Acute Care for Elders (ACE): Physical Therapy in an Interdisciplinary ACE Consult Team—Dementia, Delirium, and Beyond

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- Amanda LaLonde, PT
- Combined Sections Meeting
- January 24, 2013

Objectives

- Understand components of ACE team
- Understand how an ACE team:
  - Improves patient functional outcomes
  - Decreases LOS & hospitalization cost
- Have framework for implementing a multi-factorial, interdisciplinary program to prevent/treat delirium
- Understand best evidence for management of hospitalized older adults at risk for delirium
- Identify ways PT within an ACE team may decrease Medicare/Medicaid “never events” and improve discharge planning for observation patients

Why are we all here?

- Gray Tsunami...

  - Age 65+ predicted to increase from 35 million (2010) to 71 million in (2030)

University of Wisconsin ACE Team

- Clinical Nurse Specialist (team leader), Geriatric Medicine, Pharmacy, Physical Therapy, Social Work
- Consult-based service, discipline-specific rounding, daily interdisciplinary team meeting

Benefit of ACE Model

- Older adults only 13% of the population, but 36% of hospital admissions
- Nearly 50% of hospital spending
- Most clinicians not trained to manage older adults correctly
- Increase LOS (and costs)
- Increased likelihood of SNF/institutionalization at discharge, potentially long-term

Benefit of ACE Model

- Potential adverse outcomes due to hospitalization (avoidable)
  - Delirium
  - Restraint use
  - Falls
  - ADL/functional decline
  - Infections
  - Poor nutrition
  - Improper medication use
Comprehensive Geriatric Assessment (CGA)

“Multidimensional interdisciplinary diagnostic process focused on determining a frail older person’s medical, psychological, and functional capability in order to develop a coordinated and integrated plan for treatment and long-term follow-up.”


CGA: Interdisciplinary Teams

- High likelihood of multiple overlapping problems = need to assess multiple domains
- Multiple domains = include multiple disciplines
- Getting beyond compartmentalized care
  - Increased need for teams
  - Increased PT autonomy
    - The diagnosis is just the tip of the iceberg...
    - Need to start asking... WHY?

Research: Interdisciplinary Models

- Meta-Analysis of CGA care versus usual care
  - Significant improvement in odds of being alive, in own home if received CGA
  - Less cognitive decline
  - Increased ability to perform ADLs
  - Cost reduction (some studies)
  - Decreased LOS

Effectiveness of acute geriatric units on functional decline, living at home, and case fatality among older patients admitted to hospital for acute medical disorders: meta-analysis. BMJ 2009; 339:b4060.

Research: Interdisciplinary Models

- Hospital admission alone is risk for
  - Functional decline
  - Frailty
  - SNF admission
- BMJ 2009 Meta-analysis: Acute geriatric units versus conventional care
  - Units reduced ADL decline by 18%
  - Lower risk of functional decline
  - More likely to live at home at discharge
  - No differences in case fatality

Research: Interdisciplinary Models

- ID model benefits are particularly true for
  - Wards versus Mobile Units via research
  - UW ACE team IS a Mobile Service
- Have had success at UWMC—2011 data showing decreased LOS and cost savings
  - Per patient: $3,039 average
  - Cost savings for years 2007-2011 is estimated to be $3,622,488 total; $812,217 per year
  - $600,000 per year after adjusting for staff salaries
Use of Interdisciplinary (ID) Model
Hip fx population
- 310, 000 (2003)
- Re-admission rates 20-30% in first 30 days
  - Delirium, dehydration, underlying cardiopulmonary disease
- Medical ID consultation associated with
  - Improved 1-yr mortality
  - Decreased LOS
  - Decreased incidence of delirium
  - 61% non-ID treatment
  - 48% ID treatment group

Medical consultation for patients with hip fracture. In: UpToDate, Schmader, KE (Ed), UpToDate, Waltham, MA, 2012.

