ACOVE-3 Rejected Quality Indicators

ACOVE-3 INVESTIGATORS

WR-515/1
August 2007

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BENIGN PROSTATIC HYPERPLASIA (BPH)

IF a male vulnerable elder complains of new or worsening LUTS, THEN an American Urological Association (AUA) symptom score AND an assessment of whether symptoms are bothersome (or IPSS score) should be performed.

IF a male vulnerable elder with BPH is newly treated with terazosin, tamsulosin, alfuzosin, or doxazosin, THEN follow-up should be documented in the chart within 1 week with assessment for orthostatic changes or dizziness.

IF a male vulnerable elder is newly started on terazosin, tamsulosin, alfuzosin or doxazosin, THEN the patient should be told to take the alpha-blocker just before sleep.

IF a male vulnerable elder has gross hematuria attributable to the prostate (after exclusion of other sources of hematuria), THEN a 5-alpha reductase inhibitor should be offered.

IF a male vulnerable elder with LUTS and a prostate > 30 grams selects medical management, THEN the medical record should document discussion with the patient about the benefits of combination therapy with an alpha-blocker and a 5-alpha reductase inhibitor.

IF a male vulnerable elder with BPH and a prostate size <20 gm is treated surgically, THEN documentation should exist that a transurethral incision of the prostate (TUIP) was discussed.

BREAST CANCER

IF a female vulnerable elder is diagnosed with breast cancer, THEN geriatric screening/assessment should be performed.
IF a female vulnerable elder is diagnosed with locally invasive breast cancer and is not currently a candidate for breast conserving surgery, THEN neoadjuvant systemic therapy should be offered.

IF a female vulnerable elder is diagnosed with estrogen receptor positive ductal carcinoma in situ (DCIS), THEN adjuvant hormonal therapy with tamoxifen should be offered.

**COLON CANCER**

IF a vulnerable elder is to have elective abdominal perineal resection or other procedure with planned creation of an ostomy, THEN there should be preoperative ostomy training/counseling.

**CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)**

IF a vulnerable elder has COPD (GOLD stage \( \geq 1 \)) and uses an inhaler, THEN annual reassessment of correct inhaler use should be documented.

IF a vulnerable elder with COPD has a moderate or severe exacerbation and is newly treated with oral corticosteroids, THEN the patient should be treated with oral corticosteroids 14 or fewer days.

IF a vulnerable elder has severe-very severe COPD (GOLD stage III-IV), THEN it should be documented that the patient previously completed/was referred to a pulmonary rehabilitation program in the past year.
CONTINUITY

IF a vulnerable elder is discharged from a hospital to home and survives at least four weeks after discharge, THEN the patient should be seen at home for at least one follow-up visit within 4 weeks of discharge.

DEMENTIA

IF a vulnerable elder is newly diagnosed with dementia with recent onset symptoms (2-3 years), THEN the clinician should order neuroimaging.

IF a VE has been diagnosed with moderate to severe Alzheimer’s disease or mild to moderate vascular dementia, THEN there should be a documented discussion with the patient and/or caregiver of the option of treatment with memantine.

IF a VE with dementia has a caregiver, THEN the caregiver should be screened for depression.

IF a VE with dementia has a caregiver who screens positive for depression, THEN there should be documentation that the caregiver was advised to seek care/was already under care.

IF a VE has dementia, THEN a physical exercise program should be prescribed.

IF a vulnerable elder is placed in physical restraints, THEN each of the following measures should be enacted: (i) Inclusion of additional methods to physical restraints in the care plan that address the target behavioral disturbance or safety issue; (ii) Consistent release from the restraints at least every two hours; (iii) Face-to-face reassessment by a physician or nurse at least every four hours and before renewal of the restraint order; (iv) Observation at least every fifteen minutes, and more frequently if indicated by the patient’s condition, while the patient is in restraints; (vi) Interventions every two hours (or as indicated by patient’s
condition or needs) related to nutrition, hydration, personal hygiene, toileting, and range of motion exercises.

