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## Assisted Living Column



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## Why bad things happen to good people?

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Mrs. Ruth Johnson presents to the emergency room from your long term care facility where she has been a resident for the last several years. She is in the emergency room for evaluation of a respiratory infection; she also has a Stage IV pressure injury which is packed. The ED physician discusses their findings and plan of care with her family and closes with he can't believe this happened. Leading the family to believe that this bad outcome must be the result of poor care. The belief is, by all here, that bad outcomes are always the result of bad behavior but of course this is not always the case. Additionally, the arrow of blame is always easy to point toward the long term care facility because of the many years of reports of poor care, abuse, and neglect delivered by these facilities by various forms of media.

In situations like this a bad outcome may occur despite the standard of care being followed. Remember, a large percentage of the people that are cared for in this setting are frail, elderly, immunocompromised, and deconditioned. But this bad 'situation' could be prevented by not only providing evidenced based care while clearly explaining expectations and the care being providing in your care setting. Of course, making a bad situation better won't necessarily change an outcome such as an infection, wound or death – sometimes bad outcomes occur even when good people are doing everything right.

## Standard of care/evidence based care

To begin it's important to understand the definition of 'standard of care'. That is care at the level at which the average, prudent provider in a given community would practice. It is how similarly qualified practitioners would have managed the patient's care under the same or similar circumstances.

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In addition to standard of care it's critical to also understand what evidence based care is. Because, sadly, some of our standards of care are not based on evidence based care. Evidence based practice (EBP) is based on research, clinical guidelines, and other information resources based on high quality findings. These Evidence Based Practice guidelines are rated on their levels of evidence and grades of recommendations used by the National Guideline Clearinghouse.<sup>1</sup>

Levels of evidence:

IA	Evidence from meta-analysis of randomized controlled trials
IB	Evidence from at least one randomized controlled trial
IIA	Evidence from at least one controlled study without randomization
IIB	Evidence from at least one other type of quasi-experimental study
III	Evidence from non-experimental descriptive studies, such as comparative studies, correlation studies, and case-control studies
IV	Evidence from expert committee reports or opinions or clinical experience of respected authorities, or both

Grades of recommendations:

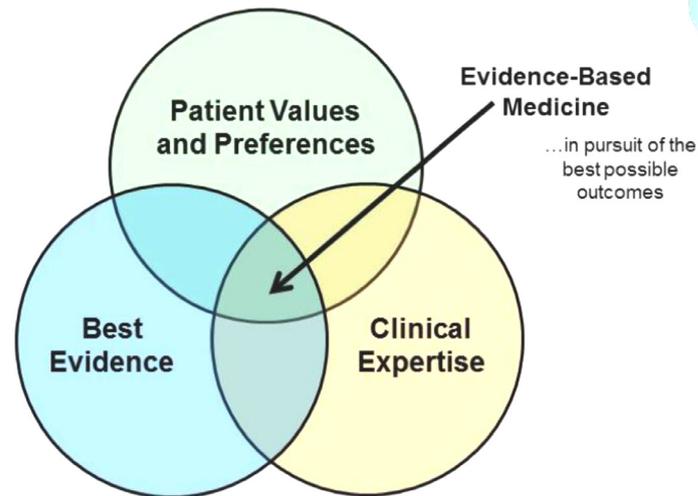
A	Directly based on Level I evidence
B	Directly based on Level II evidence or extrapolated recommendations from Level I evidence
C	Directly based on Level III evidence or extrapolated recommendations from Level I or II evidence
D	Directly based on Level IV evidence or extrapolated recommendations from Level I, II, or III evidence

Dr. John Haugom published insights about the growing importance of using evidence-based medicine.<sup>2</sup> He began by describing a case similar to our Mrs. Johnson noted how the practice of evidence-based medicine can assist us, our patients and their families determine the most appropriate medical treatment.

Evidence-based medicine includes three key components (Fig. 1): research-based evidence, clinical expertise (i.e., the clinician's



## Components of Evidence-Based Medicine



**Fig. 1.** The three components of evidence-based medicine.

accumulated experience, knowledge, and clinical skills), and the patient's values and preferences.

Practicing evidence-based medicine is important in today's healthcare environment because this model of care offers providers one of the best ways to achieve the Triple Aim's objectives of improved quality, improved patient satisfaction, and reduced costs. These are the measures that we are increasingly being held accountable. Also providing evidence-based medicine is the best way to avoid legal issues that can arise even in the face of negative or bad outcomes.

With evidence-based medicine, a provider can assess the strength of the evidence as well as the risks and benefits of ordering diagnostic tests and treatments for each cancer patient. Such an approach, coupled with the provider's clinical experience, enables the provider to better predict if a treatment will do more harm than good. It also helps the organization establish a systematic approach to caring for patients with specific conditions.

Evidence-based medicine is not just about using evidence to design treatment plans; It also encourages a dialogue between patients and providers, so patients can share in the decision-making and make their values and preferences known. Together, patients and their families with providers can determine an appropriate course of action—or no course of action if that's the joint decision. The benefit of this approach is that providers listen to patient concerns and take them into consideration to determine the appropriate treatment plan as well as manage expectations based on the likely course.

