Patient Safety Conference

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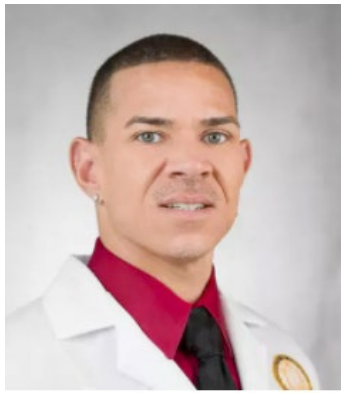
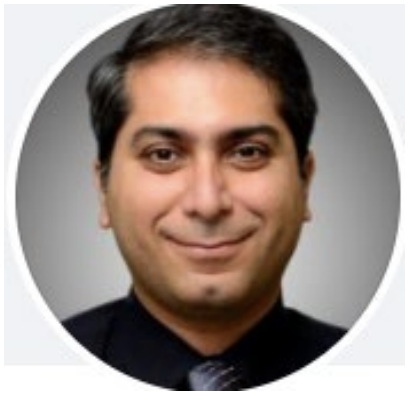
Outline

- Minute 1-5: Introduction & Objective
- Minute 5-30: Case Presentation
- Minute 30-40: Teaching Topic
- Minute 40-45: Discussion

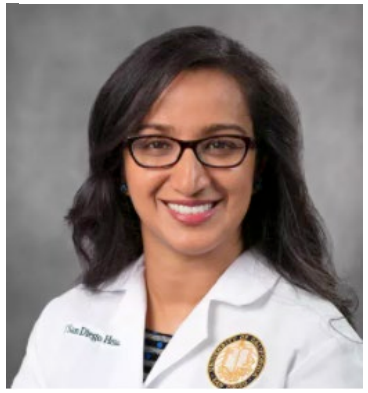
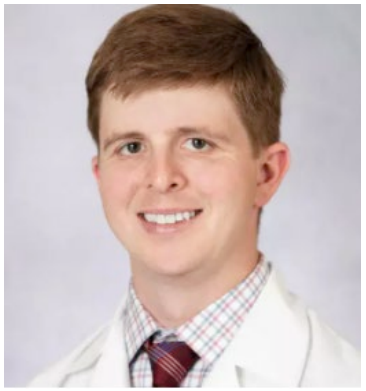
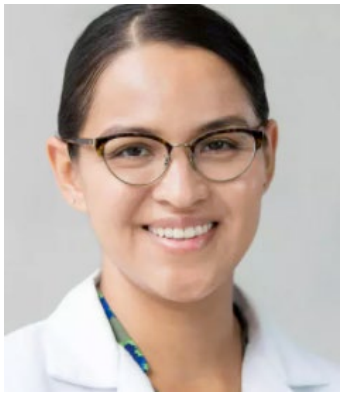
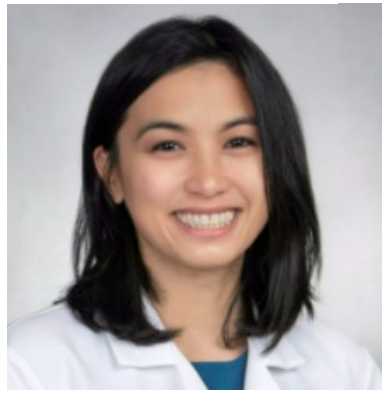
The 4Ms of Age-Friendly Health System



