Emergency Department Care Transitions for Cognitive Impairment: A GEAR 2.0-ADC Scoping Review

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BACKGROUND

- Approximately two-thirds of ED visits completed by older adults result in discharge
- Up to 40% of these patients have some degree of cognitive impairment (CI)
- Transitions between the ED and home are risky, particularly for patients with CI

OBJECTIVES

To conduct a scoping review to describe ED care transition interventions delivered to older adults with CI, identify relevant patient-centered outcomes, and determine priority research areas for future investigation

METHODS

- PRISMA reporting guidelines were used
- Two research questions were identified by the Geriatric Emergency care Applied Research 2.0 Network – Advancing Dementia Care (GEAR 2.0-ADC) stakeholders:
- Priority Question 1: "What interventions delivered to ED patients with impaired cognition and their care partners improve ED discharge transitions?"
- Priority Question 2: "What measures of quality ED discharge transitions are important to varying groups of ED patients with impaired cognition and their care partners?"
- Scoping review results were used to generate research priorities
- GEAR 2.0-ADC stakeholders voted to identify priority research questions

ACKNOWLEDGEMENTS

FIGURES & TABLES

PRISMA Flow Diagram
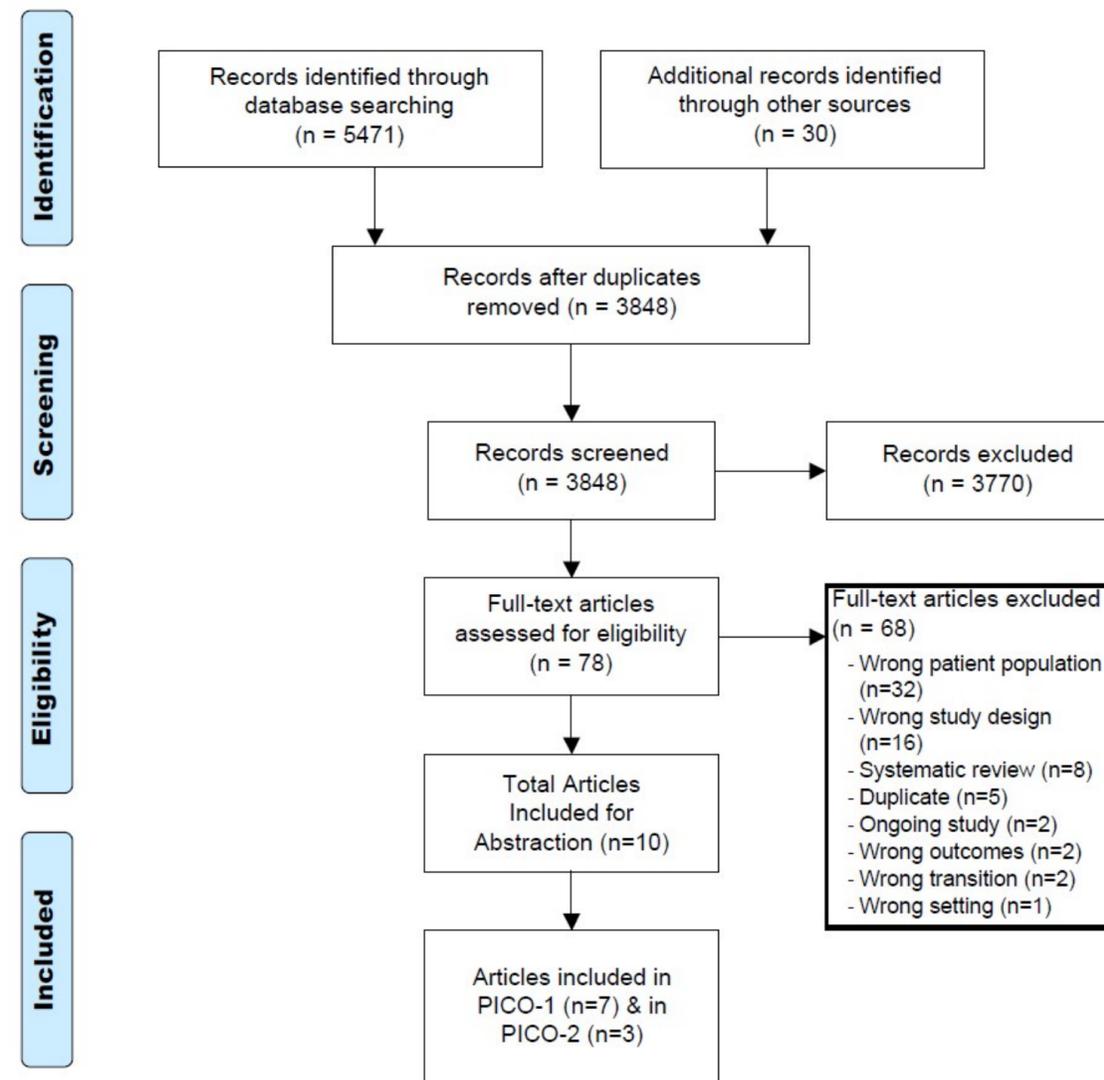
Priority Research Questions

1 - What improves outcomes of ED-to-community care transitions among ED patients with impaired cognition and their care partners and how can these be personalized for vulnerable populations?

2 - What matters most to ED patients with impaired cognition and their care partners during the ED-to-community transition and how can these priorities best be measured?

3 - What barriers, facilitators, and strategies, specifically leveraging implementation science methods, influence engagement, uptake, and success of care transition interventions, including national guidelines, policies, and best practices?

4 - How can care partners and community organizations be best engaged and empowered to improve ED-to-community care transitions?

5 - How can communication quality surrounding ED-to-community transitions be optimally measured?

RESULTS

- Few care transition interventions studies for patients with CI exist
  - Variable components, settings, personnel, and outcomes
- Patients with CI reported negative perceptions related to transitions
  - Feeling overwhelmed with information
  - Feared loss of independence
  - Feared cost of long-term care
- Patients with CI and their care partners suggested new care transition metrics
  - Care coordination between hospital staff
  - Involvement of care partners in care management
- Priority research questions were identified and should guide future studies

LIMITATIONS

- Emphasis on "ED-to-community" transitions
- Use of the term "cognitive impairment" over "dementia"

CONCLUSIONS

- Patient-focused intervention approaches could provide greater benefits for older adults with CI
- Federal policy initiatives and reimbursement could enhance clinical use of ED-to-community care transition interventions
- Identifying what matters to patients with CI and their care partners can innovate care transitions interventions