

Better Health While Aging Podcast Transcript

086 –Interview: Creating Age Friendly Health Systems at UCSF

By Leslie Kernisan, MD MPH

Leslie Kernisan:

[0:00] Hello everyone. Welcome to Better Health While Aging, a podcast that gives you strategies and information about improving the health and wellbeing of older adults.

We discuss common health problems that affect people over age 60, the best ways to prevent and manage those problems, and we also often address common concerns and dilemmas that come up with aging parents and other older loved ones. Like what to do if you're worried about falls, or safety, or memory, or even the quality of an older person's healthcare.

[0:31] I'm your host Dr. Leslie Kernisan. I'm a practicing geriatrician, so that means I'm a medical doctor specialized in geriatrics, which is the art and science of modifying healthcare so that it works better for older people and for their families.

[0:46] In today's episode we'll be talking with my UCSF geriatrics colleague, Dr. Stephanie Rogers MD, MPH, and we'll be talking about age-friendly health systems. Dr. Rogers is an assistant professor in our division of geriatrics and she is our lead inpatient geriatrician at UCSF's main hospital, Moffitt Long Hospital.

Over the past few years, she's been helping to design, implement, and deliver several innovative programs, designed to help older adults avoid common complications of hospitalization.

These include programs addressing hip fracture care, delirium prevention, and also something called an acute care for elders unit. We'll be talking more about what that is.

These programs are being pursued as part of an initiative to make UCSF a more age-friendly health system. As you may know, hospitalization has historically been somewhat risky for older adults, so it's been really wonderful to see over the past few years how Dr. Rogers and her colleagues have been making UCSF a much better and safer hospital for our older patients.

I'm just so delighted to have her on the podcast today to tell us more about what we know and what we're learning about making hospital care and health systems better for older adults. To tell us more about the particular programs that she's been working on at UCSF and that hopefully will be coming to a hospital near you soon, Stephanie, welcome to the show.

Stephanie Rogers:

[2:09] Thank you, I'm happy to be here.

Leslie Kernisan:

[2:10] I did cover age-friendly health systems, or discuss them, in Episode 39 with Amy Berman of the Hartford Foundation. That was about two years ago when the Hartford Foundation was funding the initial efforts to get this project going. It's been awhile since that episode and I think this concept of age-friendly health systems is just so important.

I thought it would be great for us to start by having you telling us what exactly is an age-friendly health system, and why is it so important?

Stephanie Rogers:

[2:41] Well, Age-Friendly Health Systems is a national initiative run by the Institute on Healthcare Improvement and the John A. Hartford Foundation.

The goal is to assist health systems in redesigning care to ensure that every older adult, and their families, and their caregivers get the best care possible no matter which healthcare setting they're in. Whether they're at home, or in nursing homes, or are in the hospital.

They have this bold aim to try to make 20% of healthcare systems “age-friendly” by 2020. It's really an exciting time because there's a lot of payment reform going on nationally, and this is driving some of these changes in allowing health systems to really put their money where their mouth is.

So much of what we do in geriatrics is population health, thinking about how healthcare is delivered, for not just a patient but for their family, and making sure that they get care in the right place.

One of the things that I really like about age-friendly health systems, is they aim to integrate with the community organizations, addressing social influencers of health, like housing, and food insecurity. Really focusing on achieving good health outcomes, eliminating harm, and creating value for both the patients and the health system.

Leslie Kernisan:

[4:06] Now I think for us in geriatrics, it's often very obvious to us the many ways in which the hospital or healthcare system is not age-friendly, but I feel like that's often news to people.

Intuitively they think, “Well, so many older people get hospitalized, so of course isn't the hospital well set up to serve them?” That's actually not so true.

So can you tell us more? I remember Amy Berman had covered that there were “four M's”, four particular things they wanted to encourage hospitals and health systems to focus on. Can we review those briefly?

Stephanie Rogers:

[4:45] Sure. There's really four things that age-friendly health systems should focus on. The first “M” is what matters. That is knowing, and acting upon what patients want, what their goals are, and their care preferences.

The second “M” is medications. As you know, older adults can often have larger medication lists, so really focusing on what the right combination of medications are for older adults so they can meet their goals.

The third “M” is mobility and maintaining independence. Building areas for adults to optimize their independence and their mobility, whether you're in a hospital or nursing home, or even at home.

The last one is mentation. We want to make sure that we're always identifying and treating things like dementia, depression and delirium.

What's kind of cool about these four “M's” is they're all interrelated. Sometimes de-prescribing a medication can improve someone's mentation and their mobility, and those are the things that matter to the person. Although we list them separately, they are often very interrelated.

Leslie Kernisan:

[6:03] I love those. They're obviously near and dear to us in geriatrics.

I don't mean to make anybody in the audience worried, but the truth is that historically there hasn't been as much attention paid to those four things as perhaps there could be.

This is a great initiative to help non-geriatricians. Because so much of healthcare is provided by non-geriatricians, applying these principles of what we know is often so helpful for older adults:

Addressing what matters, reviewing that with them and making sure that the healthcare team is aware of it.

Medications, making sure they're all necessary and not causing harm or an unwarranted harm.

Mobility, helping people remain mobile, maintain their strength, addressing fall risk.

Mentation, things that have to do with how the brain is thinking and functioning. Making sure we think about delirium and dementia, and I think you may have mentioned one other?

Stephanie Rogers:

[7:06] Depression also, yes.

Leslie Kernisan:

[7:08] Depression. So helping people's minds be at their best.

How is this different from usual healthcare?

Stephanie Rogers:

[7:17] That's a great question. I often get that question even in general, how is a geriatrician different than any other doctor?

How is an age friendly health system different than usual care that's out there?

I describe it like this very often, a lot of health professionals are disease focused. Maybe you have diabetes, or high blood pressure, and we become kind of siloed into treating just diseases.

What we've learned in our extended training for older adults, is that we know older adults are very unique. Often they have many medical problems that have lasted many years.