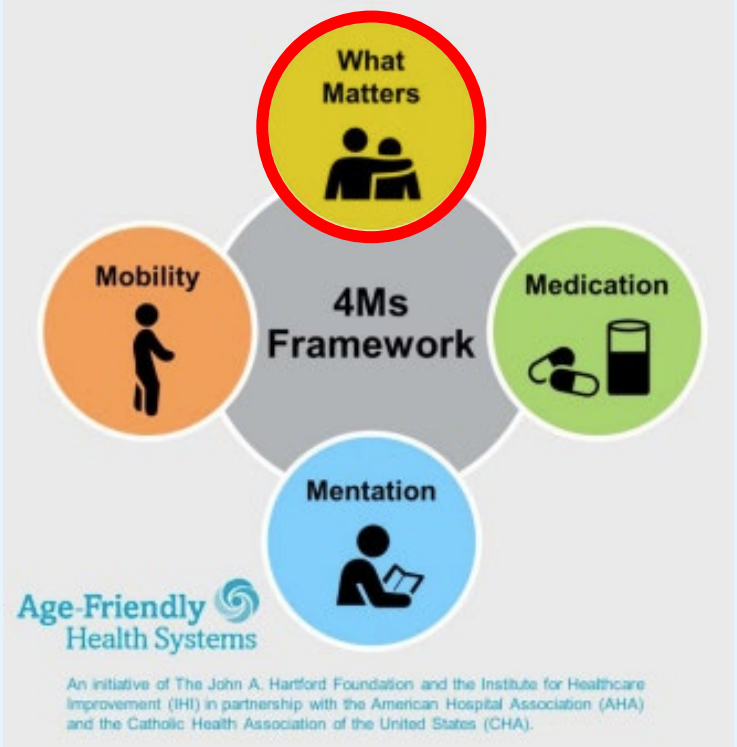
UC San Diego Health Part of National Initiative to Improve Senior Patient Care

First in San Diego to implement evidence-based approach to provide high quality of care to seniors

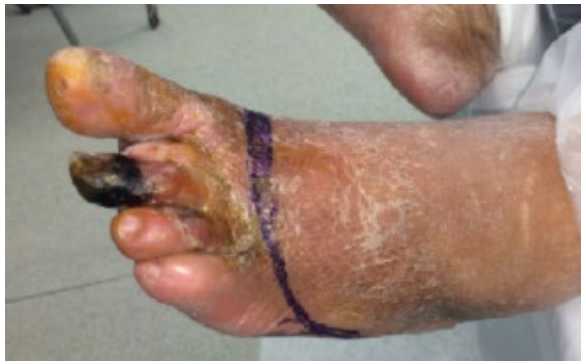






Objective of this presentation

- Understand the important role of applying "What Matters Most" to patients, to improve patient care outcomes!



Case 1: 74yo M admitted for Gangrene of Right Toes



Medical History

PMHx & PSHx

- T2DM (since 1989, latest A1c 6.3) complicated by diabetic nephropathy -> ESRD -> Right, deceased donor renal transplantation (1/25/20) c/b CMV infection
- Multiple Myeloma (8/2020), iron def anemia
- h/o DVT & PE, coumadin discontinued due to GI bleed
- Non-obstructive CAD (cath 2017), HTN, HLD
- Obesity s/p laparoscopic Roux-en-Y gastric bypass (2006)
- OSA on CPAP
- Osteoporosis
- TIA, PTSD, Anxiety

Medications:

- Insulin: Aspart SSI
- Tacrolimus
- Valganciclovir
- Potassium Phos
- Iron Sulfate
- Nifedipine
- Atorvastatin
- Gabapentin

Allergies: Fosinopril

Pertinent Social History & Prior Function

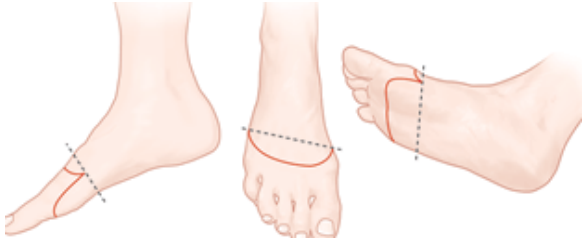
SHx:

- ETOH socially (1-2 drinks yearly); denies tobacco or illicit drug use
- Retired postal-service agent; lives at home with spouse.

Prior Function (according to patient's wife):

- Independent with ADL & iADLS
- Mentation is intact
- Ambulates without any assistive device
- Helps-out with house chores

Hospital Course



- June 22nd – admitted to inpatient for wet gangrene of right toes with surrounding cellulitis
  - Vascular team consulted: no urgent surgical intervention. Recommend starting pt on Heparin drip -> upper GI bleed
  - ICU – EGD revealed gastric ulcer w/ clot s/p clipping & 3U pRBC
- July 24: once stabilized, Podiatry service performed R foot tarsometatarsal amputation (TMA)
  - Bone biopsy showed no evidence of osteomyelitis
  - ID recommended: IV Rocephin ppx, post-surgically for total of 2 wks
- July 26: CLC admission (VA's subacute rehab unit) for complete IV Abx, wound care, rehabilitation, and nutrition optimization

While at the CLC…

- Patient developed Post-surgical **wound dehiscence and progression of distal RLE gangrene,** while still on IV Abx (ppx)
  - Different surgical interventions were purposed to patient, including TMA revision vs Below Knee Amputation (BKA).
- Patient was in constant pain interfering with sleep and refusing to work with Physical Therapist majority of time
- With the narcotic use, patient developed constipation
- Overtime patient was noted to be more and more depressed, with poor appetite
- Podiatry service continues to follow on the case, insisted with the plan for **TMA revision…**

Let's stop for a moment and find out "What Matters Most" to the patient?