Specifically, Dr. John Haughom identified five ways EBM can add value to healthcare:

#1: Helps providers stay current on standardized, evidence-based protocols.

There's an explosion of scientific knowledge being published, making it difficult for clinicians to stay current on medical best practices. In fact, for a primary care physician to stay up to date, they'd need to read 17 articles a day, 365 days a year. This is an impossible task, but evidence-based medicine offers clinicians a way to stay current with best practices using standardized, evidence-based protocols.

#2: Uses near real-time data to make care decisions.

Healthcare staff now has better access to data and more knowledge because of improved technology, such as electronic medical records (EMRs), decision support systems, built-in protocols, data warehouses, and sophisticated analytics. With this improved access to healthcare data, staff can use evidence-based medicine to provide better patient care based on near real-time data.

#3: Improves transparency, accountability, and value.

Payers, employers, and patients are all driving the need for the healthcare industry to show transparency, accountability, and value (e.g., high quality and safe care at the lowest possible cost). Practicing evidence-based healthcare can help the industry achieve these goals. According to the manual Evidence-Based Practice Manual: Research and Outcome Measures in Health and Human Services, "Evidence-based healthcare expresses commitment to improve the transparency of reasoning behind policies, increase accountability by justifying decisions on the basis of valid information that can stand up to scrutiny, gauge uncertainty by making explicit the strength of evidence supporting policy, and make policy decisions driven by the best outcomes for the healthcare dollar."

#4: Improves quality of care.

Although the U.S. spends more money per person on healthcare than any other nation in the world, there is broad evidence that Americans often do not get the care they need. With evidence-based medicine, care improves because clinicians have access to previously untapped data and best practices vetted and agreed upon by peers. Again EBM can be different from the standard of care especially when new findings are first available as it typically takes many years for EBM to become the standard of care.

#5: Improves outcomes.

The most important reason for the interest in evidence-based medicine is that it works. There's a lot of data that shows if health systems diligently use the best clinical evidence and

expertise, and ensure treatments are consistent with patient values, they'll realize better outcomes in every way. But, again even when delivering standard of care especially when it's EBM care can at times result in 'bad' outcomes. These 'bad' outcomes are unavoidable, they are outcomes not proximately caused by the negligence of any party or that is unforeseeable or not preventable by exercise of reasonable precautions but rather the natural progression of disease or condition.

### Managing expectations

One of the best resources to assist in educating patients and their families regarding the likely course is through the use of the ePrognosis tool.<sup>3</sup> Although many geriatric prognostic indices have been published, they may be difficult for busy providers to remember and use. The goal of the team behind ePrognosis is to provide a repository of published geriatric prognostic indices where providers could go to obtain evidence-based information on patients' prognosis.

To locate prognostic indices, the ePrognosis team conducted a systematic review of the literature, published in *JAMA* January 11, 2011. Users are recommended to refer to this systematic review for detailed information on the accuracy, generalizability, potential for bias, and usability of these indices. These indices are designed for older adults who do not have a dominant terminal illness. For patients with a dominant terminal illness, such as advanced dementia, cancer, or heart failure, prognostic indices specifically designed for those purposes should be used.

The information on ePrognosis is intended as a rough guide to inform clinicians about possible mortality outcomes. It is not intended to be the only basis for making care decisions, nor is it intended to be a definitive means of prognostication. Of course, providers should keep in mind that every patient is an individual, and that many factors beyond those used in these indices may influence a patient's prognosis.

### A good RAbBIT to improve outcomes

Another essential component of managing expectations is not only those of the patient and family but other members of the health care system. In our opening story, which occurs all too often, the emergency room physician was unaware of the scope of practice of most LTC facilities as a result a patient that could have easily been assessed and sent back to her home for care is instead admitted to the acute care hospital.

Educating those caring for patients in the acute care setting about the clinical capabilities of long term care facilities is essential. Many Medical Centers have established coalitions with their neighboring long term care facilities. Coalition meetings will typically focus on strategies to reduce 30-day readmission rates. In some communities, long term facilities have established a grid that explains what each facility can provide to their patients. These services may include IV fluids and antibiotics, ventilator support capabilities, ability to manage total parental nutrition, and capability to provide BIPAP or CPAP. Making this information available in a grid format (such as an excel spreadsheet) not only provides information to the providers in the emergency room but also gives assistance to discharge planners who are looking to assist patients choosing the facility that would be best suited to care for them when they are going through their initial search for a facility to live in. Besides regular education of the ED staff an additional measure that can be taken is to send every patient with a single sheet describing the scope of services available at your facility. This can be on the back of a RAbBIT form. RAbBIT stands for Rapid Assessment + Initial Treatment (figure 2). This process is ideal for patients that need to be assessed quickly, have their treatment started and sent back to their home facility for completion of therapy. Take for example a patient with pneumonia who needs labs, chest X-ray, pic line and first dose of antibiotics- this can be done in the ED more effectively and timely than at the facility. Unfortunately without

providing the ED the heads up in your plan and ability of your facility all of these patients would be admitted. This education on your services and use of the RAbBIT form/process could eliminate many avoidable Hospitalizations along with the poor clinical and financial consequences associated.