DEPRESSION

IF a vulnerable elder has depression associated with bereavement, THEN he or she should be treated with an antidepressant medication with or without interpersonal psychotherapy.

END OF LIFE

IF a vulnerable elder is living with metastatic cancer, THEN depression should be assessed at each outpatient encounter.

IF a cognitively intact vulnerable elder who was conscious during the last 7 days of life died an expected death, THEN the medical record should contain documentation about a discussion of spirituality or how the patient was dealing with death or religious feelings.

IF a vulnerable elder has poor functional status and he or she is living at home, THEN the patient should be assessed for the need for practical support and assistance with activities and independent activities of daily living.

FALLS

IF a vulnerable elder reports a history of two or more falls (or one fall with injury) in the past year, THEN there should be documentation of footwear review at least once in the past year, or no more than three months from when the history of falls is reported to the provider.
IF a vulnerable elder reports a history of two or more falls (or one fall with injury) in the past year, THEN vitamin D supplementation (at least 800 IU vitamin D3 or equivalent) OR assessment of 25-hydroxyvitamin D3 should be documented in the past year, or no more than three months from when the history of falls is reported to the provider.

IF a vulnerable elder reports a history of two or more falls (or one fall with injury) in the past year AND is found to have a 25-hydroxyvitamin D3 level ≤ 40 nmol/l, THEN vitamin D supplementation (at least 800 IU vitamin D3 or equivalent) should be offered.

HEARING LOSS

ALL vulnerable elders with no prior hearing aid use should undergo hearing screening that includes use of an Audioscope testing at 1000 Hz and 2000 Hz in both ears.

IF a vulnerable elder has sudden hearing loss, THEN the patient should be referred to an otolaryngologist within 48 hours.

IF a vulnerable elder’s ear canal remains completely occluded by cerumen despite efforts to remove it, THEN the patient should be offered referral to an otolaryngologist within 90 days.

HEART FAILURE

IF a vulnerable elder has heart failure, a left ventricular ejection fraction < 0.40, advanced (moderately severe or severe) heart failure (e.g., NYHA III-IV), a potassium less than 5.0 mEq/L, and a creatinine of 2.5mg/dl or less (2.0 mg/dl for women) THEN he or she should be treated with an aldosterone antagonist.
IF a vulnerable elder has mildly to moderately severe symptomatic heart failure (e.g., NYHA II-III), has left ventricular ejection fraction $\leq 0.30$ while on optimal medical therapy, and is expected to survive for at least one year THEN he or she should be offered treatment with an implantable cardioverter defibrillator (ICD).

IF a vulnerable elder has heart failure, THEN he or she should have his or her activity level documented at each outpatient visit using one of the following: Assessment of current level of activity, Documentation of a standardized scale, and Completion of an assessment tool.

IF a vulnerable elder has heart failure and angina or significant ischemia, and is without documented contraindications to revascularization, THEN he or she should be offered coronary artery angiography to evaluate the need for revascularization.

IF a vulnerable elder has mildly to moderately severe symptomatic heart failure (e.g., NYHA II-III), has left ventricular ejection fraction $\leq 0.30$ while on optimal medical therapy, and is expected to survive for at least one year THEN he or she should be offered treatment with an implantable cardioverter defibrillator (ICD)

HOSPITALIZATION/SURGERY

IF a hospitalized VE who has dentures is eating in the hospital, THEN the dentures should be accessible.

IF a vulnerable elder has hearing loss (i.e., outpatient record contains diagnosis of chronic hearing loss or documents that patient wears hearing aids) and is hospitalized, THEN at least one physician, nurse practitioner, or physician assistant inpatient progress note should contain documentation that the patient is hearing impaired.
IF a vulnerable elder is undergoing major elective surgery with planned inpatient stay, THEN a serum creatinine with GFR should be performed within 8 weeks prior to surgery and the results documented in the hospital or outpatient record.

