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# Motivating Factors for Participating in the Geriatric Emergency Medicine Guidelines 2.0

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## Abstract

**Background:** One in five emergency department (ED) visits is by older adults aged 65+. Clinical practice guidelines are needed to optimize patient care by translating the best available evidence into actionable recommendations to guide person-centered management for this medically complex and growing patient population. Our objective was to understand contributors' experiences and share best practices to inform other guideline working groups.

**Methods:** We conducted a qualitative study based on thematic analysis with an interpretivist paradigm in June-July 2025, using semi-structured interviews of Geriatric Emergency Department (GED) Guidelines 2.0 contributors to understand their experiences. Interviews were transcribed, independently reviewed by team members, and reflexively coded to identify themes.

**Results:** We interviewed 18 participants. Four main themes emerged: 1) motivations for participation, 2) varying opportunities to be involved, 3) personal benefits, and 4) challenges for improvement. Participants contrasted the strengths of shared learning and development with the burdens of organization and coordination.

**Conclusion:** Contributors to the GED Guidelines 2.0 reported a positive experience. They joined because they wanted to contribute to better care of older patients and to achieve personal and professional goals. Many cited that their roles aligned with their strengths and expertise. They also gained skills and knowledge on systematic reviews and benefited from networking. Future groups planning a similar process should consider having multiple levels of leadership, experts in systematic reviews, regular reminders, and creative incentives to improve the process and foster improved networking opportunities within their disciplines.

**Key words:** geriatric, clinical practice guidelines, scholarly volunteering, community of practice, best practices

## Introduction

Older people, ages 65 years and above, accounted for 21.2% of Emergency Department (ED) visits at a rate of 58.4 visits per 100 people in the United States in 2022.[1] Older patients typically have greater socioeconomic, functional, cognitive, and caregiving needs than younger patients and require tailored care. Applying practices and guidelines developed from evidence for younger patients to this group can be potentially harmful.[2,3] Even more so, management of older adults who often have non-specific presentations, multiple comorbidities, and multilevel needs is complex to deliver appropriately in EDs.[4] Factors contributing to this challenge include the lack of relevant guidelines and resources for their implementation, workflow implementation challenges, and differing priorities among ED staff.[5] Early, summary level guidelines for Geriatric Emergency Medicine (GEM) were designed to assist in the care of older adults by advocating for a more person-centered and holistic approach, but these are now dated.[6]

Clinical practice guidelines (CPGs) optimize patient care by translating the best available evidence into actionable recommendations that help clinicians and patients make informed decisions. CPGs are developed through systematic reviews of the literature, weighing the benefits and harms of interventions, and considering patient values, preferences, and resource implications. Guidelines establish recommendations that, if supported by substantial evidence, become standards of care and guide medical professionals' decision-making.[7] These tools have been part of clinical practice at multiple levels, from bedside to global-scale decisions.[8] CPGs also help bring attention to potentially harmful interventions, improve consistency of care, and influence public policy.[9] A systematic review on the implementation of CPGs reported improvements in the structure and process of care in 17 of 19 studies and in patients' health outcomes in 6 of 9 studies.[10] Hughes et al. reported an overall positive effect of ED interventions on older patients' functional status when guidelines were followed.[11]

The Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach has often been used to guide the creation of CPGs providing a transparent, standardized framework for assessing both the quality of evidence and the strength of recommendations. This approach enhances the clarity, reliability, and applicability of guidelines, and facilitates shared decision-making when evidence is uncertain or patient preferences vary.[12] Developing effective CPGs also relies on having a multidisciplinary group of experts, including patients with lived experiences when appropriate, with varying expertise and perspectives.[13]

The first Geriatric ED guidelines were published in 2014. To update these initial best practices the Geriatric Emergency Department (GED) Guidelines 2.0 group was created.[14] The initiative for this group started in 2019, has grown to over 60 members, and followed the GRADE methodology. A first-of-its-kind, the GED Guidelines 2.0 group is composed of largely volunteer emergency physicians, geriatricians, nurses, and allied health professionals from all over the world. This collaborative has already published 11 related articles providing evidence syntheses on medication safety, imaging, frailty, dementia, and delirium for the CPGs.[14-24]. An annotated bibliography of these publications is available in Supplement 1.

