Un caso clinico su
'la post-acuzie': utilità clinica
(o spreco di risorse)

Brescia, 15 luglio 2016
Grg Journal Club

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FONDAZIONE
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PER PUNTI:

Il percorso: cosa deve fare la post acuzie

La letteratura

Due casi clinici

Alcuni risultati

Conclusioni

Utilità clinica

Cosa deve fare una post acuzie
John Morley, JAMDA 2014
(RR,MT,SB 2004)

Department of Health and Human Services
ADVERSE EVENTS IN SKILLED
NURSING FACILITIES:

February 2014

Table 8: Costs of Hospitalizations Associated With Adverse Events

Hospitalization Type	Estimated Number of Hospitalizations	Estimated Average Costs	Estimated Total Spending
Hospitalizations for medication events	7,203	$8,372	$57,729,935
Hospitalizations for resident care events	7,511	$8,967	$67,350,098
Hospitalizations for infections events	5,679	$14,599	$82,899,180
Hospitalizations Associated With All Events	**20,393**	**$10,276**	**$207,979,213**

Source: OIG analysis of SNF stays for 653 Medicare beneficiaries discharged in August 2011.

Table 3: Adverse Events Identified Among Medicare SNF Residents by Category

Types of Adverse Events	Percentage*
Events Related to Medication	**37%**
• Medication-induced delirium or other change in mental status	12%
• Excessive bleeding due to medication	5%
• Fall or other trauma with injury secondary to effects of medication	4%
• Constipation, obstipation, and ileus related to medication	4%
• Other medication events	14%
Events Related to Resident Care	**37%**
• Fall or other trauma with injury related to resident care	6%
• Exacerbations of preexisting conditions resulting from an omission of care	6%
• Acute kidney injury or insufficiency secondary to fluid maintenance	5%
• Fluid and other electrolyte disorders (e.g., inadequate management of fluid)	4%
• Venous thromboembolism, deep vein thrombosis (DVT), or pulmonary embolism (PE) related to resident monitoring	4%
• Other resident care events	14%
Events Related to Infections	**26%**
• Aspiration pneumonia and other respiratory infections	10%
• Surgical site infection (SSI) associated with wound care	5%
• Urinary tract infection associated with catheter (CAUTI)	3%
• *Clostridium difficile* infection	3%
• Other infection events	5%
Total	**100%**

*The percentages for conditions listed within the clinical categories do not sum to 100 percent because of rounding.
See Appendix D for percentage estimates and confidence intervals.
See Appendix F for a complete listing of all adverse events identified by the reviewers.
Source: OIG analysis of SNF stays for 653 Medicare beneficiaries discharged in August 2011.

Cosa NON DEVE fare una post-acuzie:

-Aumentare i costi
(avere un hospitalist aumenta I costi di lab e non riduce le cadute nè le riammissioni); Gloth, Jamda 2011;12-384-386

-Ricevere i pazienti non adeguati
(hospice care vs SNF for terminal illness); WANG, Jamda 2016

-NON essere in rete per la scelta del migliore luogo post-acuto
(unico pagatore, offerta di servizi non in concorrenza, bundle payment); Burke et al, Jamda 2016, 17:364-369

-Allettare i pazienti; favorire il sonno diurno; sfavorire il sonno notturno (less functional recovery);
Alessi, Sleep 2008; Martin, Sleep 2011; Dierzewsky, Jags 2014

-Rifiutare i pazienti con delirium; Jones, Jamda 2010
-Defilarsi sui fragili (black, female, old, low income, hispanic); Freburgeer, Arch Ph Med 2013

Cosa DEVE fare una post-acuzie:

-Assessment (all articles)
-Curare i malati secondo le linee guida
(scompenso cardiaco, recente IMA); Nazir Jamda 2015:825-831
(infezioni e antibiotici) ; Temkin Antib Res 2015
(review dei farmaci); Runganga Clin Interv Aging 2014
(Chronic critical illness); Kahn , Med Care 2013
(nutrizione e disfagia); Heckert, Stroke 2009
(BPCO); Van Dam, Prim Care 2014

-Ridurre i rischi di rericovero da riacutizzazione/problemi incidenti
(SCC 25%, falls/ortopedics 11% , GI 7%); Inzitari, Jamda 2014: 687

-Curare la depressione ed insonnia; Martin Am J Ger Psy 2012

-Attenzione alla diagnosi e cura del delirium non segnalati da Hosp
(30% fratture, 20% ortop non frattura, 24% infezioni)
Elalem, Jamda 2015; Marcantonio, Jags 2010 (from 46 to 12%)

Cosa DEVE fare una post-acuzie:

-Considerare la funzione premorbosa nella predittività del recupero (1 year before); Buurman, Jamda, 2016,17:225-231
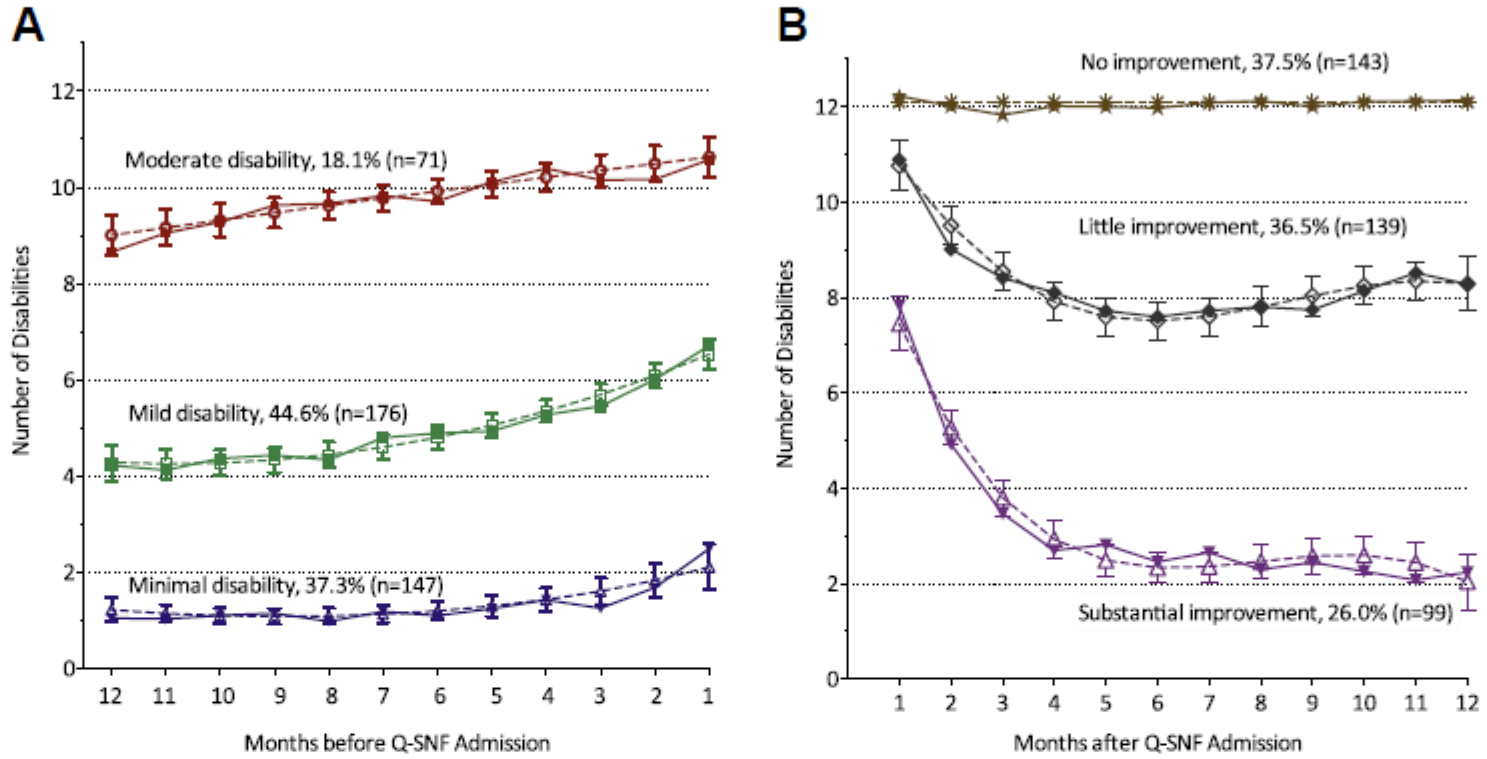
-Prevedere un percorso specifico per pazienti molto gravi (Severe dementia: rehosp 44%, or NH 24%, 24% home, 8% dead) Nahanishi, Jamda 2016:92

-Aumentare comunicazioni tra il personale (67% readmission per polmonite risparmiate)

-High presence model (enhance, activate): LOS from 28 to 12 days, less riadmissions; Deveraux, Jamda 2106

-Tracking frequency of locomotion (min/die, functional assessment of results)

-Transition to home (follow up telefonico: reduced readmission from 36 to 12%) (attivare il territorio con AS) Jamda, 2014 e 2016

A
B

Moderate disability, 18.1% (n=71)
Mild disability, 44.6% (n=176)
Minimal disability, 37.3% (n=147)

No improvement, 37.5% (n=143)
Little improvement, 36.5% (n=139)
Substantial improvement, 26.0% (n=99)

Number of Disabilities

Months before Q-SNF Admission
Months after Q-SNF Admission

Disability trajectories before (A) and after (B) a Q-SNF admission. Number and percentage of participants for each trajectory are shown in parentheses. The number of disabilities ranged from 0 to 13 based on 4 basic activities (bathing, dressing, walking inside the house, and transferring from a chair), 5 instrumental activities (shopping, housework, meal preparation, taking medications, and managing finances), and 4 mobility activities (walking a quarter mile, climbing a flight of stairs, lifting or carrying 10 lb, and ...ng). Solid lines indicate observed trajectories; dashed lines indicate predicted trajectories. The error bars represent 95% confidence intervals for the predicted severity of ...bility. The dual model was adjusted for age, sex, race, educational level less than high school, number of chronic conditions, physical frailty, cognitive impairment, depressive ...ptoms, and acute admission, using information available just before or at the time of hospital admission. Panels 1A and 1B are interconnected; of the participants with minimal ...bility before the pre–Q-SNF admission (n = 147), 52% (n = 83) transitioned to substantial improvement, 32% (n = 38) to little improvement, and 16% (n = 20) to no ...ovement. A, Before Q-SNF-admission; B, after Q-SNF admission.

Adattare il trattamento riabilitativo allo stato premorboso

Table 2

Change in ADL Self-Performance Scores Between Admission and Discharge

	Mean Change (SD)	% No Change, Stable	% Improved
Long-form ADL Scale 0−28			
Full sample	3.35 (4.43)	26.1	64.9
Discharged home	3.86 (4.48)	22.8	70.4
Hip fracture	3.80 (4.52)	23.3	69.6
Early loss (dressing and personal hygiene) 0−8			
Full sample	0.96 (1.53)	48.9	45.9
Discharged home	1.11 (1.56)	44.5	51.2
Hip fracture	1.08 (1.54)	46.9	49.4
Mid/late loss (bed mobility, transfer, eating, toilet use) 0−16			
Full sample	1.78 (2.56)	35.9	56.1
Discharged home	2.05 (2.59)	32.6	61.2
Hip fracture	1.98 (2.58)	33.3	60.0
Walking (in room and corridor) 0−8			
Full sample	1.32 (1.98)	45.6	49.2
Discharged home	1.52 (2.02)	41.1	54.5
Hip fracture	1.74 (2.13)	39.5	57.1
Locomotion (on and off unit) 0−8			
Full sample	1.20 (1.93)	47.4	46.8
Discharged home	1.37 (1.97)	43.5	51.5
Hip fracture	1.42 (1.99)	43.9	51.6

Table 2. Residents had a mean ADL change of 3.4 points between admission and discharge based on the long-form ADL scale. Individuals who were discharged home had a mean ADL change of 3.9 points, and individuals who had a hip fracture on admission had a mean ADL change of 3.8 points; these subsamples demonstrated greater improvement in ADL self-performance compared with the full sample across all scales. There were few individuals who declined in ADL self-performance during their stay.

People involved. The rule would require that:

- the physician responsible for the home health plan of care be involved in the ongoing process of establishing the discharge plan, and

- the patient and caregiver(s) be involved in the development of the discharge plan and informed of the final plan.

American Hospital Association

Influence of a Transitional Care Clinic on Subsequent 30-Day Hospitalizations and Emergency Department Visits in Individuals Discharged from a Skilled Nursing Facility

The Post Discharge Clinic (PDC) at James A. Haley Veterans Affairs Hospital (JAHVAH) was created to oversee care transitions of veterans admitted to SNFs for postacute care and subsequently discharged to the community. The PDC intervention consisted of a one-time, approximately 2-hour visit shortly before discharge from the SNF, during which a trained nurse practitioner, under supervision of a geriatrician, conducted medication reconciliation (covering preadmission, hospital, and SNF discharge), ordered medical supplies and equipment and home health services if needed, provided individual or caregiver education, and communicated the information to individual's primary outpatient care provider through electronic medical records.