What Matters Most to patient?

- Patient missed his family dearly, tired of prolonged hospitalization
- He wants to regain his independence, the severe pain from the surgical wound is preventing him from working with Physical Therapist
- He prefers to have **right below-knee amputation (BKA)** for faster recovery and retain his functional status via prosthetics!

Time course: hospitalized for 2.5mo

hospitalized for dry gangrene of right toes, s/p TMA on 7/24. Bone biopsy showed no signs of osteomyelitis. ID still recommended 2 wks of ceftriaxone IV ppx

22 June – 26 July

26 July – 27 Aug.

CLC admission: complete IV Abx, wound care, rehabilitation, and nutrition optimization

Surgical wound noted to worsen, " yellow slough in wound bed and tunnelling at top of wound"

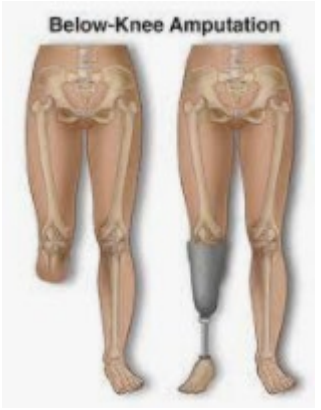
2 Aug.

2 Sep.

Pt underwent R BKA, as per pt's wish!