They have long lists of medications. They have complex social needs, their support systems may not be as big. They may have cognitive or functional issues, so memory problems. They may need to use a walker to get around or up and down stairs. They could have sensory impairments, like hearing issues or visual issues.

As geriatricians or in age-friendly health systems, we don't just focus on the disease. We actually add in all these other complex factors in caring for the person.

[8:31] To add on to what you were saying before, as geriatricians we focus on the four “M’s” all the time.

Part of building an age-friendly health system, is building these four “M’s” into the system, so that every patient, whether they see a geriatrician or not, have these things addressed.

This is what's really fun and exciting about building these programs, is because there's a lot that we can do to make sure that every patient gets this kind of care.

Leslie Kernisan:

[8:58] Before we started recording our interview, you had shared with me some slides from a presentation you gave, and I just loved these six characteristics that you had mentioned. Which is probably something that I know the Institute for Healthcare Improvement and the John A. Hartford Foundation have been just so instrumental in articulating specifics.

We can go from these ideas, to specific things that we can ask health systems to do or that people can look for. So along with those four “M’s”, I really love this list of six characteristics, which were:

Leadership, committed to addressing ageism. So often some of these issues, like falls or confusion are overlooked because sometimes people and health providers are like, “oh that's just getting old.” That's not necessarily fair to our older patients.

Evidence-based clinical programs, based on what we know in geriatrics.

Multidisciplinary clinical staff, the idea of a team, which has always been really important to us in geriatrics. I know a lot of the projects you worked on involve teams and I'm really excited for you to share that with the audience.

A systematic approach recording care, with organizations beyond their walls. You were mentioning this, this connection with the community.

[10:17] This is one of my all-time favorites; a strategy to coordinate with and support family caregivers.

How could we not love that? Because of course for every patient I think the family and the care circle are so important, but it's especially obvious and visible to us in geriatrics how important families are.

A clear process for talking to patients and older adults about their goals and their preferences, so that we can make sure we provide care that's in line with that.

Stephanie Rogers:

[10:42] Exactly, and that goes along to with the leadership committed to addressing ageism.

This is the idea that in geriatrics we focus a lot on not providing too much care or too little care, and sometimes in healthcare someone can look at someone's age and make a decision on that, but like we talked about before a person is very complex.

They have a lot of complex factors that can determine their care and we don't discriminate based on age. We want to know what the patient's goals and preferences are and that we give care that's concordant to that, not a number.

Leslie Kernisan:

[11:16] Yes, so important.

I found an article about it written in part by Terry Fulmer who helps lead the Hartford Foundation. At one point they said that we need not just quality improvement, because we have been working on quality improvement for hospitals and for older adults for quite a long time, but that we really need a social movement.

Stephanie Rogers:

[11:40] Yeah.

Leslie Kernisan:

[11:41] To recognize the importance of adopting the entire healthcare system so that it's a better fit for what older adults need. I'm just so excited to see this movement taking off.

I want you to tell us more about what's going on at UCSF. Just to start with, how did you become involved in UCSF's initiative to start creating an age-friendly health system there?

Stephanie Rogers:

[12:08] Well I get very excited about this topic. It's been a really fun road so far. It really started in residency for me, when I was doing an internal medicine fellowship here and something didn't quite feel right when I was taking care of certain patients.

I felt like we could do something better, and I started meeting other folks here at UCSF, whether they were nurses or pharmacists, who had the same ideas that I did. We started getting together and meeting, and talking about how we could do things better and in particular for older people.

When I started on faculty here, I started forming these interest groups and started soliciting ideas throughout the health system on areas that we thought we could improve health.

Eventually this grew into this kind of 10-year strategic plan on how we can actually reform the entire system. At the same time, this national age-friendly health system movement was just starting up.

We heard about that, and we said that's exactly what we're trying to do and so we kind of jumped on board to align with the IHI and the Hartford Foundation on that.

Leslie Kernisan:

[13:25] Yes that is such a wonderful convergence of interest and energy.

I think it's so cool how it started with you just connecting with other people of different disciplines and thinking how can we make this better.

The Institute for Healthcare Improvement and the Hartford Foundation specifically funded some pilot sites for this, right?

Stephanie Rogers:

[13:50] They did.

Leslie Kernisan:

[13:51] And are we a pilot site at UCSF?

Stephanie Rogers:

[13:53] We were not a pilot site, but we are now in the next wave of institutions.

Although towards the end of that pilot year, they did invite us to Boston to kind of meet with everyone. They saw that we were doing the exact same things that these pilots were doing.

So, officially not a pilot site, but kind of in that same point in the road of development.

Leslie Kernisan:

[14:15] Great. Sounds like you connected with UCSF's leadership and they were interested in supporting this.

Stephanie Rogers:

[14:22] Yes, well, to be honest it took a few years to get there, to really get the leadership's support.

I think a lot of it is, in geriatrics we've always kind of branded ourselves as, we're doing good care, we're doing the right thing for patients. This is always very important.

Leadership was very excited about that, but they wanted to see the hard numbers. How does this fit with their strategic goals? How is this going to be valuable for them to invest in?

We really started looking at all the broad range of evidence out there for geriatric clinical programs and realizing this actually saves money in addition to helping people.

UCSF has very clear strategic goals. What we did, is we found out what was most important to UCSF and we picked the programs that aligned with those strategic goals.

The other thing that just kind of fell into place, at the right time, was payment reform. We used to be in a fee-for-service kind of world, but now with the Affordable Care Act and accountable care organizations, insurance companies are starting to pay for population health, so trying to keep people healthier and out of the hospital.

That really bodes well for a lot of these geriatric clinical programs because we try to provide just the right care, in the right setting for everybody. That actually ends up saving money and improving care. It was those two factors that came together at just the right time, to really get the leadership invested in this.

Leslie Kernisan:

[15:58] I love that you bring that up.

