JAMDA 23 (2022) 1286–1287

JAMDA

journal homepage: www.jamda.com

Editorial

# Adapting Emergency Care for Persons Living With Dementia: Results of the Geriatric Emergency Care Applied Research Network Scoping Review and Consensus Conference

Christopher R. Carpenter MD, MSc [a,*], Scott M. Dresden MD, MSc [b], Manish N. Shah MD, MPH [c], Ula Hwang MD, MPH [d]

[a] Department of Emergency Medicine, Washington University in St Louis School of Medicine, Emergency Care Research Core, St Louis, MO, USA
[b] Department of Emergency Medicine, Northwestern University Feinberg School of Medicine, Chicago, IL, USA
[c] BerbeeWalsh Department of Emergency Medicine, University of Wisconsin-Madison, Madison, WI, USA
[d] Department of Emergency Medicine, Yale School of Medicine, New Haven, CT, USA

In an aging world, the emergency department (ED) is the front porch of the 21st century health care system, straddling the inpatient world of medical and surgical practice with the outpatient environment of office visits, home health, and long-term care.[1] Geriatric emergency medicine has emerged as a subspecialty within emergency medicine with a focus on the large and rapidly growing segment of ED patients with unique health care and social service needs: older adults. Geriatric emergency medicine, and the associated geriatric EDs take a more holistic approach to emergency care that revolves around the identification of common age-related syndromes and evidence-based approaches to align management recommendations with patient preferences and patient-reported outcomes that matter.[2]

"Altered mental status" in older adults is one common syndromic presentation to the ED, one that includes patients with both delirium and dementia. Historically dementia among ED patients has not been studied to the same degree as delirium. Despite this lack of attention, persons living with dementia (PLWD) are potentially at greater risk for adverse events when accessing emergency care. Unrecognized cognitive impairment can lead to substandard care, safety risks, and worse outcomes for older patients. Some research indicates an increased risk of ED revisits associated with dementia, whereas other studies show no such association.[3,4] Similarly, community-dwelling older adults with dementia have higher average expenditures for hospital and ED services, whereas long-term care facility residents have lower expenditures.[5] Some of the variability in observed outcomes is likely due to the reality that the spectrum of dementia severity in ED settings is unmeasured, as are the association of social determinants of health and health care disparities amid PLWD in the acute care setting. Nonetheless, symptom severity is associated with ED visit rates and the presence of dementia can alter emergency medicine's approach to and accuracy of common presentation.[6]

The United States National Plan to Address Alzheimer's Diseases includes multiple recommendations pertinent to ED care of PLWD. For example, milestones include credentialing of the health care workforce (including emergency medicine) to deliver dementia-specific care and including mandatory education of ED professionals as a condition of federal payment for services, raising transdisciplinary awareness of the importance of early detection of cognitive impairment, developing quality measures aligned with patient-centered outcomes, and collating existing evidence to identify gaps in knowledge and practice for alternative acute care models for PLWD.[7] The National Plan also targets a reduction in avoidable ED use by PLWD.

This issue of the *Journal of the Medical Directors Association* includes 4 articles from the Geriatric Emergency Care Applied Research 2.0—Advancing Dementia Care (GEAR 2.0-ADC) Network that identify multistakeholders' research priorities for the emergency department recognition of cognitive impairment, care transitions of patients with cognitive impairment, communication strategies for PLWD, and efficacious management of PLWD while in the ED.[8–11] Funded by the National Institute on Aging (NIA), GEAR 2.0-ADC engages PLWD, their care partners, social workers, geriatricians, neuropsychologists, pharmacists, nursing, and emergency medicine physicians to identify essential research questions and subsequently provide pilot funding (in partnership with the Emergency Medicine Foundation and West Health Institute) and infrastructure support to begin answering those unknowns.[12] GEAR 2.0-ADC's priorities provide a patient-centered foundation on which investigators can design research proposals, while clinicians can build protocols based on contemporary knowledge. The GEAR 2.0-ADC effort is not the first attempt to identify emergency medicine research priorities around an aging population, but it is the first to focus on and partner with PLWD and their care partners.[13] Several cross-cutting themes emerged from these 4 manuscripts that are worth highlighting.

Research reported in this publication received support from the National Institute of Aging of the National Institute of Health under Award Numbers R21/R33AG058926 and R61/R33 AG069822. The content is solely the responsibility of the authors and does not represent the official views of the National Institutes of Health.