Table 3. Thirty-Day Hospital Use After Skilled Nursing Facility Discharge

Characteristic	Total, N = 351	Pre-PDC, n = 134	PDC, n = 217	P-Value
Number of rehospitalizations, n (%)				
0	290 (83)	103 (77)	187 (86)	.02
1	51 (15)	28 (21)	23 (11)	
2	9 (3)	2 (1)	7 (3)	
≥3	1 (<.5)	1 (1)	0 (0)	
Inpatient days per 1,000 patient follow-up days, (n)		60	33	<.001
ED visits at Veterans Affairs hospital, n (%)				
0	267 (76)	93 (69)	174 (80)	.08
1	62 (18)	31 (23)	31 (14)	
2	19 (5)	9 (7)	10 (5)	
3	2 (1)	0 (0)	2 (1)	
4	1 (<.5)	1 (1)	0 (0)	
≥1 ED visits, n (%)		41 (31)	43 (20)	
ED visits per 1,000 patient-days, (n)		13	9	.03

For all subjects, 30-day post-SNF discharge was used in calculation of follow-up days, except the 10 who died. For the 10 subjects who died, follow-up was limited to the number of days to death.
PDC = postdischarge clinic; ED = emergency department.

Uso delle risorse

TRENDWATCH
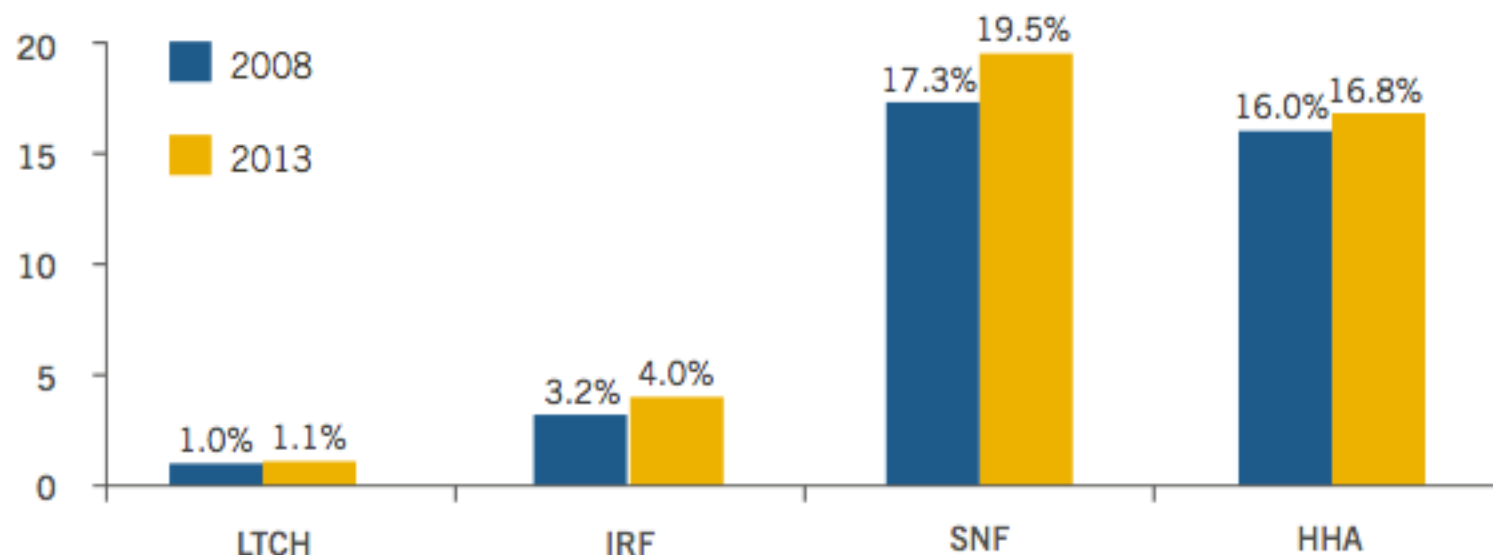
The Role of Post-Acute Care in New Care Delivery Models

PAC has been of increased interest to policymakers as a result of a 2013 Institute of Medicine (IOM) report that identified the sector as the source of 73 percent of the variation in Medicare spending. As a result, hospitals, health systems, PAC providers, payers and other stakeholders have taken steps to learn more about and improve PAC services, which are used by almost 42 percent of Medicare beneficiaries discharged from a hospital.

A primary cause of the variance in PAC payments relates to the initial care setting that follows hospitalization in a short-term acute-care hospital. Average per discharge payments to PAC providers vary considerably by venue.

For example, average Medicare payment for a 30-day episode for a patient with congestive heart failure (CHF) whose post-acute discharge site was an LTCH was more than twice the payment for a patient who was discharged to a SNF, and about 27 percent more than that for a patient whose initial post-acute venue is an IRF. However, these data do not account for differences in severity of illness across the PAC settings.

The percentage of Medicare beneficiaries discharged from a hospital to a PAC setting increased between 2008 and 2013.
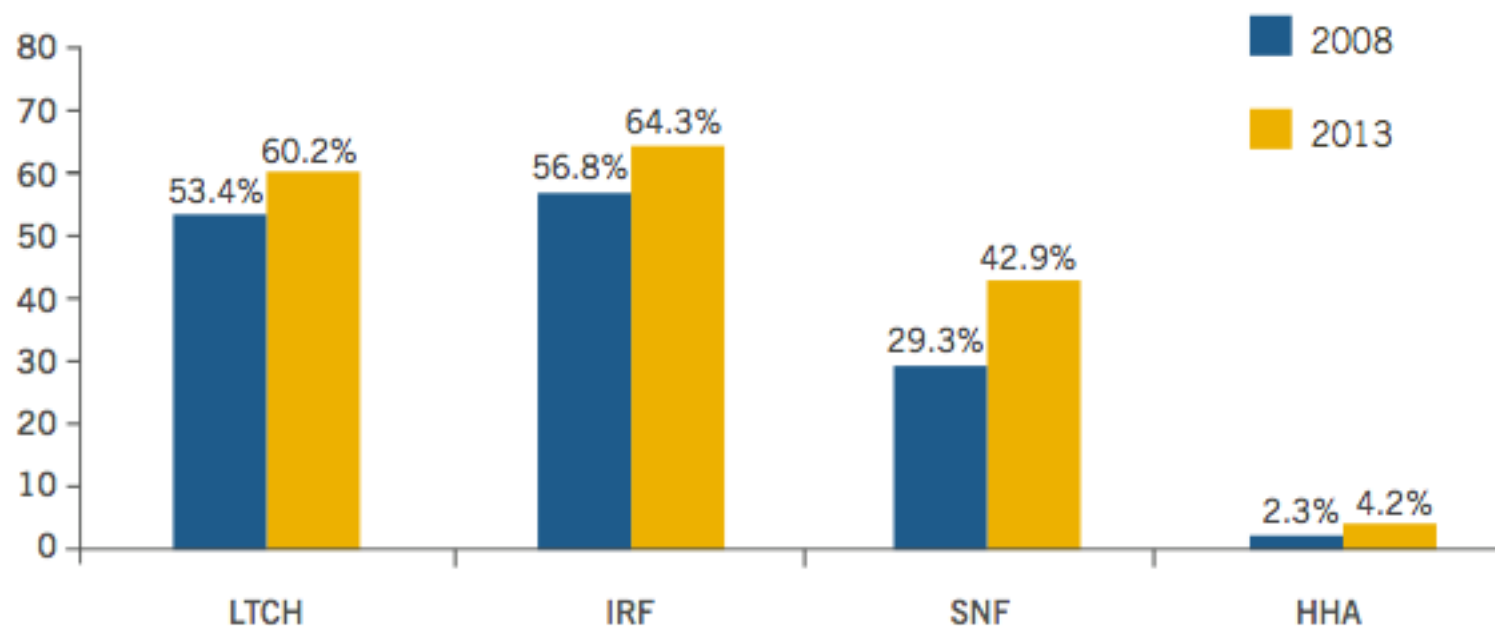
Chart 1: Patients Discharged from Hospital to PAC Setting, 2008 and 2013

A majority of patients admitted to PAC are later transferred to a second PAC setting.

Chart 2: Percent of Patients that Progress to a Second PAC Setting, from Initial PAC Setting, 2008 and 2013

Legend:
- 2008
- 2013

Setting	2008	2013
LTCH	53.4%	60.2%
IRF	56.8%	64.3%
SNF	29.3%	42.9%
HHA	2.3%	4.2%

Sources: Medicare Payment Advisory Commission. (June 2008). *A Data Book: Health Care Spending and the Medicare Program*. Washington, DC. Medicare Payment Advisory Commission. (2015). *March Report to the Congress: Medicare Payment Policy*. Washington, DC.

CMS Final Rule:
Comprehensive Care for Joint Replacement
Bundled Payment Program

Final Rule: Hip & Knee Bundled Payment

- **90-day episode**
  - Triggered by MS-DRG 469 + 470
    - All diagnoses falling into both MS-DRGs
    - No risk adjustment

  - **Includes all related Part A & B care**
    - No unrelated hospital readmissions
    - No unrelated Part B services
    - All post-acute care

Final Rule: Hip & Knee Bundled Payment
• **Retrospective payment methodology**
✓**FFS payments continue**
✓**Settle up to variable discount**
✓**Quality measurement**
✓**Stop-loss and stop-gain**

Composite Quality Score

Score based on:
– Elective hip/knee complications within 90 days – HCAHPS (all patients, not just hip/knee)
– Voluntary patient-reported outcome measure HCAHPS and complications points based on national percentile of performance
– Credit for significant improvement
PRO measure points for reporting data (not level of performance)

The HCAHPS survey contains 21 patient perspectives on care and patient rating items that encompass nine key topics: communication with doctors, communication with nurses, responsiveness of hospital staff, pain management, communication about medicines, discharge information, cleanliness of the hospital environment, quietness of the hospital environment, and transition of care.

Composite Quality Score

Percentile	Complications Points	HCAHPS Points
≥ 90th	10.00	8.00
≥ 30th to < 90th	5.50 - 9.25	4.40 – 7.40
< 30th	0.00	0.00

➕

Data submitted?	PRO Measure Points
Yes	2.00
No	0.00

Composite Quality Score	Quality Category
< 4.0	Below Acceptable
≥ 4.0 to < 6.0	Acceptable
≥ 6.0 to ≤ 13.2	Good
> 13.2	Excellent

American Hospital Association

When New Medicare Payment Systems Collide

Robert E. Mechanic, M.B.A.
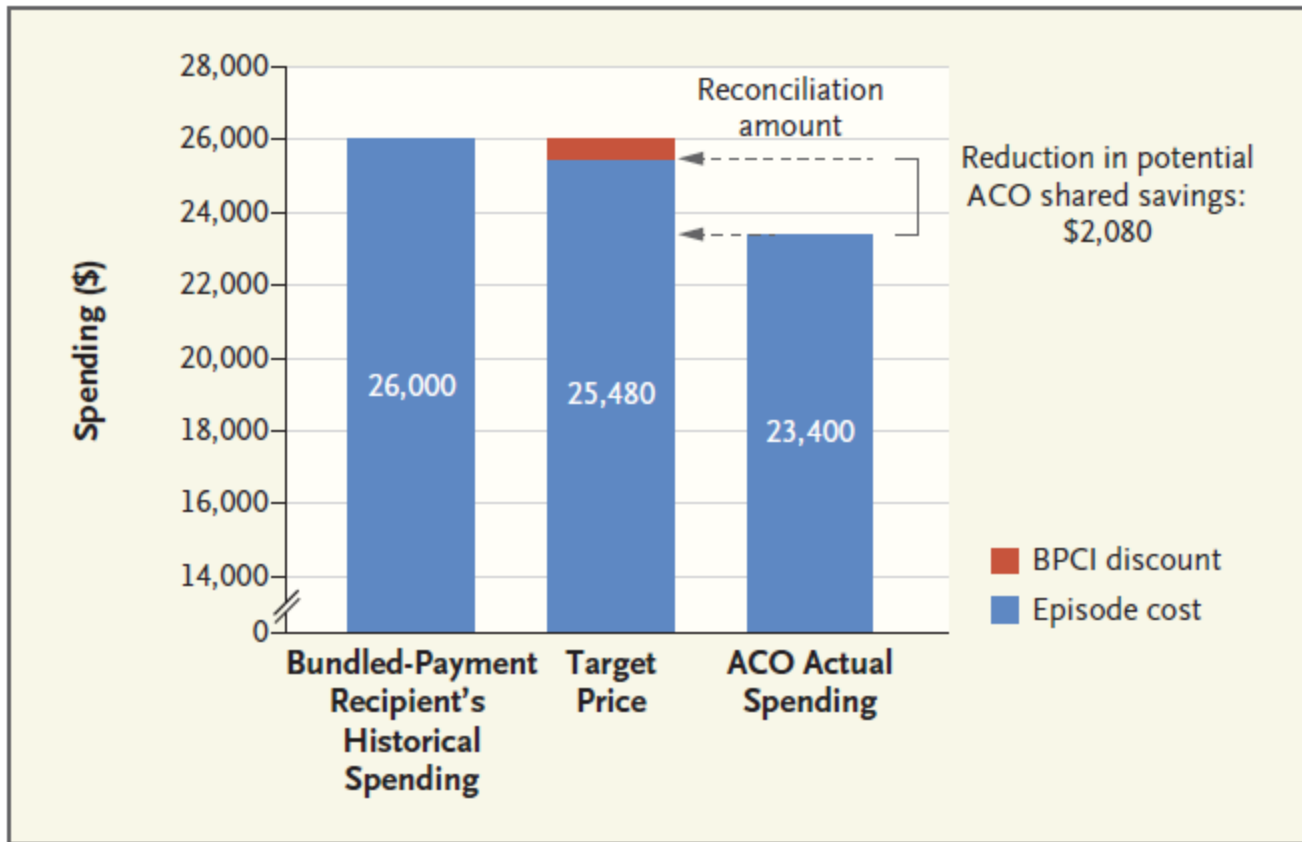
Sample Interaction between BPCI and ACO Financial Reconciliation: Spending for a 90-Day Joint-Replacement Episode.

