

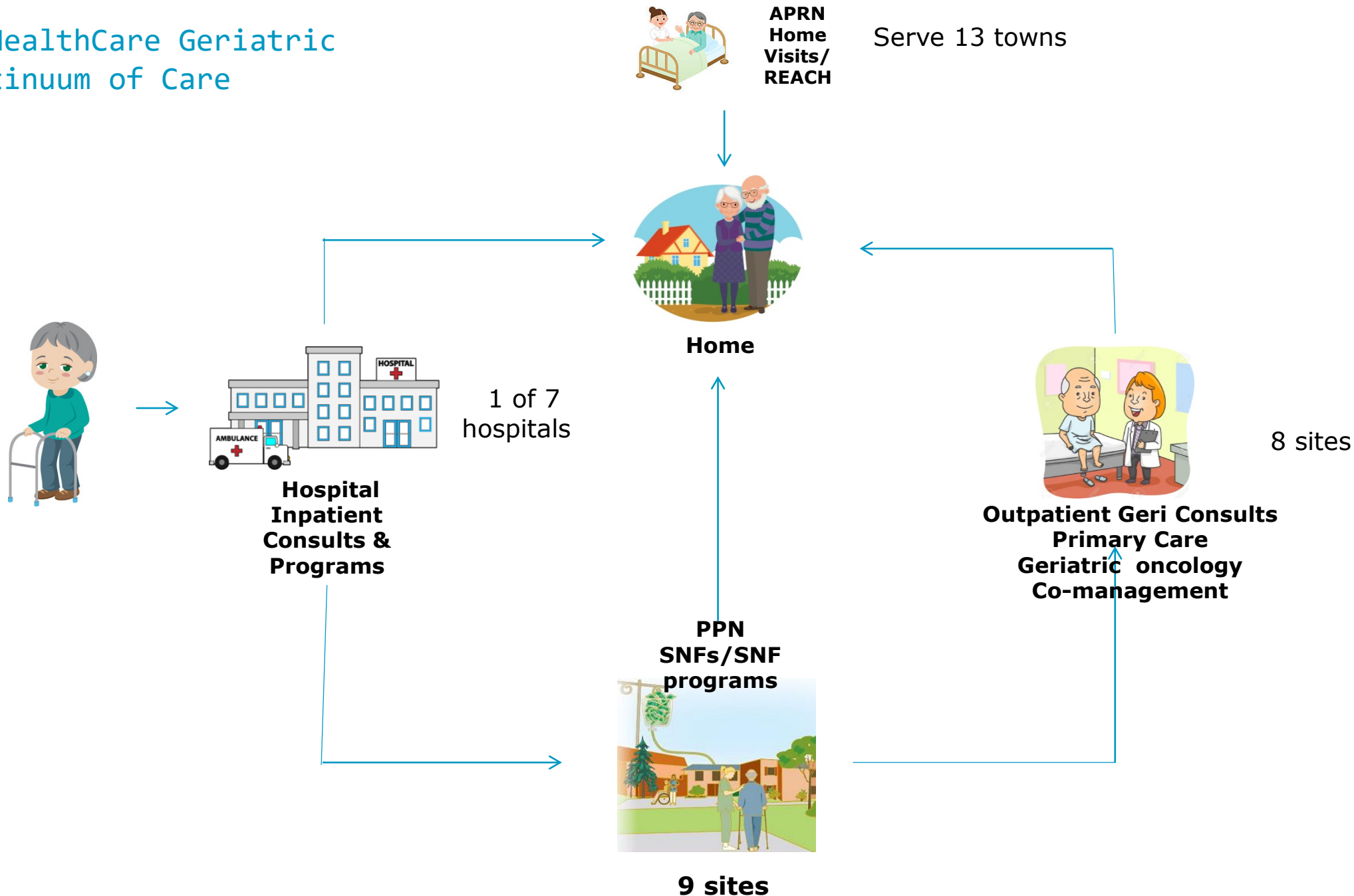
Hartford HealthCare

Senior Services



Christine Waszynski DNP, APRN, GNP-BC, FAAN
Hartford Hospital February 6, 2020

Hartford HealthCare Geriatric Continuum of Care



Integration of AFHS into Hartford HealthCare

HHC Mission: To improve the health and healing of the people and communities we serve

Core Values

- Caring-individualized care; dignity
- Safety –promoting safe mobilization
- Excellence-evidence based practice
- Integrity-trust

Goal: To provide an integrated, seamless, comprehensive care system linking seniors and their families to the services required and requested to maintain and restore health in alignment with expressed patient goals/wishes.

4 M's

- What Matters
- Medications
- Mobility
- Mentation

Hartford Hospital Hartford CT



Inpatient Geriatric Team Players

2 geriatricians
1 geriatric nurse practitioner
2 masters prepared nurses with geriatric certification

GRN Champs
GRNs
GPCAs

Keeping In Touch
Activity Cart
Meal Mates
Mobility
Safety
VOLUNTEERS



Geriatric Education

Nursing Staff

Nurses

- General Nursing Orientation
- Nurse Residency
- Annual Competency
- Geriatric Resource Nurse Program
- GRN Champ Program
- Fellowships/rotation

Nursing Assistants

- General orientation
- Annual Competency
- Geriatric PCA

Other Staff

Providers

- New hire orientation
- Grand rounds
- Geriatric consults
- Geriatric rotation

Rehab

- Inservices
- Mobility volunteer rotations

All hospital staff

- Annual competency

ADAPT- Making Delirium Awareness a Priority

- Began in 2012
- Supported by hospital administration
- Inter-professional Team (representation across departments and disciplines n=42)
- Plan for structure (delirium care pathway)
 - Build supports in EHR to guide documentation and gather data
 - Education (classroom/CESI/bedside)
 - Adjunct Support (volunteer programs; therapeutic activities)
 - Quality / research/ feedback

