

PartnerED Care: Coordinated ED Transition for Assisted Living Patients with ADRD



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“For people living with dementia in assisted living centers, real-time, standardized communication from the primary care team to emergency providers may reduce avoidable hospitalizations.”

RATIONALE: Transitions from long term care to the emergency department (ED) are characterized by poor-quality communication between primary care providers and the ED. Incomplete or inaccurate information leads to ED provider uncertainty and can result in duplicative testing, care delays, and avoidable hospitalizations, particularly for people living with dementia (PLWD). Previous standardized communication interventions (e.g., INTERACT) have demonstrated reductions in all-cause hospitalizations but have not focused on PLWD residing in assisted living communities (ALCs).

OBJECTIVE: To adapt a standardized communication intervention for use with PLWD presenting to the ED from ALCs; pilot the feasibility of using electronic health records (EHR) to identify PLWD and implement the communication intervention; and ascertain clinical outcomes, such as hospitalization, from EHR and Medicare data.

SETTING: EDs in Minnesota, Wisconsin, and Florida.

POPULATION: ED visits by members of Bluestone Physician Services (Bluestone) Accountable Care Organization living with dementia residing in ALCs.

INTERVENTION: A real-time standardized communication tool delivered by a patient’s acute care manager (ACM) by telephone and fax to the ED care team; key information such as the reason for the ED visit, patient’s known medical problems, goals of care, and available outpatient resources are relayed with a goal of reducing avoidable hospitalizations.

OUTCOMES: The primary clinical outcome is the proportion of ED visits resulting in hospital admissions as documented in the EHR. The secondary clinical outcomes are the proportion of ED visits resulting in hospital admissions, 72-hour return to ED visit, and 60-day rehospitalization in Medicare claims. Implementation endpoints are: time to ACM call after ED registration, successful contact with ED provider, key metrics recorded by the ACM in the EHR (ED disposition, time to ACM contact, successful contact with ED provider, and type of ED staff contacted).

IMPACT: If successful, this pilot study will inform a large-scale embedded pragmatic clinical trial to test this type of standardized communication between primary and emergency care teams to reduce avoidable hospitalizations. Given the potential harms and related costs associated with avoidable testing and hospitalizations, this care coordination is a practical approach that could have a significant impact.