Given that the GED Guidelines 2.0 is the first emergency medicine (EM) specialty group to create GRADE guidelines, there is a lack of knowledge of why participants volunteer their time to this lengthy and time-consuming endeavor. Hence, the objective of this study was to better understand the experiences of those contributors to ultimately help guide other EM specialties who are considering creating their own guidelines.

## Methods

### Study Design

We conducted a qualitative study based on thematic analysis and informed by an interpretivist paradigm, using virtual semi-structured interviews in June and July of 2025.[25-27] Participants included members of GED Guidelines 2.0 from various institutions worldwide. The

study was approved by our hospital Institutional Review Board. The methodology and reporting of this study fulfilled the Consolidated Criteria for Reporting Qualitative Research (COREQ) and the Standards for Reporting Qualitative Research (SRQR) checklists [Supplements 2 and 3].

**Subject Selection/Enrollment**

We recruited 23 out of 64 members from the GED Guidelines 2.0 group, which consists of an international cohort of participants. Given that the creation of the GED Guidelines 2.0 group originated from GEM interest groups emails, the GED Guidelines 2.0 group overall primarily consists of ED physicians. Nurses, pharmacists, occupational and physical therapists, and medical trainees joined largely by word of mouth. We recruited participants based on convenience sampling. The PI and co-leader of the GED Guidelines group (SWL) provided a comprehensive list of emails of participating members. Interested members responded to the recruitment email and completed a pre-interview survey to collect demographic variables using REDCap electronic data capture tools hosted at our hospital. Participants were recruited until data saturation was reached.

**Instrument Development**

Interviews used a topic guide of 16 open-ended questions [Supplement 4], developed based on the instrument used by Krczal, E, 2024.[28] The questions were modified, and additional probing questions were added to better fit the context of clinical research collaborative groups and, specifically, the GED Guidelines 2.0 group based on co-authors' extensive experience conducting qualitative research. We piloted our interview guide with a similar cohort who was not eligible to participate in this study and adjusted the questions and probing questions for clarity and to better fit the allotted interview time of 30 minutes. The final version of our instrument was divided in 4 themes: (1) Experience in the GED Guidelines group, (2) Organization, (3) Communication, and (4) Leadership.

**Data Collection**

Upon responding to a recruitment email and consenting, participants were prompted to complete a 10-question online survey (using REDCap) which served to collect demographic variables such as gender, age, race/ethnicity, country of birth and residency, professional role, and involvement in the GED Guidelines 2.0.[29] Interviews lasted approximately 30 minutes each and were conducted virtually by a trained member of the research team, CDH, a female physician (MD) and emergency medicine resident with no prior relationship to the participants. CDH is the only member who knows the identity of the final participants. The participants were informed that the interviewer was a clinician-researcher interested in Geriatric Emergency Medicine. The interviews were conducted and recorded over the software Zoom, then transcribed by TranscribeMe, an online transcription service. Member checking included the constant comparative method and an opportunity for interviewees to review their transcripts to resolve

inconsistencies. Each transcript was de-identified prior to analysis. No demographic information remained attached.

## Analysis

Data were analyzed using thematic analysis, following both inductive and deductive coding processes.[30] Transcripts of interviews were independently reviewed and coded by two study members (GW, CDH) using an inductive approach, and themes emerged during group discussion. We conducted interim analysis, and interviews ended upon reaching thematic saturation when no new themes emerged.

## Results

Out of 64 GED Guidelines 2.0 members, 18 (28%) participants were interviewed. Fifty-six percent of the participants were men and the age range was wide (Table 1). Thirteen participants (72%) self-identified as White, 2 (11%) as Asian, and 1 (6%) as Middle Eastern. Fourteen (78%) were attending physicians, 1 (6%) was nurse, 2 (11%) were resident physicians, and 1 (6%) was a student. Eleven (61%) reported being involved in 1 GED Guideline 2.0 group, 6 (33%) in 2 groups, and 1 (6%) in 3 groups. Four (22%) were not involved in any other research collaborative groups while 14 (78%) were. In terms of when participants joined the GED Guidelines 2.0 group, 4 (22%) joined in 2020, 5 (28%) in 2021, 2 (11%) in 2022, 2 (11%) in 2023, and 5 (28%) in 2024.