ADAPT

Actions to enhance Delirium Assessment Prevention and Treatment

- **Screening** all patients (improve recognition)
- **Preventative** measures for high risk patients (40% cases are preventable)
- **Quick response** by health care team to a positive delirium screen (cause; safety; preservation of function) decreases severity and duration of delirium
- **Evidence based interventions** to improve outcomes

Application of Universal Evidence-Based Best Practice Strategies

- Information in Patient Handbook –patient and family to report S/S of delirium promptly. Family encouraged to participate in care
- Delirium assessment integrated into rounds and handoffs
- Early mobilization/noise reduction/ sleep enhancement efforts
- Personalized care “Hartford HealthCare Cares About Me” poster

Application of Universal Evidence-Based Best Practice Strategies

- Creation of a sensory modulation room for patients and families (Therapeutic HUB)
- Volunteer programs that focus efforts towards patient experiencing or at high risk for delirium
 - Keeping in Touch Volunteer Visiting Program; Meal Mates; Activity Cart; Safety Volunteers; Mobility Volunteers
- Activated EHR alerts on medications that may cause delirium
- Standardized provider order sets
- Provide data driven feedback to change practice

1 Deter

- No harmful drugs*
- Avoid abrupt discontinuation* (Drugs, ETOH, nicotine)
- Avoid/limit Devices (catheters, lines, leads)

2 Detection

- Review CAM/CAM-ICU & RASS/mRASS Scores
- Daily cognitive assessment
- Determine baseline mental status

3 Diagnosis / Do

- Physical exam
- Med review
- Determine potential causes*
- Differential diagnosis
- Document acute encephalopathy
- Activate Delirium order set in EPIC
- Diagnostics
- Drugs for hyperactive pts (RASS/mRASS ≥ +2)
 - Haldol IV or Seroquel PO per delirium order set
 - If contraindicated consult pharmacist
- Scheduled acetaminophen

5 Daily Visit

- Cognitive assessment
- F/U Diagnostics
- Review meds-adjust prn

7 Discharge

- Document course and cause of Delirium if known
- Degree of resolution
- Discontinue unnecessary psychotropics
- Follow up for Delirium if not resolved
- Document on W10/After Visit Summary

Risk Factors

- Age > 65
- **D**ementia
- Substance **D**ependency
- Hx **D**elirium
- ICU/**S**D
- Impaired vision/hearing

- ED screen of pts age >65
- Attention screen
- SQID?

CAM or CAM-ICU Positive

4 Discuss

- Provider + Nursing
 - +/- Pharmacist
- Huddle
- Make Plan

6 Daily Dialogue

- Provider + Nursing
 - +/- Family
- Progression Rounds
- **Is Patient Improving?**

- Age > 65:
 - Geriatric medicine consult
- Age < 65 or major psychiatric Dx:
 - Psychiatric consult
 - Family meeting

1 Deter

- Mobilize to maximum
- Uninterrupted night-time rest (noise, bundle care, eye shields, earplugs)
- Eyeglasses/hearing aids
- Whiteboard up to date
- Daily goals of care
- Calendar/clock/familiar items
- Assist with food/fluids
- Comfort
- "HHC Cares About Me" poster
- Family as partners
- Volunteers for social interaction

2 Detection

- CAM every 8 hours and prn
- Determine baseline mental status
- Notify provider immediately of first positive CAM or CAM-ICU and activate "Acute Confusion" CPG

3 Do

- Fall prevention
- Discontinue/ Disguise devices
- Family teaching - brochure
- Provide Distractors (music, flashball, animal)
- T-A-D-A (Tolerate, Anticipate, Don't Agitate)¹
- Reassurance
- Individualize plan of care in EPIC
- Nurse - Nurse handoff
- Nurse - PCA handoff

