Dementia and transitional care: Gaps in research and practice

July 16 2019, by Beth Prusaczyk

Credit: VUMC

Patients with dementia are hospitalized at higher rates and involved in transitional care more frequently than those who are cognitively unimpaired. Yet, current practices for managing transitional care—and the research informing them—have overlooked the needs of patients with dementia and their caregivers.

"Patients with dementia have only been considered in a small portion of decades of transitional care studies," said Beth Prusaczyk, Ph.D., a recent postdoctoral fellow in The Center for Clinical Quality and Implementation Research at Vanderbilt University Medical Center. Prusaczyk is among the experts beginning to develop evidence-based practices to support patients with dementia in transitional care.

"The research has excluded patients with dementia for several reasons: because of IRB hurdles, and out of the concern that they can't fully appreciate participation," Prusaczyk said. "There is also an erroneous assumption you can't get good data."

Needs Going Unmet

In a new study published in the *Journal of Gerontological Nursing*, Prusaczyk and colleagues showed that older patients with dementia at one major teaching hospital were less often provided with transitional care steps including patient education, discharge planning, and documentation of medication history, as compared to patients without dementia.

The study used a chart review of 210 patients aged 70 and older who were discharged from an inpatient stay other than the ED. The 126 patients with dementia—60 percent of those included—experienced significant differences in their transitional care. The researchers assumed charts reflected steps taken with patients or caregivers.

Care teams collected medical histories from the patient, family member or other provider for only 60 percent of patients with dementia, compared to 86 percent of patients without. Patients with dementia also received discharge education far less frequently. This included education about:

- In-hospital medications (77 percent of patients with dementia; 100 percent of patients without)
- Diagnoses (45 percent; 83 percent)
- Follow-up needs (42 percent; 81 percent)
- Medication regimens after discharge (47 percent; 80 percent)

Prusaczyk says the researchers confirmed these trends during qualitative interviews with providers at the hospital. "They didn't necessarily set a high priority for these types of transitional care activities for patients with dementia or their caregivers," she said.

Aligning Care

In a separate study of the same patient cohort, published in Journal of Interprofessional Care, Prusaczyk's group applied social mapping and network analyses to identify 14 unique types of actors engaged in discharge communications. Both clinicians and non-clinicians (e.g. social workers, case managers) contributed to discharge planning. Perhaps concerningly, primary care physicians did not participate, unless responding to queries initiated by case managers.

"I'd like more research to understand why transition care teams are still struggling to communicate internally, but especially with primary care providers. This is obviously significant with an older patient with dementia," Prusaczyk said.

Prusaczyk, who is a former hospital social worker, acknowledges the "pressures and challenges" of managing care transitions across complex teams. Still, there are clear opportunities to better understand and serve the needs of patients with dementia.

"My focus is identifying changes we can enact now. System-level changes are needed, but there are communication tools available today

that improve retention—making sure patients have their glasses, using teach-back and more visual aids," Prusaczyk said. "The change can happen if it is prioritized."

More information: Beth Prusaczyk et al, Differences in Transitional Care Provided to Patients With and Without Dementia, *Journal of Gerontological Nursing* (2019). DOI: 10.3928/00989134-20190530-02

Beth Prusaczyk et al. Networks of hospital discharge planning teams and readmissions, *Journal of Interprofessional Care* (2018). DOI: 10.1080/13561820.2018.1515193

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