**Table 1. Participant Characteristics**

| | Total (n=18)<br>n (%) |
|---|---|
| Gender | |
| Female | 8 (44) |
| Male | 10 (56) |
| Age Group (years) | |
| Under 25 | 0 (0) |
| 25-34 | 4 (22) |
| 35-44 | 5 (28) |
| 45-54 | 4 (22) |
| 55-64 | 3 (17) |
| 65 and above | 1 (6) |
| N/A | 1 (6) |
| Race/ethnicity | |
| Asian | 2 (11) |
| Middle Eastern | 1 (6) |
| White | 13 (72) |
| Prefer not to answer | 2 (11) |
| Country of Residence | |

| | |
|---|---|
| Canada | 2 (11) |
| Switzerland | 2 (11) |
| United Kingdom | 1 (6) |
| United States | 13 (72) |
| Professional Role | |
| Attending Physician | 14 (78) |
| Nurse | 1 (6) |
| Resident Physician | 2 (11) |
| Student | 1 (6) |
| Number of GED* Guidelines 2.0 groups involved | |
| 1 | 11 (61) |
| 2 | 6 (33) |
| 3 | 1 (6) |
| Involved in other research collaborative groups | |
| No | 4 (22) |
| Yes | 14 (78) |
| Year joined GED Guidelines 2.0 | |
| 2020 | 4 (22) |
| 2021 | 5 (28) |
| 2022 | 2 (11) |
| 2023 | 2 (11) |
| 2024 | 5 (28) |

*GED= Geriatric Emergency Department

**Theme 1: Motivations for participation - improving geriatric ED care**

Participants largely reported wanting to improve the care of geriatric patients as the motivation for participating in the GED Guidelines. Specifically, they reported a passion and interest in geriatric ED care and a desire to improve care for older adults. Many participants joined because the topics aligned with their work and interest in the care of older adults in EDs. One mentioned:

> *that [geriatric] group in particular needs a lens focused on it to make sure that the care we're providing fits with what the patient would actually want, that the risks and benefits of the interventions we do is understood so that we're not doing interventions that people may think are going to be helpful that aren't as likely to be helpful. -IV4*

Many others also mentioned joining the GED Guidelines 2.0 group because they wanted to contribute by sharing their expertise and improve care for their geriatric patients because

*... at the end of the day, one of my goals as an emergency physician is not just to provide good care to the patients I see, but… help shape the way we provide care to patients at large in US emergency medicine* (IV4).

Others expressed the importance of these guidelines in their line of work and de-implementation:

*My goals for the project are the same goals as everybody, which are to ensure that the guidance that we provide about older adult patients and their management in the ED is consistent with best available evidence… I've been a part for many years in advocating for improving care for older adults in the ED... just because certain things we think help older adults doesn't mean that they necessarily do. -IV13*

Another mentioned needing guidelines for geriatric patient care, especially in EDs:

*… is long overdue. We see a lot of geriatric patients. They need a lot of specialized care. And we really don't know how to do that, and we don't have anything to guide us. General emergency medicine guidelines don't really always apply to older adults. And any geriatric guidelines don't also apply because they're talking about a different setting. We have a very unique setting. We have a lot of unique challenges. -IV19*

**Theme 2: Varying opportunities to be involved**

The GED Guidelines 2.0 group had varying opportunities to be involved, not only by training level and experience as a student, nurse, attending, or resident but also by project role. Because this was largely a volunteer group, there were no barriers to anyone joining and contributing to any group or subcommittee.

The process of assigning specific roles to each subgroup varied. One assumed a leadership role "*because I had written one scoping review and taken one class on systematic reviews, I had the most experience in the group and so have been leading the group*" (IV3). Another shared:

*It was a good opportunity to influence policy and practice using my background as a researcher. I'm a research methodologist. [I have] a unique perspective, an interdisciplinary perspective, to contribute to guidelines that support not only clinical practice and policy, but accreditation moving forward. -IV5*

Many reported that their contributions played to their strengths. One mentioned that "*I'm like the citation and figure guy. So I'm more on the artsy side. So I like to make nice-looking figures and pull data in a way that's ... like layman's terms so anybody can understand it. And citations. I'm very good at organizing things. And I'll read something and I'll be able to pull a citation out*" (IV1). Many also had their roles change as projects further developed:

*I suppose, methodological input firstly, and then a specific expertise on outcomes, and then a collaborator on the systematic reviews in terms of article selection and paper writing. -IV10*

Participants' roles also varied. Leaders of subcommittees were involved with:

*I am the leader of… subcommittee... So far, what that's entailed is I've organized the group, recruited the participants for the group, and I lead the monthly meetings… with the assistance of several colleagues have helped to divide the various tasks…. -IV13*