RAbBIT  
Rapid Assessment + Initial Treatment



### The warm hand-off

There is always a high risk for adverse events when a patient is transferred between the hospital and the skilled nursing facility. Historically, though there has been some level of communication between facilities at the nursing level, the communication between the clinicians of the two settings has been minimal if not non-existent. The warm handoff refers to the clinician of the discharging facility making direct contact with the clinician of the receiving facility in order to have direct communication about the patient. The communication is intended to happen in real time and when done effectively is believed to be a tool that reduces risks associated with transfers. Effective communications should include the following details when the long-term care facility is executing a transfer to the hospital;

1. What is the clinical change in condition that has been observed?
2. What do you suspect is the clinical reason for the change in condition?
3. What are the reasons why the current change in condition can't be evaluated in the current care-setting?
4. Once evaluation is completed, what treatment options can be handled at the facility to prevent a hospital admission?
5. Status of advance directives.
6. Current goals of care of the patient and their health care representative.
7. The contact information of the transferring prescriber.

In a study by Campbell et al.,<sup>4</sup> a total of 2417 patient discharges from skilled nursing facility to hospital were evaluated. Interventions were put in place to implement a warm handoff with these discharges and over time, warm handoffs were documented at an increasing rate. Initially warm handoffs occurred at a rate of 15.78%. Over time, that rate increased to 46.89%. The main barrier that was encountered was clinician concern regarding the purpose of the handoff and how this additional burden would impact their workload. Addressing workload and efficiency issues will be key in achieving universal acceptance of performing a warm handoff, however, it is currently believed that implementation of a warm handoff reduces risks associated with transferring a patient between care settings and enhances patient safety.

### Preparing for the unexpected

One additional area to cover in this area of bad outcomes even under the delivery of EBM is in the area of emergency preparedness. Recent emergency situations facing LTC facilities have highlighted the importance of being prepared for emergencies some of these bad outcomes could have been avoided through emergency preparedness. Of course there will be extraordinary situations which are impossible to plan for, resulting in bad outcomes but in others better planning can prevent poor performance.

There has been increasing activity among long-term care facilities in the area of disaster planning. The Centers for Medicare and

Medicaid have adapted their emergency preparedness rules for long term care in recognition of important these centers can be in managing a crisis. Requirements for long-term care are now very similar to those that have been established for hospitals.

The following areas have been identified as having primary importance when preparing a disaster plan for a long-term care facility;

1. Maintenance of adequate food and water supplies for residents and for staff.
2. Redundant emergency power systems must be in place and tested periodically to ensure that they are fully functional.
3. Facilities must not operate in silos. Collaboration should exist between the facility and its neighboring long-term care facilities and hospitals. This collaboration should include written plans of collaboration that all involved parties agreed to and performance of periodic drills.
4. Procedures for producing emergency short-term medical records as a backup if the primary electronic medical record system is now operational. The emergency backup records will also be of importance if it is necessary to transfer residents to other facilities. In that event, the records must be in a format that will enable them to accompany the resident to their destination facility. In addition, procedures must be in place to make sure that as residents are moved, their medications and other essential medical supplies go with them and are available when needed.
5. Each facility should have an area that can house residents who must be transferred from other facilities.
6. Maintenance of systems that will be used to electronically track movement of any resident that is to be sent to another facility or that is to be accepted from another facility. These systems should also be designed to track the movement of on duty staff.
7. Have a prepared procedure for communication of information to patients and their families and representatives. This is an item that is often overlooked but is of utmost importance. We have already seen examples of the panic that can be created when loved ones who are trying to get information about family members who may have been stranded or evacuated are met with obstacles instead of updates.

So many of the problems we have discussed in this article can be managed with effective patient-centered communication. There is an increasing body of evidence that is telling us that the behavior and

medical care decision making that is done by patients and family members is influenced strongly by the information they have received, usually verbally, from their physician. In today's complex healthcare environment it is becoming increasingly difficult for patients to have effective communications with their primary care providers for several reasons. Hospitals have been identified as expensive centers of care.

For several years now there have been prominent efforts to reduce the utilization of emergency departments and hospitals with many efforts aimed at reducing re-hospitalization rates. These efforts have led to the emergence of services such as CVS Health, where you can go to see a doctor as an alternative to going to the emergency room are an alternative to having a primary care physician. Centers like CVS Health provide acute care services at lower costs and eliminate the need for a significant number of emergency room visits. This potentially creates a serious problem in the doctor-patient relationship where there is now a shift to what we will refer to as the retailer-patient relationship. Urgent care and similar healthcare centers are not the best setting to imagine setting foundations for meaningful discussions regarding goals of care because they typically are not in a favorable position under their current structure to manage a patient's long-term health issues.

Bad outcomes are not always avoidable outside of extraordinary situations, even under the best planning and care but with planning, managing expectations and following best practices these bad outcomes can certainly be mitigated, reducing unnecessary stress and anxiety in our already overwhelmed system. Through providers communicating clearly and following EBM even bad situations can be made better.

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