I think sometimes we feel motivated, we want to make a change and want to do well, and I think you're bringing up something really important. It's useful to figure out for the big players, what's important to them, and how can you align with what's important to them. Which incidentally is also what we do as clinicians.

We talk to our patients and find out what is important to them, instead of telling them what they should do, figure that out, and try to see where we can align and overlap and help them reach their goals.

Once they were interested, what were the first programs that they wanted you to work on or that you wanted to work on?

How did it first get started?

Stephanie Rogers:

[16:42] Well, again this took quite a bit of time too, but we looked at the landscape.

What do we expect at UCSF in the next 10 to 15 years? What's the population going to look like? Where are the biggest gaps in care? Where are we not doing as well on our health outcomes? Where are we not doing as well on our cost outcomes? Lets put our money in those places first.

We picked a couple programs in the inpatient setting and a couple programs in the outpatient setting. We wanted a good focus on transitions of care between those settings.

In the inpatient setting we decided to build an ACE unit, a hip fracture geriatrics-orthopedics co-management program, work on delirium prevention, and do something we call, geriatric workforce training.

This is training everybody in the institution, no matter if you're a cardiologist or a surgeon or a pharmacist, you get training in geriatric care.

Also making sure that our nurses have what's called a NICHE designation. NICHE is a nursing certification; Nurses Improving Care for Healthsystem Elders. We wanted to be a designated hospital here.

[17:58] In the outpatient setting, we already had a couple programs going on, but we really wanted to expand our Care at Home Program. Which is where our providers actually go into the home to provide primary care.

We previously had a one-year waiting list for that program and we really wanted to expand that availability.

Leslie Kernisan:

[18:16] Well, amazing!

Since I know you personally mostly work in the hospital, let's especially talk about some of those.

Maybe we'll start with the ACE units. ACE stands for Acute Care for Elders and it's actually something I have not ever talked about on the podcast.

Let's start with what is an Acute Care for Elders unit?

Stephanie Rogers:

[18:40] Sure. ACE units have actually been around for about 20 years. They're all over the country. They are actually localized units in the hospital where a multidisciplinary team, so lots of members of the team are trained in geriatric syndromes and geriatric challenges.

The unit itself actually promotes independence, mobility, these four “M’s”, mentation, it looks at medications and we talked about what matters with patience.

It's a specialized unit that really focuses on this population. The goal of ACE units is to keep people who are somewhat independent in the community, and live at home with support of their family, to keep them in that setting after discharge.

I'm sure you've talked about before. Sometimes when older patients go into the hospital, they get weaker and they may get confused.

Leslie Kernisan:

[19:36] It's not sometimes, it's really common.

It's part of the risk of hospitalization that we were we were talking about.

Tell us more about that, because I think ACE units were originally developed, and one of the first big studies was actually done by, Seth Landefeld, who used to be our division head of geriatrics.

Although he did that work, I think at Case Western, right before he came to UCSF to found our division. But they [ACE units] were created to address a specific problem, which is that so many older people would develop these complications in the hospital, and come out worse than they were before, separate from their illness.

Stephanie Rogers:

[20:15] The goal is to keep people who are somewhat independent, just as independent as they were before they came in the hospital, so they don't have to go to a nursing home afterwards, which happens often.

ACE units, there's tons of studies out there that show that they do great things. The one my health system cared about was, that it actually reduces costs, it reduces readmissions, and reduces the time that a patient stays in the hospital.

But in addition to those things, it had a lot of outcomes that patients cared about. It improves their functional performance, improves their nutrition, improves their high-risk medication use, reduces

delirium, it reduces the possibility that they're going to get a pressure ulcer, it reduces the likelihood that they're going to fall.

All these things that patients care about, ACE units have been shown to improve outcomes for too.

Leslie Kernisan:

[21:15] And by functional performance, we mean your ability to walk, get up out of bed, get dressed, shower, all those things that people often take for granted.

I think people are often blindsided by the way it's so easy for an older person just by lying in bed and being sick for a few days, how quickly people can lose strength when they're older, compared to when they're younger. Even younger people lose strength lying in bed for a week.

Stephanie Rogers:

[21:46] I've heard from a lot of families, where they have a loved one that goes into the hospital for something like a pneumonia or their diabetes, something like this, and they actually think that their loved one is going to get better.

Instead, what happens is they come out and they feel like their loved one is worse. They're not able to do as many things as they used to do, they can't shower by themselves, they're more confused and the families are confused.

They thought, "I put my loved one in the hospital to get better. Yes that disease is now gone or improved, but their life is not better."

I think that's really frustrating for families and patients, and this is the exact reason that the ACE unit exists.

Leslie Kernisan:

[22:30] It's basically a kind of special ward, right?

Stephanie Rogers:

[22:36] Yes. Just like you have pediatric wards, you can have a geriatric ward too.

Leslie Kernisan:

[22:40] Yes, because as people reach a certain stage of age or frailty, or I think you don't even necessarily to be frail, I want you to tell us more about who gets placed in the ACE unit, but just a certain stage where you're more vulnerable to these hospital complications.

Being in a ward that is set up to help you avoid those, can really make a difference.

We were saying the things that the ACE unit helps people avoid is, one, losing too much strength and ability to manage their daily tasks.

Then you mentioned nutrition, helping them avoid becoming malnourished, and maybe dehydrated also, during their stay.

I think you mentioned falls, help reduce the risk of falls. That is a huge issue in the hospitals, older people falling during hospitalization and then of course if people go home weak they're more likely to fall and get hurt after hospitalization.

Stephanie Rogers:

[23:36] The interesting thing about that fact is, a lot of hospitals try to keep patients in bed because they're worried that they're going to fall, but many studies have shown that the more you get patients up and walk them around, they maintain their strength and their muscles, and there's actually less falls.

A lot of health systems are doing the counter intuitive thing. We actually want people up and walking around so that they don't fall, not only in the hospital, but at home later, when they go home.