Types of ACE Models: Units/Wards
- Designated units or wards
- Home-like—carpeted, spacious rooms with large windows, large clocks, and calendars
  - Activities in hallways
  - Puzzles, aquarium
  - Music, art
- Specially trained staff
  - Care of elders
  - Patient satisfaction
  - ID teams

Types of ACE Models: Mobile
- Mobile ID teams that see patients on all hospital floors
- Ability to provide CGA to anyone in hospital
  - Similar members and roles
  - PT/OT, Pharmacy, Social Worker, RN, MD, Dietician, Facilitator
- Successful UW mobile ACE model
- Improved patient/family satisfaction, medication compliance, increased team communication and delivery of care

Components of UW ACE team
Mission Statement
- To offer patients 65 and older a proactive and comprehensive interdisciplinary team geriatric evaluation directed toward preserving function and independence and preventing the hazards of hospitalization

Program Goals
- Improve quality of care of the hospitalized elderly
- Improve patient safety
- Prevent functional decline
- Prevent onset or worsening of delirium
- Reduce hospitalized length of stay
- Facilitate discharge to appropriate setting
- Assist with transitions of care settings

Components of UW ACE team
Role of Nursing
- Ensure that nurses recognize the uniqueness of the geriatric hospitalized patients
  - Respect for lived experience; at risk for iatrogenic illnesses
- Delirium: Education of family and staff regarding all areas related to delirium
  - Risk factors, prevention, treatment, management
- Delirium: Increase awareness that a delirious patient impacts the system at every level with an increased need for collaboration
Components of UW ACE team

Role of Nursing: Delirium Protocol

- Appropriate levels of cognitive stimulation
- Day/night sleep cycle
- Mobility
- Visual/hearing issues
- Nutrition/elimination concerns
- Environmental awareness/modifications
- Orientation methods
- Consistency of nurse/patient relationship
- Safety/Risk issues (falls, restraints, staff safety)
- Education of patient/family (risk factors/prevention, treatment, resolution of symptoms)

Role of Nursing: System-wide advocacy

- Formation of EBP nursing guidelines for:
  - Delirium (CAM, risk factors, prevention)
  - Pain in the geriatric patient
  - Fall prevention (early alert triggers)
  - Restraints—low bed and restraint alternatives
- Sitters: Rounding team and metrics on judicious personal safety assistant (PSA) use
- Recognition of staffing needs with delirious patients
- Diversional activity carts

Role of Pharmacy

- Completes a secondary medication reconciliation
  - Admission order omissions
  - Medication & dosing discrepancies
  - Primary review done at admit by ward Pharmacist
- Considers age-related changes that may alter medication pharmacokinetic/dynamic characteristics
  - Ex: Creatinine clearance
- Evaluates medications that may impact a wide range of geriatric syndromes
  - Confers with the ward pharmacist and nursing staff
  - Patient behavior
  - Medication management

Role of Pharmacy: Medications that may lead to Delirium

- Antihistamines
- Anticonvulsants
- Opiates
- NSAIDs
- Corticosteroids
- Benzodiazepines
- H2 receptor antagonists
- Dopamine agonists (Parkinson’s meds)
- Antibiotics
- Cardiovascular drugs

Role of Pharmacy: Medications that may lead to Delirium

- Inappropriate drug prescription
  - Compliance
    - Regimen complexity, cost, fear of side effects, cognitive impairment, visual/hearing impairment, failure to thrive
  - Over/under-dosage
    - Renal function
    - Hepatic function
  - Drug interactions
  - Polypharmacy
  - Anti-cholinergic burden

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Components of UW ACE team

Pharmacy Role: Geriatric Syndromes

- Mobility and self-care
- Medication management and adherence
- Safety and injury potential
- Health promotion (primary/secondary prevention)
- Nutrition and elimination issues: bowel/bladder
- Disposition issues
- Pain
- Skin integrity
- Depression, anxiety, delirium, dementia, altered thought processes

