NEW INITIATIVES TO IMPROVE CLINICAL OUTCOMES FOR WV'S ELDERLY

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New Initiatives: Improving Clinical Outcomes For WV's Elderly

- Goal:
  - *Review new initiatives designed to improve clinical outcomes for WV's elderly, and explore other areas of need of attention*
- Objectives:
  - *Describe the CIRAC program (Cognitive Impairment Recognition in Acute Care), including rationale, implementation, and outcomes*
  - *Describe the RBADS (Rational Benzodiazepine Avoidance and De-prescribing Strategies) program, including expectations for outcomes*
  - *Describe the "ICOG" initiative and invite attendees to review their own experiences with poor clinical results in elderly West Virginians*
    - Explore factors which may be amenable to clinical interventions
    - Propose next steps for ICOG to consider

New Initiative #1 - CIRAC

- Cognitive Impairment Recognition in Acute Care
  - *Why would a special initiative be needed to recognize Cognitive Impairment?*
    - From the MAP (Make a Plan for WV, for care of persons with dementia) process, a huge gap in acute care of PWD was noted.
      - *Up to 45% of hospitalized elders may have cognitive impairment*
      - *Many signs of cognitive changes are subtle and may be ignored or not recognized*
      - *Failure to recognize cognitive impairment in hospitalized patients leads to poor outcomes*
      - *And to poor transitions of care and discharge planning*

New Initiatives - CIRAC

- Cognitive Impairment Recognition in Acute Care
  - *Why is CIRAC needed?*
- ~45% of hospitalized elders have cognitive impairment
  - *Due to dementia, delirium, or delirium-on-dementia*
  - *20% to 50% of patients with CI will not have a diagnosis listed, in fact will have no notation in their chart*

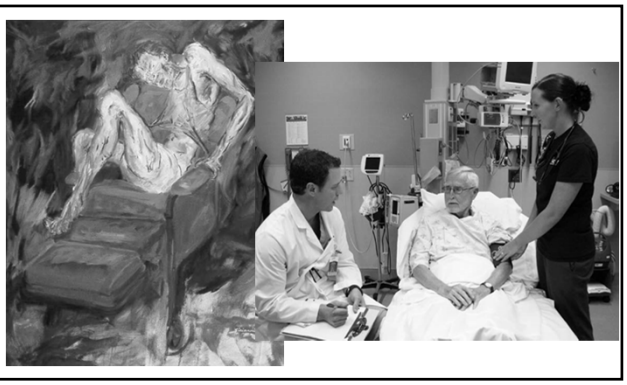
Why dx not noted?

- A simple oversight?
  - *Can be!*
    - Pace of hospitalization
    - Reluctance to confront pt with dx
- More often it is because CI is not known or suspected
  - *Study of persons > 70yo with chronic heart failure, in hospital for procedure*
  - *Cardiologists suspected CI in 12%*
  - *Tested and found to have CI: 45.6%, half of them severe*

New Initiatives - CIRAC

- *Why is CIRAC needed?*
  - Many signs of cognitive changes are subtle and may be ignored or not recognized
    - *Why?*
      - Patient-based reasons
      - System-based reasons
    - *If the behavior is one of the below, it is readily recognized:*
      - Elderly patient asks for "Mommy"
      - Pt. cannot carry on a simple conversation
      - Is repetitive
      - Pt. cannot be awakened
      - Pt. acts paranoid, is having hallucinations, talks "out of their head"

- *If the behavior is, rather, one of these, it may **not** be recognized as evidence of CI:*
  - Pt. described as "Poor Historian"
  - When given food tray, pt. makes no attempt to eat, or is "flustered" by the tray set-up, especially if more than once
  - Pt. repeatedly fails to follow instructions or answer questions
  - Person appears "bewildered"
  - Pt. unexpectedly wets or soils bed
  - Pt. becomes extremely agitated over a small matter



- Other than signs being subtle, why else might CI not be recognized?
  - *Attribution of sx/sx to aging*
  - *Attribution of sx/sx to cantankerousness*
  - *Patients may be superficially intact*

New Initiatives - CIRAC

- *Why is CIRAC needed?*
  - System-based reasons for failure to recognize?
    - ***"Fog is more dangerous than dark, as it gives the illusion of seeing."*** *Aleksandra Ninkovic*

- Fog is produced in healthcare by:
  - *Shortened LOS*
  - *More procedures during a shortened LOS*
  - *Fragmented care teams*
  - *EHR*
  - *Even….architecture and design*

New Initiatives - CIRAC

- *Why is CIRAC needed?*
  - Failure to recognize cognitive impairment in hospitalized patients leads to **poor outcomes**
    - *Inappropriate treatment (of the primary condition and the CI)*
      - Ex.: Agitated pt. treated with benzodiazepine
      - Ex.: Pt. can't confirm meds, so old list used
    - *Inappropriate testing; wrong diagnostic decisions*
    - *Failure of patients to be adequately nourished and hydrated*
    - *Patient and family dissatisfaction*
    - *Increased patient agitation, Increased rate of falling, Increased polypharmacy*

New Initiatives - CIRAC

- *Why is CIRAC needed?*
  - Failure to recognize leads to poor transitions of care and poor discharge planning
  - "The results of a poor transition of care are rarely seen by the discharging provider."
    - Cotter, Smith, Boling "Transitions of care: the next major quality improvement challenge" British Journal of Clinical Governance 7:3, 2002

New Initiatives - CIRAC

- *Failure to recognize leads to poor transitions of care and poor discharge planning*
  - What happens if a patient with cognitive impairment is sent home, but nobody knows they are impaired?