Leslie Kernisan:

[24:04] Okay, given the ACE unit is meant to help people maintain more of their strengths, help avoid them getting confused and maintain good nutrition and all that, so they can be strong enough to go home and be as independent as they were before, what do you and your team do within the ACE units to help that happen?

What are you doing and how's the ACE unit set up to make that more possible?

Stephanie Rogers:

[24:29] We actually have daily interdisciplinary rounds on all of the patients. This is when the bedside nurse, the geriatric pharmacist, the geriatric physical therapist, occupational therapist, the chaplain, the geriatrician and the primary team all meet together to talk about the patient.

We talk about the medical reasons that they're there, but the majority of the time, we as a team decide how are we going to mobilize this patient today. How are we going to keep them awake and active? What sort of things do they like to do with their time? Can we have a volunteer or a chaplain visit them? Are they feeling lonely or socially isolated?

As a team, what are we going to do about that, how's their nutrition? How's their sleep? We're focusing on all these other things that are not related to the disease, and as a team we're making a plan for the day.

Leslie Kernisan:

[25:23] Right. To contrast it to usual hospital care, a patient may not be seen by all those different disciplines. Even if they were, those different professionals are often not together, talking about it collaboratively.

Stephanie Rogers:

[25:39] Exactly. They're usually just very focused on the diseases and the medications and not these other things.

Leslie Kernisan:

[25:47] Right, so interdisciplinary rounds.

Stephanie Rogers:

[25:51] Then we also try to have activities to give patients things to do, reasons to get out of the room and stay active.

We have what we call “ACE-ercise”, which is our group exercise class run by our physical therapist and occupational therapist. We have art therapy. We have a volunteer program. We are soon about to start group lunches so that everybody can get out of their room and sit with each other and talk and eat lunch together.

Redesigning the floor to optimize patients being mentally awake and challenged during the day, and then also same thing functionally. We really want everybody to maintain their peak level of function and cognition while they're here.

We try to make their lives as normal as possible, so that they maintain those skills.

Leslie Kernisan:

[26:43] And then you mentioned sleep too. I think another innovation of the ACE units 20 years ago was not waking people up at night.

Stephanie Rogers:

[26:52] That's one thing we do in rounds, is we actually look at all the things that are happening in the middle of the night. We see if we can retime some medication administrations, or is the patient's blood pressure stable enough that we don't have to check it overnight tonight.

We really look at how we can make the room dark and quiet and minimize interruptions that they get at night.

Leslie Kernisan:

[27:15] Well that sounds fantastic. How many beds do we have in UCSF's ACE unit?

Stephanie Rogers:

[27:21] We actually have one unit, which has 36 beds. However given our hospital is always full, not all of the beds are always older adults.

The ACE team, the interdisciplinary rounds, only focuses on the older patients on the unit. Any day we probably have anywhere from 12 to 22 older patients a day.

Leslie Kernisan:

[27:43] How does the hospital, how does it get decided who will go to the ACE unit versus a different bed? Or who gets prioritized?

Stephanie Rogers:

[27:55] Yes, we work with the primary admitting teams, whether it's a surgeon or a medicine doctor, we let them know what our criteria is.

Our criteria is someone who is community-dwelling, who they think subjectively or cognitively frail, and is at high risk for getting delirium or losing some function during the hospital.

We really allow those teams to select, because they are seeing these patients in the emergency department. We let them select who they think would be best for this type of care.

Leslie Kernisan:

[28:29] When you say community-dwelling, that means people who live at home or assisted living, but not nursing homes.

Stephanie Rogers:

[28:36] Exactly.

Leslie Kernisan:

[28:37] Nursing home patients currently just go to a regular bed.

Stephanie Rogers:

[28:42] Well if someone thinks that they would really benefit, we take care of all.

ACE units do this differently everywhere, it's just what we have decided to do here at UCSF.

Sometimes older patients end up here because there was a bed up here, and we're always happy to take care of them.

Leslie Kernisan:

[29:04] Well I think it's just so fantastic and amazing.

When I was a resident at UCSF, which is starting to feel like a long time ago, about 15 years ago, we didn't have this at all, and I wish we had. Better late than never.

Do you think they'll eventually expand it? I feel like there are enough vulnerable adults.

Stephanie Rogers:

[29:24] There are these other models of ACE care out there.

There's a mobile ACE unit and virtual ACE units. This is where you have interdisciplinary teams that move around the hospital to take care of older adults.

That's always in the back of our mind as a way to expand this care to more folks in our health system.

Leslie Kernisan:

[29:43] It also sounds a little bit like universal design, in that this is especially important and valuable if people are older and have already developed some vulnerabilities, or at high risk. Also, wouldn't everybody like to not be woken up at night? And to get more opportunity to socialize and move around, to have their medication reviewed and to have all their providers talking to each other, right?

Stephanie Rogers:

[30:07] Actually, because we're designing an age-friendly health system, our ACE unit is like our unit where we will do a small test change.

Maybe there is some sort of systemic fix that we can put into the entire health system that will allow everyone to sleep better.

We kind of test these things in the ACE unit, see how they work, and if they're working great, sometimes it's just changing something in the electronic health record that alerts providers that this medication is going to wake them up in the middle of the night, this administration of this medication.

Then we can expand that to everyone if we make a fix there. It's really exciting to have that ability to do that.

Leslie Kernisan:

[30:48] It reminds me of one of other guests on the podcast recently, Bill Thomas, was just talking about this inclusiveness. When we design something that works well for the more vulnerable members of our society, everybody ends up benefiting. That's what this makes me think of.

ACE units are amazing, in short.

Would you tell the audience, you said there are a lot of them, but do most hospitals have ACE units?

Stephanie Rogers:

[31:19] Unfortunately, most hospitals do not have ACE units.

Leslie Kernisan:

[31:24] Not yet.

Stephanie Rogers:

[31:25] Not yet, but in the last year I've had nine different institutions visit our ACE unit, just from the Bay Area, because their health system is looking to build ACE units.