Pharmacy Role: System Changes

- Delirium guidelines
- Local, state and national poster presentations
- Workshops on the interdisciplinary team model
- Updated order sets for hospital admission
- Best practice alerts
- Pharmacist-targeted workshops
- Staff resource for medication-related issues and questions

Pharmacy Role: Geriatric Syndromes

- Onset
- Delirium Pharmacotherapy
  - EPSEs Sedation, respiration control
  - Parenteral (15-30 mins)
  - PO, IV, IM
  - PO, IV

Components of UW ACE team

Delirium Pharmacotherapy

<table>
<thead>
<tr>
<th>Drug</th>
<th>Haloperidol</th>
<th>Physostigmine</th>
<th>Benzodiazepine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advantages</td>
<td>No efficacy advantage over other phenothiazines</td>
<td>Less sedation and agitation</td>
<td>When sedation, lowest incidence in hospital, adverse effect profile in fatality</td>
</tr>
<tr>
<td>Disadvantages</td>
<td>Oral route and higher cost</td>
<td>Oral route and higher cost; rapidity of effect varies</td>
<td>Black box warnings</td>
</tr>
<tr>
<td>Administration</td>
<td>PO, IV, IM</td>
<td>Oral, IV</td>
<td>PO, IV, IM</td>
</tr>
<tr>
<td>Dosing</td>
<td>0.5-5 mg q 30-60 mins for initial control; Maintenance = the daily dose for initial control</td>
<td>Dopamine</td>
<td>0.5-2.5 mg q 24-48 hrs (every 4-6 hrs)</td>
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<tr>
<td>Pharmacokinetics</td>
<td>Clearance decreased with aging</td>
<td>Clearance decreased with aging</td>
<td>Clearance decreased for fat soluble agents</td>
</tr>
<tr>
<td>Route</td>
<td>PO, IV (15-20 mins)</td>
<td>PO, IV</td>
<td>PO (15-30 mins)</td>
</tr>
<tr>
<td>Monitoring</td>
<td>EPSEs</td>
<td>Sedation</td>
<td>Sedation, respiration</td>
</tr>
</tbody>
</table>

Role of Social Work: Why is discharge planning important?

- Hospital stay is a brief window in the life of the patient
  - What comes before and after is just as important
- Frail elders are especially at risk
- Poor planning results in failed care plans
- Poor handoffs result in unnecessary readmissions
- Delirium: Highly impacts disposition
  - Increases LOS
  - Increases cost of care

Role of Physical Therapy

- Primary roles of physical therapy
  - Mobilization
  - Discharge planning
- Mobilization is challenging with both hyper- and hypo-active delirious patients
  - Tendency for PT/Nursing to state “Hold PT today” — because of this, patients will not be mobilized

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Components of UW ACE team
Role of Physical Therapy
- Delirious patients often have delayed discharges
  - Agitated behaviors
  - Restraints
  - Sitters
- Key component of breaking delirium is early and aggressive mobilization
- Facilitates faster discharge planning
- PT represents the entire therapy team
  - PT, OT, Speech, Swallow
  - Makes recommendations accordingly

Role of Physical Therapy: Problems Created by Immobility
- Changes in the Neurosensory System
  - Social isolation—feelings of loneliness
  - Mood changes—increased anxiety, irritability and depression
  - Decreased performance on cognitive testing
  - Perception of time intervals distorted
  - Affects EEG pattern of sleep
    - Less time spent in deep sleep
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Role of Physical Therapy: Sleep Cycle and Mobility
<table>
<thead>
<tr>
<th>Standard Phase</th>
<th>Sleepy, Go to Bed</th>
<th>Wake Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>6:00-7:00</td>
<td></td>
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<tr>
<td>6:00-7:00</td>
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</tr>
</tbody>
</table>

Adapted from: Ancoli-Israel, S. All I Want Is a Good Night’s Sleep. Mosby; 1996.

