary. That's what drives implementation at all the hospitals, increased by our coordinated continuum of care. The resources has been this boom in the outpatient capacity and value based volumes of care. Going forward, ED doesn't have to take all of this themselves. So, outpatient, value based resources, we connect to them to do a lot of the things we can't do.

Adam: The tele-health resource has been right for the patients. We know that keeping patients in a familiar environment. We know that patients 65 and older with the possibility of cognitive illnesses later on this orientation occurs. I'm at home, in a comfortable space, care through tele-medicine; something that I'm super excited about. I get to work with people like Jesse Pines. Let's make sure that we get paid for the services we provide, whether it's in-person or virtual.

Maura: I'm going to give you two. 1) It's enhanced appreciation for all of long-term care facilities, not only in illness but in health. And that our investment in these long-term facilities in keeping residents healthy and collaborating with them so that we don't bring them back someone with COVID. So, that they properly take care of that person and/or properly isolate that person. So the critical role in long-term facilities in both in health and in illness. 2) And that we've seen a lot of sadness and racial instability in ageism, and a lot of us are feeling burnt out. It's also been a chance for us to be advocates in our healthcare system. Spoke with an organization in Boston about the possibility of the weather being crappy this winter, so where are our patients going to walk? They can't go to the mall. We started talks on an ambulatory system to advocate for their well-being for older adults in the hospitals and outside.

Kevin: I'm going to sneak mine in as well. Invited recently, I'm not sure why, to a sort of closed meeting at ACEP for medical schools and that sort of thing. Being in that entire meeting was emergency doctors are a misnomer. Not defined by where we work but an acute care specialist. We need to begin to think outside the walls. Reaching tele-health and all where we can bring information to the patient rather than the patient to the space. Our ability to direct healthcare will only be increased. The need for patients to have safe acute unscheduled care has never been greater and it will depend on our ability to outside our four walls.

I can't thank Dr. Kennedy, Dr. Aldeen, and Dr. Perry enough for strong perspectives that is pivotal for all of us. I personally will take from this a reminder that we, all of us in our healthcare systems and our leaders, COVID is surging again and patient safety is going to be increasing important. We can't just sit on the sidelines; we've got to be advocates for our older adults in our communities.

#### **RESULTS OF POLL:**

61% OF RESPONDENTS SAY THEY HAVE PALLIATIVE CARE IN THEIR ED

58% OF RESPONDENTS SAY THEY HAVE DELIRIUM SCREENING IN THEIR ED

68% OF RESPONDENTS ARE ALLOWING VISITORS / CARE GIVERS IN THEIR ED

**Lauren:** That was a good panel discussion on what their best practices are and sharing good tips and tricks for everybody. After that, enlightening, but also depressing when I hear COVID levels.

Let's talk about something so much more fun. By-laws. So, Phil, if you could please.

**Phillip:** (Presentation) – "Proposed changes to the bylaws, add resident and fellows" So, as one of my last secretarial duties, it would be to review some potential by-law changes.

The Executive Committee had discussed potentially evolved changes in the Section, perhaps establish some junior members in ACEP and one way that we were thinking of doing that is by adding both a resident and fellow member to the Board. So, we'll talk about it very briefly and then we'll have discussion around it. It's very straight forward. Let's just talk about the fellow position before the resident position. The thought was to have an emergency resident. As part of the Executive Committee, it would be a two-year term, as a part of the section to be a part of the meetings and to help with. And from a fellow standpoint or description, I think we need to discuss the term for that fellow.

And the reason for that is because emergency medical and geriatric medical are a one-year life and for ACEP is every two years. Our discussion needs to be the length of that fellow term to serve this role and I may just add a pro and con for both and then we can discuss it for thoughts and discussions. The thought of two years (coughing in background, did not catch wording) so that would fit nicely with that. I don't think it would be the worst thing in the world if someone was elected to the fellowship and then serve for an additional time period pending after leaving fellowship. If future elections were, the number of people running, we can use past elections as a guide, as long as we don't have 15-20 people running, so I wouldn't want to discourage interest from making it a one-year fellowship for being involved. If there are multiple people it would be one-year as a fellow or two-years as a fellow. The membership, by virtue of voting, can sort of make that determination.

**Maura:** When do we vote with respect to when individuals are voting? Do we know when? Currently we are offering a shift because either way if it is a one-year term we are electing them in the next year fellowship or will they run over?

**Tony:** Can I make a suggestion? I like the two-year term, but I worry that if we have a two-year term and its fellows, then at least half the fellows are precluded from running in a year where there already is one. Perhaps the position could be something like going to be a fellow, recent fellow. Maybe you could make that role something within a year in any direction and so it is, therefore, more broader to define so that kind of solves Maura's role around where you are in your fellowship. Also, perhaps the two-year thing it would be a bit more challenging one-year anyway. That's just one thing. Just an idea.