I think we are at a tipping point, which is exciting.

Leslie Kernisan:

[31:43] Yeah, that's something people can do, is ask and find out if your hospital has one, or is interested, or maybe if they hear that enough people in their community are interested that will help them make the decision.

Let's talk about one of the other projects that you mentioned, which is the UCSF hip fracture co-management service, so tell us about that.

Stephanie Rogers:

[32:05] We know that patients who break their hip are often the most frail, and we really wanted to focus on these patients. There's really good evidence out there that having a geriatrician work with an orthopedic surgeon to take care of these patients has good outcomes.

This was a really exciting process, because again we had a really motivated group of interdisciplinary physicians and nurses from the emergency department, from orthopedic surgery, from anesthesia, from medicine, and we all work together to get to form what we call a hip fracture protocol.

What we think is the best care for every patient who breaks their hip, from the time that they come to our emergency department to 90 days after they leave the hospital.

We basically just looked at all of the evidence out there and put this protocol together.

Leslie Kernisan:

[33:05] What were the sort of issues, or things that were coming up with usual hip fracture care? How did this protocol address them or improve on?

Stephanie Rogers:

[33:15] Well, I think like most healthcare, it can often be disjointed and siloed, so we wanted to bring this team approach to care.

We know that the sooner the orthopedic surgeons can fix the fracture, the better the outcomes are going to be for the patient, both in their ability to walk again and be independent. Also to prevent delirium, get out of the hospital faster, be more likely to go home rather than to a rehab facility after discharge.

We really focused on this quick time to the operating room.

Controlling pain and preventing delirium with them getting up to work with physical therapy as soon as the hip is fixed. These were the main parts of the protocol.

Leslie Kernisan:

[34:12] Pain is always interesting question, because people are often concerned that if you give an older person with a hip fracture pain medication, that the pain medication might make them confused.

Did you find a way to navigate that balance?

Stephanie Rogers:

[34:31] There is a procedure that can be done, where either an ED physician or anesthesiologist, can actually put some numbing medication in a nerve, in your hip and it can numb the entire hip and leg, so that we don't have to use opioids or systemic pills that can make older adults confused.

I recently saw this work so well. We had an older woman who was 102 years old and she came into the emergency department with a broken hip.

She was really upset and in a lot of pain and writhing. The ED physicians did this nerve block really quickly and instantly she was very calm and comfortable.

She went right into the operating room, stayed in the hospital only two days. In that entire hospital stay she only used a half of a pill of a pain med.

Leslie Kernisan:

[35:25] Oh my God, that's amazing.

I love that, because that's really the beauty of this process. Where a group comes up with the better ways [to provide care] and then makes it easy for other providers to access that and to start from there.

Instead of everybody doing what pops into their head, which may or may not be our latest understanding [of best practices].

Stephanie Rogers:

[35:51] Exactly. Everybody knows their role.

Everybody knows what they need to be doing and we hold each other accountable.

It's always fun when I walk into the emergency department and I see the emergency physician, we look at each other we know exactly what's going on and how we're moving forward in it, and it is really great.

Leslie Kernisan:

[36:11] The pain medication you said, and especially focusing on these nerve blocks, which create less risk of confusion and systemic side effects, also can allow you to avoid the constipation, and getting to the OR faster.

Then you said afterwards, is there more to it afterwards?

Stephanie Rogers:

[36:31] We try to stand the patient up out of bed, with help from our physical therapists, as soon as they get back to their room. Or if they get back too late at night, we will let them sleep and do it first thing in the morning.

We know that the earlier that we get patients up, the more likely that they are going to be able to maintain their level of independence and go back home with their family.

This is very different than the old way of thinking. They used to let people lay around for days, wait till their pain was better and all of these things, to get people moving.

Now we know that we want you up and doing the things that you normally do, brushing your teeth, going to the bathroom, brushing your hair, all these things, back doing those as soon as possible.

If we get you to the operating room very quickly, you're up and standing within 24 hours to 36 hours of breaking your hip, which is really kind of exciting.

Leslie Kernisan:

[37:29] Now that is fantastic.

Does the team help teach families how to comfortably help their older loved one move around?

I think often families are a little bit worried when they see the older person standing up, "Is that good for your hip? You could fall. I don't know how to help support you."

Stephanie Rogers:

[37:48] We as team start thinking about how they're moving around in the hospital and what's that going to look like at home.

We engage in particular, our physical therapist, they really engage the families and the caregivers, teaching them how to safely help their loved one move around. They teach them how to use equipment, if they are going to need new equipment.

We practice in the hospital before they go home so that everyone feels like they're on the same page and they know exactly what they're doing.

The great part about having a geriatrician, kind of co-manage these patients with the orthopedic surgeons, is that we're also thinking about what their home life looks like and we're starting to talk about safety needs and those sorts of things from the day the patient comes into the hospital.

We're preparing for those things from day one.

Leslie Kernisan:

[38:38] A lot of those people must also have ongoing chronic conditions, that may or may not be managed the way we would as geriatricians, do you also end up making recommendations for the primary care physicians about their other conditions?

Or is that not within the scope of this program?

Stephanie Rogers:

[38:58] No, we absolutely do that.

In fact, sometimes as a patient gets older, the things that are important to them are somewhat different to, and so it's very common that they're on a lot of blood pressure medications. But these medications are making their blood pressure so low that when they stand up they're feeling dizzy, and it could be what contributed to the fall in the first place.

If we suspect something like that is happening, we'll actually call the primary care physician. Sometimes we'll even talk with the families and the primary care doctors all together, before they leave the hospital to see if we can come up with the perfect on medication regimen for them.

We think this is really important that everybody works together and is on the same page.

Leslie Kernisan:

[39:42] We know that hip fractures often is such a sentinel or potentially life-changing event for older adults, and a lot of them do have difficulty regaining the same, or historically, have had difficulty regaining the same level of independence and mobility.