IF a vulnerable elder is undergoing elective major surgery, THEN the following functional status and sensory impairment issues should be documented in the chart, within 8 weeks prior to surgery regarding the presence or absence of the following: a. Hearing impairment, including need for hearing aid b. Visual impairment, including need for glasses c. Dependence in activities of daily living (ADLs) d. Dependence in instrumental activities of daily living (IADLs).

IF a vulnerable elder is undergoing elective major surgery, THEN a screening nutritional assessment should be performed within 8 weeks prior to surgery.

HYPERTENSION

IF a VE is newly diagnosed with hypertension AND is obese, THEN screening for obstructive sleep apnea or a formal sleep study should be performed within 6 months (if not done in the past).

IF a vulnerable elder has been newly diagnosed with hypertension, THEN an assessment for microalbuminuria should be performed within 3 months or have been done within 3 months prior to the diagnosis.

IF a vulnerable elder is newly diagnosed with hypertension, THEN measurement of serum calcium level should be performed within the next 3 months or have been done in the 3 months prior to diagnosis.
IF a vulnerable elder has systolic blood pressure persistently elevated $\geq 160$ mmHg for $>6$ months AND the patient has been prescribed 3 or more full-dose antihypertensive medications AND the provider has documented that the patient is compliant with medications AND the patient has chronic kidney disease, THEN the diagnosis of atherosclerotic renal artery stenosis (ARAS) should be considered as a possible cause of refractory hypertension by documentation of one of the following: 1) ARAS is listed in the differential diagnosis in the medical record, 2) documentation of discussion of possible diagnosis with the patient, or 3) ordering of diagnostic tests (renal MRA, renal artery Doppler ultrasound, or nuclear renal function test).

IF a vulnerable elder with the diagnosis of hypertension is receiving any antihypertensive medication more than once daily, THEN justification for more than once-daily dosing should be in the medical record at the time the regimen is increased to more than once-daily dosing, and can include reasons such as labile blood pressure, orthostatic hypotension or postural symptoms on qd dosing, inadequate control prior to usual daily dose (i.e., early morning hypertension in a patient on morning dosing), financial considerations (i.e., if a generic formulation is favorable due to price but requires more frequent dosing as in generic metoprolol), or co-morbid congestive heart failure requiring hydralazine.

IF a vulnerable elder with a diagnosis of hypertension receives a new prescription for an alpha-blocker, THEN presence or absence of orthostatic hypotension and/or symptoms of orthostatic hypotension should be documented within 3 months.

IF a vulnerable elder with a diagnosis of hypertension is given a new prescription for clonidine, THEN the chart should document or patient should report [patient interview] that 1) the patient’s blood pressure has been above goal despite 3 or more antihypertensive medications,
2) the patient has been non-adherent to all oral antihypertensive medications, or 3) the patient has had adverse reactions to 3 or more antihypertensive medications in the past.

**IF** a vulnerable elder has a diagnosis of hypertension and is not already on statin therapy for hyperlipidemia, **THEN** treatment with a statin REGARDLESS OF LIPID LEVELS should be offered at least once as documented in the medical record or reported by the patient [patient interview] OR else one of the following should be documented: 1) reported prior adverse event on a statin, 2) chronic hepatic insufficiency, 3) total cholesterol level <156 mg/dL, or 4) that the elder is unlikely to benefit from the statin due to limited life expectancy or other equivalent wording.

**ISCHEMIC HEART DISEASE**

**IF** a vulnerable elder has an acute coronary syndrome and has hypersensitivity or severe gastrointestinal intolerance to aspirin therapy, **THEN** the elder should be prescribed thienopyridine therapy within 1 hour of presentation.

**IF** a vulnerable elder < 75 years of age, without contraindications to revascularization has acute coronary syndrome accompanied by symptoms of heart failure, **THEN** the medical record should document that the elder was offered immediate catheterization or explain why immediate catheterization is not appropriate for the patient.