The authors declare no conflicts of interest.

* Address correspondence to Christopher R. Carpenter, MD, MSc, Campus Box 8072, 660 S Euclid Ave, St Louis, MO 63110, USA.
*E-mail address:* carpenterc@wustl.edu (C.R. Carpenter).

https://doi.org/10.1016/j.jamda.2022.05.016

## Limited Quantity of Dementia Care Research in Emergency Department Settings

Each scoping review identified a surprisingly small cache of published research. The paucity of dementia-focused research may reflect concerns about the ethical recruitment of this population during times of emergency,[14] a philosophy of therapeutic nihilism since curative therapy for dementia does not exist and ED interventions for acute cognitive dysfunction are lacking,[15,16] or the novelty of an emerging clinical focus. In many ways, this level of research reminds us of the state of geriatric emergency medicine research in the early 2000s, a state that has been addressed through a similar sustained effort by NIA, the Hartford Foundation, the Atlantic Philanthropies, and others.[17]

## Inadequate Reporting Around Diversity, Equity, and Inclusion

The NIA (https://www.nia.nih.gov/research/osp/framework) and leading geriatrics organizations are now focusing on the impact of structural racism on older adults and their families, including ageism, classism, racism, sexism, homophobia, and xenophobia, but the GEAR 2.0-ADC scoping reviews noted scant reporting on these elements of inclusivity.[18] This research blind spot is a consequence of insufficient examples of prior geriatric emergency medicine clinical investigations that fully encompass inclusivity, as well as the lack of focus of Enhancing the Quality and Transparency of Health Research (EQUATOR) Network reporting standards on representative diversity. Strategies to recruit, retain, and report more representative samplings of older adults in research around PLWD await development.[19] In the meantime, the GEAR 2.0-ADC findings seem largely Anglo-centric or Franco-centric with limited ability to extrapolate to settings where English or French were not the primary language and ethnic diversity is prevalent.

## Balancing Inspiration With Pragmatism

Not surprisingly, GEAR 2.0-ADC scoping reviews identified reports from academic settings, often using research coordinators to collect data or perform interventions rather than nurses or physicians. Although some of the dementia screening, communication, or care transition interventions used personnel or equipment that is not routinely available in the average ED, almost all used time-on-task that is often identified as a barrier to improving the process of care for PLWD.[20] The tension between desirable care noted by GEAR 2.0-ADC for PLWD and their care partners vs the strain of delivering emergency care for all patients with time-critical diagnoses in the ED was palpable in the key stakeholders' discussions and voting to prioritize the research questions. To create interventions with the optimal potential for scale-up via implementation science, future emergency medicine research including PLWD will need to investigate real-world settings with disruptive, pragmatic innovations.[21,22]

Transforming geriatric emergency care for a cognitively frail population will require rational adaptations to research methods and more transparent inclusivity. A patient-centered focus on appropriate autonomy and maintaining functional capacity aligns with representative stakeholder's priorities.[23] Ultimately, a model of geriatric emergency medicine that is safe, effective, and acceptable for PLWD and their stakeholders could catalyze dementia-friendly care for downstream inpatient and outpatient services with enhanced communication, reliable infrastructure, and transdisciplinary outcome measures.[24,25]