Are there research studies on either your program, or other ones? What are they finding in terms of the impact?

Stephanie Rogers:

[40:07] It's exactly what you're saying.

This can be a very big, sentinel event for a family, and we do try to have these conversations upfront of what we think it's going to look like from, not only this week, the next couple weeks and over the next year.

Unfortunately a high number of patients who break their hip will die within a year, so we try to talk to families about this at the very beginning.

One thing I always like to do is talk about what the best-case scenario is going to be, what the worst-case scenario could be, and then where we think that person may fall in that spectrum.

That really helps them have expectations for in best case, we expect the person to be walking at home with a walker for the rest of their life, and the worst case they could possibly die.

I think most likely for your family member what could happen is that they may need to walk with a walker, but they're going to need a 24-hour caregiver to help them with things like showering, getting up out of their chair, going to the bathroom.

We talk about those things the first day that they're in the hospital.

Leslie Kernisan:

[41:22] But in terms of the program, are people who go through this co-management able to walk with a walker 90 days later? I imagine yes.

Stephanie Rogers:

[41:31] Absolutely.

They're more likely to get back to their base line function, or pretty close to it. They're more likely to be living at home and not in a nursing home.

Leslie Kernisan:

[41:43] I love it.

Does everyone who breaks a hip get it? Or just the ones who get flagged as higher risk?

Stephanie Rogers:

[41:53] At this hospital, yes. Every patient who breaks their hip gets this program.

We're going to actually be expanding in the next year to more of what we call fragility fractures. These fractures are because of osteoporosis. Whether it's your arm or your ankle, it should be treated the same way.

We're going to take all the things that we learn from this program and expand it to more of these other types of osteoporosis related fractures.

Leslie Kernisan:

[42:19] Oh that's great.

A lot of older adults get elective orthopedic procedures, elective joint surgeries, especially knee replacements, hip replacements.

Now they're usually I think younger and less frail than the ones who come in with a broken hip, but is there a role for this kind of co-management program for those elective surgeries at this point?

Stephanie Rogers:

[42:40] There are studies out there that show that geriatrics co-management can improve the outcomes for these types of patients, and I think we're going to be moving into some of that care also.

The geriatrics orthopedic co-management service is a well-researched type of service, so all of these types of orthopedic procedures are benefited from having a geriatrician co-manage.

A lot of that is because function is such an important aspect of everything that they do, and what we do, and working together we really have lots of good outcomes.

Leslie Kernisan:

[43:15] Fantastic, I love it.

Well, we'll have you talk about one more program at UCSF, because you mentioned it before, and it's also so important, which is a delirium reduction project.

We have talked about delirium a few times on the podcast. We had Dr. Inouye, who's done so much work on delirium for episode 62.

Maybe we can briefly recap, what is delirium? Then, what is that project at UCSF looking like?

Stephanie Rogers:

[43:45] Delirium is hospital confusion.

It can be caused by many things like you said, sometimes it's medication, sometimes it's lack of sleep. It could be an underlying medical condition like an infection, but it is very distressing for patients and families.

It's also very hard for the staff, because they're trying to take good care of these patients and they're often confused. That's how our delirium reduction campaign kind of came into fruition.

We had a neurohospitalist, Vanya Douglas, was talking to a lot of the nurses and the nurses were saying, "We need help taking care of these patients. We can tell that they're suffering and they're confused. We want to know how to better take care of these patients."

He actually designed a pathway that he made on the neuro units, that studied and it ended up having great outcomes. Then we just disseminated that program throughout the entire institution.

Leslie Kernisan:

[44:47] Delirium is that state of new or worse than usual confusion that is so common in the hospital, I will point out that people do become delirious outside the hospital too.

I say that because I think sometimes people don't realize that. It comes from being quite sick and of course being stressed, physical stressors and mental stressors.

Even if you weren't sick enough to have delirium before you got to the hospital, just everything you go through in the hospital, especially surgery or a really serious illness was involved, could make you delirious.

Then when people are older and frailer, it takes even less for them to become delirious in the hospital and it's super common.

For the delirium reduction project, is it more about how you treat people once they have delirium?

Or is it more about preventing delirium? Or is it both? Tell us a little bit more about what it actually looks like.

Stephanie Rogers:

[45:45] It's actually both.

Patients will have better outcomes if you actually prevent delirium in the first place obviously, so one thing that we do is, we do a screening test.

When every patient comes into the hospital, its called, "AWOL" and it tells us who is high risk of getting delirium and who is low risk of getting delirium.

If you're high risk, we're going to concentrate all of our resources on that group of people to prevent delirium.

Then in addition, every patient that's in the hospital, this is every age, gets a screening test for delirium. If anytime they become positive and have new onset of delirium, they actually go into this same pathway where the high-risk patients are in.

That pathway is very interdisciplinary, every discipline in the hospital has a role to play. The nurses really focus on mobility and sleep, and those sorts of things.

Our pharmacists do an evaluation of the medication, so we know that certain medications are more likely to cause confusion. The pharmacist will make recommendations to the doctors to either change a medication or stop a medication, to try to prevent delirium.

Then our physicians, we have this order set in our electronic health record that guides the doctor into some things that they can do to help prevent delirium.

For instance, we talked about earlier, stopping checking blood pressure overnight to allow the patient to sleep. Is the patient stable enough to do that? Or do they need their urinary catheter right now, can that be removed?

Everybody in the hospital is working together and communicating about these high-risk patients or these patients that are delirious.

Leslie Kernisan:

[47:34] Wow, that is fantastic.

I know that historically, delirium has often been under recognized by health providers. That's what a lot of studies had shown, was that an older person might be delirious and it may not have been noticed by the hospital staff.

Either they're confused and people sometimes assume, "oh they're always like that," when in fact they're worse than usual. That might reflect our ageism, that if somebody looks like they're quite old and they're acting confused, we assume it's their usual state and maybe it's not.