For accountable care organization (ACO) payment reconciliation, CMS sets ACO spending on episodes of care that involve providers receiving bundled payments at the target prices for those episodes. ACO shared-savings awards are generally 50% of actual savings, but they can be up to 100% in some models. BPCI denotes Bundled Payments for Care Improvement.

Specificità

Tutti fanno tutto?

Individualizzare il servizio ed il trattamento in base alle richieste cogenti

In base alla tipologia di post acuzie:

geografica,

sociale,

clinica,

funzionale

avverrebbe una diversa

Tipologia di rimborso economico:

Fee for service

Severity based

Outcome based

Arch Phys Med Rehabil. 2013 April ; 94(4): 622–629

Does Post-Acute Care Site Matter? A longitudinal study assessing functional recovery after a stroke

COMPARISON OF ITALIAN AND NORWEGIAN POSTACUTE CARE SETTINGS FOR OLDER PATIENTS IN NEED OF FURTHER TREATMENT AND REHABILITATION AFTER HOSPITALIZATION

J.F. Abrahamsen[1], R. Rozzini[2], S. Boffelli[2], A. Cassinadri[2], A.H. Ranhoff[3], M. Trabucchi[4]

Hospitalization for acute disease or injury may, in older home- dwelling patients, be associated with functional decline and increasing dependency. Some patients are not able to return to their own home after acute hospitalization and need further multidimensional geriatric based care to regain their functional capacity.

There are numerous facilities that offer this kind of care, different terms are used, different patients are selected and different kind of care is offered.

The 19-bed Italian SAC unit was established in 2011 as part of the geriatric department at the Fondazione Ospedale Poliambulanza in Brescia, Italy . In addition to treating and rehabilitate patients after an acute hospital admission, this treatment option was also available for home dwelling elderly patients with chronic disease to avoid early flare-up, relapse and acute hospitalization.

The 19-bed Norwegian IC unit was established in 2005 as a collaboration between the municipality of Bergen, and the two hospitals serving the town. Emphasis was put on selecting patients from the acute medical and orthopaedic hospital departments that had a treatment and rehabilitation potential, and that the treatment period should be rather short, preferably ≤14 days, to allow a rather high turnover of patients that were able to receive CGA based treatment and care.

Table 1

Inclusion criteria and treatment options for older patients receiving hospital subacute care (SAC) in Italy and nursing home intermediate care (IC) in Norway

	Italian Subacute Care	Norwegian Intermediate Care
Inclusion criterias		
Similar		
Home dwelling before acute hospitalization	yes	yes
In need of multidisciplinary geriatric based treatment that do not		
have to be performed in an acute hospital ward, but neither can be performed at home	yes	yes
Have been diagnosed and started treatment in the acute hospital ward	yes	yes
Not terminally ill	yes	yes
Respiratory and circulatory stable	yes	yes
Considered to have a rehabilitation potential	yes	yes
Rather similar		
Transferred from acute hospital ward	mainly (>90%)	yes
Only patients aged ≥ 70 years	mainly (>80%)	yes
Different		
Patients should be able to return home within 14 days	No, upper limit 40 days	yes
Patients with acute delirium	yes	no
Admitting patients with moderate/ severe cognitive impairment*	Yes	no

Table 1
Inclusion criteria and treatment options for older patients receiving hospital subacute care (SAC) in Italy and nursing home intermediate care (IC) in Norway

	Italian Subacute Care	Norwegian Intermediate Care
Treatment options		
Comprehensive geriatric assessment	yes	yes
Examination by doctor and nurse on admission	yes	yes
Individual assignment to therapy	yes	yes
Critical evaluation of medication and drug interactions	yes	yes
Fixed panel of blood samples on admission and availability of additional blood sample	yes	yes
Weekly intervention team meetings for goal setting	yes	yes
Nurse and health care worker present 24h and all days/week	yes	yes
All patients assessed by physiotherapist	When needed	yes
Ward-round to all patients with doctor and nurse	daily	2/week + when needed
Individual nutritional intervention	yes	yes
Meals served in separate dining room	no	yes
Availability of radiological examination	yes	by transfer to hospital
Doctor available 24 h and all days/week	yes	No†
Staffing (full positions)		
Doctors	2	2
Geriatricians	2	1
Nurses	12	15
Physiotherapists	0.5	1.2
Occupational therapist	0	0.8
Health care workers	10	8

Table 2

Characteristics of Italian patients treated in a hospital subacute care unit and Norwegian patients treated in a nursing home intermediate care unit

	Italian patients n= 664	Norwegian patients n=961
Demographics		
Age (mean ±SD)	82 (6,1)	84 (6.2)
Male sex	294 (44%)	304 (32%)
Live alone	217 (33%)	644 (67%)
Years of education	5 (0-24)	-
Patients transferred from		
Acute internal med/pulm/ cardiology/geriatric dep.	411 (62%)	628 (65%)
Orthopaedic dep.	28 (4%)	352 (37%)
General + vascular surgery dep.	60 (9%)	0
Other hospital or hospital dep.	233 (34%)	-
Own home	34 (5%)	0

Geriatric assessment

2 weeks before hospitalization

Barthel Index pre admission	85 (0-100)	-
I-ADL pre- admission	3/8 (0-8)	-
CDR	0 (0-4)	-

During postacute admission

More than 5 diagnosis	616 (96%)	567 (59%)
Use more than 5 drugs	572 (92%)	760 (79%)
CIRS -severity	1.7 (0-4)	-
CIRS- comorbidity	2 (0-9)	-
Acute delirium at admission	124 (19%)	0
Acute delirium at discharge	7 (1%)	-
MMSE	25 (0-30)	26 (8-30)
Barthel index admission	40 (0-100)	75 (10-100)
Barthel index discharge	60 (0-100)	85 (15-100)
I-ADL admission	3/8 (0-8)	-
Geriatric depression scale*	3/15 (0-15)	7/30 (0-29)
MNA-SF		10 (2-21)
Blaylock scale	21 (4-36)	-
Tinetti scale admission	6 (0-28)	-
Tinetti scale discharge	18 (0-29)	-

Table 3
Outcome at discharge in Italian patients treated in a hospital subacute care unit and Norwegian patients treated in a nursing home intermediate care unit

	Italian patients n=664	Norwegian patients n=961
Improvement of functional status		
Patients with improvement in BI	510 (79%)	623 (67%)
Improved units on BI	20 (0-75)	5 (0- 70)
Improved units of Tinetti scale	8 (0-26)	-
Resolved acute delirium	117/124	
Days in postacute care (mean , ±SD)	16.7 (9.7)	13.5 (3.75)
Discharged home	420 (64%)	785 (82%)
Without assistance, except family	399 (74%)	446 (29%)
with nurse assisted home care	45 (8%)	515 (71%)
with private care at home	99 (18%)	0
Discharged to nursing home	58 (9%)	132 (14%)
Discharged to rehabilitation	85 (13%)	14 (1.2%)
Transferred to acute hospitalization	41 (6%)	26 (2.7%)
Discharge to hospice	9 (1.4%)	0
Dead during postacute treatment	47 (7%)	2 (0.2%)

Abbreviations: CIRS, Cumulative Illness Rating Scale, MMSE, Mini-Mental-Status Examination; I-ADL, Instrumental Activities of Daily Life, MNA-SF, Mini Nutritional Assessment- Short Form, CDR, Clinical Dementia Rating. Categorical variables are described as numbers and % of patients

Table 4

Simple and multiple logistic regression for predictors of return to own home in Italian patients treated in a hospital-subacute care unit and Norwegian patients treated in a nursing home intermediate care unit

	Italian SAC unit						Norwegian IC unit					
	Univariate			Multivariate			Univariate			Multivariate		
	OR	95% CI	p	OR	95% CI	p	OR	95% CI	p	OR	95% CI	p
BI admission*	1.03	1.02-1.05	<0.001	1.04	1.02-1.05	<0.001	1.06	1.05-1.07	<0.001	1.08	1.06-1.10	<0.001
BI improvement†	9.41	5.75-15.39	<0.001	16.72	7.74-36.14	<0.001	1.57	1.08-2.19	0.02	4.21	2.84-7.14	<0.001
MSSE*	1.07	1.04-1.10	<0.001	0.99	0.93-1.05	0.73	1.15	1.10-1.93	<0.001	1.07	1.01-1.13	0.02
GDS*	0.80	0.74-0.87	<0.001	0.86	0.78-0.94	0.001	0.95	0.92-0.97	<0.001	0.98	0.94-1.02	0.24
Age*	1.01	0.99-1.04	0.31	-			0.97	0.95-1.00	0.03	1.02	0.98-1.06	0.28

SAC= Sub Acute Care, IC= Intermediate Care, OR= odds ratio, CI=confidence interval, BI, Barthel index, MMSE, Mini Mental State Examination, GDS, Geriatric; Depression Scale. OR were estimated using logistic regression models and adjusted for the covariates as described in the Methods section; *Variables are per unit increase, †Experienced any BI improvement during postacute care

We conclude that some caution should be taken when clinical outcomes from different countries and societies are compared, because end-points, like the ability to return to home and the use of NH, is influenced by health care and sociodemographic differences.

Both the Italian hospital SAC model and the Norwegian NH IC model presented in this article are feasible and good alternatives, but more firm inclusion criteria based on knowledge about the long term clinical outcome of both patient groups may further optimize the selection of patients suitable for these different PAC options.

Due casi clinici

B.M., 70 anni

Motivo ricovero

Assessment

Obiettivi

Procedure

Outcome

P.B., 82 anni

Motivo ricovero

Assessment

Obiettivi

Procedure

Outcome

Motivo del ricovero

B.M., 70 anni

Ricoverato in Geriatria Per:

-Insufficienza Respiratoria Globale Acuta (NIV) A Genesi Mista

-Scompenso Cardiaco

-BPCO Riacutizzata (Tabagismo Attivo)

 -Voluminosa Massa Addominale Di Ndd (Sospetta Neoplasia Mesenchimale)

In Anamnesi:

-Ipertensione Arteriosa

-Coronarosclerosi Con Indicazione A Terapia Farmacologica

-Pregressa Insufficienza Renale Acuta Con Acidosi

-Ipotiroidismo Subclinico

-Obesita'

-Pregressa Polmonite Multifocale e Ards (2012)

P.B., 82 anni

Ricoverato In Geriatria Per:

-Polmonite (ab ingestis?)

-Insufficienza respiratoria ipossiemica

-Emiparesi Destra, Disartria E Disfagia Da Emorragia Cerebrale Lenticolo-capsulare Sinistra

-Piccolo Ematoma Sottodurale Fronto-parietale Destro

-Meningiomi Multipli

In Anamnesi:

-Decadimento Cognitivo (D. Di Alzheimer in follow up UVA)

Prostatectomia(1980)

Asportazione Di Meningioma (2010) Asportazione Di Neoplasia

Cutanea In Regione Parietale Destra (2012)

Chi è il paziente

B.M., 70 anni

Separato

Vive solo

Autosufficiente

Gestisce locali notturni

Non abile nella gestione della propria patologia

(ricovero nel 2012 in GER poi UCSA per scompenso cardiaco, obesità, insufficienza respiratoria)

Scarsi controlli clinici periodici

P.B., 82 anni

Paziente di 82 anni, coniugato

Vive a domicilio con la moglie

Deficit cognitivo lieve-moderato (CDR 2) Autosufficiente (Barthel 85/100)

Buona presenza dei familiari

Regolare assunzione dei farmaci

Follow up regolari

Sintesi pre-ricovero in GER

B.M., 70 anni

Ricovero in geriatria e poi in UCSA nel 2012:

Insufficienza respiratoria globale

Scompenso cardiaco, BPCO

Obesità

Indicazione a diuretico, broncodilatatori, calo ponderale, follow up periodici per eventuale LTOT (never done)

P.B., 82 anni

Ricovero in neurologia il 24-3 per

Alterazione del sensorio ed afasia e disfagia, sfumato deficit emisoma dx.

Trasferito in riabilitazione specialistica per recupero motorio e trial della deglutizione.

Nel frattempo posizionato PICC per NPT (dopo rimozioni SNG).

Nel frattempo (neuro) polmonite.

Nel frattempo (riab) nuovo ab ingestis e insufficienza respiratoria

Assessment premorboso

B.M., 70 anni

MMSE 30/30

GDS 0/15

IADL 0/5 f. perse

BADL 0/6 f. perse

CDR 0

Tinetti 28/28

P.B., 82 anni

MMSE 19/30

GDS -/15

IADL 5/5 f. perse

BADL 2/6 f. perse

CDR 2

Tinetti 28/28

Sintesi ricovero in GER

B.M., 70 anni

Afferito al PS per dispnea ed edemi declivi. Ricoverato per riscontro di insufficienza respiratoria globale a genesi mista. Eseguita terapia antibiotica, diuretica e NIV e broncodilatatrice con miglioramento del quadro respiratorio, ma riscontro ecografico e tac di voluminosa massa addominale a verosimile genesi neoplastica (mesenchimale ?) con nodulazioni peritoneali e sospette ripetizioni epatiche. In attesa di valutazione chirurgica (debulking ?), si trasferisce in UCSA per prosecuzione cure

P.B., 82 anni

All'ingresso in reparto paziente soporoso,risvegliabile agli stimoli verbali, dispnoico a riposo, cute e mucose asciutte. Per grave insufficienza respiratoria ipossiemica, terapia con MV 60 % e frequenti tracheoaspirazioni. Ai controlli ega miglioramento respiratorio, sospesa O2 terapia. Terapia antibiotica, aerosolterapia.