5 Daily Care

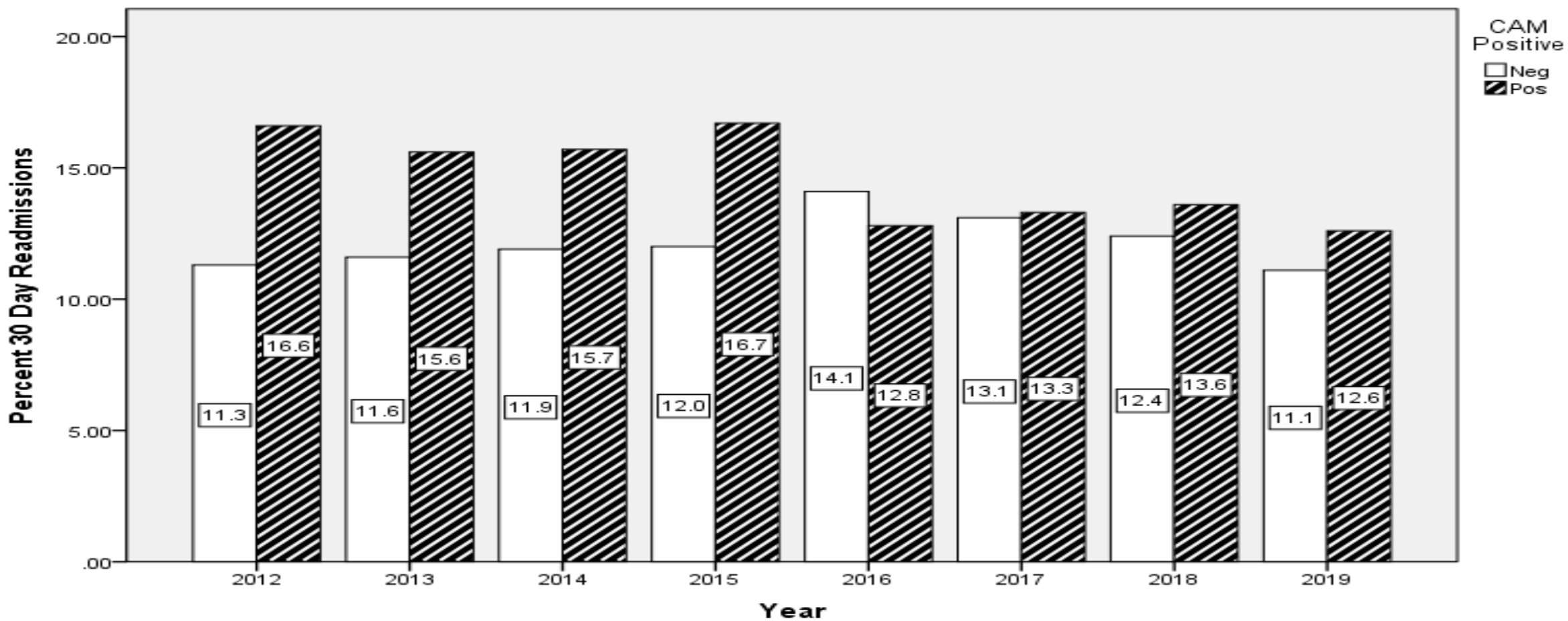
- CAM or CAM-ICU every 8 hours + prn
- Comfort/calm/consistent
- Toileting
- Feed/hydrate
- Mobilize to maximum
- Maintain normal sleep/wake cycle
- Touch/backrub
- Assess response to medications
- Family & volunteer involvement
- Alternative therapies (Reiki, Pet, Art, Music)
- Document progress

7 Discharge

- Document successful strategies
- Discuss ongoing needs
- Discharge with one time use Distractors (doll, animal)
- Discuss follow-up with family
- Document individualized care needs on W10/After Visit Summary

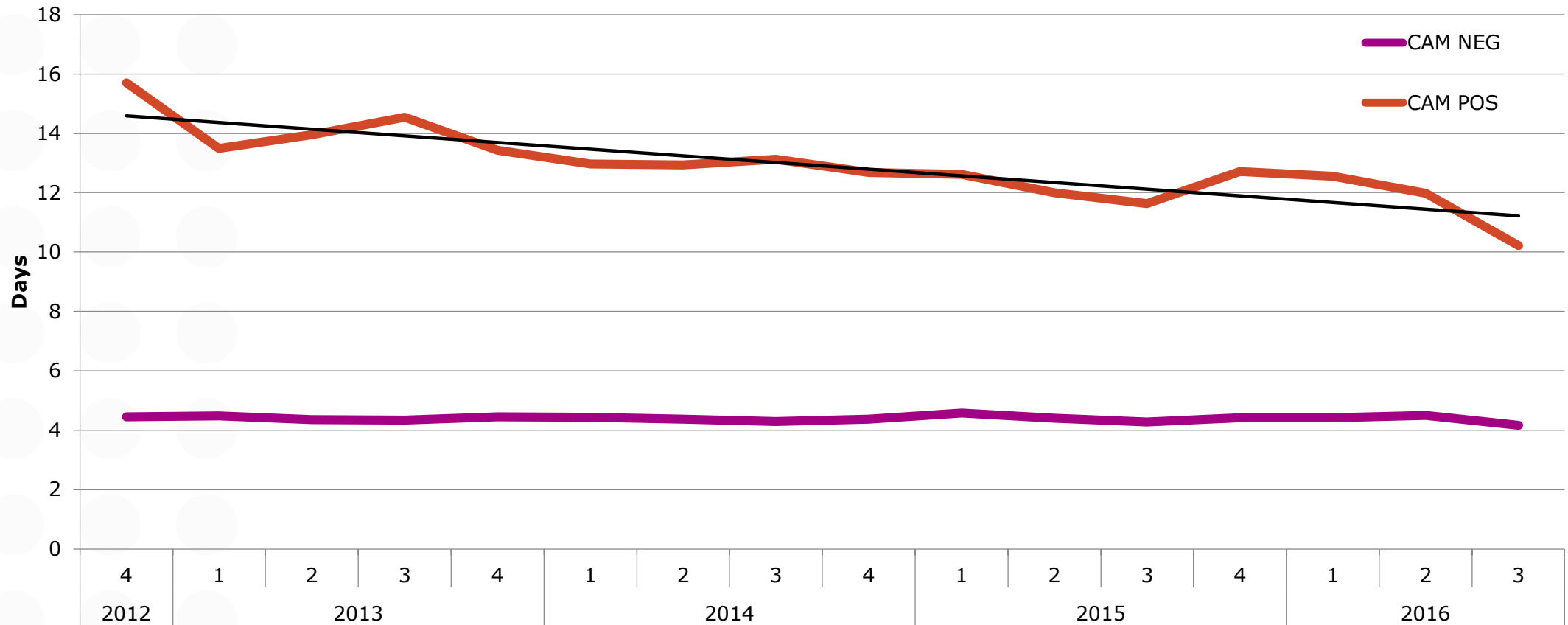
*see back of brochure for more information ¹ Flaherty, 2011

