Office-Based Intervention Improves Vulnerable Elderly Care

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Los Angeles — A practice-based, paper-and-pencil-based intervention can improve quality of care for community-based vulnerable elderly patients with dementia or incontinence, Dr. David B. Reuben reported at the annual meeting of the Society of General Internal Medicine.

The Assessing Care of the Vulnerable Elders (ACOVE-2) trial, funded by Pfizer and Rand Health, was implemented in two large group practices in California with patients ages 65 years and older who had dementia or incontinence. The intervention group included 357 patients, and the control group had 287 patients, Dr. Reuben, director of the multicampus program in geriatric medicine and gerontology at UCLA.

Study sites included a primary care practice with 30 physicians serving 22,000 patients (67% of whom were in managed care programs) and a multispecialty practice with 100 physicians and 140,000 patients (50% in managed care programs).

The ACOVE-2-study intervention group redesigned their practices to identify eligible individuals, collect data, develop structured visit notes to suggest appropriate care, provide patient education, and link patients to community resources.

The structured visit notes were filled out by the physician. For example, the visit note for preventing falls included check boxes for the degree of vision, gait, and mobility. The dementia visit note included check boxes for long- and short-term memory; a simple math question about making change for a $10 purchase; and a range of other questions.

After the intervention, overall care patterns improved: 45% of patients at risk for falls received a specialty exam and 89% received recommendations to improve strength/gait problems, compared with 12% and 58%, respectively, before the intervention.

In addition, after the intervention, 33% of patients with incontinence received a recommendation for behavioral restraint before drug therapy, compared with 4% before the trial. However, there was no significant difference between intervention and comparison groups in the management of dementia. The structured visit notes included check boxes to minimize the time needed to fill out each section. “If it was quick, we knew doctors would do it. If it took time, doctors wouldn’t do it,” Dr. Reuben said.

Patient education materials for each condition were in every exam room, so the physician didn’t have to leave the room and interrupt the flow of the visit. For example, if a patient had problems with falling, the doctor might check the referral box for tai chi classes and pull a list of classes organized by zip code from the rolling cart that was in every room.

“I think the most interesting and controversial aspect of patient education material was the follow-up sheet,” Dr. Reuben said. The follow-up sheet included patient instructions for treatment and a list of questions for the patient to answer as homework before the next visit.

Physicians may encounter problems adapting ACOVE processes to their own practices, Dr. Reuben said. “One thing I can guarantee. If you try to do this exactly how it was done, it won’t work or you won’t do it. You must ask ‘what can I do to tweak it’”

More information about ACOVE, including forms and physician and patient education materials, has been made available at www.geron.ucla.edu/centers/acove/index.htm.