Quotidianamente mobilizzato in carrozzina.

Avviata NPT (MIDLINE per NPT), dieta per disfagia; trasferito in UCSA

Assessment in UCSA

B.M., 70 anni	P.B., 82 anni
MMSE 30/30	MMSE 0/30 (afasia)
GDS 8/15	GDS nv/15
IADL 1/5 f. perse	IADL 5/5 f. perse
BADL 3/6 f. perse	BADL 5/6 f. perse
CDR 0	CDR 3
Tinetti 14/28 (8+6)	Tinetti 1/28
Peso 135 Kg	Peso 63 Kg
CIRS severità 1.6	CIRS severità 2.1
CIRS comorbilità 3	CIRS comorbilità 4
Scala IIA 3 (autosuf, terapia)	Scala IIA 3 (autosuf, terapia)

Obiettivi

B.M., 70 anni

Compenso cardiaco e respiratorio

Calo ponderale

Recupero funzionale premorboso

Tono dell'umore (insight malattia)

Stabilità resp (O2?)

Valutazione LTOT

Valutazione intervento CGE

P.B, 82 anni

Compenso respiratorio

Terapia infezione

Recupero funzionale premorboso

Procedure:

PICC - NPT (temporaneo?)

Trial nutrizionale disfagia

Obiettivi

B.M., 70 anni:

Giovane ma neoplastico (con mts!)

Gravità malattie cardiorespiratorie/metab

Buono stato cognitivo/funzionale premorbosi; attuale dipping; depresso

Procedure finalizzate alla sopravvivenza e ritorno allo stato quo ante? (bassa aspettativa del paziente)

Survival rates for gastrointestinal stromal tumors (American Cancer Society)

Resectable versus unresectable tumors

The AJCC staging system provides a detailed summary of how far a GIST has spread. But for treatment purposes, doctors are often more concerned about whether the tumor can be removed (resected) completely with surgery.

Whether or not a tumor is resectable depends on its size and location, whether it has spread to other parts of the body, and if a person is healthy enough for surgery. Tumors that can clearly be removed are defined as resectable, while those that can't be removed completely (because they have spread or for other reasons) are described as unresectable. In some cases, doctors may describe a tumor as marginally resectable if it's not clear if it can be removed completely. If a tumor is considered unresectable or marginally resectable when it is first found, treatments such as targeted therapy may be used first to try to shrink the tumor enough to make it resectable.

Localized, larger (marginally resectable) tumors

Tumors that are larger or in certain places may be harder to remove completely and might require more extensive surgery that could cause health problems later on. Because of this, once a biopsy is done to confirm the tumor is a GIST, treatment with imatinib is usually started. It is continued at least until the tumor stops shrinking. If the tumor shrinks enough, surgery might be done if the doctor thinks he or she can remove the remaining tumor safely.

If the tumor doesn't shrink enough to make surgery possible, imatinib is often continued as long as it seems to help. If it is no longer working or if the side effects are too severe, sunitinib (Sutent) may be tried instead. If sunitinib is no longer working, the targeted drug regorafenib (Stivarga) may help some patients.

Survival rates for gastrointestinal stromal tumors (American Cancer Society)

It is very hard to get accurate numbers on survival rates for GISTs. Part of this is because these tumors are not common. In the past, they were often classified as other types of cancers, which made the numbers available for study even smaller.

Treatment has also changed dramatically in recent years now that newer, targeted therapy drugs are being used.

The survival rates below are based on people treated many years ago, largely before these newer treatments were used, so people being treated for GISTs today are likely to have a better outlook.

The 5-year survival rate refers to the percentage of patients who live *at least 5 years* after their cancer is diagnosed. Five-year rates are used as a standard way of discussing prognosis. Of course, many people live much longer than 5 years. Five-year *relative* survival rates, such as the numbers below, assume that some people will die of other causes and compare the observed survival with that expected for people without the cancer. This is a more accurate way to describe the chances of dying from a particular type and stage of cancer.

Survival rates for gastrointestinal stromal tumors (American Cancer Society)

The rates below are based on the stage of the cancer *when the person was first diagnosed*. When looking at survival rates, it's important to understand that the stage of a cancer does not change over time, even if the cancer progresses. A cancer that comes back or spreads is still referred to by the stage it was given when it was first found and diagnosed, but more information is added to explain the current extent of the cancer. (And of course, the treatment plan is adjusted based on the change in cancer status.)

Based on people diagnosed between 2003 and 2009 the overall relative 5-year survival rate of people diagnosed with a malignant GIST was estimated to be about 76%.

If the tumor was confined to the organ where it started, the 5-year relative survival was 91%.

If it had grown into nearby tissue (or spread to nearby lymph nodes) when it was first diagnosed, the 5-year relative survival was around 74%.

If it had spread to distant sites when it was first diagnosed, the 5-year relative survival was 48%.

Last Medical Review: 04/04/2014; Last Revised: 02/08/2016

Obiettivi

P.B., 82 anni:

Più vecchio

Grado di deficit cognitivo (? Esegue, Ride)

Stato funzionale premorboso moderato

Eventi intercorrenti ospedalieri

Procedure finalizzate al ritorno allo stato quo ante (alta aspettativa dei familiari)

Kumfor F[1], Hodges JR[1], Piguet O[1].

J Alzheimers Dis. 2014;42(1):201-10. doi: 10.3233/JAD-140351.

Ecological assessment of emotional enhancement of memory in progressive nonfluent aphasia and Alzheimer's disease.

Fan Zhang, Yuan Wan Ho, Helene H. Fung*

Aging and Disease Volume 6, Number 3; 208-215, June 2015

Learning from Normal Aging: Preserved Emotional Functioning Facilitates Adaptation among Early Alzheimer's Disease Patients

Takeda et al.

Laughter and humor as complementary and alternative medicines for dementia patients

BMC Complementary and Alternative Medicine 2010, **10**:28

Summary

Dementia patients should be cared for taking into consideration their individual capacities, which differ from patient to patient.

Most laughter and smiling is preserved in dementia patients until the end of the clinical course, even though laughter and smiling as a means of communication is lost during the early stages of the disease.

Laughter and smiling associated with pleasant feelings, with the exception of laughing in response to feelings of disharmony, and laughter induced by the release of tension can be used in the treatment of dementia patients. The use of humor, covering issues of the fulfillment of instinctive needs and expectations, as well as feelings of superiority (Table 1), can be a good and effective complementary and alternative intervention in the treatment of dementia patients.

Table 1: Relationship between laughter/smiling and the progression of dementia

Type of laughter/smile	Preservation in dementia	
	Early stages	Advanced stages
A1. Release from strong tension	+	+
A2. Release from weak tension	+	+
B1. Fulfillment of instinctive needs	+	+
B2. Fulfillment of expectations	+	-
B3. Feelings of superiority	+	-
B4. Feelings of disharmony	+/-	-
C1. Cooperative	-	-
C2. Defensive	-	-
C3. Aggressive	-	-
C4. Devaluating	-	-

The neural circuit underlying laughter may have three main brain components: (i) cognitive areas, such as sections of the frontal lobe that help a person understand the situation; (ii) a movement area (probably the supplemental motor area) that triggers muscle movements to induce a smile or laughter; and (iii) an emotional component that actuates the perception of happiness after an amusing experience, possibly facilitated by the nucleus accumbens .

Procedure

B.M., 70 anni

Terapia cardiaca e respiratoria

Calo ponderale (dieta)

Mobilizzazione, cammino assistito e FKT

Tono dell'umore (antidep)

Procedure:

Valutazione LTOT (ok)

Valutazione CGE/psico (ok)

Peci, 82 anni

Compenso respiratorio

Terapia infezione

Recupero funzionale premorboso

Ri alimentazione

Procedure: FKT

PICC - NPT (temporaneo?)

Trial nutrizionale disfagia

Procedure e percorso

B.M., 70 anni

Intervento CGE

Valutazione oncologica

Ritorno a casa

Malattia cronica stabilizzata

Autosufficienza e guarigione

Tempo previsto: 40 giorni

(GER -UCSA - CGE – riab?)

P.B, 82 anni

Guarigione infezione

Recupero nutrizionale

Ripresa del cammino

Dimissione protetta

(SAD + NPT?)

Tempo previsto: 30 giorni

(UCSA – casa)

Costs of Malnutrition in Institutionalized and Community–Dwelling Older Adults: A Systematic Review

Pedro Abizanda MD, PhD [a,*], Alan Sinclair MD, FRCP [b], Núria Barcons RDN [c],

Major costs in malnutrition: This difference was explained mainly by a higher use of health care resources in patients with malnutrition (medical consultations, hospital admissions, and LOSs). On the other hand, additional costs associated with patients with DRM were approximately 4 times higher for older patients (V1.5 billion) (1.67 billion), compared with the younger patients (V500 million) ($555 million).21 This difference might be partially explained by the fact that an older age is associated with an overall increase in disease prevalence.

Results of this review support the concept that prescribing nutritional oral supplements to ensure sufficient protein and energy intake might represent a beneficial strategy to improve the nutritional status in malnourished institutionalized and community-dwelling older adults.

Only studies with long-term interventions showed significant cost savings (V11.62/$12.90 million saved per year).These results agree with a meta-analysis demonstrating that the use of ONS in at-risk patients significantly reduces the rate of readmissions in hospitalized patients, mainly in those 65 years or older (6 randomized controlled trials, n 1⁄4 834, effect size 0.18; 95% CI 0.31 to 0.04; P 1⁄4 .011), with important economic implications for the health care system.

Differences in Nutrient Intake and Biochemical Nutrient Status Between Sarcopenic and Nonsarcopenic Older Adults—Results From the Maastricht Sarcopenia Study

Background: There is growing evidence of a relationship between nutrients and muscle mass, strength, and physical performance. Although nutrition is seen as an important pillar of treating sarcopenia, data on the nutritional intake of sarcopenic older adults are limited.

Objective: To investigate potential nutritional gaps in the sarcopenic population, the present study compared nutrient intake and biochemical nutrient status between sarcopenic and nonsarcopenic older adults.

Design: The Maastricht Sarcopenia Study included 227 community-dwelling older adults ($\geq$65 years) from Maastricht, 53 of whom were sarcopenic based on the European Working Group on Sarcopenia in Older People algorithm. Habitual dietary intake was assessed with a food frequency questionnaire and data on dietary supplement use were collected. In addition, serum 25-hydroxyvitamin D, magnesium and α-tocopherol/cholesterol, plasma homocysteine and red blood cell n-3, and n-6 fatty acids profiles were assessed. Nutrient intake and biochemical nutrient status of the sarcopenic groups were compared with those of the nonsarcopenic groups. The robustness of these results was tested with a multiple regression analysis, taking into account between-group differences in characteristics.

Results: Sarcopenic older adults had a 10%–18% lower intake of 5 nutrients (n-3 fatty acids, vitamin B_6, folic acid, vitamin E, magnesium) compared with nonsarcopenic older adults ($P < .05$). When taking into account dietary supplement intake, a 19% difference remained for n-3 fatty acids intake ($P = .005$). For the 2 biochemical status markers, linoleic acid and homocysteine, a 7% and 27% difference was observed, respectively ($P < .05$). The higher homocysteine level confirmed the observed lower vitamin B intake in the sarcopenic group. Observed differences in eicosapentaenoic acid and 25-hydroxyvitamin D between the groups were related to differences in age and living situation.

Conclusions: Sarcopenic older adults differed in certain nutritional intakes and biochemical nutrient status compared with nonsarcopenic older adults. Dietary supplement intake reduced the gap for some of these nutrients. Targeted nutritional intervention may therefore improve the nutritional intake and biochemical status of sarcopenic older adults.

