P052 Utility of data captured by transition referral forms for program evaluation and research

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Introduction: Increase in functional decline of older adults after discharge from the emergency department (ED) has been reported; however, evaluations of interventions to mitigate this problem are infrequent. Data collected in the ED on older adults may document functional status, yet their utility for research is unknown. This study aimed to assess the usability of data collected by ED Transition Coordinators (EDTC) during routine assessments for functional decline research. Methods: EDTCs assess all patients 75 years old presenting to the ED and complete a standardized Transition Assessment Referral (TAR) form that documents patients independence and daily functioning. To measure the utility of these forms for research purposes, trained research staff evaluated the TARs completed in April 2017 by TCs in the University of Alberta Hospital ED by extracting data from the TARs into a purpose-built REDCap database. Researchers selected and assessed for completeness and clarity the following variables unique to the TARs: facility vs. non-facility living, independence with 14 Activities of Daily Living (ADLs), community services in place, and homecare referrals for discharged patients. The proportion of TARs with data for each variable and the proportion of forms with unambiguous responses in each section are reported. Results: Overall, 500 forms were analysed; patients were 41% male with a mean age of 82 (SD = 11.2). Homecare referrals, facility vs. non-facility living, and independence with 14 ADLs/IADLs were the most frequently documented variables (81%, 78%, and 79%, respectively); however for ADLs/IADLs, 59% of the 79% had one or more missing components. While fall history was reported in 301 forms (60%), only 107/301 (36%) reported the number of falls in the last 90 days. The referral to homecare variable was complete in 217/268 (81%) forms; however, 99% of files were missing data about goals of care, personal directives, and receipt of community services. Conclusion: Although some information on elderly patients is consistently reported, many of the social service/human factors associated with functional decline are not recorded. While data on the TARs may be useful for studying functional decline in the ED, exploring the barriers to form completion may improve adherence thereby increasing their research utility.

Keywords: transitions in care, elderly, secondary data usage

P053 Characteristics and outcomes of patients seen by transition coordinators in the emergency department

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Introduction: Emergency Department (ED) Transition Coordinators (TC) have been introduced to many EDs. In Alberta, the EDTC role was designed to evaluate the home needs of senior patients (75 years of age) to enable safe return home after an ED visit, thereby mitigating admissions and return ED visits. The effectiveness of this role at achieving its objectives has received limited evaluation. Methods: TCs assess all ED patients 75 years old, and physicians request TC assessment for patients <75 years. The TC assessment includes completing a Transitional Assessment Referral (TAR) form that collects information on comorbidities, living arrangements, connections to community and homecare services, independence in activities of daily living (ADLs), and referrals, and disposition. Trained research staff extracted data from consecutive TARs for patients presenting during April 2017 into a REDCap database. The proportions of patients seen by TCs who were admitted, had an unplanned return to the ED within the study period, or received a new homecare referral were assessed. Categorical variables are reported as proportions; continuous variables are reported as mean and standard deviation (SD) or median and interquartile range (IQR), as appropriate. Results: In April 2017, there were 9849 visits to the ED; of these, TCs assessed 478 patients during 500 visits. The mean age was 82 (SD = 11.2) and 41% were male; 22 patients presented twice during April 2017. Patients had a median of 2 (IQR: 1, 5) co-morbidities and 40 (8%) patients reported falls in the past 90 days (median = 1; IQR: 1, 2). Overall, 144 (29%) patients lived in a care facility, while 204 (41%) lived at home; residence was unclear or not documented for 152 (30%). Patients reported being independent in a median of 9/14 (IQR: 3, 13) ADLs. An existing homecare connection or receipt of homecare services was documented for 185 patients (37%). Finally, 59 (12%) visits included a new or updated homecare referral, while 200 (33%) ED visits ended in admission. Conclusion: Elderly patients seen in the ED assessed by EDTCs are complex, and despite being well connected, they frequently need hospitalization. In a small proportion of cases,