New Initiatives - CIRAC

- The process of CIRAC
  - *UNIVERSAL OBSERVATIONS*
    - **All** staff are taught the sx/sx of cognitive impairment (the "red flags")
  - *See Something/Say Something*
    - **All** staff relay their observations to clinical persons who can proceed with evaluation and treatment

CIRAC

- To do CIRAC in your facility:
  - *Toolkit available at*
  - *http://www.alz.org/wv/in_my_community_104039.asp*
    - …wv/in_my_community_104039.asp
  - *Alternatively, you may go to www.alz.org/wv and click on Professional Training and then on Acute Care Resources.*

New Initiatives: Improving Clinical Outcomes For WV's Elderly

New Initiative #2 - ICOG

- Since the early 80's, Geriatrics Education has been a recognizable entity in WV

Geriatrics Education Initiatives in WV

Organization	Activity	Time
Medical schools	Education (students, residents, occasionally fellows; including CRIT/GRIT)	Ongoing
Schools of Nursing, Social Work, Pharmacy, Dentistry, etc	Discipline-specific professional education	Ongoing
WVGS, NASW-WV, WV ACP, WV AFP, WVMS, WVCEOLC, etc	CE, CME	Ongoing
WV GEC	Wide-ranging multi-professional Geriatric Education efforts (including "AGES")	1990's - 2016
WV Partnership for Elder Living	Initiatives to "foster West Virginians' opportunities to live and age with dignity and purpose"	2010 - present
Alzheimer's Assoc., AARP, Catholic Charities, few others	Lay education	Ongoing
Bureau of Seniors Services, WV Medical Institute	State agency and institutional education	Ongoing

Improving Clinical Outcomes in Geriatrics

- At least 35 years of Geriatric Education efforts: **Have Clinical Outcomes Improved?**
  - *Higher Education Policy Commission and Benedum Foundation convened "ICOG"*
    - Front line clinicians (physicians and mid-levels)
  - *ICOG met and discussed WV's elderly's greatest health needs*
    - Will plan projects and seek funding to address them

ICOG

- ICOG participants discussed greatest needs and reviewed…
- United Health Foundation's publication "America's Health Rankings Senior Report 2016"
  - *West Virginia was 46th in the overall ranking.*
  - *42 individual health-associated parameters reviewed*
    - Poverty, education, smoking, falls, flu vaccine, ICU use, etc.
  - *WV was 49th or 50th in nine of them*
  - *6 of these 9 lowest rankings were in the categories of Clinical Care and Outcomes.*

America's Health Rankings
Senior Report 2016

See full report at :
http://cdnfiles.americashealthrankings.org/SiteFiles/PressReleases/Final%20Report-Seniors-2016-Edition.pdf

		RANK	
Clinical Care			
Dedicated Health Care Provider (% of adults aged 65+)	92.9	38	96.9
Flu Vaccine (% of adults aged 65+)	69.8	2	70.7
Health Screenings (% of adults aged 65 to 74)	83.1	40	92.3
Recommended Hospital Care (% of hospitalized patients aged 65+)	96.3	47	98.7
Diabetes Management (% of Medicare beneficiaries aged 65 to 75)	79.4	28	86.2
Home Health Care (number of workers per 1,000 adults aged 75+)	122.5	12	278.8
Preventable Hospitalizations (discharges per 1,000 Medicare beneficiaries)	81.2	49	24.4
Hospital Readmissions (% of hospitalized patients aged 65+)	16.3	49	12.4
Hospice Care (% of decedents aged 65+)	43.5	43	65.5
Hospital Deaths (% of decedents aged 65+)	24.4	45	15.3
Clinical Care Total	-0.098	48	
All Determinants	-0.304	45	
Outcomes			
ICU Use (% of decedents aged 65+)	16.8	46	4.4
Falls (% of adults aged 65+)	26.6	9	20.6
Hip Fractures (hospitalizations per 1,000 Medicare beneficiaries)	7.1	44	3.1
Health Status, Excellent or Very Good (% of adults aged 65+)	34.4	45	50.7
Able-bodied (% of adults aged 65+)	55.7	49	69.6
Premature Death (deaths per 100,000 adults aged 65 to 74)	2,343	48	1,394
Teeth Extractions (% of adults aged 65+)	33.6	50	6.4
Frequent Mental Distress (% of adults aged 65+)	10.1	50	4.7
All Outcomes	-0.328	48	
Overall	-0.631	46	