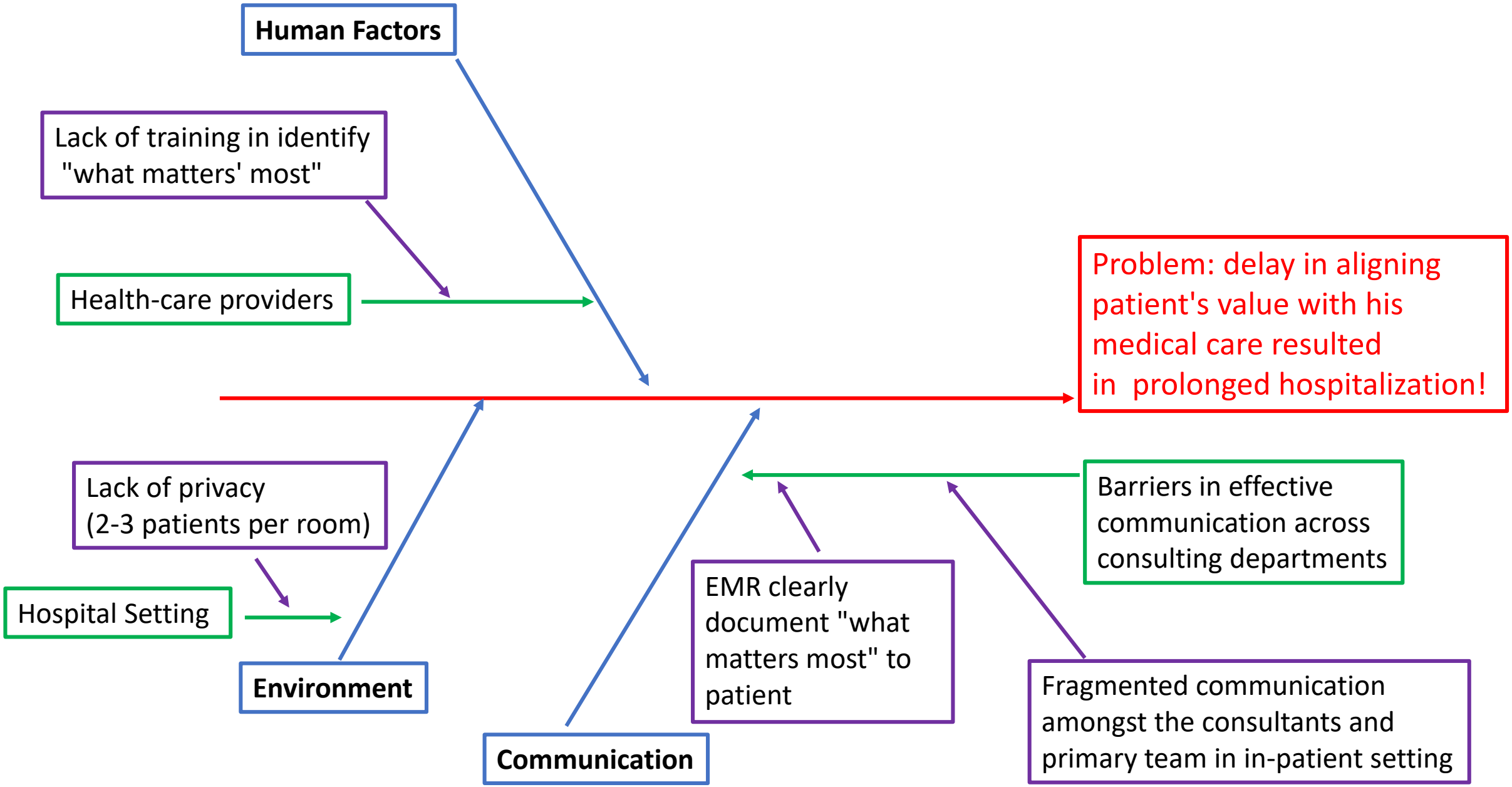
Discharged from hospital

10 Sep.



Root-cause Analysis

What went wrong with this patient care?


Human Factors
Lack of training in identify "what matters' most"
Health-care providers
Problem: delay in aligning patient's value with his medical care resulted in prolonged hospitalization!
Lack of privacy (2-3 patients per room)
Hospital Setting
Environment
Barriers in effective communication across consulting departments
EMR clearly document "what matters most" to patient
Communication
Fragmented communication amongst the consultants and primary team in in-patient setting

Case 2: 79yo M admitted for pill-induced esophagitis and stage 3 sacral pressure ulcer

Medical History

PMHx & PSHx

- Ph+ B-cell ALL – diagnosed 6/2021, required prolonged hospitalization
  - Completed 2 cycles of intrathecal methotrexate infusion, on induction therapy of prednisone and Dasatinib
- NSTEMI s/p angiogram 7/2012 with finding of non-obstruvitve CAD in RCA & proximal LAD
- Complete heart block s/p pacemaker 6/27/2013
- A fib on anticoag.
- HTN, HLD
- OSA on CPAP
- BPH
- GERD, Constipation

Medications:

- Dasatinib
- Eliquis
- Simvastatin
- Metamucil

Allergies: Sulfa-containing drugs

FMHx: distant cousin with history of leukemia. Otherwise no other cancer history

Pertinent Social History & Prior Function

SHx:

- ETOH socially (1-2 drinks during holiday); Former smoker, quit 41 years ago; denies illicit drug use
- Retired electrical technician
- Serves as primary caregiver for his significant other (who is paraplegic), lives at home.

Prior level of function:

- 2months ago (in April 2021), pt was independent with ADL & iADLS.
- Since last hospitalization (June 2021), pt developed deconditioning required walker for ambulation.

During this admission (July 2021), pt developed new-onset stage 3 sacral ulcer as a result of severe weakness, unable to get off bed.

What Matters Most to patient?

Assessment & Plan
[redacted] is a 79yo man with recently diagnosed ALL (was previously on dasatinib), NSTEMI in 2012, Complete heart block s/p pacemaker 2013, Afib , HTN, OSA on CPAP, BPH, hospitalized from 7/13-8/2/21 for esophagitis, improving. PT is transferred to CLC for short-term skilled needs including rehabiliation with PT/OT & wound care for sacral pressure ulcer.

4Ms of Age-Friendly Health System:
- What Matters most: 1) healing of decubitus ulcer; 2) getting stonger, able to ambulate freely without assistance. 3)Commuting concern, would like to d/c after the doctor's appointment on 8/17
- Medication: Home & Inpt medications reviewed, changes will be made accordinly.
Will avoid medications on beer's list.
- Mentation: AAO to selft, time (date of the week, month & year), place (La Jolla VA. PHQ-2 score of 1 out of 6.
- Mobility: pt was able to ambulates independently prior to June hsopitalization. Pt was discharged home with greater dependence on walker to ambulate. Pt is working with PT & OT.