Or people can also become very quiet and spaced-out when they're delirious, hypoactive delirium, so then they're just so quiet. Then people don't notice the quiet person who's actually spaced-out and inattentive and is delirious.

That is still an issue that should be addressed.

So right now, UCSF is screening every older person for delirium?

Stephanie Rogers:

[48:27] Every person in the hospital.

Whether you're young or old, because we know that younger people get delirium too, and this is both at Parnassus and at Mission Bay.

Whether you're in the ICU or on the floor, every 12 hours a nurse is doing a delirium screen.

Leslie Kernisan:

[48:41] That is amazing.

Stephanie Rogers:

[48:42] And we have over 90% compliance with those screens.

Leslie Kernisan:

[48:45] I remember it's often a ballpark, that among older adults during a hospitalization, about a third of them, that's a figure that's come out in some studies, will experience delirium at some point.

Is that what you're finding? It's a lot of people to put into the protocol.

Stephanie Rogers:

[49:04] We actually found that about 17% of patients get delirious.

About that same number, about 19% of patients, and there's some overlap in those groups, are high risk for delirium.

At any one time, there's probably a little less than 20% of patients in the protocol, so 1 in 5 are getting the protocol.

Leslie Kernisan:

[49:25] It's still a lot, but it's fantastic if you are able to deliver the protocol to that many people.

I imagine it's one thing to deliver a protocol to 10 patients, and this must be... how many at a time are getting it?

Stephanie Rogers:

[49:39] It's a lot.

For every unit, every nurse is taking care at least one of these patients.

Leslie Kernisan:

[49:46] Let's just talk briefly about prevention. What are things that prevent delirium?

Also, I think there's a study, about 40% of delirium can be prevented right?

It can't all be prevented.

Stephanie Rogers:

[50:01] I think it's around 30%, about a third of cases.

Leslie Kernisan:

[50:04] Can be prevented.

It's not a guarantee that the person won't get delirious, but preventing 30% of it is still helping a lot of people.

Stephanie Rogers:

[50:14] A lot of what we do, it seems like simple things, but we really focus on making sure that patients are sleeping well at night and that they're in a dark room or it's not noisy and they're not getting interrupted.

During the day, we try to keep them awake and not taking a lot of naps. We try to make sure the lights are on and that they're window shades are open and they're getting in good light so that their circadian rhythms are intact.

We also want them to be cognitively stimulated. Do they enjoy talking to people or reading or doing puzzles or knitting?

We want their minds to be active during the day, so we spend a lot of time with that.

We really encourage family members and caregivers that they know well, to be at the bedside and to help us with these tasks. We ask them to bring in items from home, pictures or things that they can use to reminisce with their family members.

Those are some of the biggest things that you can do to prevent delirium. We spend a lot of our time working on those.

Leslie Kernisan:

[51:19] Once the person does have delirium, either they got flagged as having it when they came in, or they developed it, I know all those things are so important to do, because it's part of supportive care, to help the mind recover from whatever stressor brought on the delirium.

We also usually look for, is there something triggering or bringing on this delirium?

Do you have a kind of pathway for the clinical team to follow, to check for those?

Stephanie Rogers:

[51:49] Absolutely.

Every physician or extended provider, like a nurse practitioner or physician assistant, has been educated on how to work up delirium, to look for the possible medical causes of delirium.

We have pocket cards that they carry around in their white coats to remind them of the sorts of things that they need to look for.

Every time I see a patient who is confused, I actually take out this card and I go step by step, and I do these steps to make sure that I'm ruling out all the causes of delirium.

It's really great because the patients know what to expect, the nurses know what to expect, all the physicians know what they're doing, and it really makes a well-coordinated pathway.

Leslie Kernisan:

[52:31] I think that's what we're coming back to, a good pathway is just so important to give people an easy, evidence-based starting ground, to do the right thing.

It's not necessarily right for everybody, but at least you're providing the foundation to make it easy for health providers to do something that we think is most likely to be most helpful.

Stephanie Rogers:

[52:54] I think that's the basis of the entire age-friendly health system, is putting things into place to reduce the variability of care, so everybody is getting the same good care every time, no matter where they are in the hospital, no matter what age they are, no matter what's going on with them.

That's part of the challenge and that's part of the exciting thing about working on age-friendly health system, we get to think about innovative ways to really put all of these things in place.

Leslie Kernisan:

[53:23] Well that is wonderful.

Are there informational materials? I think UCSF has a website about delirium for the public?

Stephanie Rogers:

[53:32] Yeah, absolutely. It's delirium.ucsf.edu

We had a great group of medical students last year who went around and talked to many families and caregivers about delirium.

We tried to get families and caregivers of all ethnicities and languages. We wanted to understand what they wanted to know about delirium, what they needed to help take care of their confused loved ones, and we put together this website.

It has information on delirium, but in addition, it has very practical tips or things that families can do to help their loved one with delirium.

Leslie Kernisan:

[54:14] Oh great. We will definitely share that in the show notes, because I have an article on hospital delirium on Better Health While Aging, and it gets so many people visiting.

I think the problem is that many people's older loved one is not hospitalized at a place like UCSF, that has implemented this kind of project.

They describe something that sounds like delirium, and say, “but the doctors haven't told us what that is? Or that this is it, or why aren't they doing something about it? Or I asked if it could be delirium and they told me to not to worry about it, and what should they be doing?”

I think for people who are patients in a healthcare system that for whatever reason has not yet been able to do this, there's a lot of frustration.

They want to know what they should be doing, what should they be asking about, because they want to be proactive and they want to know how to advocate.

So that's great that you have created this resource, and we will be sure to share it in the show notes.

You mentioned that as a resource for family and caregivers, but what other things have you and UCSF been doing to address this aspect of the age-friendly health system, and connecting better with the care circle?

Stephanie Rogers:

[55:33] One unique thing that we have at UCSF, are these patient & family advisory councils.

