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In Conversation With... Heidi Wald, MD

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Editor's note: Dr. Wald, MD, MSPH, is the Chief Quality and Safety Officer at SCL Health in Denver, CO. She has previously served as a physician advisor for the Colorado Hospital Association and as a Quality Committee Chair for the American Geriatrics Society. We spoke with her about patient safety concerns when caring for frail older patients.

Dr. Wald has no conflict of interest to disclose.

Dr. Kendall Hall: How did your career path bring you to this intersection of patient safety and care for older patients?

Dr. Heidi Wald: It started just after residency, when I joined a hospitalist program. The Institute of Medicine's report on medical errors [1999] had just come out and that really influenced my interest in safety. Like many hospitalists at that time, I grew in my career with the patient safety movement really gaining momentum in the national spotlight. I practiced as a hospitalist for several years and decided to do a geriatric fellowship at the University of Colorado, where I got to work with mentors who had been very influential in safety.

I see geriatric medicine as two-thirds about function and one-third about safety and mitigating harm to patients. During that time, fewer geriatricians were focused on the harm piece, but because of my background as a hospitalist I approached geriatrics as a patient safety puzzle. These patients are the most vulnerable physiologically and they are the first people to suffer effects of unsafe conditions. If we are able to provide safe care for our complex frail older patients with multiple chronic conditions, then we can provide safe care for every patient.

KH: When you are referring to frail older patients, how are you defining that?

HW: Frailty relates to physiology as opposed to age. You can have an 80 year old in amazing physical condition [that would not be considered frail], or you can have a really frail 70 year old. Frailty is ultimately associated with increased mortality. It is a syndrome that is distinct from advanced age by itself.

KH: You mentioned your approach to geriatric medicine, with one-third of it focused on safety and mitigating harm. What does that look like?

HW: In frail older patients, every intervention has to have a risk-benefit analysis. The therapeutic window for many of our interventions is much narrower in these patients. For example, in middle age I might be able to handle diuresis, but if my physiology is that of a [frail] 90 year old, it will be very different. You have to think much more carefully about all of the consequences of what you propose.

KH: When you are thinking about the consequences of proposed care, how and with whom are you having these discussions? It seems that this is a much more patient-centric approach to safety than you might see for other efforts.

HW: Absolutely, I would say that an example is the aging diabetic. A diabetic patient may be very used to tight control of their blood sugars, and that's okay when they're younger. However, as they get older the consequences of a hypoglycemic event are really magnified on their cognitive function, their risk for falls, etc. Our guidance for frail older patients with diabetes is a more liberal approach to blood sugar control. It is helping patients re-set their priorities as they get older and while not every patient is able to engage in that conversation, many are. [As another example,] if you're getting dizzy every time you stand up because we're over treating your blood pressure, you may fall and you could sustain a fracture. That would be a huge disturbance. At some point we have to be less focused on the interventions used in studies with young people and instead really pay attention to the potential short-term consequences of misjudging treatment in older, frail patients. Sometimes, that conversation has to also happen with the family to reset their expectations regarding the approach to caring for their loved ones.

KH: This is a shift in thinking about goals for the patient, and not all care providers have been trained to think this way. Does this support the need for more specialized care and providers? I'm thinking of the geriatric ED [emergency department] and ACE [acute care of the elderly] units.

HW: I think the geriatric ED is one example, the ACE unit is another example. I worked as a co-director of an ACE unit at the University of Colorado Hospital for more than 10 years. One can create carved out models of care in a variety of settings across the continuum. You can setup your system, such as your admission order sets and your protocols, to make it easy to do the right thing, pick the right medication, and pick the right activity order. You can also have a very proactive multi-disciplinary team and discharge planning model for those patients. That's what we did for our ACE service. The units can also be used as an opportunity to teach residents and other students about geriatric care principles.

The tension is, why shouldn't we provide this level of care for everybody? Of course the answer is that we don't have the resources to do that and not everybody needs that. But there are programs that have been created in hospitals and hospices that have done things to "geriatricize" their whole hospital or their whole system. In these cases, they are training their nurses on recognition of delirium, implementing mobility programs that prevent people from sitting in the bed for long periods of time without assistance to get up and ambulate, and focusing system-wide on advanced care planning. That is the model that we see right now with the Hartford Foundation in partnership with the Institute for Healthcare Improvement, the American Hospital Association, and many other partners as the Age Friendly Health System initiative.

This relates to the patient safety conversation in an interesting way. Two years ago, I wrote an editorial called "The Geometry of Patient Safety: Horizontal and Vertical Approaches" in the Journal of the American Geriatrics Society. The idea is that there are four risk factors that underlie many of our hospital acquired conditions, (i.e., pressure ulcers and catheter associated infections, falls, and delirium). They all have common risk factors and those risk factors are frequently found in frail older patients – advanced age, impairments in physical function, diminished cognitive function, and mobility impairment. If you try and treat those common risk factors, then you will mitigate those harms in hospitals. I think the approach that we are going to fix specific conditions is a more vertical approach. Whereas, working on mobility, delirium prevention, skin care, etc. is a more horizontal cross-cutting approach. That is a framework that has been helpful to me. The argument is that we likely need to do both. We are only going to get so far with siloed, vertical approaches and we probably need to also implement some global or horizontal approaches.

KH: Can this approach be used for other patient populations too, or is it just for frail older patients?