SACRAL PRESSURE ULCER: resolved

- Healing of decubitus ulcer
- "Getting stronger soon", able to go home to care for his significant other at home!
- Due to transportation limitation, patient inquired to discharge from hospital after an upcoming heme/onc appointment

Time course: hospitalized for ~1 mo

13 July – 2 Aug.

hospitalized for esophagitis, pancytopenia, new development of stage 3 sacral pressure ulcer

2–13 Aug.

CLC admission for rehabilitation and wound care. After understanding what is needed to speed up the discharge process, Pt was very motivated to work with the interdisciplinary team.

18 Aug.

Pt was ready for discharge by 13 August. Due to transportation limitation, to ensure pt make it to his upcoming VA appt -

What is the major difference in healthcare outcome between the two cases?

Comparing the two cases

	Case 1 – Gangrene LE	Case 2 – Deconditioning result in pressure injury
Medical Complexity level	Complex	Complex
"What Matters" most to pt addressed?	Yes	Yes
Does medical care align with what matters most to pt?	There was a delay, but eventually it was recognized	Yes, throughout the hospital stay
Length of Stay	2.5mo	~1mo

"What Matters Most?"

Patient-centered care approach / Shared-decision practice

https://patientprioritiescare.org/how-it-works/explainer-video/

Timeline

March 2012, Michael Barry, MD & Susan Edgman-Lebitan, PA, introduced the concept of asking patients "what matters most to you [the patient]?"

Institute for Healthcare Improvement (IHI) and other organizations around the world incorporated it in the context of end-of-life care

The Age-Friendly Healthy Systems initiative subsequently expanded it across all elder care settings.

Importance of "What Matters Most"

- When identified in a specific, actionable, and reliable manner, patients' values can guide medical decision making for health care professionals
- When worked toward one common goal, it will motivate patient to adhere to the care plan, therefore improve health care outcome
- Studies have shown when aligning care with each older adult's priorities reduces unwanted burden (length of hospital stay and medical costs)

When and where should the conversation take place?

Regular and Annual Wellness Visits

- A longer annual wellness visit can be conducive to an initial "What Matters" conversation. Regular wellness visits are also an excellent opportunity to continue "What Matters" conversations over time.

New Diagnosis or Change in Health Status

- Schedule an initial "What Matters" conversation one week after the older adult has received a new diagnosis or change in health status, and use this information when planning a course of care.

Life-Stage Change

- Initiate a "What Matters" conversation during a primary care appointment with an older adult who has just entered retirement or enrolled in Medicare. Review "What Matters" information at each visit following the life-stage change for any updates on the older adult's care.

Chronic Disease Management

- Discuss "What Matters" during primary care visits, revisiting past conversations and discussing any changes or updates to the older adult's goals and preferences.

Inpatient Visits (hospital, nursing home, skilled nursing facility)

- Ask older adults what is important to them at every hospitalization and document any new information.

Proposed interventions to incorporate "What Matters Most" to our practice

Human Factors (People)

- Patient and caregiver
- all healthcare provider (physicians, NP, RN, case manager) should be oriented/ trained
- Interpreter – if there is language barrier

Equipment Factors

- Document "What Matters" Conversation, in EMR
- Immediately following the conversation's or within 24hrs
- Use patient's own words as much as possible

Environmental Factors

- Both in inpatient and outpatient
- Conversation is preferred in a meeting room > exam room
- Pt dressed in his or her own clothes rather in a patient gown
- Sitting around a table as equals, chairs facing each other

Information Factors

- Screen for potential cognitive impairment, prior to start of conversation
- Look over notes of previous conversation about older adult's goals and preferences

Communication Factors

- Share information with all care team
- Inform PCP during any transfer of care (ie. Discharge from facility), if conversation occurs outside of ambulatory setting

Policy/Procedure (Process)

- Use measuring tools (I.e. CollaboRATE) to assess effectiveness

Discussion

Special thanks to Dr. Gupta, Dr. Yourman, and Dr. Motarjemi for helping me to prepare for this presentation!

References

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The end!

Thank you!