A participant reported performing more administrative tasks by "*scheduling members of the group and organizing meetings and all that*" (IV6). Many helped with coming up with Patient/Problem, Intervention, Comparison, and Outcome (PICO) questions, data collection, risk of bias analysis, data analysis and/or drafting manuscripts.[31]

**Theme 3: Personal Benefits from participating in the GED Guidelines 2.0 group**

Participants reported multiple personal benefits from participating in the GED Guidelines 2.0 group, such as 1) networking, 2) learning about systematic reviews, 3) methodology, and 4) academic growth and professional goals. Many expressed gratitude and excitement regarding networking "*with a lot of people*" (IV5) and helping "*me connect with a lot of other geriatric researchers across the country*" (IV2). Another mentioned that:

*It's been amazing to be a part of this for there to be so many collaborators from all over the world. And they're such experts in this field. And so I just feel really grateful that as a student and then as a young resident to get to see what this is like has been really incredible. -IV18*

*I've had the pleasure and luxury of working with some of the smartest people in geriatric emergency medicine… It's great to not just understand more about their thought processes and their research in these specific topics, but also understand how to place that in the bigger context of fame. -IV19*

Many also expressed that with this unique group being multidisciplinary and including researchers from all over the world, they have learned a lot more about teamwork and "*communicating with a lot of authors, trying to juggle all the different personalities and what different people like*" (IV1). Participants also benefited from joining the GED Guidelines 2.0 group and developed methodological skills. One mentioned that "*I think getting to lead the group was a good professional growth experience. I think learning about systematic reviews was great*" (IV2). Another mentioned:

*I've also learned a lot just on how to run a systematic review through being involved in that team… So developing a protocol, doing the literature review, doing the data collection, all that's been new. -IV4*

Most participants also wanted to learn more about certain parts of clinical research, such as the GRADE approach, conducting systematic reviews and meta-analyses, implementing clinical policy-making, and guideline development. Many had taken courses surrounding such topics, "*But taking the classes is not the same as doing it in real life. So I feel like I am continuously learning***"** (IV3).

Participants in our study also reported they were looking for academic growth or demonstrating academic contribution for advancement purposes and obtaining academic credit in the form of publications and involvement in national organizations. A few were invited to join by their mentor or advisor:

*I was part of the GEAR Research Network. And as part of that, they had different research priorities and different domains that aligned with the GED guidelines work... When I started my fellowship and started networking and getting involved in various networks, like GEAR, the GED Guidelines 2.0 started. I was invited to participate by my mentor who encouraged me based on my research interest to lead the… group. -IV17*

A few sought academic advancement or credit through the GED guidelines:

*Another reason that I joined is because our promotion, academic promotion, and in our case, our salary is linked to academic promotion. Promotion is made easier or is granted when you are involved in national organizations that allow you to share your expertise, disseminate your knowledge. And so it is part of the game in academic medicine to get involved on a national level with groups around areas of interest. -IV9*

**Theme 4: Challenges for Improvement/Lessons learned**

When asked about lessons learned, participants agreed on a few things. The overwhelming majority said that though the projects lasted a lot longer than expected, organization was key to success not just in producing deliverables but also in having a good experience. They appreciated "*breaking the whole project down into subgroups and having each subgroup have different leaders*" (IV3) and having "*one central communicator, communicating with multiple different groups, and then bringing them together as a whole*" (IV1). Another mentioned:

*For a group doing systematic reviews, you need a leader to keep everyone in line. You need someone who has experience doing the statistical analyses and the meta-analyses and making all the tables. You need enough people to do the data abstraction, the risk of bias... And we're all working other lives. This is not paid work, so we're doing it in our spare time, amongst other things. -IV3*

Another crucial factor that participants mentioned helped tremendously and would like more of during the 5 years of work was the amount of expertise in group members:

> *I would make sure that I invite people who have done this previously. I think that experience and expertise is really critical in making this work. So I would want to make sure that we had people who could be the expert mentors and then also people who were leading the groups that had some familiarity with kind of where we were hoping to get towards at the end. -IV18*

Many participants shared that communication was challenging due to collaborators coming from different time zones, and a lot of this work started around the time the COVID-19 pandemic started. Many recommended an alternative inclusive channel for communication like Slack. Many also requested having more reminders and updates, especially because members joined and left the group throughout the years:

> *I think more reminders about timelines and such could have been helpful. But at the end of the day, they're busy emergency clinicians, and they have their own grants and projects to get done themselves. So it's free work. That's the thing we forget is that these clinicians and doctors who get paid quite well are doing free work for a good cause. And so I think we need to sometimes offer some leniency on that. -IV5*

Another participant mentioned what would have been more helpful would be an organized document such that:

> *I would give everybody a one sheet page of start date, end date, writing time here, abstraction here, deciding on the question here. You know I would have just said I would have just said mid-April, we got to have this done. Got to have the first draft by here, second draft by here. That's the one thing I would do next time…. -IV8*

Finally, a few participants recommended having a way to motivate as well as thank people for volunteering their time:

> *I think members need some kind of incentive other than goodwill. And money is not really too much of an incentive for us… We offer manuscript authorship, but we're doing two PICO questions, and there's only potentially four manuscripts… maybe the guideline leadership can send a certificate of appreciation... Those are free, and it just takes time to make it nice. But it could be a motivator for somebody. -IV7*

With regards to giving credit to anybody involved in the projects, another participant mentioned:

> *With a group this large… you can't have 500 people on one manuscript… everyone should get recognition. [It is] hard to tease out who should get recognized and who doesn't... But then you only have one first author, usually, and one senior author… [It would be good] for the people who put in above and beyond who have really been invested but didn't get first or senior authorship had other opportunities to really get recognized. -IV17*

Ultimately, many agreed that keeping people engaged over such a long period is challenging:

> *This is a really big undertaking with lots of enthusiastic people. And it's a process that's taking a very, very long time. And thinking about how to keep people engaged and to ensure that people's effort is recognized gets increasingly challenging in a large project with a long timeframe. -IV13*

## Discussion

We found that despite having to balance clinical, administrative, academic, and other responsibilities, GED Guidelines 2.0 members reported participating because they desired to contribute to better care for their geriatric patients and to achieve personal and academic goals. Further, participants reported that despite limited experience with systematic reviews, there were multiple opportunities to be involved. Future projects though should ensure adequate participation by more experienced participants.

Participants in this study largely reported joining the GED Guidelines 2.0 group because of their work and interests caring for geriatric patients in the ED, wanting to improve their care, and recognizing that current ED guidelines are insufficient for guiding care for older adults. There is a paucity of literature on why people join large, international, primarily voluntary, especially in the field of emergency medicine. Our overall findings match those of Spence et al., who interviewed early- and mid-career researchers and found 6 main categories of involvement in interdisciplinary research: 1) pursuing multiple disciplines because of many interests, 2) being sought after due to niche expertise 3) pursuing complex problems that require multidisciplinary input, 4) being a leader who connects all kinds of members of a group, 5) being exposed to colleagues' of leaders' interdisciplinary research activities, and/or 6) seeking research jobs that might better fit personal priorities.[32] However, due to the nature of the GED Guidelines 2.0 largely being of voluntary nature, none of our participants mentioned joining specifically to obtain a paid long term research position. However, as a nascent subspecialty area, EM guidelines work, in the future, may develop to a level that could include full-time research opportunities.

Our study also found that many participants joined for perceived benefits including professional and personal growth and achievement of goals. Our findings were consistent with those reported by McKinnon et al., who interviewed medical students who participated in COVID-19 urgent public health research studies through the Volunteers in Research program. They found that the primary motivators for students' participation were the desire to contribute to the response to COVID-19, make a difference and gain unique insight during the pandemic, gain hands-on experience in clinical research, utilize research networking opportunities, add to their resumes, and explore a potential career in research.[33] Furthermore, Dusdal and Powell performed a retrospective case study and found that participating in international research

collaboration leads to increased high-quality papers and greater research impact. They also found that motivations for collaborating internationally included "research organization and researcher reputation, higher visibility, opportunities for multidisciplinary research, access to research funds… mentoring younger researchers… development of new methods and sharing knowledge… extending their networks." They also found that personal motivations included making friendships and maximizing scientific output.[34] These findings are consistent with our participants' benefiting from networking, learning about systematic review and team dynamics, methodology, and academic achievement. Future study could include an analysis of collaborative projects undertaken by members of the network we created during the Guidelines 2.0 process.