ESPEN guidelines on nutrition in dementia

Dorothee Volkert, Michael Chourdakis, Gerd Faxen-Irving, Thomas Frühwald, Francesco Landi, Merja H. Suominen, Maurits Vandewoude, Rainer Wirth, Stéphane M. Schneider
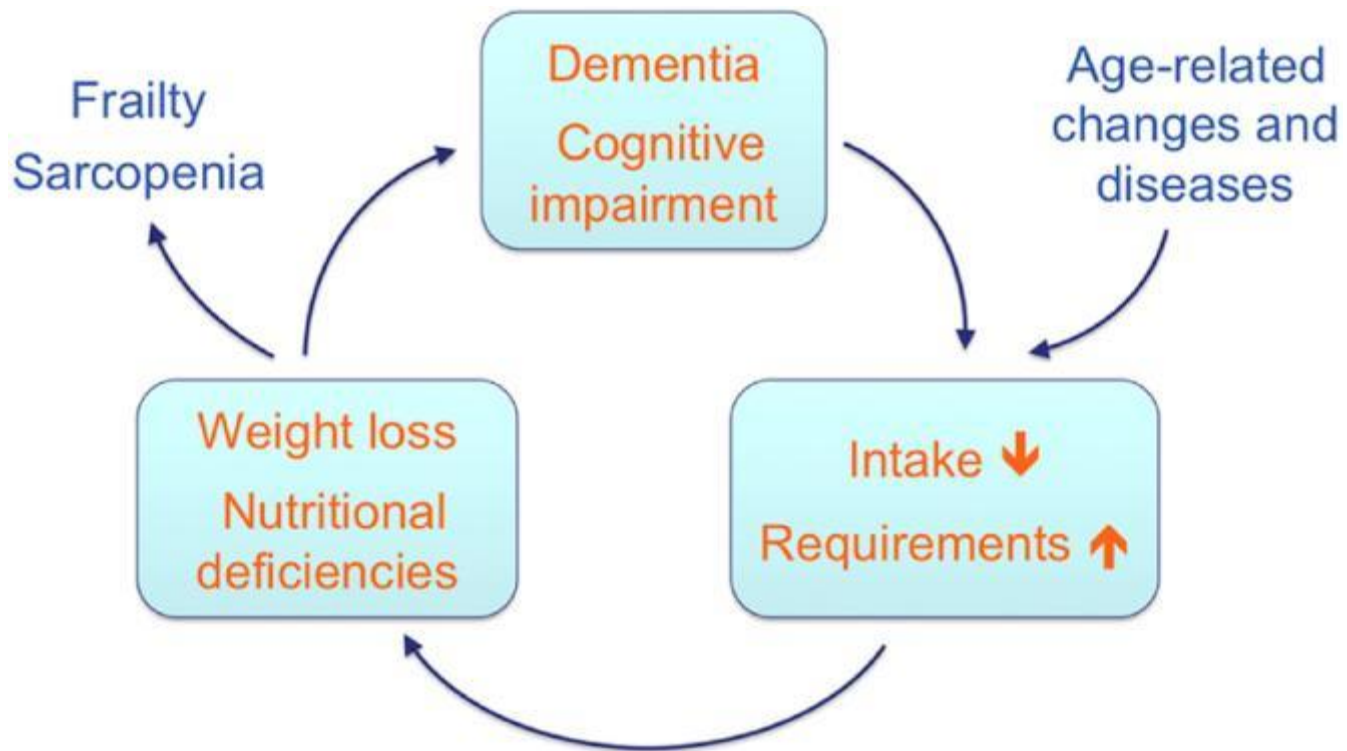
ESPEN guidelines on nutrition in dementia

Dorothee Volkert [a, *], Michael Chourdakis [b], Gerd Faxen-Irving [c], Thomas Frühwald [d], Francesco Landi [e], Merja H. Suominen [f], Maurits Vandewoude [g], Rainer Wirth [a, h],

Conclusion: Nutritional care and support should be an integral part of dementia management. In all stages of the disease, the decision for or against nutritional interventions should be made on an individual basis after carefully balancing expected benefit and potential burden, taking the (assumed) patient will and general prognosis into account.

Artificial nutrition and hydration

Enteral tube feeding and parenteral nutrition allow the provision of energy and nutrients to patients who are unable to consume adequate amounts orally. These modes of feeding, however, in particular via PEG, are invasive interventions implying potential complications that are not negligible [56] and have to be weighed against the potential benefits of improved nutrition.

For ethical reasons, randomized controlled trials studying the effects of artificial nutrition compared to no intervention are not available.

Existing observational studies on the effects of tube feeding in patients with dementia are generally of poor quality. In most studies the control group is not adequate, the population is not well defined and the stage of dementia remains unclear. Studies on the effects of parenteral nutrition are completely lacking. Therefore, existing scientific evidence is inconclusive, and recommendations have to include expert consensus.

15. We recommend that each decision for or against artificial nutrition and hydration for patients with dementia is made on an individual basis with respect to general prognosis and patients' preferences. (Grade of evidence: **very low**)

ESPEN guidelines on nutrition in dementia

Dorothee Volkert [a,*], Michael Chourdakis [b], Gerd Faxen-Irving [c], Thomas Frühwald [d], Francesco Landi [e], Merja H. Suominen [f], Maurits Vandewoude [g], Rainer Wirth [a,h],

Conclusion: Nutritional care and support should be an integral part of dementia management. In all stages of the disease, the decision for or against nutritional interventions should be made on an individual basis after carefully balancing expected benefit and potential burden, taking the (assumed) patient will and general prognosis into account.

16. We suggest tube feeding for a limited period of time in patients with mild or moderate dementia, to overcome a crisis situation with markedly insufficient oral intake, if low nutritional intake is predominantly caused by a potentially reversible condition. (Grade of evidence: **very low**)

17. We recommend against the initiation of tube feeding in patients with severe dementia. (Grade of evidence: **high**)

19. We suggest parenteral fluids for a limited period of time in periods of insufficient fluid intake to overcome a crisis situation. (Grade of evidence: **very low**)

20. We recommend against the use of artificial nutrition (enteral nutrition, parenteral nutrition and parenteral fluids) in the terminal phase of life. (Grade of evidence: **very low**)

18. We suggest parenteral nutrition as an alternative if there is an indication for artificial nutrition, as described in recommendation 16, but tube feeding is contraindicated or not tolerated. (Grade of evidence: **very low**)

<u>Commentary:</u>

There are no data available regarding the effects of parenteral nutrition in patients with dementia.

As in patients without dementia, artificial nutrition should be predominantly performed via the enteral route whenever possible. In case of contraindications for enteral nutrition, parenteral nutrition may be a substitute. If additional nutritional support is necessary for a period shorter than 10 days or if nasogastric feeding is not accepted, peripheral parenteral nutrition might help to overcome a crisis situation of low intake. The same is true if a central venous line is already in place for other reasons, i.e. in the perioperative period.

In any case a medical indication is required, the individual patient's will has to be considered, and potential risks have to be weighed against the potential benefits of improved nutrition (see also recommendation 15).

Thus, parenteral nutrition will be reserved to justified individual cases of mild to moderate dementia. In the vast majority of cases, careful hand-feeding according to individual needs and capacity (comfort-feeding) is the best alternative.

Midline catheters: indications, complications and maintenance

The midline catheter

The midline catheter was first introduced during the 1950s by the Deseret Medical Corporation (Anderson 2004). The device was manufactured by Becton Dickinson and used on patients who needed one week of IV therapy (Anderson 2004). Improvements to the design continued until the 1980s when the peel-away plastic introducer was developed. During the 1990s adverse events related to anaphylaxis and phlebitis caused the midline catheter to receive negative evaluations and some products, that is those associated with aquavane, were even removed from the market (Mermel *et al* 1995, Goetz *et al* 1998, Anderson 2004). It was felt that aquavane, an elastomeric hydrogel material that becomes hydrated and expands after catheter insertion and which was used to form a coating on some of the midlines available at that time, may have contributed to these adverse events (Mermel *et al* 1995, Goetz *et al* 1998, Anderson 2004).

In recent years the midline catheter has been redeveloped culminating in its present design. This redevelopment has also included the way in which the device can be inserted by using either a cannula with a peel-away sheath or the Seldinger technique using specific Seldinger insertion kits. These kits are widely available either as part of a midline catheter pack or separately, and are used to aid insertion of midline catheters in patients with particularly fragile or difficult to locate veins (Sansivero 2000). The midline catheters available today are made of polyurethane or silicone and are between 20-25cm in length with the tip extending no further than the axillary vein (RCN 2005). They may be single or double lumen, with an outside diameter of between 2 and 5 French (Fr), 15-19 gauge, depending on the material and the number of lumen (Cowley 2004). Midline catheters can be referred to as peripherally inserted catheters (PICs) although this can lead to

Advantages and disadvantages of the midline catheter

Advantages	Disadvantages
Suitable for all intravenous (IV) fluids and drugs that would usually be administered through a peripheral IV cannula (Infusion Nurses Society (INS) 2006).	As the distal tip finishes no higher than the axillary vein (Figure 4), continuously infused dextrose solution >10%, vesicants or corrosive substances cannot be administered due to the risk of extravasation (INS 2006).
Infusion rate of up to 70ml per minute may be achieved when an IV pump is used with a 5 French (Fr) catheter (Vygon 2006).	A midline catheter would not accommodate high volume fluid replacement in excess of 70ml per minute using a 5Fr or smaller catheter (Vygon 2006).
Longer dwell time than peripheral cannulae, therefore reducing the need for repeated cannulation (Anderson 2004).	Infusing fluid by gravity is not always possible and an infusion pump may be necessary to infuse drugs and fluids at the desired rate.
Does not require X-ray confirmation as the tip lies in a large vessel of the upper arm (Figure 4).	Mechanical phlebitis can be a frequent complication (Anderson 2004).
Provides long-term alternative for IV therapy when central venous access is not required or there is no clinical benefit (Mermel *et al* 1995). Recent research showed a dwell time of a maximum of 296 days (Griffiths and Philpot 2006).	Despite the use of ultrasound-guided placement, compromised anatomy such as the presence of lymphoedema, previous infection or phlebitis affecting the arm will preclude the use of a midline catheter (Terry *et al* 1995, RCN 2005).
Ease of insertion.	Lack of trained personnel to insert the device.
Patient comfort. Patients are able to maintain a greater degree of mobility compared to peripheral cannulae. If a community IV therapy service is available patients can be discharged home with a midline catheter *in situ* (Harwood *et al* 1992, Anderson 2004).	Lack of patient consent or the patient has a history of non-concordance with venous access devices. Patient is advised not to swim with a midline catheter *in situ* because of increased risk of infection.
Patient comfort, as the relatively greater flow rate of blood around the catheter tip dilutes medications likely to irritate the vessel wall and therefore reduces the risk of chemical phlebitis (Gorski and Czaplewski 2004).	
Midlines are ideally suited for older patients, who may have limited venous access or medical conditions that contribute to increased length of therapy (Anderson 2005).	

The tip of the midline catheter positioned in axillary vein

Axillary vein

Midline catheter tip
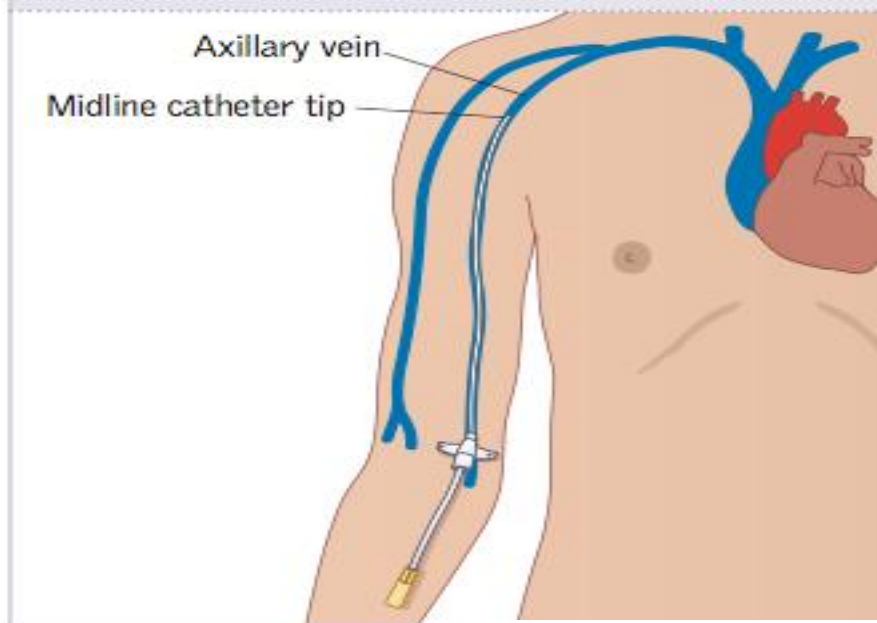
StatLock™ and transparent semi-permeable membrane dressing

Phlebitis

Phlebitis is an inflammation of the vein causing damage to the tunica intima. It is characterised by erythema, swelling, pain, heat and venous cor (a hard and palpable thrombosed vein) along the course of the vein in which the midline catheter dwells (Gorski and Czaplewski 2004). Phlebitis i graded according to severity and many trusts use phlebitis scores as a matter of routine when carin for all types of VADs. Nurses caring for patients with these devices should be competent to assess the access site and initiate the correct interventio and/or treatment (RCN 2005). There are three main causes of phlebitis, namely, mechanical, chemical and infective. However, additional factors such as the age of the patient and any co-morbidities will also have an effect on the patient's risk factors for developing phlebitis.

Diario clinico

B.M., 70 anni

Prima settimana:

All'ingresso il signor Bocchio era in scadenti condizioni generali, vigile, eupnoico in O2 a riposo, obiettività cardio-polmonare era caratterizzata da toni parafonici e ronchi diffusi. Edemi diffusi. Auto allettato.

Sentimenti di ineluttabilità.

Funzionalmente eseguita mobilizzazione in sedia, inizia FKT motoria.

Colloquio su possibili outcome (anche con avvocato)

P.B, 82 anni

Prima settimana:

All'ingresso paziente in scadenti condizioni generali, soporoso ma risvegliabile, eupnoico in O2 a riposo, obiettività cardio-polmonare era con rantoli alle basi. Edemi. Allettato.

Afasia, disfagia.

Funzionalmente eseguita mobilizzazione in sedia, inizia FKT motoria.

Iniziata NPT via Midline, trial disfagia.

Diario clinico

B.M., 70 anni

Seconda settimana (dopo stimolo):

Paziente , vigile, eupnoico in O2 a riposo, obiettività cardio-polmonare era caratterizzata da toni parafonici e ronchi diffusi. Edemi diffusi.

Mobilizzato.

Clinicamente progressivo(difficult) miglioramento clinico durante la degenza. Buon calo ponderale.

Funzionalmente eseguita mobilizzazione in sedia, FKT motoria con deambulatore antibrachiale, ripresa della marcia.

P.B, 82 anni

Seconda settimana:

Paziente cosciente, apirettico, in migliori condizioni generali, eupnoico in O2 a riposo,

Mobilizzato.

Afasia, persiste disfagia (sospesa nutrizione per os: ab ingestis) .

Funzionalmente eseguita mobilizzazione in sedia, prosegue FKT motoria (cammina con antibrachiale, controlla il tronco).