**Maura:** It could be an advanced trainee.

**Tony:** Right. Yeah. Some version of fellowship or going to have a fellowship.

**Phillip:** Yeah. Great points by both of you. One question, does it have to be a geriatric fellowship, per se? Maybe it could be an ACEP member or fellow. If it's a fellow interested in geriatrics member, maybe that could be someone potentially eligible for the role. And, no, it does not specifically have to be someone interested in geriatrics or need to be an ACEP member. Do we like the idea of an advanced trainee? Or a fellow / advanced trainee?

**Maura:** I like fellow / advanced trainee with geriatric focus. Somewhere that they are trainee should be or have been a focus around geriatric care. Post residency advanced trainee.

**Don:** So, aren't we talking about a resident position as well? I would say an advanced trainee.

**Maura:** The idea is that if someone is a resident now and has been moved to an advanced geriatric fellowship. I'm for it. Unless there is someone with a focus on geriatrics would also be allowed to apply for it. Don't we want a big tent? If they're interested, don't we want them?

**Tony:** Yes, I think that's a good point. Someone by virtue who has some interest in geriatrics. I hope I'm wrong, maybe in a year there'll be 15 people lined up for the role. I suspect not. I would like them to be an active member.

**Jennifer:** We wanted them to be a GEMS liaison and really focus on resident issues. Or someone who would like to be a resident.

**Maura:** Have a geriatric voice at the table.

**Phillip:** A post residency trainee who could cover and could fall into residency category you think?

**Maura:** The only other thing that I would add, Shan and I were at a Council meeting, and this is our by-laws so it probably doesn't matter, there's a big thing around 'shall' vs 'should'.

**Shan:** So, if they start in or getting elected in October and beginning a residency, they would have to wait until they finish or are we...or, if it is a senior resident applying for fellowship and be there for two years.

**Phillip:** So remind me, in October, do people know what they are doing early post-residency?

**Shan:** So, when did the ballots go out? Two months ago?

**Nicole:** Two weeks ago. So, basically, we need to vote on now to do this. The actual people would be brought on next year.

**Phillip:** So, the process is that we vote and ACEP Council approves these changes

**Lauren:** Trying to figure out where in the application process for next year when we are soliciting prospects, when do we get nominees.

**Maura:** I think that if they are in their senior year they can apply for fellowship program.

**Phillip:** I think that at this point by the time the nominations are completed to being a fellow, I think that if they are applying as a resident in a life program we could take them and that would be just fine.

**Shan:** Maybe senior trainee, something like that? Signifying that they aren't an intern. Or you could say there are two positions and at least one is going to be a resident. Like if there are no fellows to apply it would be fine with two residents. If there is none on the fellowship level, or a senior trainee. But there would be a bit more flexibility. It's just a thought.

**Phillip:** So are there thoughts about the term of the fellow or senior advanced trainee / fellow.

**Lauren:** This is important. Do we want to be bothered by election ballots every year or every other year?

**Maura:** Every other year.

**Phillip:** Any other comments or thoughts? And, for point clarification, the election would be every two years, right? To get on cycle with everyone else?

**Lauren:** We talked about potentially hiring an interim person, but...

- Maura:** Are we allowed to make that motion? If this passes, do we need to appoint someone in an interim position?
- Nicole:** As long as we write that in our by-laws.
- Shan:** You mean like right now? This year?
- Maura:** Yeah, why not.
- Shan:** So I say in the by-laws that in the event there is an opening and, in the event that one of these positions is not open and there is a trainee, post-resident, an executive board could appoint a person to a position. Something like that, Nicole?
- Nicole:** Yes, but it still needs to go to the board for approval. We could write in what we want and they could approve on our behalf.
- Shan:** The Board could appoint someone if we're near the election.
- Maura:** 'May' or 'shall'?
- Lauren:** Okay, shall we vote?
- Lowell:** But we've changed the nature of this to, there appears to be a change to trainees, so is this the appropriate way vote now?
- Lauren:** We cannot build new questions into Zoom on the fly...so, that means two advanced trainee positions.

**RESULTS OF POLL:**

100% OF RESPONDENTS SAY WE SHOULD HAVE A FELLOW POSITION  
 79% OF RESPONDENTS SAY THE FELLOW POSITION SHOULD BE 2 YEARS  
 96% OF RESPONDENTS SAY WE SHOULD ADD A RESIDENT POSITION

Okay, thank you everybody. And while we are in the last ten minutes I would like to go over coming events with Tess Hogan who would like to tell us a bit about JGEM.