In terms of lessons learned, we identified several ways to improve the participant experience. While many seemed willing to participate because of goodwill, increasing academic credit or recognition would help motivate involvement in such a long project. This makes sense, as Tiessen et al. collected survey data and similarly found that having shared goals and objectives, reward structures, funding mechanisms, shared ownership, mutuality, complementary expertise, appropriate communication, and balanced power dynamics were motivating factors to consider for international scholar/practitioner volunteering research groups.[35] It is likely that deliberately planning future groups with both junior and senior researchers across the different areas of expertise could incorporate an inherent mentorship structure. This would ensure the continued development of experts in geriatric emergency medicine and set the stage for a robust research and clinical network that could advance care for older patients who present to EDs worldwide.

Thus, for future renditions, while most participants shared that participating in the guidelines was largely motivated by improving the care of geriatric ED patients, clinicians and researchers involved in groups like this can personally benefit from networking opportunities, gaining and utilizing skills in systematic reviews and scientific methods, and earning academic credit. Making such benefits explicit will encourage more junior and senior members to become involved in other EM guideline groups to ultimately improve the care of ED patients.

## Limitations

Limitations of this study include the potential for sample bias and social desirability. Participants who agreed to be interviewed might have been more passionate about GEM or working research groups and perhaps had a more positive experience. Though interviews were conducted virtually with a research assistant who was the only person who knew subject identities, participants' responses might not have fully disclosed certain details that would have represented their thoughts. Given that most of the GED Guidelines 2.0 members are physicians, our study largely represents the views of physicians, and their motivations, experiences, and benefits from participating in the GED Guidelines 2.0 might differ from that of other healthcare workers and researchers.

## Conclusion

The Geriatric ED Guidelines 2.0 working group members participated because they wanted to contribute to better care for older patients and achieve personal and professional goals. Future guideline working groups can improve participants' experiences by setting forth clear expectations for the working group processes and timelines, deliberate selection of members with specific areas of expertise, and the creation of inherent mentorship structures. Our findings enhance understanding of their motivations, providing necessary leadership and expertise, ensuring academic rewards, and coordinating a streamlined development process.

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**Supplement 1**

**Annotated Bibliography of the publications of the [GED Guidelines 2.0 group]**

| Article | Type of Publication | Summary |
|---|---|---|
| A Model for Developing Subspecialty Clinical Practice Guidelines: The Geriatric Emergency Department Guidelines 2.0. https://pubmed.ncbi.nlm.nih.gov/41019914/ | Concept paper | The GED Guidelines 2.0 is the first EM subspecialty guideline effort to fully adopt the GRADE approach and offers a novel blueprint for future EM guideline development. |

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|---|---|---|
| Comparative Safety of Medications for Severe Agitation: A Geriatric Emergency Department Guidelines 2.0 Systematic Review. https://pubmed.ncbi.nlm.nih.gov/40275439/ | Systematic Review | Adverse drug events are common amongst older adults receiving antipsychotic/anxiolytic medications for severe agitation. Of particularly high risk are benzodiazepines, particularly midazolam. |
| Emergency Department Programs to Support Medication Safety in Older Adults: A Systematic Review and Meta-Analysis. https://pubmed.ncbi.nlm.nih.gov/40067297/ | Systematic Review and Meta-Analysis | Involving clinical pharmacists and/or geriatricians in a multidisciplinary team improved potentially inappropriate medications deprescribing. Computerized clinical decision support systems, alone or with ED clinician education, were associated with enhanced geriatric ordering and prescribing practices. |
| Delirium, confusion, or altered mental status as a risk for abnormal head CT in older adults in the emergency department: A systematic review and meta-analysis. https://pubmed.ncbi.nlm.nih.gov/37423026/ | Systematic Review and Meta-Analysis | There is limited research that looks into whether delirium, confusion, or altered mental status is associated with abnormal acute findings on head imaging in the ED. |
| Head computed tomography findings in geriatric emergency department patients with delirium, altered mental status, and confusion: A systematic review. https://pubmed.ncbi.nlm.nih.gov/36330667/ | Systematic Review | 15.6% of older ED patients with altered mental status or confusion were found to have abnormal head computed tomography. Presence of a focal neurological deficit was a strong predictor. Anticoagulation was not. |
| A systematic review of interventions for persons living with dementia: The Geriatric ED Guidelines 2.0. https://pubmed.ncbi.nlm.nih.gov/40093231/ | Systematic Review | Due to the limited literature on interventions in ED settings for people living with dementia, there is need for research to improve experience, process, and outcomes. |
| Frailty assessment tools in the emergency department: A geriatric emergency department guidelines 2.0 scoping review. https://pubmed.ncbi.nlm.nih.gov/38162531/ | Scoping Review | There are plenty of tools, scales, and instruments for identifying frailty in older patients at ED triage with varying levels of utilization, though there were few regarding identification, interventions, and educational initiatives in the ED. |