- In comparing the I-COG group's proposals to lists of WV's greatest health needs the strongest overlap was noted in concern about "Frequent Mental Distress" and "Preventable Hospitalizations and Readmissions".
  - *Therefore the decision was made to initially focus I-COG's efforts on projects in those areas.*
  - *It rapidly became clear that, indeed, these two areas of inquiry are often closely related to each other by a single factor, the prescribing of the benzodiazepine class of medications ("BZDs").*

New Initiative #3 - RBADS

- Rational Benzodiazepine Avoidance and De-Prescribing Strategies
  - *Why is a special initiative needed regarding the prescribing of these medications to elderly patients?*

- What are benzodiazepines?
  - *"Benzos" or "BZDs"*
- "**Sedative-hypnotic agents"** in clinical use since the 1960s. The first benzodiazepine was discovered serendipitously in 1954 by an Austrian scientist. Three years later, it was marketed under the brand name Librium.
- BZDs are used for **sedation** and to treat **anxiety**, **seizures**, **withdrawal** states, insomnia, and drug-associated agitation. Due to their many uses, BZDs are widely prescribed and nearly 50 different agents are available worldwide.

- Benzodiazepines have been found to be **efficacious** in the treatment of generalized anxiety disorder (GAD), leading to a **reduction** of **emotional** and **somatic symptoms** within **minutes to hours**.
- If taken alone, BZDs have low potential to cause death by overdose.

- *So, what's not to like?!?*
  - With long-term use or higher dosages - Increased incidence of:
    - *Cognitive Impairment*
    - *Delirium*
    - *Falls*
    - *Fractures*
    - *Motor vehicle accidents*

American Geriatrics Society updated Beers Criteria for potentially inappropriate medication use in older adults. J Am Geriatr Soc. 2012; 60(4):616-31.

- Also increased over time:
  - *50% increase in incidence of dementia*
  - *200% increase in mortality*
    - *Billiotl de gage S, Bégaud B, Bazin F, et al. Benzodiazepine use and risk of dementia: prospective population based study. BMJ. 2012; 345:e6231.*

- Are Benzos over-prescribed?
  - *What do you think?*

Are Benzos over-prescribed?

- Across all age groups, BZD prescriptions have tripled and fatal overdoses have quadrupled in the past 20 years.
- BZD associated overdose deaths rose from 0.58 per 100,000 in 1999 to 3.07 per 100,000 in 2013.
  - *The rise in the rate leveled off somewhat after 2010, but not in persons over 65 years old.*
- Remember, these OD deaths are almost always caused by "co-ingestion" of BZD plus… alcohol, opioid, etc.

Are Benzos over-prescribed?

- Opioid prescribing rates peak by age 64 in most states, but BZD prescribing rates continue to increase with age.
- In West Virginia, for 1 of every 5 days of opioid treatment, the patient is also taking a BZD.
- BZD prescribing patterns (increasing rx rates with increasing age) are not consistent with the fact that a diagnosis of anxiety is most commonly documented in persons aged 30-44.

Are Benzos over-prescribed?

- A study of West Virginia drivers over 65 years of age who had collisions showed that:
  - *17% of those who were tested for drugs immediately after the crash had BZDs in their system*
  - *Only 48% of BZD-positive drivers had valid prescriptions.*
- Alprazolam (Xanax) is the most commonly prescribed BZD in West Virginia, and tied for second are clonazepam (Klonopin) and lorazepam (Ativan).

Are Benzos over-prescribed?

- In a very small chart review study at one generalist practice in WV, the physicians estimated that 19% of their patients between 65 and 90 years of age had active BZD prescriptions
  - *In fact, 31.5% did*
- **The actual rate of prescribing of BZDs to those over 65 years of age in WV in 2015 was *1,067.29 prescriptions per 1000 residents*.**

Why are Benzos over-prescribed?

- Are there differences in prescribing rates in different areas of the state, different types of practices, with different diagnoses?
- Is there an identifiable rate of diversion of BZD prescriptions written for elderly patients?
  - *And are prescribers appropriately monitoring for diversion?*
- Are patients and prescribers fully aware of the indications for BZDs, warnings regarding use in the elderly, and proven ways to safely discontinue them?

Why are Benzos over-prescribed?

- If we assume that the medications are being prescribed for anxiety, why is the incidence of anxiety so high?
  - *Are there identifiable features of the lives of many elderly in this state contributing to the high rate of prescribing?*
  - *If so, are there mitigating procedures or factors which might be instituted?*

Other questions about benzos

- What is the rate of adverse reactions?
- Does BZD use contribute to hospital admission and readmission?
- Does BZD use contribute to excess ICU use by those of advanced age with multiple morbidities?

New Initiative #3 - RBADS

- Rational Benzodiazepine Avoidance and De-Prescribing Strategies
- Grant from Benedum Foundation to ICOG to study the questions we have just posed
  - *Will include primary care sites, long-term care sites, and hospitals*
  - *Will include data gathering and education*
  - *Portions of the education will be delivered via "ECHO"*
    - ECHO = Extension for Community Healthcare Outcomes

New Initiatives #4 through…

- Your turn: What else do we need to do?