**IF** a vulnerable elder has established IHD, **THEN** he or she should be offered omega-3 fatty acid supplementation and this should be documented in the medical record or the medical record should document why omega-3 fatty acid supplementation is contraindicated for the patient.
MEDICATION USE

IF a vulnerable elder is prescribed a thiazide diuretic, THEN he or she should have electrolytes checked within 2 weeks after initiation and at least yearly thereafter.

IF a vulnerable elder is prescribed an NSAID (non-selective or selective), THEN the vulnerable elder should be advised of the associated gastrointestinal bleeding risks.

IF a vulnerable elder is prescribed an NSAID, THEN the medical record should indicate whether or not s/he has a history of 1) gastrointestinal bleeding or ulcers and 2) renal insufficiency AND, if a history is present, justification of NSAID use should be documented.

ALL vulnerable elders with cardiovascular or cerebrovascular disease should not be treated with NSAIDs.

OSTEOARTHRITIS

IF a vulnerable elder has had a diagnosis of symptomatic osteoarthritis of the knee or hip for > 3 months, THEN education about the natural history, treatment, and self management of osteoarthritis should have been given or recommended at least once.

IF a patient has had a diagnosis of symptomatic OA of the knee or hip for >3 months, THEN the patient should have been referred to an arthritis management program at least once.

IF a vulnerable elder has symptomatic osteoarthritis of the knee or hip and is overweight (as defined by body mass index of ≥ 25 kg/m2), THEN the vulnerable elder should be advised to lose weight at least annually AND the benefit of weight loss on the symptoms of osteoarthritis explained.
IF a vulnerable elder has symptomatic osteoarthritis of the knee or hip and is overweight (as defined by body mass index of \( \geq 25 \) kg/m\(^2\)) for more than 3 years, THEN the vulnerable elder should receive referral to a weight loss program.

IF a vulnerable elder has symptomatic osteoarthritis of the knee or hip and is obese (as defined by body mass index of \( \geq 30 \) kg/m\(^2\)) for more than 3 years, THEN the vulnerable elder should receive referral to a weight loss program.

IF a pharmacologic therapy for OA is changed from acetaminophen to a different agent, THEN there should be evidence that the patient has had a trial of maximum dose acetaminophen (suitable for age/comorbidities).

IF a vulnerable elder with risk factors for gastrointestinal bleeding is treated with a COX-2 selective NSAID AND daily aspirin, THEN s/he should be treated concomitantly with either misoprostol or a proton pump inhibitor.

IF a vulnerable elder who is NOT treated with low dose aspirin, has risk factors for gastrointestinal bleeding and is prescribed an NSAID, THEN the vulnerable elder should receive a non-selective NSAID plus a gastroprotective agent (PPI or misoprostol) OR a COX-selective NSAID.

IF a vulnerable elder is treated with an NSAID AND the vulnerable elder has cardiovascular or cerebral vascular disease, THEN the COX-selective NSAIDs should not be used.

IF a vulnerable elder is treated with daily NSAIDs (selective or nonselective) and has risk factors for gastrointestinal bleeding, THEN a hemoglobin or hematocrit should be performed at baseline and during the first year after initiating therapy.
IF a vulnerable elder is treated with daily NSAIDs (selective or nonselective) AND the vulnerable elder has risk factors for developing renal insufficiency, THEN a serum creatinine should be assessed at baseline and at least once in the first year following the initiation of therapy.

OSTEOPOROSIS

ALL ambulatory vulnerable elders should have a height measurement annually.

IF a male vulnerable elder not known to have osteoporosis is 70 years or older, THEN a DXA scan should be offered.

ALL female vulnerable elders should be assessed for the following risk factors for osteoporosis: Ethnicity, Weight, Smoking, Menopausal status, Alcohol use, Family history of osteoporosis, including a maternal history of hip fracture, Inactive lifestyle, Gastrectomy, History of endocrine diseases including thyroid, parathyroid and adrenal disorders, Steroid use, Customary calcium intake, Aromatase inhibitor use, Weight loss greater than 1% per year.