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| Risk factors and risk stratification approaches for delirium screening: A Geriatric Emergency Department Guidelines 2.0 systematic review. https://pubmed.ncbi.nlm.nih.gov/38847070/ | Systematic Review | Few studies examine delirium risk factors and risk scores for delirium amongst ED patients and with such heterogeneity, but we found that neurological conditions like stroke and dementia, age, certain medications, and functional impairments seemed to increase risk of delirium. |
| Delirium detection in the emergency department: A diagnostic accuracy meta-analysis of history, physical examination, laboratory tests, and screening instruments. https://pubmed.ncbi.nlm.nih.gov/38757369/ | Meta-analysis | There is scarce literature on identifying patients with delirium in the ED. We found that versions of the Confusion Assessment Method are best for ruling in delirium, and the Delirium Triage Screen is best for ruling out delirium, both based on single-center studies. |
| GRADE-Based Clinical Practice Guidelines for Emergency Department Delirium Risk Stratification, Screening, and Brain Imaging in Older Patients With Suspected Delirium. https://onlinelibrary.wiley.com/doi/10.1111/acem.70167 | Guideline | The GED Guidelines 2.0 Delirium Work Group applied the GRADE approach to assess certainty of evidence on and derive six evidence-based recommendations for risk stratification, diagnosis, and brain imaging for older ED patients with possible delirium. |
| Emergency department-initiated palliative care screening among older adults: a systematic review and meta-analysis protocol. https://pubmed.ncbi.nlm.nih.gov/41125269/ | Protocol | This outlines the palliative care screening protocol. |

**Supplement 2**

**Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist**

Developed from:

Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

| No. Item | Guide questions/description | Reported on Page # |
|---|---|---|

| | | |
|---|---|---|
| Domain 1: Research team and reflexivity | | |
| *Personal Characteristics* | | |
| 1. Interviewer/facilitator | Which author/s conducted the interview or focus group? | P.6 |
| 2. Credentials | What were the researcher's credentials? E.g. PhD, MD | P.6 |
| 3. Occupation | What was their occupation at the time of the study? | P.6 |
| 4. Gender | Was the researcher male or female? | P.6 |
| 5. Experience and training | What experience or training did the researcher have? | P.6 |
| *Relationship with participants* | | |
| 6. Relationship established | Was a relationship established prior to study commencement? | P.6 |
| 7. Participant knowledge of the interviewer | What did the participants know about the researcher? e.g. personal goals, reasons for doing the research | P.6 |
| 8. Interviewer characteristics | What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic | P.6 |
| Domain 2: study design | | |
| *Theoretical framework* | | |
| 9. Methodological orientation and Theory | What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis | P.5 |

| | | |
|---|---|---|
| *Participant selection* | | |
| 10. Sampling | How were participants selected? e.g. purposive, convenience, consecutive, snowball | P.5 |
| 11. Method of approach | How were participants approached? e.g. face-to-face, telephone, mail, email | P.5 |
| 12. Sample size | How many participants were in the study? | P.5 |
| 13. Non-participation | How many people refused to participate or dropped out? Reasons? | N/A |

572

| | | |
|---|---|---|
| *Setting* | | |
| 14. Setting of data collection | Where was the data collected? e.g. home, clinic, workplace | P.6 |
| 15. Presence of non-participants | Was anyone else present besides the participants and researchers? | P.6 |
| 16. Description of sample | What are the important characteristics of the sample? e.g. demographic data, date | P.7 |
| *Data collection* | | |
| 17. Interview guide | Were questions, prompts, guides provided by the authors? Was it pilot tested? | P.6 |
| 18. Repeat interviews | Were repeat interviews carried out? If yes, how many? | N/A |
| 19. Audio/visual recording | Did the research use audio or visual recording to collect the data? | P.6 |
| 20. Field notes | Were field notes made during and/or after the interview or focus group? | N/A |
| 21. Duration | What was the duration of the interviews or focus group? | P.6 |