Prosegue NPT via Midline

Diario clinico

B.M., 70 anni

Terza settimana:

rimane la necessità di LTOT domiciliare, ma è nettamente migliorata la tolleranza allo sforzo e si mantiene eupnoico con bassi livelli di ossigeno. Buon calo ponderale (110 Kg).

Funzionalmente marcia con deambulatore antibrachiale

Cognitivamente stabile. Eutimico

I valori di pressione arteriosa, glicemia, saturazione e frequenza cardiaca sono risultati nei range di normalità alla dimissione.

Eseguita cons. anestesiologica (ASA 4)

Si trasferisce in Chirurgia per l'intervento, come programmato.

P.B, 82 anni

Terza settimana:

Paziente rapidamente soporoso, non controlla collo e tronco.

Comparsa di febbre con riscontro di sepsi da Candida (rx torace negativo). Rimosso Midline con riscontro di Candida anche sul colturale della punta. È stata intrapresa terapia con fluconazolo ev con netto miglioramento del quadro infettivo.

Riposizionato midline dopo 14 gg. Alla scomparsa dello stato febbrile ed al miglioramento dei biologici ripresa funzionale

Diario clinico

B.M., 70 anni

Prima settimana in CGE:

Apiretico. PV nella norma. Intervento chirurgico sospeso per importante bradicardizzazione all'induzione in noto blocco AV di I grado.

Richiesta visita elettrofisiologica per eventuale posizionamento di PM.

 6-7 Sospeso Beta bloccante come da indicazioni cardiologiche

7-7 Apiretico, emodinamica stabile. FC 88 ritmico. Addome negativo. Prosegue osservazione POSIZIONATO PM

10-7 operando di domani per neoformazione peritoneale

P.B., 82 anni

Quinta-sesta settimana:

Ricomparsa di iperpiressia, secondario decadimento funzionale (trasferito in ger per accertamenti).

Tc encefalo negativa, eco addome ed ecocardio e fundus oculi nella norma.

Rimosso Midline (candida dalle emocolture).

È stata ripresa terapia con fluconazolo ev con netto miglioramento del quadro infettivo.

NPT in periferica. Ha eseguito FKT con ripresa dei passaggi posturali e dei tragitti obbligati con deambulatore.

Diario clinico

B.M., 70 anni

Seconda settimana in CGE: 11-7

Eseguito intervento: asportazione di lesione mammellonata sanguinante adesa allo stomaco e milza. Lesione epatica secondaria. Carcinosi peritoneale.

TIP per monitoraggio post-operatorio

Rientra dalla TIP, medicazione in ordine

Peso stabile 112 Kg

15-7: eupnoico, apirettico, parametri e biologici nella norma. Progressiva ripresa funzionale (cammina con deambulatore). Previsto trasferimento in UCSA lunedi 18-7. inizierà inibitore per os.

P.B., 82 anni

Settima settimana:

Soporoso e febbrile(38,2° C):(Aspirata abbondante quantita di secrezioni catarrali purulente).Ipossiemia: O2 terapia

EAB in AA: pH 7.52 pO2 53 PCO2 23

Esami: leucocitosi e aumento PCR

RX TORACE: Permane diffuso ispessimento dell'interstizio peribroncovascolare con sfumate

areole di consolidazione in sede parailare destra. Aree di consolidazione parenchimale retrocardiaco sn.

Aggravamento clinico e funzionale. Soporoso. Allettato.Prosegue antibiotico ed antimicotico. Iperpiressia.

Diario clinico

B.M., 70 anni

P.B., 82 anni

Ottava settimana:

Paziente soporoso, scarsamente risvegliabile. Sofferente.

Ipoteso.

Si tracheoaspirano abbondanti secrezioni purulente.

Si posiziona CV (monitoraggio diuresi).

Colloquio con i famigliari circa la gravità delle condizioni cliniche.

Respiro periodico, vigile, non a contatto.

Prosegue la terapia in corso. MORFINA EV

DECESSO

Obiettivi raggiunti

B.M., 70 anni

- ✓ Compenso cardiaco e respiratorio
- ✓ Calo ponderale
- ✓ Recupero funzionale premorboso
- ✓ Tono dell'umore
- ✓ Intervento
- ✓ Guarigione?

P.B., 82 anni

- ✓ Compenso respiratorio
- ✓ Terapia infezione
- ✓ Recupero funzionale (solo in fase di stabilizzazione clinica)

- ✓ Procedure:
- ✓ PICC - NPT (temporaneo?)
- ✓ Trial nutrizionale disfagia

Outcome – post

B.M., 70 anni

Multidimensional Prognostic Index:

0.56 (rischio moderato)

P.B, 82 anni

Multidimensional Prognostic Index:

0.81 (rischio severo)

NPT e PICC

CGE e PM

Obiettivo o procedura?

Francisco José Tarazona-Santabalbina, Mari Carmen Gómez-Cabrera, et al.

A Multicomponent Exercise Intervention that Reverses Frailty and Improves Cognition, Emotion, and Social Networking in the Community-Dwelling Frail Elderly: A Randomized Clinical Trial Jamda may 2016: 426-433

Objective

To ascertain if a supervised-facility multicomponent exercise program (MEP) when performed by frail older persons can reverse frailty and improve functionality; cognitive, emotional, and social networking; as well as biological biomarkers of frailty, when compared with a controlled population that received no training.

Design

This is an interventional, controlled, simple randomized study. Researchers responsible for data gathering were blinded for this study. Participants from 2 primary rural care centers (Sollana and Carcaixent) of the same health department in Spain were enrolled in the study between December 2013 and September 2014.

Patients

We randomized a volunteer sample of 100 men and women who were sedentary, with a gait speed lower than 0.8 meters per second and frail (met at least 3 of the frailty phenotype criteria).

Interventions

Participants were randomized to a supervised-facility MEP (n = 51, age = 79.5, SD 3.9) that included proprioception, aerobic, strength, and stretching exercises for 65 minutes, 5 days per week, 24 weeks, or to a control group (n = 49, age = 80.3, SD 3.7). The intervention was performed by 8 experienced physiotherapists or nurses. Protein-calorie and vitamin D supplementation were controlled in both groups.

Results

Our MEP reverses frailty (number needed to treat to recover robustness in subjects with attendance to ≥50% of the training sessions was 3.2) and improves functional measurements:

Barthel (trained group 91.6 SD 8.0 vs 82.0 SD 11.0 control group), Lawton and Brody (trained group 6.9 SD 0.9 vs 5.7 SD 2.0 control group), Tinetti (trained group 24.5 SD 4.4 vs 21.7 SD 4.5 control group), Short Physical Performance Battery (trained group 9.5 SD 1.8 vs 7.1 SD 2.8 control group), and physical performance test (trained group 23.5 SD 5.9 vs 16.5 SD 5.1 control group) as well as cognitive, emotional, and social networking determinations: Mini-Mental State Examination (trained group 28.9 SD 3.9 vs 25.9 SD 7.3 control group), geriatric depression scale from Yesavage (trained group 2.3 SD 2.2 vs 3.2 SD 2.0 control group), EuroQol quality-of-life scale (trained group 8.2 SD 1.6 vs 7.6 SD 1.3 control group), and Duke social support (trained group 48.5 SD 9.3 vs 41.2 SD 8.5 control group).

This program is unique in that it leads to a decrease in the number of visits to primary care physician (trained group 1.3 SD 1.4 vs 2.4 SD 2.9 control group) and to a significant improvement in frailty biomarkers.

Conclusions

We have designed a multicomponent exercise intervention that reverses frailty and improves cognition, emotional, and social networking in a controlled population of community-dwelling frail older adults.

Chi poteva permetterselo $?

B.M., 70 anni

LOS PER REPARTI:

GER12 gg

UCSA 22 gg

CGE 13 gg

TOTALE: 47 gg + UCSA (7)

29 gg acuzie risparmiati?

Paziente ready 4 surgery

P.B., 82 anni

LOS PER REPARTI:

STROKE UNIT 15 gg

RIAB 6 gg

GER 18 gg

UCSA 38 gg

GER 7 gg

UCSA 7 gg

TOTALE: 91 gg

BM: Acute patient with long term recovery (or: chronic exacerbations in robust?)

PB: Hospital dependent patient? Frail or sarcopenic? (NEJM)

Chi segue nel lungo termine pazienti instabili che necessitano di stare in ospedale?

TIP?
Riabilitazione Specialistica Intensiva?

E poi, quale percorso?

Original Study

Discharge Destination of Dementia Patients Who Undergo Intermediate Care at a Facility

A B S T R A C T

Objectives: Intermediate care for patients with dementia has important implications for aging in place as long as possible. In Japan, geriatric intermediate care facilities provide institutional rehabilitation services to patients under the public Long-Term Care Insurance program and aim to discharge the patients to home from the hospital. The aim of this study was to determine the association between dementia and discharge destination of patients in geriatric intermediate care facilities in Japan.

Design: This study was conducted using a retrospective study design for data from 2007, 2010, and 2013.

Setting: We used data from the Survey of Institutions and Establishments for Long-Term Care, which is a nationally representative cross-sectional survey that assessed discharges from geriatric intermediate care facilities in September.

Participants: There were 9992 discharged patients included in the analysis.

Measurements: Discharge destination was categorized as home, facility, hospital, or death. Primary disease was based on ICD-10 codes. Diagnosis of dementia included F00 (Alzheimer), F01 (vascular), F02 (other), and F03 (unspecified). Multilevel multinomial logistic analysis was used for discharge destination, with discharge to home as the reference group.

Results: Of the 9992 discharged patients, 2483 (24.8%) had dementia as the primary disease. Of the 2483 patients with dementia, 1090 (43.9%) were hospitalized, 624 (25.1%) were admitted to another facility, 605 (24.4%) were discharged to home, and 164 (6.6%) were discharged by death. Patients with dementia were more likely to be admitted to hospital (adjusted odds ratio [OR] 1.47; 95% confidence interval [CI] 1.25–1.73; $P < .001$), transferred to another facility (adjusted OR 1.94; 95% CI 1.64–2.29; $P < .001$), or discharged by death (adjusted OR, 1.46; 95% CI 1.13–1.89; $P = .004$) than discharged to home.

Conclusion: Intermediate care in residential settings might have limited effectiveness in discharging patients with dementia to home. The national dementia plan should explore intermediate care for dementia at other care settings rather than facilities.

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Characteristics of the Patients Who Were Discharged From Geriatric Intermediate Care Facilities in Japan (n = 9992)

Patient Characteristics	Destination			
	Home, n = 2897	Hospital, n = 4432	Facility,* n = 2071	Death, n = 592
Dementia as primary disease, n (%)	605 (20.9)	1090 (24.6)	624 (30.1)	164 (27.7)
Year of discharge, n (%)				
2007	1138 (39.3)	1650 (37.2)	723 (34.9)	144 (24.3)
2010	807 (27.9)	1575 (35.5)	723 (34.9)	201 (34.0)
2013	952 (32.9)	1207 (27.2)	625 (30.2)	247 (41.7)
Previous place of care, n (%)				
Home	1995 (68.9)	748 (16.9)	488 (23.6)	128 (21.6)
Hospital	801 (27.6)	3345 (75.5)	1137 (54.9)	406 (68.6)
Facility	101 (3.5)	339 (7.6)	446 (21.5)	58 (9.8)
Length of stay, d, mean (SD)	130.9 (231.9)^{a,b,c}	349.7 (553.3)^{a,d}	357.6 (400.7)^{b,e}	631.6 (787.1)^{c,d,e}
Age, years, mean (SD)	84.0 (8.3)^{a,b}	85.2 (8.2)^{c,d,e}	84.1 (8.2)^{a,c}	88.6 (7.4)^{b,d,e}
Sex, male, n (%)	763 (26.3)	1453 (32.8)	538 (26.0)	193 (32.6)
Level of required care (range, 1−5), mean (SD)	2.9 (1.3)^{a,b,c}	3.6 (1.2)^{a,d,e}	3.3 (1.2)^{b,d,f}	4.0 (1.1)^{c,e,f}
Cognitive impairment (range, 1−6), mean (SD)	2.6 (1.4)^{a,b,c}	3.0 (1.1)^{a,d,e}	2.8 (1.2)^{b,d,f}	3.2 (1.0)^{c,e,f}
Medical procedures, n (%)				
Infusion	49 (1.7)	1404 (31.7)	39 (1.9)	335 (56.6)
Sputum suction	60 (2.1)	642 (14.5)	37 (1.8)	233 (39.4)
Oxygen therapy	22 (0.8)	487 (11.0)	10 (0.5)	240 (40.6)
PEG tube feeding	67 (2.3)	414 (9.3)	72 (3.5)	51 (8.6)
Other tube feeding	29 (1.0)	239 (5.4)	30 (1.4)	59 (10.0)
Financial capacity, tax-exempted, n (%)	1252 (43.2)	2285 (51.6)	1176 (56.8)	305 (51.5)

All test statistics were significant at $P < .001$.
a, b, c, d, e, f Significant difference between values with the same letter, $P < .05$ determined using the Bonferroni correction.
*Facility included permanent nursing homes, other geriatric intermediate care facilities, group homes, and congregate housing.

In addition to the presence of dementia, discharge to hospital was more likely in patients who were older, required a greater level care, had more severe cognitive impairment, underwent medical procedures, had longer stays, had less financial capacity, or had resided at another facility or hospital; these findings are consistent with those of previous studies on intermediate care

ORIGINAL INVESTIGATION

Predictors for a good recovery after subacute geriatric care

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Background and aims. We wanted to investigate eight different geriatric assessment tests regarding the prediction of 1) a good recovery (ability to return to own home or transfer to further rehabilitation), and 2) a poor recovery (discharge to nursing home, hospice, acute hospitals or death) in elderly patients treated in a subacute geriatric hospital ward.