IF a female vulnerable elder has 1 or more risk factors listed in indicator #3, THEN a DXA scan should be performed at least once

ALL female vulnerable elders should be counseled about estrogen replacement therapy.

IF a male vulnerable elder is newly diagnosed with osteoporosis, THEN he should receive a work up including at least 3 of the following • Hyperthyroidism • History of medication use • History of alcohol use • 24 hour urine sample for calcium excretion • testosterone level • vitamin D 25OH • PTH • myeloma workup • malabsorption evaluation.
PAIN MANAGEMENT

IF a vulnerable elder has a painful neuropathy THEN s/he should be treated with gabapentin or tricyclic anti-depressants unless s/he has documented contraindications or intolerable side effects or are effectively managed with other agents.

IF a vulnerable elderly patient presents with zoster associated pain (ZAP) THEN s/he should be prescribed a trial of one of the following should be initiated: tricyclic antidepressant, gabapentin, a lidocaine patch or topical capsaicin as a first line agent.

IF a vulnerable elder requires opioids to manage chronic pain THEN a long-acting formulation should be used to establish and maintain adequate analgesia, and a short-acting opioid should be used for breakthrough pain.

PRESSURE ULCERS

IF a vulnerable elder presents with a large stage III or IV pressure ulcer with poor granulation tissue or excess exudate present and failure to demonstrate improvement with conventional moist wound healing therapy (e.g., thin film dressings, hydrocolloids, hydrogels, foam, alginates), THEN wound treatment with negative pressure wound therapy (NPWT) should be considered for treatment OR there should be documentation of why NPWT is not appropriate.

IF a vulnerable elder with a full-thickness stage III or IV pressure ulcer presents with signs of clinical wound infection such as failure to improve after a clinical course of healing, friable red granulation tissue, pale pink granulation tissue, purulent exudate, foul odor, and wound
breakdown, **THEN** the wound should be treated with a broad-spectrum topical antimicrobial for 10 to 14 days.

**SCREENING AND PREVENTION**

**IF** a vulnerable elder has not received complete primary vaccination series for diphtheria and tetanus or such history is unknown, **THEN** the vulnerable elders should receive a primary series of Td (2 doses at least 4 weeks apart and the third dose 6-12 months after the second).

**IF** a male vulnerable elder aged 65 to 74 years has a history of smoking (regardless of current smoking status) and has not been radiologically evaluated for abdominal aortic aneurysm within the past 5 years, **THEN** the provider should recommend a one-time screening by radiological/imaging study (ultrasound screening preferred) for abdominal aortic aneurysm (AAA).

**IF** a vulnerable elderly woman has had a hysterectomy, **THEN** the reason for hysterectomy (i.e., benign condition, fibroids, or malignancy) should be documented.

**SLEEP DISORDERS**

**IF** an outpatient vulnerable elder complains of sleep problems or sleep problems are documented in the patient’s medical record, **THEN** pharmacologic sleep aids containing benzodiazepines should not be used to treat the sleep problem.

**IF** a vulnerable elder reports sleep problems characterized by difficulty staying awake until desired bedtime, with earlier-than-desired morning awakening(s), **THEN** there should be documentation that the vulnerable elder was encouraged to increase exposure to bright light
in the evening hours, as close to bedtime as possible, for at least one hour per day for at least two weeks, OR documentation stating why this recommendation was not appropriate for the patient (e.g., patient using photosensitizing agent).

**IF** a vulnerable elder complains of continued sleep problems for more than 6 months AND a targeted sleep history has been completed (QI #2) AND attempts have been made and documented to address potential underlying factors AND a referral to a sleep specialist has not yet been made, **THEN** the patient should be referred to a sleep specialist for further evaluation or there should be documentation about why the referral is not appropriate for the patient.