30 Day All Cause Readmission Rates Over Time



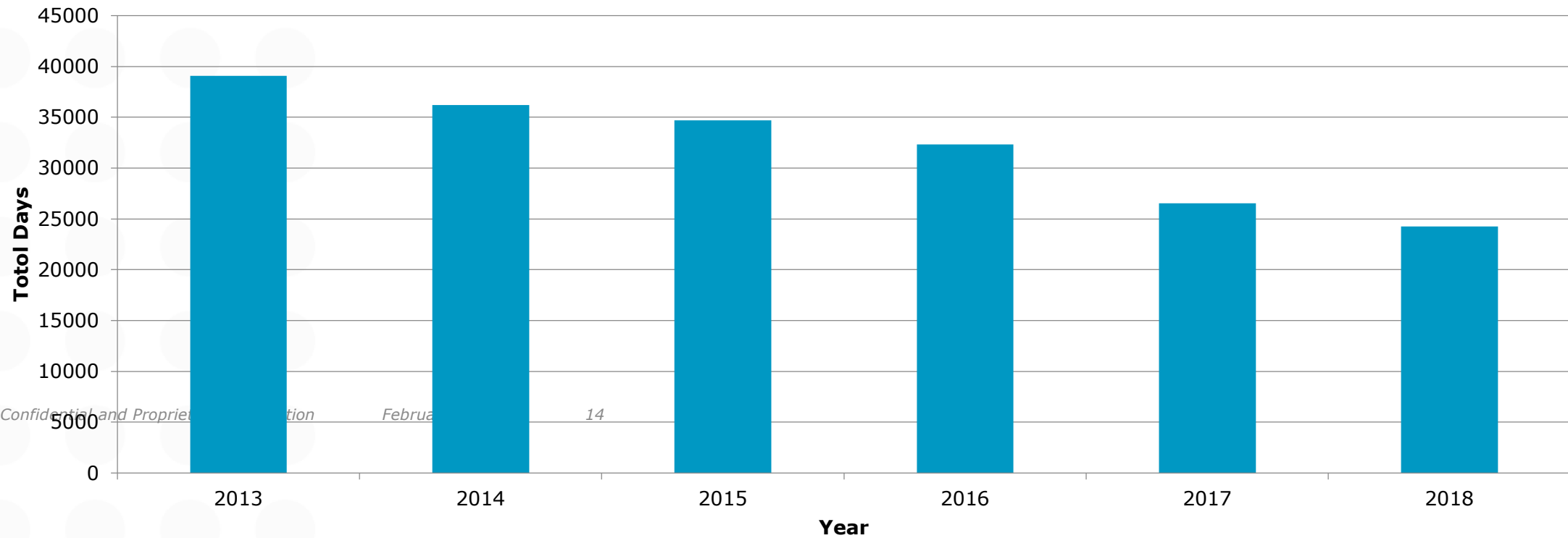
Outcome: Decreased Length of Stay In Patients with Delirium

ADAPT DATA



Delirium Attributable Days

ADAPT Data



Confidential and Proprietary Information February 14



ROI Calculator Applied to ADAPT



Scenario Name: No PAC

Find Levels (Target ROI)

1. Start		Acute Care for Elderly	
2. Population & 4M Period			
Number of annual admissions		31,000	<input type="text"/>
Amortization period (Years)		5	<input type="text"/>
3. 4M Costs			
		Per Year	
Launch - one time only expenses	\$10,000	\$2,000	<input type="text"/>
Fixed expenses		\$0	<input type="text"/>
Variable cost per admission	\$20	\$620,000	<input type="text"/>
Total annual cost of program		#####	
5. Case cost from coding & payment for HAC			
Revenue per case detected (code modification)		\$3,050	<input type="text"/>
Detection & coding effectiveness (% cases)		50.0%	<input type="text"/>
Case cost revenue offset (by detection %)		\$1,525	

Results	Total Cost Avoided	#####
	4M Costs	\$622,000
	Net Benefit	#####
	ROI	934.1%
	Years Given Back	12.23

Levels	
Target ROI	300%
Delirium Effectiveness	20.4%
Delirium Incidence (%)	10.1%
Total Program Cost	\$686,249