- Teresita:** (Presentation) – “Updates on GED projects and opportunities for 2021, Journal of GEM” I would like to share a very brief presentation. And what I want to talk to you about is the role of geriatric medicine. In case people have not heard, since January of 2020 we started to publish care review articles on the GEDC website with hopes of developing our own journal of geriatric medicine. The editors and chief are Michael Malone and our peer reviewers are a cohort of people that are on the call today. As we are going to you for potential submissions. We are in the process of getting our ISSN and developing a platform. This is just one example of our March article.

So, this is the big idea that we have been pursuing for about a decade, and that is that geriatric emergency medicine is its own sub-specialty. As defined by, we have our own knowledge-set, textbooks, fellowships, etc., and the missing link is that we have our own journal. And we now have it. Our audience is targeted at mainly residency physicians, but believe strongly that geriatric medicine is a team sport. So we need to involve also geriatricians, administrators, and those allied health personnel that work in the emergency room and are so critical to the older adults. Currently, the journal is posted on the GEDC website, similarly as to how ACEP has the annals of emergency medical. We are trying to be independent of the GEDC collaborative, we're just too young and have

no funding. So we are currently depending on the GEDC. As I said, our ISSN is pending. Everything is peer reviewed by two peer reviewers. We are developing our management and finishing our framework on B Press(?), and that should be ready in about 2-3 weeks.

What we are announcing to you today is we are going to accept manuscripts to the co-editors and chiefs and myself and Dr. Malone. And as soon as the platform is ready we will be accepting on the B Press platform and will notify. So, if you have some spare articles relating to geriatric emergency medicine in your file folder to get them published we will get them out. We are also developing and editing board and a formal funding process.

So that's just about it. Any questions from people?

**Teresita:** We will be letting you know via email and the other mechanisms to let you know what's going on.

**Lauren:** Shan, can I invite you to take the stage to tell us a bit about what's coming up?

**Shan:** (Presentation – Updating Geri ED Guidelines) Briefly, ACEP and the GAP section, the aging group, as well as stakeholders like GEDC and other leaders with Chris Carpenter and Ula Hwang and multiple other stakeholders are interested in updating the guidelines. And the first set of guidelines were published in 2014 and many of you all contributed to that. Dr. Hwang and Dr. Carpenter and Dr. Ragsdale, also being involved in this. So as we thought as we are beginning 2020 and the next decade we should update this. We are considering using a much more robust approach for this, which Dr. Carpenter has been going through this for a month and teach us about this from an evidence based approach as to what exists and recommendations for the guidelines versus the consensus approach and this takes us through the rigors of the review, trace transparency and so it's probably a 1-2 year process for team meetings, so this is just an active review and we were thinking that we would take just one document and we will publish as we go along than to wait until after the 1-2 year process. So, if you are interested please email me and I can invite you to the email list. We would like your input.

**Maura:** The other thing that Shan and I are working on is the virtual publication for fellows for across the Americas. This would be an opportunity to meet quarterly for a review that relates to geriatric emergency care to create an opportunity to meet each other and collaborate together. The intent is for this to be run by the geriatrics but the invitation is for everyone. We will be sending this through the GEMS Section announcements that went out a couple of weeks ago. But if you'd actually would be on the calendar invite you should shoot me an email.

**In attendance:**

Arvind Venkat  
Lowell Gerson  
Phillip Magidson  
Mike Wasserman  
Audrey Brousseau  
Adam Perry  
Shan Liu  
Don Melady  
Darrell C  
Ula Hwang  
Steve Meldon  
eefjeverwulgen  
Monojit Choud

Ellen Sano  
Marc Squillante  
Eric Isaacs  
Virginia Navarro-Parades  
Kevin Biese  
Rita Manfredi  
Teresita Hogan  
Katie Buck  
bpvelasco1  
Jonathan Berrios  
Fernanda Bellolio  
Heather Prunty  
James Kenny  
Adriane Lesser  
Noran Osman  
Michelle Thomas  
Arthur Sanders  
Dino  
Dave Larsen  
Joy Cohen  
Katren Tyler  
Alan-edu  
Bridget Asiedu  
Rachel Skains  
szepe  
Ramya Sree  
Jason Zimmerman  
Christopher Avila  
Amer Aldeen  
Jennifer Kristjansson  
Naomi George  
Gervais Nougou  
Dr. Tarun  
Colleen Collins  
Kari Riegler  
Danya Khoujan  
Scott Reichelder  
Ahmed Osama

Meeting ended at 2:32pm