**STROKE/AFIB**

**IF** a vulnerable male elder has an asymptomatic carotid stenosis greater than 60%, **THEN** the medical record should document the risks and benefits of carotid procedures unless there is documentation in the medical record that the patient would not want or would not be eligible for a carotid procedure or there is documentation in the medical record that a carotid endarterectomy cannot be performed with less than a 3% 30-day morbidity and mortality rate.

**IF** a vulnerable elder has sustained an ischemic stroke or a transient ischemic attack, **THEN** HMG-CoA reductase inhibitors (statins) should be offered, unless documented contraindications are present.

**IF** a vulnerable elder has been diagnosed with a transient ischemic attack or stroke, **THEN** the combination of a diuretic and an angiotensin converting enzyme (ACE) inhibitor should be
offered within 3 months after stroke or TIA diagnosis or entering a new practice unless there are documented contraindications in the medical record.

**IF** an ambulatory vulnerable elder has had a TIA or stroke **THEN** assessment of physical activity level should be documented annually.

**IF** a hospitalized vulnerable elder with a new stroke is immobile, **THEN** deep venous thrombosis prophylaxis (pharmacologic or mechanical) should be initiated by day 2 of admission.

**IF** a vulnerable elder presents with a new stroke **THEN** the medical record should document the presence or absence of language deficits while the patient is still hospitalized.

**IF** a vulnerable elder has been diagnosed with a transient ischemic attack or stroke, **THEN** the blood pressure should be lowered to the goal of \( \leq 120/80 \) mm Hg within 4 months after stroke or TIA diagnosis or entering a new practice unless there are documented contraindications in the medical record.

**IF** a vulnerable elder is hospitalized for a presumed (documented in the medical record as “new,” “rule out (r/o),” likely,” “possible”) new stroke or transient ischemic attack, **THEN** a computed tomography (CT) or magnetic resonance imaging (MRI) of the head should be performed.

**IF** a vulnerable elder is hospitalized with a new acute stroke or transient ischemic attack, **THEN** medications that precipitously drop blood pressure such as sublingual nifedipine should be avoided.
**UNDERNUTRITION**

**ALL** vulnerable elders should be recommended to take 1-2 multivitamins daily.

**IF** a vulnerable elder is hospitalized, **THEN** serum biochemical testing (albumin, pre-albumin or cholesterol) of nutritional status should be documented during hospitalization.

**IF** a vulnerable elder is admitted to a geriatrics inpatient unit, **THEN** she/he should be screened for malnutrition, dysphagia, and dehydration, and, if the patient is found to be malnourished or at risk of malnutrition, an interdisciplinary intervention should be implemented.

**IF** a vulnerable elder has a stroke and fails a swallowing screen for dysphagia, **THEN** the patient should not receive percutaneous endoscopic gastrostomy (PEG) feeding.

**IF** a well-nourished (noted to be well nourished or BMI >22) vulnerable elder has a recent (within 7 days) stroke and is able to swallow (passes a swallowing screen for dysphagia), **THEN** the patient should not receive oral supplements.

**IF** a vulnerable elder sustains a hip fracture, **THEN** the patient should receive oral multinutrient supplements.

**URINARY INCONTINENCE**

**IF** a vulnerable elder has UI and antimuscarinic medication is newly prescribed, **THEN** a post-void residual measurement should be obtained either by catheterization or by pelvic ultrasound prior to treatment with antimuscarinic drug therapy, and the result of this procedure should be documented in the medical record.

**VISION**
ACKNOWLEDGMENT

Financial Disclosure(s):

Neil S. Wenger, MD, MPH –

--Grant support: none
--Speaker's forum or consultantships: none
--Patents or financial holdings in health-related companies: none.

Author Contributions: Dr. Wenger was involved in the study concept and design, acquisition of expert panel data, analysis and interpretation of these data, and preparation of the manuscript.

Sponsor’s Role: The ACOVE project was supported by a contract from Pfizer Inc to RAND. The funding source had no role in the design, analysis, or interpretation of the study or in the preparation of the manuscript for publication.