| | | |
|---|---|---|
| 22. Data saturation | Was data saturation discussed? | P.6 |
| 23. Transcripts returned | Were transcripts returned to participants for comment and/or correction? | P.6 |
| Domain 3: analysis and findings | | |
| *Data analysis* | | |
| 24. Number of data coders | How many data coders coded the data? | P.6 |
| 25. Description of the coding tree | Did authors provide a description of the coding tree? | N/A |
| 26. Derivation of themes | Were themes identified in advance or derived from the data? | P.6 |
| 27. Software | What software, if applicable, was used to manage the data? | N/A |
| 28. Participant checking | Did participants provide feedback on the findings? | N/A |
| *Reporting* | | |
| 29. Quotations presented | Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number | P.8-12 |
| 30. Data and findings consistent | Was there consistency between the data presented and the findings? | P.13 |
| 31. Clarity of major themes | Were major themes clearly presented in the findings? | P.13 |
| 32. Clarity of minor themes | Is there a description of diverse cases or discussion of minor themes? | N/A |

573

574 **Supplement 3**

575 **Standards for Reporting Qualitative Research (SRQR)**

| Title and abstract | Page/line no(s). |
|---|---|
| Title - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended | P.1/1 |
| Abstract - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions | P.3/1 |

| Introduction | |
|---|---|
| Problem formulation - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement | P.3/30 |
| Purpose or research question - Purpose of the study and specific objectives or questions | P.5/1 |

| Methods | |
|---|---|
| Qualitative approach and research paradigm - Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale** | P.5/6 |
| Researcher characteristics and reflexivity - Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability | P.6/6 |
| Context - Setting/site and salient contextual factors; rationale** | P.6/10 |
| Sampling strategy - How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale** | P.5/17<br>P.6/18 |
| Ethical issues pertaining to human subjects - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues | P.5/9 |
| Data collection methods - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale** | P.5/7 |

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|---|---|
| Data collection instruments and technologies - Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study | P.5/24<br>P.6/10 |
| Units of study - Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results) | P.6/21 |
| Data processing - Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts | P.6/10<br>P.6/12 |
| Data analysis - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale** | P.6/15 |
| Techniques to enhance trustworthiness - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale** | P.6/11 |

Results/findings

| | |
|---|---|
| Synthesis and interpretation - Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory | P.8-12 |
| Links to empirical data - Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings | P.8-12 |

Discussion

| | |
|---|---|
| Integration with prior work, implications, transferability, and contribution(s) to the field - Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field | P.14/22 |
| Limitations - Trustworthiness and limitations of findings | P.14/10 |

Other

| | |
|---|---|
| Conflicts of interest - Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed | Title page |
| Funding - Sources of funding and other support; role of funders in data collection, interpretation, and reporting | Title page |

*The authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.

**The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.

Reference:
O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. *Academic Medicine*, Vol. 89, No. 9 / Sept 2014
DOI: 10.1097/ACM.0000000000000388

576 **Supplement 4**

577 **Interview Guide**

578

| Questions | Probing questions |
|---|---|
| *Experience in the GED Guidelines group* | |
| 1. Why did you join this group? | What are your hopes/ goals for this project? |
| | Have these benefits come to fruition in your opinion? |
| 2. Tell me about your work in the GED guidelines? | |
| 3. How does this group compare to other groups you are in? | For example: organization, leadership, communication, conflict resolution |
| *Organization* | |

| | |
|---|---|
| 4. In your experience, what are the elements that make these groups successful? | How do you define success within writing groups? |
| 5. Think of the organizational structure of the main GED group you are working on. What is working well within the group? | Why did it work well? |
| 6. What do you think is the optimal size of a working group? | |
| 7. Tell me about moments when the group did not work so well. | What are the challenges involved in being part of academic writing groups? |
| | How did group members overcome it? |
| 8. How has the group adapted? If so, what were the reasons? | |
| *Communication* | |
| 9. How would you describe the communication structure within the group? | Was this effective? How could it have been better? |
| 10. Please describe the process for developing consensus in the GED guidelines group | |
| *Leadership* | |
| 11. How would you describe leadership within the working group? | |
| 12. To what extent have you been able to bring in your ideas and opinions? | |
| 13. How did you feel when discussing challenges within the team? | |
| 14. When it came to generating the final product (e.g. a manuscript) what went well/not so well about this step? | |
| 15. When establishing a similar research group in a similar situation, what would you do the same way the next time? | Why does doing this feel so important to you? |
| 16. What would you do differently within the working group? | What are the reasons behind this? |

| | |
|---|---|
| | What do you hope to achieve when having changed this issue? |

579