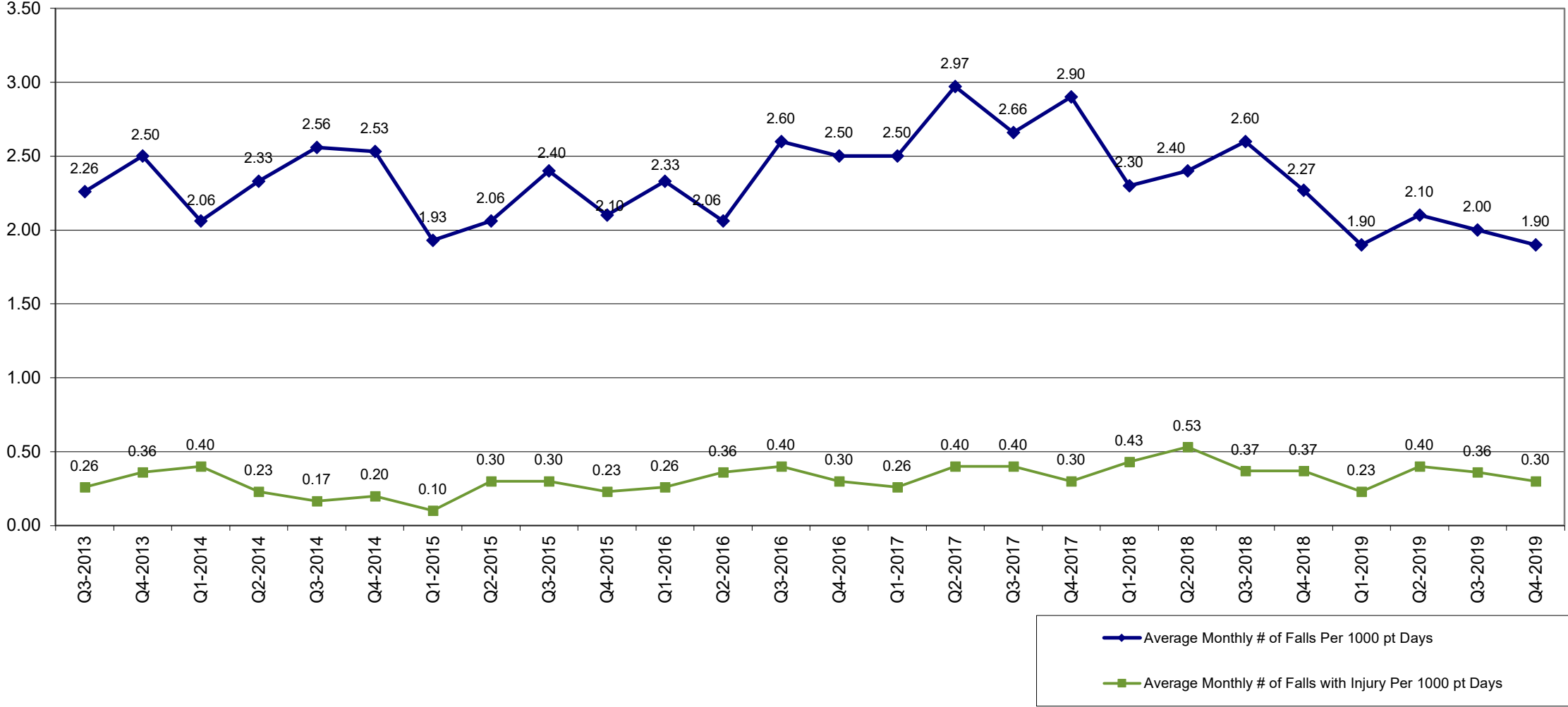
Simulation Results (ROI)	
Max	388.5%
Min	578.2%
Average	491.5%
% Below Target	0.0%

4.	Estimates/Values	Delirium	HAPU'S	Other Condition
Key Metrics	Incidence (%)	12.0% <input type="text"/>	0.0% <input type="text"/>	0.0% <input type="text"/>
	Total cases	3720	0	0
	4M program effectiveness	15.0% <input type="text"/>	0.0% <input type="text"/>	0.0% <input type="text"/>
	Cases avoided	558	0	0

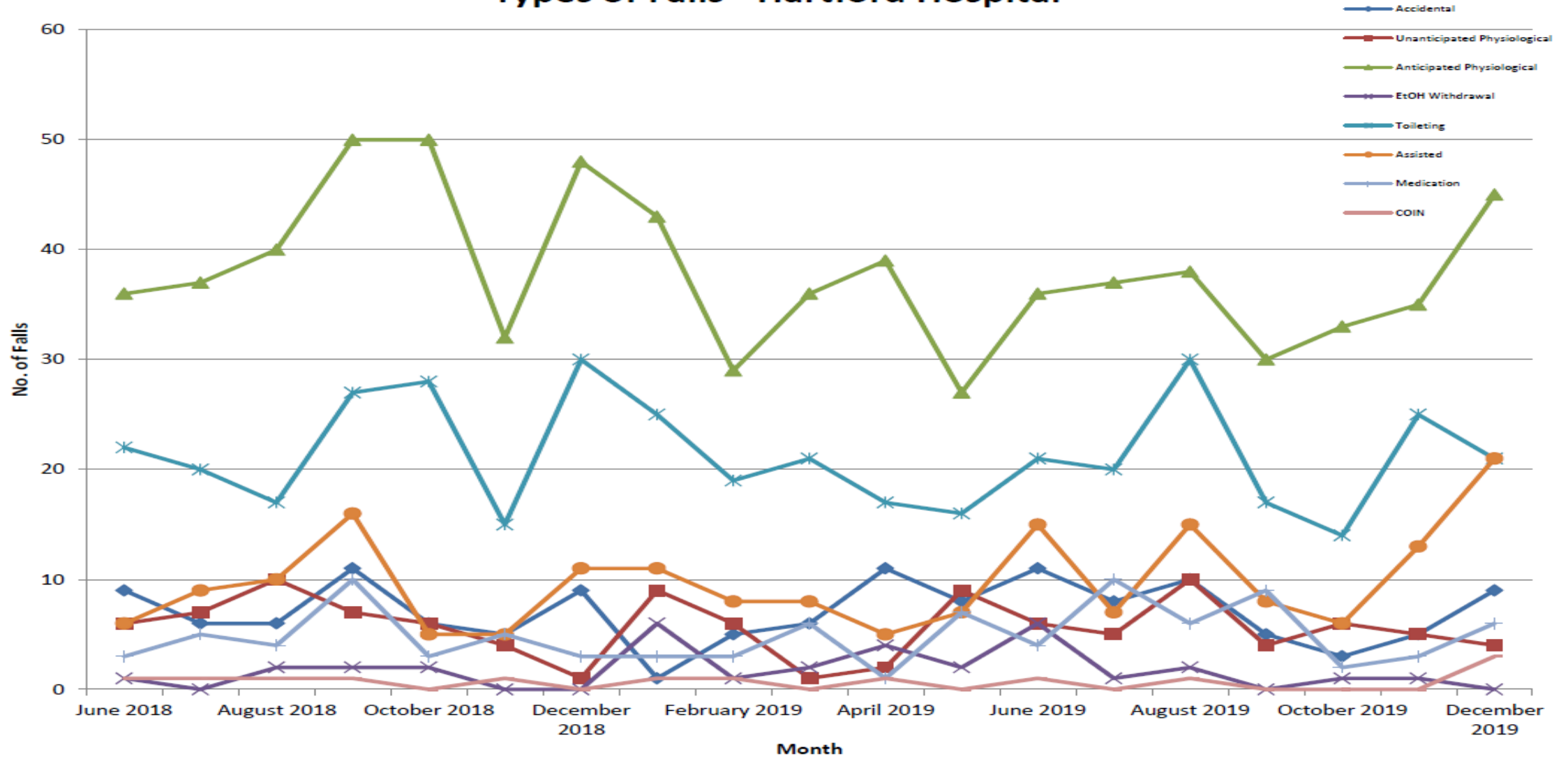
	Type of stay	Length of stay	Cost per day	Length of stay	Cost per day	Length of stay	Cost per day
HA Condition	Normal	5.0 <input type="text"/>	\$2,000 <input type="text"/>	5.0 <input type="text"/>	\$2,000 <input type="text"/>	5.0 <input type="text"/>	\$2,000 <input type="text"/>
	Extended due to condition	5.2 <input type="text"/>	\$260 <input type="text"/>	0.0 <input type="text"/>	\$0 <input type="text"/>	0.0 <input type="text"/>	\$0 <input type="text"/>
	ded hospital case cost		\$13,052		\$0		\$0

