Redesigned Emergency Department Care For Persons Living With Dementia: Early Implementation Findings And Lessons Learned: ED-LEAD Trial

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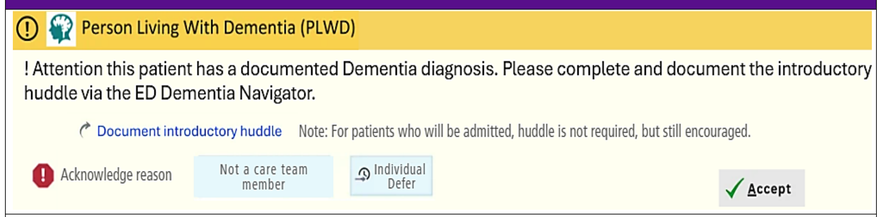
BACKGROUND

Persons living with dementia (PLWD) and their care partners visit the emergency department (ED) more frequently than older adults without dementia. Emergency Departments Leading the Transformation of Alzheimer's and Dementia Care (ED-LEAD) is an embedded, pragmatic, multifactorial trial studying three ED-to-home care transition interventions. Emergency Care Redesign (ECR), one of three interventions, restructures ED workflows to improve care and the transitions that follow.

WHAT DOES ECR ENTAIL?



Alert fires- informs ED care teams that there is a person living with dementia in the ED.

Care partner information- is documented to ensure PLWDs have assistance post discharge.

Care team huddles- introductory and discharge alerts prompt care team to hold interdisciplinary huddles at bedside. Huddles ensure shared understanding of needs.

TRAINING RESULTS

Asynchronous dementia care training goal: at least 75% full-time Physicians, Advance Practice Providers (APPs), Nurses and Social Workers at each site (see below).

Summary of Training Percent for 4 Waves Completed (n=31 EDs)*

Physicians and APPs	Nurses	Social Workers
88% (909/1027)	83% (1851/2229)	97% (99/102)

*2 of 31 EDs in Waves 1-4 were unable to promote ED-LEAD training activities due to ongoing union negotiations

METHODS

ICD-10 code-based identification strategy: flags eligible PLWD and triggers Electronic Health Record (EHR) alert for the team to conduct interdisciplinary huddles, identify a care partner, and use clinical decision supports for best dementia care.

Intervention quality is monitored through EHR-based, real-time care process data, which at this time, is available for the first three waves. For each identified PLWD who is discharged home, we track:

- ✓Documentation of the introductory (intro) huddle
- ✓Care partner identification
- ✓Use of dementia navigator components
- ✓Discharge huddle

RESULTS

Figure 1. ECR Metrics by Wave, Measure, and Site

Real-time data include the first 23 of 39 sites implementing ECR in Waves 1-3

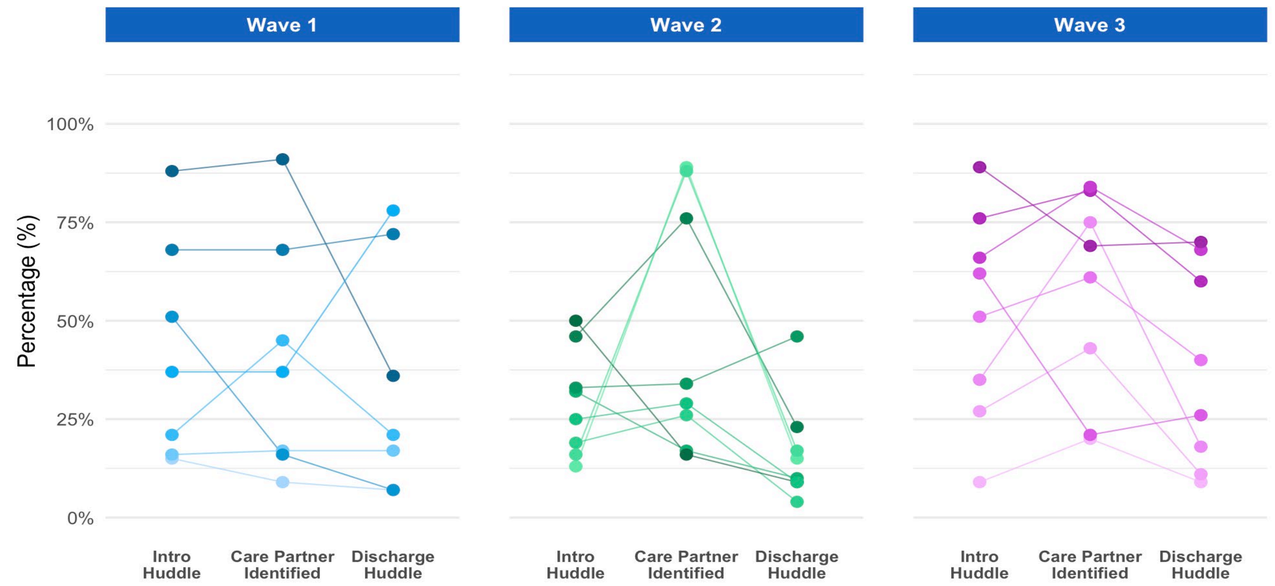


Figure 2. Proportion of ED discharged encounters that use any ECR strategy (by Wave)

	Median (IQR), %		
Wave	**Intro Huddle**	**Care Partner Identified**	**Discharge Huddle**
Wave 1	37.0 (18.5 - 59.5)	37.0 (16.5 - 56.5)	21.0 (12.0 - 54.0)
Wave 2	28.5 (18.2 - 36.2)	31.5 (23.8 - 79.0)	12.5 (9.0 - 18.5)
Wave 3	56.5 (33.0 - 68.5)	65.0 (37.5 - 77.0)	33.0 (16.2 - 62.0)

Note: IQR = Interquartile Range (25th - 75th percentile). Values represent site-level percentages for each ECR intervention measure.

LESSONS LEARNED

1. Highly engaged clinical champions and individual trainee communications accelerate training completion. Champions who are engaged, motivated, educated on the program, and actively working within the ED produce best outcomes.
2. Sites with engaged champions and onsite/rotating PIs score higher across all three metrics: Site A: 88% intro huddle, 91% care partner, 36% discharge huddle; Site B: 68% / 68%/ 72%.
3. Discipline-specific responsibilities for ECR components improve clinical quality process measure completion.
4. Huddles can be effective even when not possible at the bedside.
5. Collaborative audit and feedback is necessary between ED-LEAD team, site leadership and champions to identify gaps and remediate effectively.
6. Noted improvements with successive waves suggests improved implementation procedures from better strategies learned from prior waves.

CONCLUSIONS

We see considerable implementation variation between higher and lower performing ECR sites across each wave. We also suspect greater use of ECR strategies then what is documented in the EHR.

Process data for audit and feedback is necessary to identify gaps and develop solutions for each ED using a weekly cadence. Best practices should be shared to enhance engagement and improve intervention fidelity.

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