There's many of them actually, they sit in different infrastructures. There's an outpatient one, there's different ones if you had surgery or if you've been in the ICU.

This is really great because these are families and patients who have actually gone through our healthcare system and now want to help us do better.

Anytime we have a challenge, we can bring it to this group and we can get their feedback from real patients and families. Sometimes the ideas for how to improve things are coming from the patients and families in the first place, so they're the ones telling us this is what you guys need to do better.

This is a really amazing way to engage our community and make sure that we're really focusing on the things that work for our patients and families.

Leslie Kernisan:

[56:26] Yeah I love it, it's fantastic.

Well you've done so much, how long have you been doing this for UCSF?

Stephanie Rogers:

[56:37] I have been on faculty, I think 5 years now.

About 5 years we've been doing this and most of the clinical programs started about a year and a half ago, so they're brand new.

A lot of the design and the engagement of the leadership, and different people at UCSF, has been going on for quite a few years.

Leslie Kernisan:

[57:00] It sounds like it takes a fair amount of pre-work to get this going.

Stephanie Rogers:

[57:03] Absolutely.

Leslie Kernisan:

[57:05] It's just an amazing achievement for you and your colleagues and the medical center to have done this.

What's coming this year now?

Stephanie Rogers:

[57:15] We're continuing to make these programs better.

We are always talking to our patients and families to find out what they want and what they need, so there will be a lot of small changes I'm sure coming ahead.

One exciting thing that's happening is all of the University of California hospitals, so UCLA, UCSF, UCSD, are going to be implementing geriatric emergency departments.

They will all be working together, so they will be standardized across the UC system. We're excited to start a geriatric emergency department.

We're going to continue to work with the IHI and the Hartford Foundation sharing what we're learning and what the other places are learning, so that as this age friendly initiative expands across the world, we can do our part to help really spread this care everywhere.

So if you're not living in the Bay Area, you can actually get this care wherever you are.

We really want to make sure that what we're doing gets disseminated everywhere.

Leslie Kernisan:

[58:19] I think that was part of the Hartford Foundation's stated goal, when they launched this a few years ago, was 20% of hospitals or health systems, were to have or be working on an age-friendly health system by 2020, so that's next year.

We have examples like UCSF for others to learn from, which I think is going to help, I can imagine this kind of snowballing.

Stephanie Rogers:

[58:48] Yes we're happy to help.

Leslie Kernisan:

[58:49] I love the idea of geriatric emergency rooms. We'll have to do another episode on that subject at some point.

For now, for the listeners who now may be wondering how they can find an age-friendly health system, or at least get care that's in line with those key principles, any recommendations for what they can do?

Or how they can either get better care of themselves or help foster this movement?

Stephanie Rogers:

[59:12] I think if health systems are becoming age friendly, I think they'll start advertising this. This will obviously be something that they'll want to share with everyone.

You can probably check on the websites of the institutions that you're getting care at. I know the IHI website is going to list these sites too, so IHI.org will let people know what age friendly health systems are out there.

Leslie Kernisan:

[59:37] That's the Institute for Healthcare Improvement, a very venerable, well-organized institution, which does quality improvement related to healthcare

Stephanie Rogers:

[59:48] I think that's the best ways to find out about it.

I think aging is a universal experience and every person really needs to define what's important to them and to their loved ones, and to find places and providers that are willing to talk about these things.

If you're finding yourself somewhere where you don't get to talk about these things and have these conversations, then you should find another place to go.

There are many institutions, health systems, and providers who want to talk about your goals and what's important to you, and to really look for those types of providers.

Leslie Kernisan:

[1:00:30] If it's an elective surgery, maybe looking to find out, and asking.

People can even ask their surgeons or their institutions, what kind of programs do you have to help these kinds of surgeries be successful in older adults?

That would be something people could start with.

Stephanie Rogers:

[1:00:47] Exactly. You have to be very proactive and ask what can I do to decrease the chance I'm going to get delirium or to make sure that I can go home after this hospitalization.

Be proactive and ask these types of questions, because there are a lot of people out there that really want to do this great care.

Leslie Kernisan:

[1:01:07] Stephanie, thank you so much for coming to talk about it, but really for helping to spearhead this at UCSF.

Stephanie Rogers:

[1:01:15] Well thank you, I appreciate it.

I have to say, I absolutely love my job. I think this is so fun. I enjoy coming to work everyday and I get to work with lots of people that are passionate about this exact same thing.

I think that's the thing that really drives me, is to see how many people are really excited about making care better for older adults. So I'm happy to talk and excited to do what I do.

Leslie Kernisan:

[1:01:42] Well you are where you need to be and you are where we need you to be!

Fantastic, thank you so very much.

Stephanie Rogers:

[1:01:48] Of course, thank you so much.

Leslie Kernisan:

[1:01:50] And with that, I'm going to wrap up this episode of Better Health While Aging.

If you have any questions about something you heard in this episode, you can post it on the show notes page for the episode.

I'll also be posting some of the links to some of the resources that I mentioned in the episode.

To find the show notes, visit Betterhealthwhileaging.net and click Podcast in the main menu at the top.

Last but not least, if you've been enjoying the podcast, don't forget to support us by subscribing on iTunes, and if you've already done that, please [leave a rating and review](#).

This makes it easier for others to discover our show in iTunes, and I would love for the many people who are interested in health or aging or family caregivers, to be able to find it and give it a chance.

Thank you so much for listening. I'm Dr. Leslie Kernisan and I'm looking forward to you joining us for future episodes.

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About Dr. Leslie Kernisan and Better Health While Aging:

Leslie Kernisan, MD MPH, is a practicing geriatrician who believes it should be easier for older adults to have the best possible health and quality of life as they age.

Through her website Better Health While Aging, she provides practical information on how to address many common health problems that affect older adults. She also addresses common concerns and dilemmas related to helping older parents and other aging relatives.



Visit BetterHealthWhileAging.net to find more useful articles on aging health, family caregiving, and helping older parents.

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