- hospital and PAC combined	\$13,052	\$0	\$0
Cost adjusted for revenue offset	\$11,527	\$0	\$0
Costs avoided	\$6,432,066.00	\$0	\$0

Average Quarterly Falls



Types of Falls - Hartford Hospital








Safe Mobilization



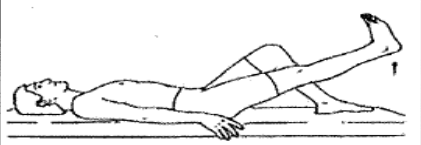
- Mobility volunteers since 2011 (PT or other health profession students)
- 17,500 mobility episodes
- Implemented Gait belt and walker for all mobilization of high fall risk patients



Bed Exercises- increase patient engagement in care

Supine Therapeutic Exercises

<p>ANKLE PUMPS Position: Laying on your back Action: Point foot up towards your nose then point down as far as you can, keep leg straight</p> <p>10-15x times 2-3x a day</p>	
<p>QUAD SETS Position: laying on your back with your leg straight Action: Squeeze thigh pushing knee down toward bed</p> <p>10-15x times 2-3x a day</p>	
<p>GLUT SETS Position: Laying on your back with your leg straight Action: squeeze buttocks together</p> <p>10-15x times 2-3x a day</p>	
<p>HEEL SLIDES Position: laying on your back with legs straight Action: slowly slide heel up towards hips with knee then return to starting position</p> <p>10-15x times 2-3x a day</p>	
<p>SHORT ARCH QUADS (TERMINAL KNEE EXTENSION) Position: laying on your back with towel roll under knee or LE/knees elevated position on bed Action: lift heel off bed straightening lower leg</p> <p>10-15x times 2-3x a day</p>	

<p>LEG ABDUCTION/ADDUCTION Position: laying on your back with leg straight Action: keep knee straight and toes toward ceiling, slide leg out as far as possible then return to starting position</p> <p>10-15x times 2-3x a day</p>	
<p>ADDUCTOR SQUEEZE Position: laying on your back, knees bent Action: place pillow between legs, squeeze legs together then relax</p> <p>10-15x times 2-3x a day</p>	
<p>STRAIGHT LEG RAISE Position: lay on your back, keep leg straight Action: lift leg off bed then back down</p> <p>10-15x times 2-3x a day</p>	

- **Do not continue** any exercise that cause pain or increase in pain. If so contact your RN or PT.

Dionne's Egress Test™

Maneuvers to test patient's ability to move away from the bed safely

Test 1



- 3 reps from sit-to-stand
 1. From sitting position, feet flat on floor, one small (1-2 inch) lift from the surface of the bed.
 2. 2 repetitions of a full sit-to-stand.
 3. Remain standing after 2nd full sit to stand

Test 2

- Step in place
 1. Three steps in place with each foot. Must clear the floor without buckling of the supporting leg
 2. May use an assistive device
 3. Stay standing after last step



Test 3



- Step forward
 1. From comfortable stance width advance and retreat each foot
 2. May use assistive device
 3. Heel must advance past toes of other stance foot without buckling of stance leg

Test 4

- Step to the Side
 1. Standing with legs in contact with edge of bed, the patient will take 3 side steps to left and right. (If knees buckle, patient is not safe for stepping transfer to chair)





Safer Mobilization



Safety Assessment Fall Evaluation Risk

Reviewed: _____
(Date) (Time) (Pt. initials) (Staff initials)



Recent Fall

Dizziness



WEAK

Weakness

Toileting Urgency



Forgetful



Your Fall Risk Score



4 or more = High Fall Risk



Recent Procedure/Surgery

Medication





Poor Vision

Poor Hearing



Low Blood Pressure

Your Safe Mobility Plan

- Bed/chair alarm
- Gait belt
- Walker
- Assistance by  or  staff members
- Wheelchair follow
- Low bed
- Other _____



Mobility Level

- Walk without Staff Assistance
- Walk with Staff Assistance
- Sit in Chair with Staff Assistance
- Sit at Edge of Bed with Staff Assistance
- Exercises as directed