Role of Physical Therapy: How to Mobilize
- Mobilize
  - As soon as possible
  - Frequently during daytime hours (at least 3x/day)
- If ambulatory: Try 2 people with gait belt & hand hold
- If debilitated: Transfer to bedside chair or slide to cardiac chair (instruct RN/CNA)
  - Educate and Document
  - Collaborate with OT, RN/CNA, Geriatric CNS for mobilization ideas/techniques
    - Especially if the patient is agitated
Components of UW ACE team
Role of Physical Therapy: How to Mobilize
- Ensure appropriate activity orders
- Patient out of bed within 6-8 hours of admission, unless bed rest ordered (discontinue if inappropriate)
- Have patient out of bed for meals
- Reduce or eliminate barriers to mobility
- Encourage independence with ADLs
- Seat patient near nurses’ station
  - Give activities to engage patient and minimize restraints

Role of Physical Therapy: Rehabilitation
Interventions
- Consult family: Verify prior level of function and cognition
- Early mobilization: Discontinue bed rest orders
- Fall prevention: Avoid restraints
  - Increased stress = increased cortisol levels = can cause increased agitation/delirium
  - Implement alarms, low bed, and sitter as needed
- Reality orientation as appropriate
  - Depends on underlying dementia and to what degree
  - ADL retraining

Components of UW ACE team
Role of Geriatric Medicine
- 4-6 Geriatricians rotate by the week
  - Monday through Friday mornings
- Billing for patients is submitted for the MD service
- ACE averages ~2.6 new patients and have 3 follow-up patients each day
- 47% of ACE consults are for a cognitive evaluation
- Patients usually have a mix of dementia and delirium
- The most common ACE discharge diagnosis related group (DRG) is delirium—over 30% of the ACE consult patients have this diagnosis

Components of UW ACE team: Reason for Consult
- Shorter hospital LOS and lower costs
  - Patients seen by ACE team within 4 days of admission
  - Versus those seen later in the hospital stay
  - Change in the culture of the hospital
  - Venue for teaching all disciplines about the elderly and team work
  - Proving value to hospital administration
    - Annual ACE Executive Summary
    - Demonstrate ID model for the hospital
    - Better management of aggression, pain, and reduced hospital readmissions
Delirium?

Could This Be Delirium?

• Diagnosis: Confusion Assessment Method (CAM)
  - Recent onset
  - Fluctuating awareness
  - Memory impairment
  - Attention impairment
  - Disorganized thinking
  - Unable to concentrate, sustain, or shift attention

• Two aspects to the diagnostic process
  - Recognize the presence of delirium
  - Uncover underlying medical illness that has caused delirium—again we need to be asking WHY?

Could This Be Delirium?

• Hyperactive (25%)—easier to diagnose, better outcomes
  - Psychomotor activity is increased
  - Agitation is prominent
  - Delusion and hallucinations more common

• Hypoactive (25%)
  - Psychomotor activity is decreased
  - Can be misdiagnosed as depression

• Mixed Delirium (35%)
• No change in activity levels (15%)—difficult to treat

Could This Be Delirium?

• Under-recognized and misdiagnosed
  - Some report up to 70%
• Expensive to treat
• Complications
  - Increased LOS
  - Increased SNF admission
  - Increased LTC needs
  - Increased cost of care
  - Increased long-term cognitive effect
Delirium: Costs

- NIH estimation
  - Additional $2500 per patient
  - $6.9 billion annual Medicare dollars (2004)
- 30% of older adults experience delirium at some point in hospitalization
- Post-operative risk 10-50%


Delirium: NICE Recommendations for Prevention in At-Risk Adults

- Ensure team that is familiar with person at risk- avoid moving between rooms or wards
- Assess and give multi-component intervention, tailored to patient needs within 24 hours of admission
- Intervention should be delivered by team trained in delirium prevention
- Address cognition—provide clocks, signs, calendar, re-orient, facilitate family visits

