

## Research - R187

### Poster

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#### Abstract Title:

**Prevalence of Geriatric Resources for Injured Older Adults in U.S. Hospitals**

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#### Authors:

Cathy A. Maxwell, PhD, RN Lorraine C. Mion, PhD, RN, FAAN Ann Minnick, PhD, RN, FAAN

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#### Background & Purpose:

A rapid rise in admissions of hospitalized injured older adults (HIOAs) is occurring in U.S. hospitals. The Institute of Medicine challenged hospitals to build a healthcare workforce that is trained to meet the needs of an aging population. Objective: To evaluate the presence of nine geriatric resources targeted to care of injured older adults in hospitals (trauma centers [TC] and non-trauma centers [NTC]).

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#### Study/Project Design:

Descriptive national study using 4 sources: 1) CNO survey; 2) 2009 HCUP NIS; 3) 2009 AHA Survey Data; & 4) prior study.

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#### Setting:

U.S. hospitals (including trauma centers)

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#### Sample:

128 hospitals (nationally representative sample), including 55 trauma centers and 73 non-trauma centers

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#### Procedures:

Data sources were linked using an AHA identifier. Descriptive statistics were conducted for hospital characteristics (U.S. region, bed size, location, ownership, teaching status, and trauma center status) and nine resources targeted to geriatric-specific care. Chi-square analyses were conducted to examine differences among TCs (by levels [I,II, III/IV] and NTCs.

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#### Findings/Results:

128 hospitals in 24 states returned surveys. Representative distributions were achieved across geographic regions, hospital bed size, location (urban, rural), teaching status, and trauma center status (level I: n=9; level II: n=16; level III/IV: n=30; NTC: n=73). The presence of targeted geriatric resources in hospitals was < 50% for 7 of 9 resources (geriatric acute care models (n=12, 9%), comprehensive geriatric assessment (n=40, 31%), geriatric services (n=57, 45%), geriatricians (n=43, 34%), geriatric APNs (n=18, 14%), gero-psychiatric services (n=49, 38%), and adoption of QIs related to cognitive and functional status (median: 22 [range 0-45]). Presence of computerized support for geriatric conditions was higher (CAUTI checklists (n = 91, 71%), PU risk assessment (n = 100, 78%). Chi-square analyses revealed significant differences among TC levels and NTCs for presence of geriatric acute care models (level I [22%], level II [31%], level III/IV [7%], NTCs [4%]; p = .004), geriatric services (level I [78%], level II [63%], level III/IV [50%], NTCs [34%]; p = .022), and geriatric APNs (level I [56%], level II [44%], level III/IV [7%], NTCs [6%]; p < .001).

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#### Discussion/Conclusions/Implications:

The availability of geriatric resources in U.S. hospitals (including trauma centers) is low. Interventions to improve availability of these resources should be implemented. Future research should be directed at establishing the relationship between resources and patient outcomes in both trauma centers and non-trauma centers.