Your Responsibilities

(for a Score of 4 or More)

- Avoid Sitting on Edge of Bed Alone
- Permit Staff To.....**
 - Use a Gait Belt and Walker for mobilization
 - Stay with You During Toileting
 - Set Exit Alarm

Toileting Plan

Urinal
Bed Pan

Commode
At Bedside



Bathroom

Rehab Recommendations

Date: _____

- Advance patient per Progressive Mobility Protocol
- Do not progress pt. without prior approval from rehab staff

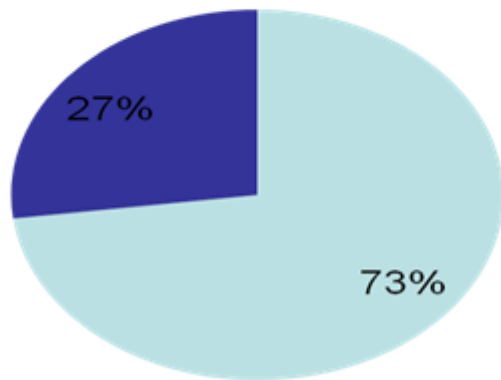
Notes:

Personalized activities for patients with cognitive impairment

- Observations were made on 74 agitated patients over a 6 month period.

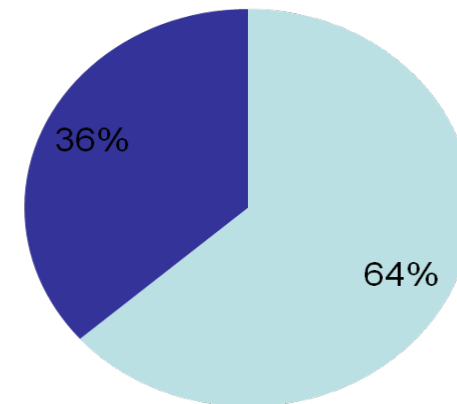
Response During Therapeutic Activity

■ Positive Response ■ No Change



Response One Hour After Compared to Prior

■ Positive Response ■ No Change



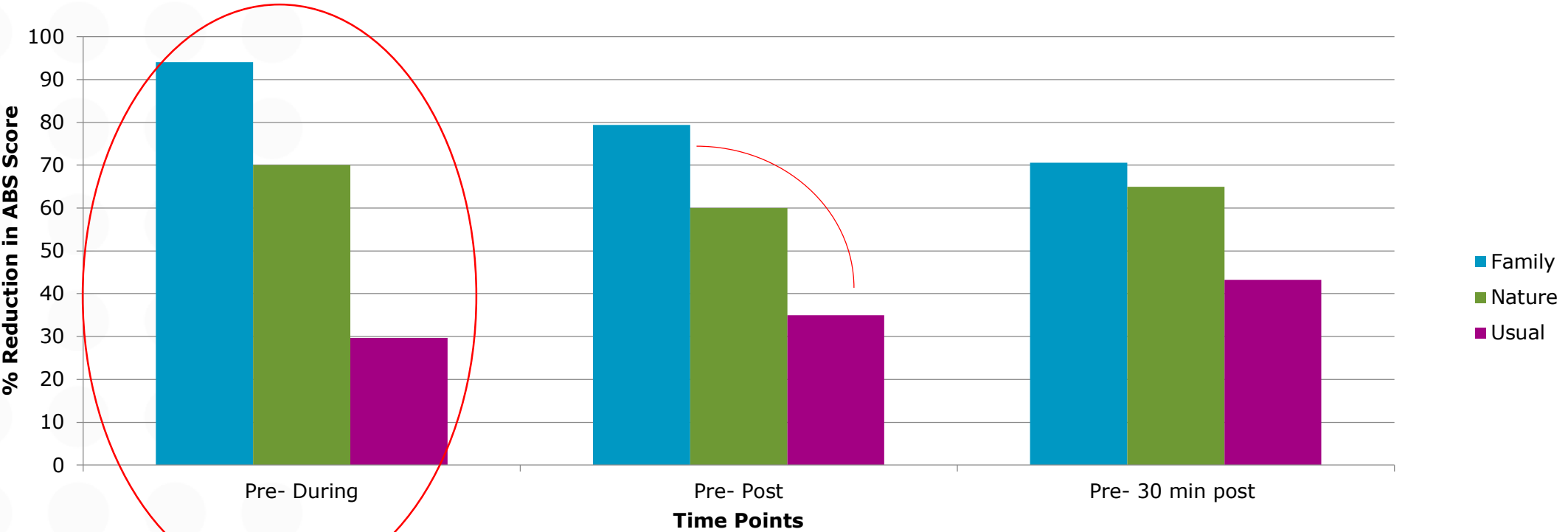
Family Video Messaging

- Non pharmacological intervention to:
 - Provide comfort and connection to agitated patients with altered mental status
 - Engage families in care
 - Provide comfort to families
 - Offer a personalized intervention for staff

Example of Family Video Message



% of Participants Experiencing a Decrease in Agitation



The Therapeutic HUB

Healing

Understanding

Belief in patient as person



The Therapeutic HUB multi-sensory stimulation environment



Patients may feel safer and more “normalized” in a controlled, multisensory environment compared to a clinical, hospital room



Findings to date Jan 2018-2020

Approximately 400 patients worked with a nurse in the HUB

Most have altered mentation (dementia/delirium/both)

- Agitated patients become more calm
- Withdrawn patient become more engaged
- Improved eating
- Improved mobilization
- Improved mood

Families express increased satisfaction
Opportunities for education

Staff implement bedside activities
Items brought to bedside for those who can not visit the HUB