HW: These are good principles of care for every patient. This gets to some work that I've done in creating a white paper for the American Geriatric Society on mobility. In acute care, the questions with regard to mobility is who is going to ambulate the patient? What is in the nursing skillset? And not just skill set, but also who has the time? Are CNA's the right people to walk the patients? And in what circumstances? When do you need a PT consult or a PT to supervise ambulating the patient? In the health system I'm at right now, we're increasingly marrying our falls prevention work with our safe mobility and safe patient handling work because it just makes sense. Our prior approach to falls was, "if we keep them in bed they won't fall." That is particularly bad for our older patients. We were deconditioning people who are used to being mobile in their own homes because we are afraid they would fall. We placed fall prevention above safe mobility. And so that is a challenge that many people in healthcare are frustrated with. We don't want patients falling and breaking a bone while in the hospital under nurse supervision. However, at the same time, allowing our patients to get deconditioned while we're presumably healing them is also not acceptable and ultimately leads to decline. Some people call it "hospital acquired disability" or "hospital associated disability."

The idea is that functional decline related to hospitalization may be independent from the disease process that you are treating but is related to the circumstance of how we provide care. For example, what happens to me, at my age, when I'm on bed rest for a week? I'm weak, but I haven't lost so much muscle mass to the point that I can't get up and walk around. But if I'm 80 and I didn't start with a lot of muscle mass to begin with, because I'm frail and I have sarcopenia, I can no longer get up on my own. I've lost function and that may land me in skilled nursing for a couple of weeks. Hopefully I recover that function, but maybe it's led to functional incontinence because I'm not able to get up and move quickly enough to get to the restroom. There are all sorts of consequences that we have to think about in frail older patients that we don't have to think about in other patient populations.

KH: What are three areas of harm where frail older patients are at greatest risk? Where should we be focusing our efforts?

HW: Numbers 1, 2, and 3 are medications in the healthcare setting! Medication is such a key part of our therapeutic efforts. However, there is a narrower therapeutic window in our frail older patients. It's not just the single medication that's the problem – it's the combination of side effects. For example, if you're using

two medications that are sedating, even if they're in different classes or treating different problems, those side effects tend to stack on top of each other. And of course there are interactions of medications. One of the buzz words in recent years is this idea— or concept– of de-prescribing. This is kind of like extreme medication reconciliation or rationalization of medications.

If you do a home visit for a patient or if you ask them to bring their medications in, everybody comes in with a huge bag full of bottles. Half of the bottles are empty, expired, or you prescribed it to them two years ago and they no longer should be taking it. The best way to do medication reconciliation is to identify what the patient is actually taking and match it with what you think they should be taking. I think that's why phone calls to patients after discharge by pharmacists are a useful adjunct to decrease readmissions. Medication issues are so hard. It's not just about the list of what the patient was prescribed, it can be about what they still have at home.

A home visit for medication management can be helpful. Many frail older patients will have a family member fill up pill boxes for them. This way the patient knows what they are supposed to take and when. It is pretty good to have a system where somebody is supervising those medications. Pill boxes can be pretty effective and low-tech.

KH: Besides medications, are there other patient safety topics related to frail older patients that you would like to discuss?

HW: It is important to talk about delirium, cognition, and advanced care planning. Delirium can lead to serious outcomes in patients. For example, prolonged length of stay, falls, and malnutrition. However, it also has many of the same underlying risk factors we see for other harms, including: hydration, pain control, removing sedating or acting medications, orienting-reorienting patients, and other types of basic interventions, which can prevent onset of delirium.

Certain medications do predispose you to delirium, but I would say that delirium, or geriatric syndromes, are actually a combination of different sets of risk factors. Some risk factors are inherent to the patient. They are old, they have some mild cognitive impairment, they have mobility issues, or they're hard of hearing, etc. Then you have the acute medical factors, such as the chronic medications that they are already taking and any new medications we add during an acute episode. Pain is also a big medical factor in delirium, as are dehydration and acute infections. Finally, you have environmental factors, which can be the impetus for re-doing an ACE unit or designing certain types of geriatric-friendly units. So certainly medications play a role, but there are a host of other risk factors.

KH: Where do you see advanced care planning fitting in with the patient safety puzzle? Is the focus predominantly understanding patient goals and wishes, or not exposing them to harm?

HW: Anybody who has cared for older patients worries about the harm we inflict on patients when we're trying at all costs to prevent a death, rather than trying to prolong or enhance function. Do all of those situations lead to a specific safety event? Probably not. But can they? Yes. If a patient who is hospitalized for something, and is already quite debilitated, falls in the hospital and experiences a hip fracture, they can enter a functional decline and spiral as safety events and functional decline pile up. Advanced care planning is about avoiding unnecessary care when it could be a safety issue for patients and where it is not

aligned with their goals.

KH: In your new role as the Chief Quality and Safety Officer at SCL Health, what patient safety issues are keeping you up at night?

HW: SCL Health is made up of eight hospitals and over one hundred ambulatory sites in Colorado and Montana. What keeps me up at night is any harm that we might cause to the patient. The mission of safety is one of our six core values for the health system. In addition to patient safety programs and the development of patient safety culture, we also tie in our associate safety. If we are taking good care of our associates we'll subsequently also take better care of our patients. We are very proud of our associate safety record. We don't want anybody that comes into our system to suffer harm. I'm not sure if I have just one thing that keeps me up at night, but I feel that it is incredibly meaningful work to help this system be the best that it can be in terms of improving our care reliability across the whole system.