## References


1. Hwang U, Shah MN, Han JH, Carpenter CR, Siu AL, Adams JG. Transforming emergency care for older adults. *Health Aff*. 2013;32:2116–2121.
2. Southerland LT, Lo AX, Biese K, et al. Concepts in practice: geriatric emergency departments. *Ann Emerg Med*. 2020;75:162–170.
3. Amjad H, Samus QM, Huang J, et al. Acute care utilization risk among older adults living undiagnosed or unaware of dementia. *J Am Geriatr Soc*. 2022;70:470–480.
4. Kent T, Lesser A, Israni J, Hwang U, Carpenter CR, Ko KJ. 30-day emergency department revisit rates among older adults with documented dementia. *J Am Geriatr Soc*. 2019;67:2254–2259.
5. Daras LC, Fent Z, Wiener JM, Kaganova Y. Medicare expenditures associated with hospital and emergency department use among beneficiaries with dementia. *Inquiry*. 2017;54:46958017696757.
6. Hunt LJ, Coombs LA, Stephens CE. Emergency department use by community-dwelling individuals with dementia in the United States: an integrative review. *J Gerontol Nurs*. 2018;44:23–30.
7. Alzheimer's Association National Plan Care and Support Milestone Workgroup, Borson S, Boustani MA, Buckwalter KC, et al. Report on milestones for care and support under the U.S. national plan to address Alzheimer's disease. *Alzheimers Dement*. 2016;12:334–369.
8. Nowroozpoor A, Dussetschleger J, Perry W, et al. Detecting cognitive impairment and dementia in the emergency department: a scoping review. *J Am Med Dir Assoc*. 2022;23:1314.31-1314-e86.
9. Dresden SM, Taylor Z, Serina P, et al. Optimal emergency department care practices for persons living with dementia: a scoping review. *J Am Med Dir Assoc*. 2022;23:1314.e1-1314.e29.
10. Carpenter CR, Leggett J, Bellolio F, et al. Emergency department communication in persons living with dementia & care partners: a scoping review. *J Am Med Dir Assoc*. 2022;23:1313.e15-131.e49.
11. Gettel CJ, Falvey JR, Gifford A, et al. Emergency department care transitions for patients with cognitive impairment: a scoping review. *J Am Med Dir Assoc*. 2022;23:1313.e1-1313.e13.
12. Hwang U, Carpenter CR, Dresden S, et al. The Geriatric Emergency care Applied Research (GEAR) Network approach: advancing stakeholder consensus and research priorities in geriatrics and dementia care in the emergency department. *BMC Geriatr*. 2022;12:e060974.
13. Carpenter CR, Heard K, Wilber ST, et al. Research priorities for high-quality geriatric emergency care: medication management, screening, and prevention and functional assessment. *Acad Emerg Med*. 2011;18:644–654.
14. Prusaczyk B, Cherney SM, Carpenter CR, DuBois JM. Informed consent to research with cognitively impaired adults: transdisciplinary challenges and opportunities. *Clin Gerontol*. 2017;40:63–73.
15. Carpenter CR, Malone ML. Avoiding therapeutic nihilism from complex geriatric intervention "negative" trials: STRIDE lessons. *J Am Geriatr Soc*. 2020;68:2752–2756.
16. Carpenter CR, Hammouda N, Linton EA, et al. Delirium prevention, detection, and treatment in emergency medicine settings: a Geriatric Emergency Care Applied Research (GEAR) Network scoping review and consensus statement. *Acad Emerg Med*. 2021;28:19–35.
17. Rosen T, Shah M, Lundebjerg NE, et al. Impact of Jahnigen/GEMSSTAR scholarships on careers of recipients in emergency medicine and on development of geriatric emergency medicine. *Acad Emerg Med*. 2018;25:911–920.
18. Lundebjerg NE, Medina-Walpole AM. Future forward: AGS initiative addressing intersection of structural racism and ageism in health care. *J Am Geriatr Soc*. 2021;69:892–895.
19. Hunold KM, Goldberg EM, Caterino JM, et al. Inclusion of older adults in emergency department clinical research: strategies to achieve a critical goal. *Acad Emerg Med*. 2022;29:376–383.
20. Chary AN, Castilla-Ojo N, Joshi C, et al. Evaluating older adults with cognitive dysfunction: a qualitative study with emergency clinicians. *J Am Geriatr Soc*. 2022;70:341–351.
21. Shih RD, Carpenter CR, Tolia V, Binder EF, Ouslander JG. Balancing vision with pragmatism: The geriatric emergency department guidelines-realistic expectations from emergency medicine and geriatric medicine. *J Am Geriatr Soc*. 2022;70:1368–1373.
22. Southerland LT, Hunold KM, Van Fossen J, et al. An implementation science approach to geriatric screening in an emergency department. *J Am Geriatr Soc*. 2022;70:178–187.
23. van Oppen JD, Coats TJ, Conroy SP, et al. What matters most in acute care: an interview study with older people living with frailty. *BMC Geriatr*. 2022;22:156.
24. Mooijaart SP, Carpenter CR, Conroy SP. Geriatric emergency medicine—a model for frailty friendly healthcare. *Age Ageing*. 2022;51:afab280.
25. Carpenter CR, McFarland F, Avidan M, et al. Impact of cognitive impairment across specialties: summary of a report from the U13 conference series. *J Am Geriatr Soc*. 2019;67:2011–2017.