Delirium: NICE Recommendations

- Address dehydration & consumption
- Assess for hypoxia
- Address infection: Treat cause, avoid unnecessary catheterization
- Address immobility: Mobilize soon after surgery, provide readily accessible walking aids. If unable to walk, provide active ROM exercises
- Address pain: Look for nonverbal signs of pain, especially in dementia population

Delirium: Risk factors

- Risk factors: CVA, Parkinson’s, advanced age, sensory impairment
- Dementia risk factor: Delirium develops in 22-89% per meta-analysis of studies
- Precipitating factors: Poly-pharmacy, infection, immobility, restraint use, catheters, malnutrition
- Occurs in 30% of elderly CABG patients
- Occurs in 50% of hip fracture patients

Delirium: Role of ID Teams

- Due to fluctuating nature: Provider teams are essential
  - Each has a different role, different patient experience
  - Putting together the clinical presentation gathered from each provider enhances identification, diagnosis and treatment
- PT role
  - Per NICE guidelines and evidence, need to mobilize this population early and often
  - Train staff on safety and complex patient mobilization

Delirium: Prevention & Treatment

• Treatment is NOT as effective as prevention
• Little evidence about treatment of delirium once it has developed
• Early Geriatrics Consult may be helpful in prevention of delirium
  • RCT, n=126, of those >65 years admitted for surgical hip fracture
  • Proactive Geriatrics/Interdisciplinary consults reduced delirium risk 32 vs 50%

Role of PT in ACE: Delirium

• Every time you see the patient
  – Open shades, lights ON
  – EDUCATE STAFF
  – Mobilize
  – Orient
  – Signs, pictures, handouts
  – Give “busy” work/activities
  – Move to nursing station, take outside, etc.

PT Autonomous Practice

• Back to the CGA model
  – Must consider the WHY in all areas
  – Not just the quick home safety eval, WFL, needs SNF story
• Assess meds, history, and current admission in relation to PT
• Don’t just go along with a plan that doesn’t seem right
  – Question the MDs, question the plan, use your clinical skills for support
  – Not challenging the system is detrimental to care and growth

PT Autonomous Practice

• Use of the ACE experience and ID model to increase confidence
• Look at meds on ALL older adult patients
  – Question indication, repetition
  – Resistance at first, respect as a result
• Suggest referrals
  – Geriatric clinics, falls clinics, memory clinic

PT Autonomous Practice

• Use PT consult/educational role
  – Patients, family, staff
  – Deleterious medications, available older adult services, less restraint use
• Complete quick cognitive screens
  – Clock, SLUMS, Animal naming
• Activity orders: few reasons for bed rest
  – WHY in bed?
  – Show evidence of early mobilization (PLENTY out there)

PT Autonomous Practice: Cognitive Testing

CLOSE YOUR EYES
PT Autonomous Practice: Cognitive Testing

Literature Review: Hip Fractures and Delirium Prevention

- *Journal of Gerontology.* 2003 Nov; 58(11):1042-1045. Time to ambulation after hip fracture surgery; relation to hospitalization outcomes. CONCLUSION: 131 patients, time to ambulation was significantly less on orthopedic floors compared to general surgery patients. Time to ambulation was an independent predictor of new pneumonia, new onset delirium, and to prolonged length of hospital stay.

- *Clinical Orthopaedics and Related Research.* 2004 Aug; (425):44-49. The Older Orthopaedic Patient. CONCLUSION: Older patients undergoing orthopaedic surgery are more likely to have peri-operative complications. Early mobilization after surgery, avoiding certain drugs, avoiding restraints (including Foley catheter), encouraging hydration, promoting normal sleep, compensating for sensory disorders, and stimulating daytime activities are important to minimize complications.