Methods. Consecutive 664 community-dwelling patients aged ≥ 70 years, transferred from acute medical and geriatric wards to a subacute geriatric ward were included. Demographic data and eight different geriatric assessment tests were recorded, and odds ratio for having a good versus poor recovery was assessed with logistic regression analysis.

SUBDIVISION OF PATIENTS INTO GOOD AND BAD OUTCOME AFTER SUBACUTE CARE

The patients that were able to return home (n = 420) and patients discharged for further geriatric rehabilitation (n = 85), were defined as having a good recovery. The rest of the patients that needed readmission to an acute hospital ward (n = 41) were discharged to nursing home (n = 58), to hospice (n = 9) or died during the stay in the subacute ward (n = 47), were defined as having a poor outcome.

Table I. Differences between patients with good and bad outcomes after subacute care.

|	N*	All patients	Good outcome	Poor outcome	p-value
	664	664 (100%)	505 (76%)	159 (24%)	
Demographic characteristics					
Live alone	655	212 (32%)	163 (33%)	49 (31%)	0.36
Male sex	664	293 (44%)	216 (43%)	77 (48%)	0.23
Age	664	82 (6)	82 (6)	82 (7)	0.66
Education (years)	657	5 (0-20)	5 (0-20)	5 (0-20)	0.82
Two weeks before admission					
CDR	636	0.53 (0.92)	0.43 (0.80)	0.89 (1.18)	< 0.001
BI pre	657	85 (0-100)	85 (0-100)	70 (0-100)	< 0.001
Assessment during stay in subacute care					
Blaylock scale	655	21 (5)	20 (5)	24 (6)	< 0.001
BI admission	657	40 (0-100)	40 (0-100)	20 (0-100)	< 0.001
BI discharge	648	60 (0-100)	70 (0-100)	20 (0-100)	< 0.001
Tinetti scale admission	658	6 (0-28)	7 (0-28)	1 (0-28)	< 0.001
Tinetti scale discharge	651	18 (0-29)	20 (0-29)	1 (0-28)	< 0.001
Scala III tot	650	2.9 (0.3)	2.9 (0.32)	3.0 (0.28)	0.004
CIRS severita	650	1.8 (0.3)	1.7 (0.3)	1.9 (0.3)	< 0.001
CIRS comorbidity	650	2.5 (1.4)	2.4 (1.3)	3.1 (1.5)	< 0.001
MSSE (best score)	619	25 (0-30)	26 (4-30)	21 (0-30)	<0.001
Cognitive impairment (MMSE < 24)	619	244 (40%)	170 (35%)	74 (59%)	< 0.001
GDS admission	502	4 (0-14)	4 (0-14)	4 (0-14)	0.47
GDS discharge	494	3 (0-15)	2 (0-15)	4 (0-12)	< 0.001
Depressive symptoms (GDS ≥ 6)	494	56 (11%)	38 (9%)	18 (26%)	< 0.001
Delirium at admission (cat)	659	125 (19%)	86 (17%)	39 (25%)	0.002
Change in fictional status					
BI loss at admission[a]	640	40 (0-100)	40 (0-90)	40 (0-90)	0.90
Improved BI score [b] (nom)	649	20 (0-75)	25 (0-75)	0 (0-65)	< 0.001
Improved BI (cat)	649	510 (79%)	449 (90%)	61 (41%)	< 0.001
Improved Tinetti score [b] (nom)	654	8 (0-26)	8 (0-26)	0 (0-24)	< 0.001
Improved Tinetti (cat)	654	506 (77%)	444 (89%)	62 (40%)	< 0.001
Return to pre BI [c] (cat)	640	212 (33%)	192 (39%)	20 (15%)	< 0.001
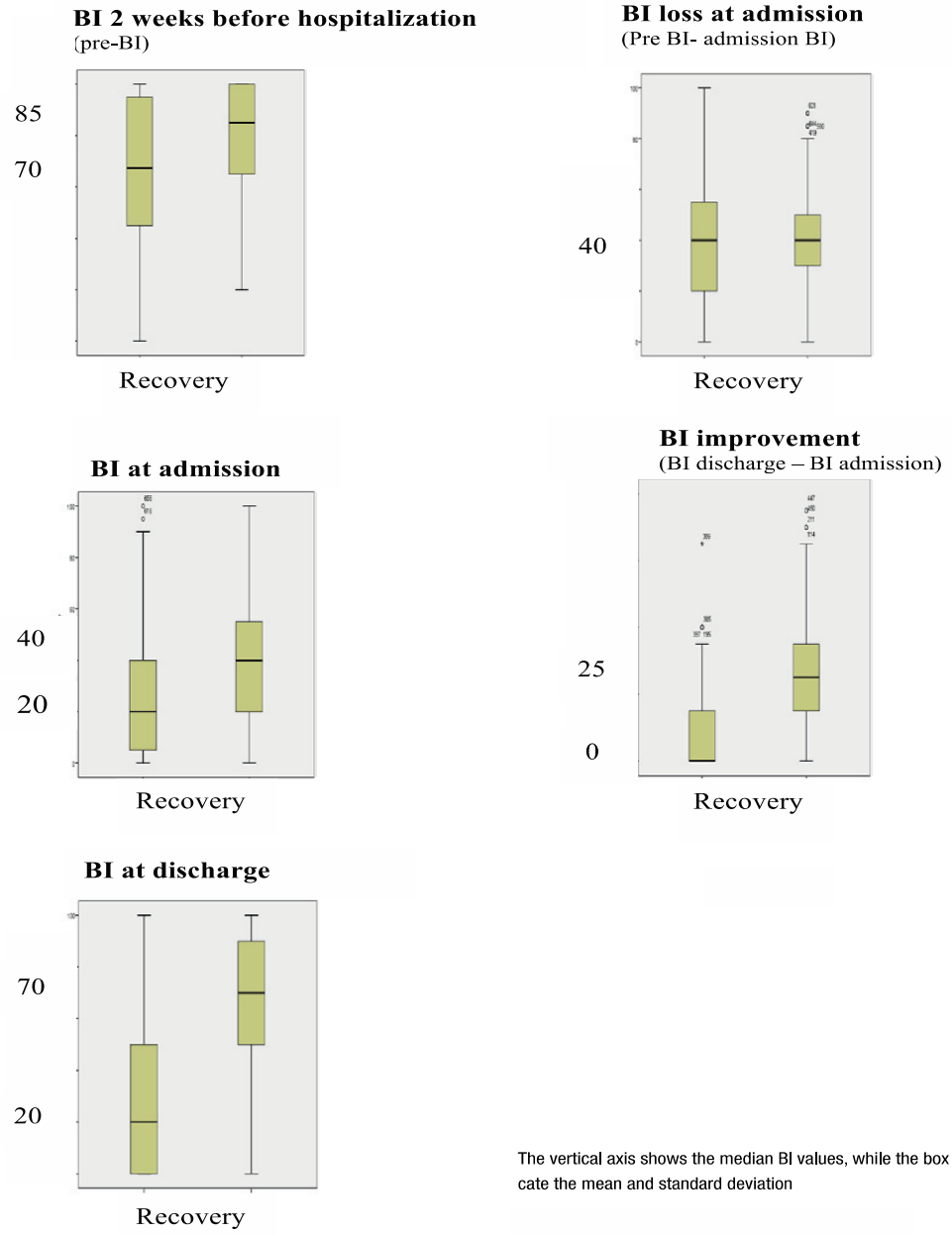
Figure 1. Trajectories of functional status before and during subacute care in patients experiencing a poor (columns to the left) and good (column to the right) recovery.

Table III. Univariate and multivariate regression analysis for predicting a good *versus* bad outcome with two separate multivariate models including either BI sum score or the Tinetti scale.

|	Univariate			Multivariate					
				Model 1, Barthel Index			Model 2, Tinetti scale		
	R	95% CI	p	R	95% CI	p	R	95% CI	p
Age	0.99	0.97-1.02	0.67	-			-		
Education	1.01	0.96-1.06	0.67	-			-		
Male sex	0.91	0.83-1.70	0.36	-			-		
Live alone	1.05	0.71-1.56	0.79	-			-		
Geriatric assessment									
BI 2 weeks pre admission	1.03	1.02-1.04	< 0.001	0.99	0.97-1.01	0.17			
BI loss at admission[a §]	1.00	0.99-1.01	0.70	-			-		
BI admission	1.03	1.02-1,04	< 0.001	1.01	0.99-1.03	0.36			
BI discharge[#]	1.04	1.04-1.05	< 0.001						
Any improvement in BI*	12.15	7.82-18.88	< 0.001	**6.77**	**3.41-13.45**	**< 0.001**			
Return to pre BI[b]	3.74	2.25-6.21)	< 0.001	1.77	0.89-3.53	0.10	2.06	1.04-4.11	0.04
Tinetti admission	1.08	1.05-1.11	< 0.001				0.99	0.95-1.04	0.68
Tinetti discharge[#]	1.14	1.11-1.17	< 0.001						
Any improvement in Tinetti*	11.28	7.34-17.34	< 0.001				**4.58**	**2.36-8.89**	**< 0.001**
Blaylock scale[§]	0.88	0.85-0.92	< 0.001	0.98	0.89-1.07	0.66	1.01	0.94-1.10	0.75
Scala III tot[§]	0.35	0.16-0.73	0.005	1.42	0.51-3.92	0.50	1.53	0.57-4.08	0.40
GDS admission < 6	1.19	0.75-1.92)	0.46	-					
GDS discharge < 6	3.52	1.87-6.61)	< 0.001	**2.19**	**1.04-4.59**	**0.04**	**2.43**	**1.20-4.92**	**0.01**
MSSE ≥ 24	1.09	1.06-1.12	< 0.001	**2.19**	**1.10-4.30**	**0.02**	**1.97**	**1.05-3.71**	**0.04**
CIRS severita[§]	0.28	0.16-1.50	< 0.001	1.38	0.33-3.5.81	0.66	1.01	0.26-3.91	0.99
CIRS comorbidity[§]	0.74	0.65-0.85)	< 0.001	0.94	0.71-1.20	0.66	0.96	0.74-1.25	0.75
Delirium at admission	0.62	0.40-0.96	< 0.001	1.80	0.61-5.30	0.19	1.53	0.55-4.27	0.42

We conclude that assessing the functional status with BI at admission and during the hospital stay, before discharge, as well as performing GDS and MMSE once during the stay, may give the best prediction of recovery after subacute care.

Assessment with BI gives the optimal prediction of short term recovery, and further assessment with some of the other functional tests may be redundant and could be substituted with the

assessment of frailty and nutrition.

Outcome dei pazienti: totale e per gruppi (n.242)

Dove va:		Totale (242)	4 AT neg (177)	4 AT pos (65)
Casa		71.8%	76.8%	56.8%
Riabilitazione		11.4%	11.6%	10.8%
RSA		9.4%	4.5%	24.3%
Ospedale (riacut/programma)		4.0%	4.5%	2.7%
Hospice		0.7%	0.9%	0.0%
Lungodegenza		2.7%	0.9%	5.4%
ADI dimissione (casa)		2.1%	0.9%	5.9%
Badante dimissione (casa)		14.1%	11%	21%
Barthel dimissione		63.2+29.6	70.6+25.5	40.4+30.3
Durata degenza (giorni)		15.1+9.8	15.1+10.4	15.0+8.2
Decesso		7%	3.4%	17%

Mortalità totale intraospedaliera - UCSA
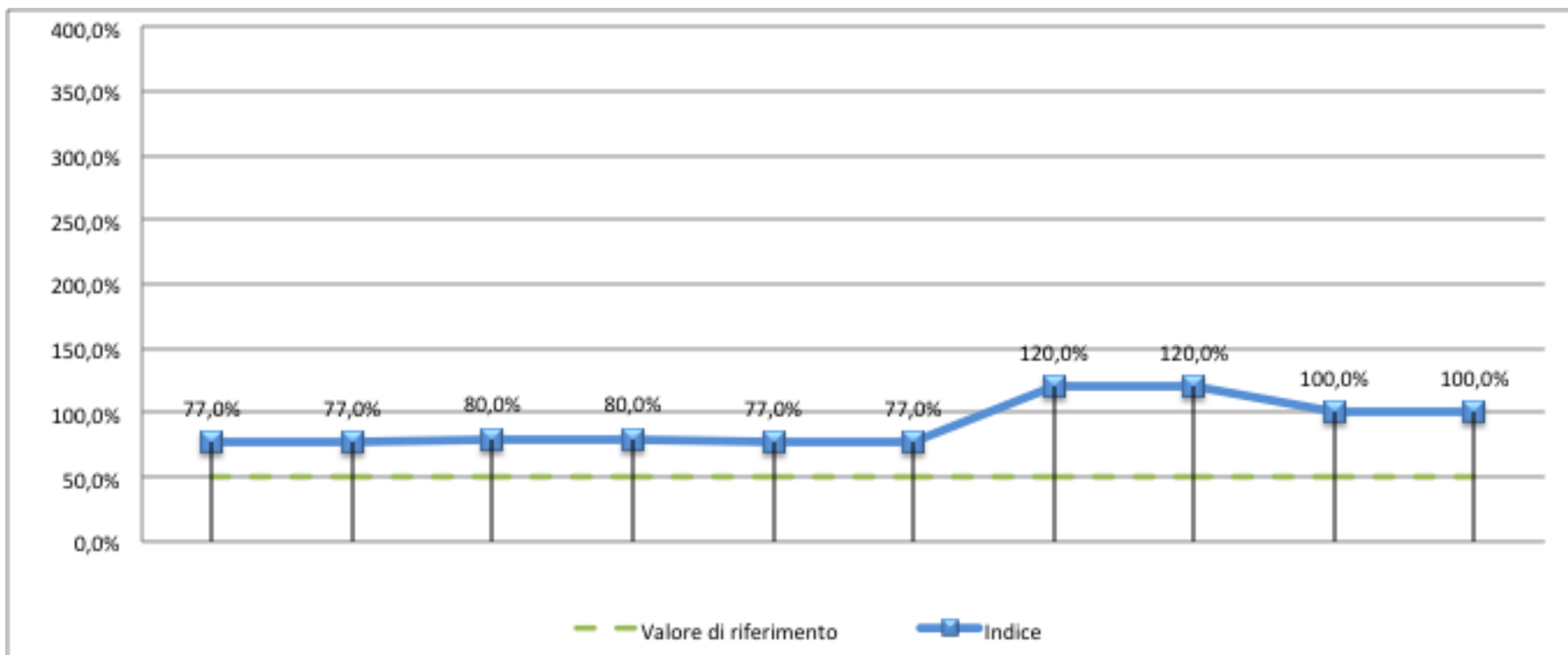
Si intende numero dei pazienti deceduti sul totale dei dimessi (dal 7 al 12% max)

Ucsa Poliambulanza: Follow Up (10-2014)
Pazienti Ricoverati In Ucsa Dal 11-2011 Al 11-2012:

Pazienti UCSA	280	N.	%
Responders		195	
Rericoverati		121	62.1
Non rericoverati		74	37.9

	Deceduto (N, %)	Non deceduto (N, %)	%
Rericoverati	65 (53.7)	56 (46.3)	121
Non rericoverati	27 (36.5)	47 (63.5)	74
	92	103	

Decesso per discharge (398)

	casa	rsa	osped	hospice	Riab S	Riab G	tot
decesso							
No (n, %)	163 (62)	16 (47)	15 (50)	0 (0)	24 (73)	14 (61)	232 (58)
Si (n, %)	102 (38)	19 (53)	15 (50)	11 (100)	9 (27)	9 (39)	166 (42)
totale	265	35	30	11	33	23	398

Tavola di contingenza decesso 1no2si * vadove

			vadove					
			CASA	RSA	OSPEDALE PER ACUTI	HOSPICE	12	RIABILITAZIONE SPECIALISTICA
decesso 1no2si	1	Conteggio	163	16	15	0	0	24
		% in vadove	61,5%	45,7%	50,0%	0,0%	0,0%	72,7%
	2	Conteggio	102	19	15	11	1	9
		% in vadove	38,5%	54,3%	50,0%	100,0%	100,0%	27,3%
Totale		Conteggio	265	35	30	11	1	33
		% in vadove	100,0%	100,0%	100,0%	100,0%	100,0%	100,0%

Tavola di contingenza decesso 1no2si * vadove

			vadove	Totale
			rgg	
decesso 1no2si	1	Conteggio	14	232
		% in vadove	60,9%	58,3%
	2	Conteggio	9	166
		% in vadove	39,1%	41,7%
Totale		Conteggio	23	398
		% in vadove	100,0%	100,0%

Ricoveri ripetuti entro l'anno dopo UCSA
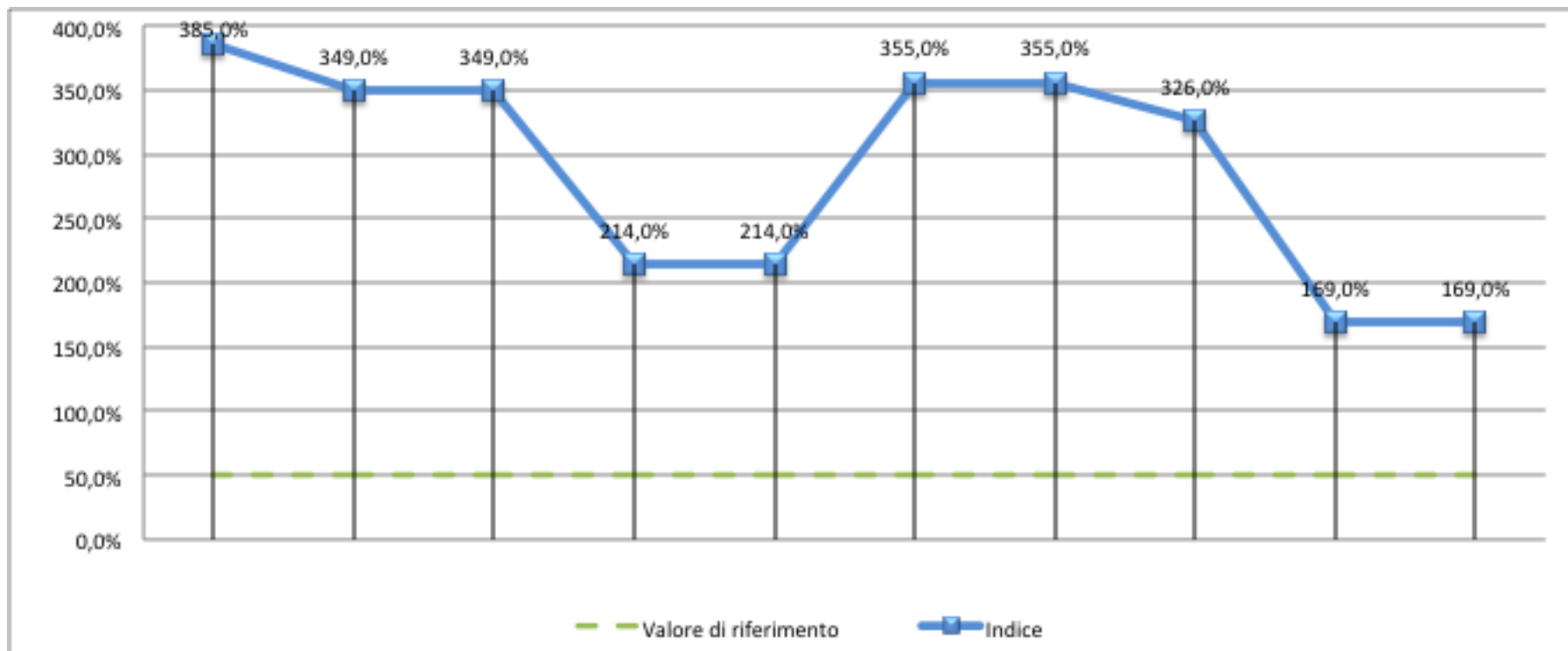
Si intende un ricovero successivo ad un altro ricovero dello stesso paziente che avviene nella stessa o in un'altra struttura ospedaliera entro l'anno di dimissione considerato, *e per lo stesso MDC* (dal 3.85 al 1.69%)

Leading the Transformation of Health Care Delivery — The Launch of NEJM Catalyst

Thomas H. Lee, M.D., Edward W. Campion, M.D., Stephen Morrissey, Ph.D., and Jeffrey M. Drazen, M.D.
New England Journal of Medicine

Health care delivery is in a period of historic transition. The pressure for major improvements in quality and efficiency exists everywhere — and thus is not driven by the Affordable Care Act alone. The real driver is the medical progress of recent decades, which has dramatically enhanced what medicine can do but has also increased its potential for creating waste, disappointing quality, and chaos for patients. Even if costs were not an issue, the need to reorganize health care would be compelling. Given economic realities, that need is an imperative.

Not All High-Risk Populations Are the Same
May 5, 2016
Brian W. Powers, AB & Sreekanth K. Chaguturu, MD

Selected Utilization and Health Status Information for the Costliest 1% of Patients Whose Care Is Managed by Partners HealthCare, According to Payer Type.*			
Variable	Medicare	Medicaid	Commercial
Average annual spending for high-cost patients ($)	146,584	85,347	101,359
Proportion of overall spending accounted for by high-cost patients (%)	14	17	22
Average no. of co-occurring chronic conditions in high-cost patients	8.1	5.1	4.4
Most prevalent chronic conditions (% of high-cost patients)	Hypertension (88) Chronic kidney disease (67) Ischemic heart disease (64) Congestive heart failure (61) Hyperlipidemia (60)	Depression (24) Anxiety (23) Hypertension (20) Bipolar disorder (15) Asthma or COPD (14)	Hypertension (55) Hyperlipidemia (43) Depression (25) Arthritis (25) Chronic kidney disease (25)

* Populations represent the costliest 1% of patients in each payer category, according to 2014 health care spending. Spending for Medicare and Medicaid patients represent total medical expenses. Spending for commercially insured patients was cost standardized across payers. Chronic conditions were identified using the Center for Medicare and Medicaid Services chronic condition grouper. Data are from an internal analysis of 2014 claims data from Partners HealthCare. COPD denotes chronic obstructive pulmonary disease.

That reality has important implications for health systems and physicians. As reform activities shift payment away from fee-for-service models, the incentives to improve care for high-cost patients will continue to grow.

Specific patient subgroups and clinical trends will vary with the demographics, payer mix, and catchment area of a given physician group or health system. Sustaining performance across populations will require a diversified approach tailored to the particular clinical realities of target populations.

Focusing on high-cost patients has become an attractively simple approach to improving care and reducing costs. But this policy panacea is challenged by the reality that patient demographics, health needs, and utilization patterns vary substantially among populations. Optimizing investments in this area will require improving analysis of which patients are amenable to care-delivery interventions and prioritizing interventions according to the specific needs of subpopulations.

How the Freestanding Emergency Department Boom Can Help Patients

Nir Harish, MD, MBA, Jennifer L. Wiler, MD, MBA, and Richard Zane, MD

Yale Department of Emergency Medicine, University of Colorado School of Medicine, CU Business School, CU Health System

3. **Offer an alternative to hospitalization.** Hospital admissions make up a third of all U.S. health spending. At least 10% of hospital admissions are for patients with conditions, such as pneumonia, that require care and observation but don't require a hospital admission with its full array of services, such as in-house specialists or operating rooms.

   To serve such patients, University of Colorado Health has partnered with Adeptus Health, a publicly traded, for-profit operator of FSEDs. Together, they have integrated FSEDs and, soon, "micro-hospitals" into the UC Health System. The micro-hospitals will offer patients initial emergency care, observation, and short-stay admissions in a lower-cost environment close to home, while still being fully connected to the larger system of care with the same electronic medical record. And all of the FSEDs and micro-hospitals are equipped with telemedicine services to offer consultations with hospital-based specialty physicians, without the time and costs of transportation to the hospital.

Caring for Older Adults in a Value-Based Model

Griffin Myers, MD, MBA, Geoff Price, MBA and Mike Pykosz, JD

Oak Street Health, Chicago, Illinois

Based in Chicago, Oak Street Health provides value-based primary care exclusively to older adults in underserved urban neighborhoods, driving industry-leading patient satisfaction scores, quality metrics, and a reduction in hospitalizations.

KEY TAKEAWAYS

1. Focusing exclusively on one population — for us, older adults, who are typically low-income and living in underserved, urban neighborhoods — allows care teams to truly "specialize" in the unique needs of that population.

2. Devoting more resources to primary care — measured in time spent with a physician, number of primary care visits, or simply dollars of primary care expense — can reduce unnecessary and expensive acute episodes.

3. The population health model is most effective when practically implemented, relying as much on culture and routine as on technology.

The Challenge: The average older adult is 73 years old and has significant health concerns: 24% have diabetes, 17% have congestive heart failure, and 12% have major depression. Yet she (55% are female) is also ill-equipped to manage her health: 56% have a high school education or less, 45% live under 200% of the federal poverty line, and 29% live alone. The average older adult makes just three visits to a primary care physician/provider per year, each lasting a mere 17 minutes. The mismatch is even worse for older low-income adults and for those in underserved urban neighborhoods where access to health care services is often poor.

Our Team-Based Model

Oak Street care teams consist of a physician, nurse practitioner, registered nurse, medical assistant, care manager, and clinical informatics specialist. Team members have explicit roles during and between visits, and teams have structured daily "huddles" to ensure that resources are focused on patients with greatest need.

One unique part of our team-based approach is the role of the clinical informatics specialist, whom Oakies lovingly call the "ninja." As one may expect, practicing medicine in an at-risk model with a highly comorbid population requires the collection, analysis, and use of an enormous amount of data at the bedside. While medical scribes are a growing part of the health care workforce, Oak Street ninjas are tasked with far more than mere data entry. They capture and structure clinical data at the point of care and deliver population health insights as the clinician executes the care plan, during and between visits. Typically "ninjas" are pre-medical or medical students who defer their studies for a year or two to join Oak Street. They undergo intensive training on ICD-10, data documentation processes, CPT coding, population health dashboards, and other technology platforms.

40%+

reduction in hospitalizations of managed care patients

Why I Believe in Hospital at Home

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> *As the health system shifts to value-based care, HaH will challenge the traditional, facility-based model. ... And technological advances, such as biometrically enhanced telehealth modalities, will make HaH more viable."*

Conclusioni

Identificare i pazienti che si possono beneficiare per una UCSA non è facile (una consulenza di 20' ?), peraltro dobbiamo intendere quale OBIETTIVO (guarigione e ritorno a casa vs stabilizzazione e NH placement vs death?)

Bisogna studiare bene il paziente per sapere quali fattori possono predire un possibile recupero ed un outcome positivo (durante la degenza)

Le procedure sono mezzi, non obiettivi

I costi sono ripagati dal risparmio della degenza in acuto (e dalla possibile riduzione delle riospedalizzazioni?)