- *Disability and Rehabilitation.* 2005; 27(18-19):1123-1127. Five-year experience with the 'Sheba' model of comprehensive orthogeriatric care for elderly hip fracture patients. CONCLUSION: 538 patients, mean age 83.2 years, treatment within this facility was associated with low rates of major morbidity and mortality, short stay and acceptable functional outcomes. Data provided clinical evidence to support the concept that hip fracture represents a geriatric rather than orthopedic disease—surgical, medical, rehab management all occurred at the same facility.

- *Aging Clinical and Experimental Research.* 2008 Apr; 20(2):113-122. Orthogeriatric care for the elderly with hip fractures: where are we? CONCLUSION: Orthogeriatric care should be viewed as a radical alternative to the traditional model of care for improved outcomes in the fractured elderly. Key points of care are early surgery, immediate mobilization, prevention and management of delirium, pain and malnutrition, as well as comprehensive geriatric assessment (CGA).
Literature Review: Hip Fractures and Delirium Prevention

- **Age and Aging.** 2007 Mar; 36(2):190-196. Proactive care of older people undergoing surgery (POPS): designing, embedding, evaluating, and funding a comprehensive geriatric assessment service for older selective surgical patients. CONCLUSION: 108 patients, 54 non-POPS vs 54 POPS. POPS group had fewer post-op complications including pneumonia and delirium, fewer pressure sores, better pain control, faster mobilization, less inappropriate catheter use, and length of stay was reduced by 4.5 days.

Never Events - Observation - and Transitions of Care

- **Patient Protection and Affordable Care Act of 2010**
  - Requires the Secretary to issue Medicaid regulations effective July 1, 2011 prohibiting federal payments to states for any amounts expended for providing medical assistance for health care-acquired conditions (HCACs)
  - Define the term “health care-acquired condition” in accordance Medicare’s inpatient hospital statutory language at 1886(d)(4)(D)(iv)
  - Apply Medicare’s provisions re: identifiable hospital-acquired conditions (HAC) and never events to Medicaid regulations, excluding any condition identified for non-payment under Medicare that may not be applicable to Medicaid

Never Events - Observation - and Transitions of Care

- Ten Category 1 HCACs—of which half can be caused by immobility or prolonged hospitalization associated with delirium
  - Stage III and IV Pressure Ulcers
  - Falls and Trauma
  - Catheter-Associated Urinary Tract Infection (UTI)
  - Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following TKA or THA
  - Surgical site infection

Never Events - Observation - and Transitions of Care

- Affordable Care Act (ACA)
  - Will penalize hospitals for 30-day readmissions of patients with geriatric diagnoses including Pneumonia, CHF, or acute MI
  - These patients are all at high-risk of delirium with associated prolonged hospital stay or readmission because of side-effects from a delirious episode during hospital admission
  - These patients are all being referred to our Transitions of Care Program at UW Hospital

Never Events - Observation - and Transitions of Care

- Dementia patients are often admitted with increased confusion or a fall
  - Likely not a diagnosis that qualifies for Inpatient Classification
  - May also experience pre-hospital delirium
  - Delirium is **NOT** considered a diagnosis for Inpatient Classification (even though it can be life-threatening)
  - Often not safe to return to prior living situation without therapy/SNF rehab intervention
  - **ALSO** high risk of readmission within 30 days (risk of Medicare non-payment)
  - Referral to Transitions of Care Program

Never Events - Observation - and Transitions of Care

- At UWHC, currently focused primarily on CMS-identified diagnoses of CHF, acute MI, and pneumonia
  - Expanding to include complicated geriatric diagnoses at high risk of failure at home
  - MD, APN, and RN Case manager
  - Enhanced discharge POC, med reconciliation, red flags, expedited follow-up for OP visits
  - Can overlap with HH services
  - Bridges care between hospital and primary care teams, prevention of re-hospitalization
  - Outcomes to be tracked by Health Innovation Program

**References**

- Francis J, Young G. Diagnosis of delirium and confusional states. In: UpToDate, Amsbury M, Schmader K (Eds), UpToDate, Waltham, MA, 2012.

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