- Qualitative data: “Feels like home”
“ I feel more normal”



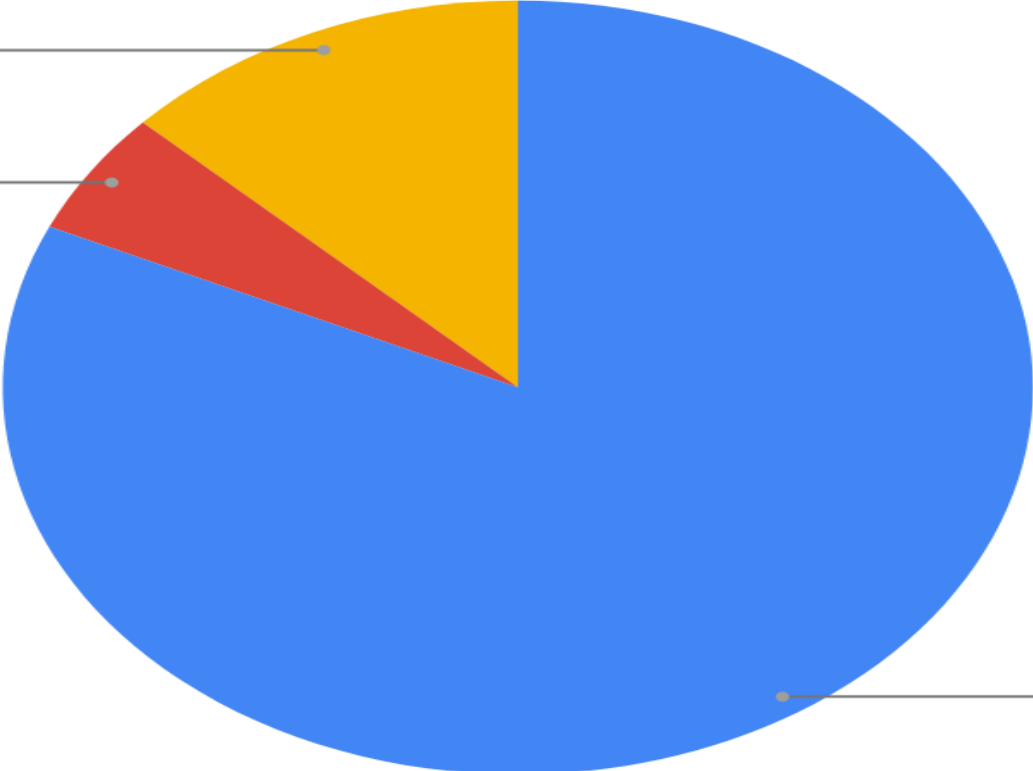
Pilot study suggests the HUB improves cognition and normalizes arousal levels.

Benefits of Therapeutic HUB

Effect on Mood and Behavior

moderate
13.0%

negative
5.2%



positive
81.8%

Voice over powerpoint with video: Therapeutic HUB

- <https://vimeo.com/266874016/f693ff3a99>

Our 4 M Age Friendly Health System Focus

- Focused on 5 inpatient units
 - 2 medical units
 - 1 medical oncology unit
 - 1 transplant medical unit
 - 1 cardiac ICU

What You Can Do

What Matters	Nurse	PCA
Discuss goals of care in rounds	X	
Patient friendly goals on white board	X	X
Ask pt what matters to them today	X	X
Mutuality/individualization in EPIC	X	
HHC Cares About Me poster in room	X	X
Identify pts for Therapeutic HUB	X	X
Identify pts for Keeping in Touch	X	X
Mobility		
Mobilize level 5 ambulatory patients to maximum and document distance	X	X
Give exercise sheet to patients and encourage them to do them	X	X
Mentation		
Screen CAM and RASS every 8 hours	X	
Notify nurse of any changes in patient's behavior		X
Activate Acute Confusion CPG for CAM + pts	X	
Medication		
Identify new high risk meds and discuss with provider/pharmacist	X	
Teach pts not to take OTC "PM" meds	X	

Unit based data collection tool

UNIT _____ DATE _____ PTS AGE _____ DATA COLLECTOR _____

Make the following observations when you assume care of the patient for your shift:

HHC Cares About Me Poster completed Yes No

Patient Friendly Goals On Whiteboard Yes No

Exercise Sheet in the Room Yes No

Is a gait belt being used during mobilization Yes No

Review the patient's EMR for the following:

Goals of Care documented in EPIC Yes No

Individuality/ mutuality section populated in EPIC Yes No

Does the patient have a progressive mobility level charted within the past 24 hours Yes No

Documentation of exercises in EPIC in past 24 hours Yes No

Has the patient walked more than 150 feet in past 24 hours if capable Yes No N/A

CAM done every 8 hours Yes No

RASS done every 8 hours Yes No

Has baseline mental status been done this admission? Yes No

Do the CAM and RASS match the notes or verbal report? Yes No

Is there a specific intervention charted in the care plan if pt is CAM positive ? Yes No N/A

Review the patient's EMR for the following types of medications:

Category of Medication	Present on Admission	Newly Prescribed During this Admission
Antipsychotics		
Benzodiazepines		
Diphenhydramine		
Muscle Relaxants		
Sedative Hypnotics		
Tricyclics		

CollaboRATE Assessment: (ask the patient to answer each of these 3 questions on a scale of 0-9)

Thinking about this hospitalization.....

1. How much effort was made to help you understand your health issues? Score = ____

2. How much effort was made to listen to the things that matter most to you about

your health issues? Score = ____

3. How much effort was made to include what matters most to you in choosing what to do next? ____

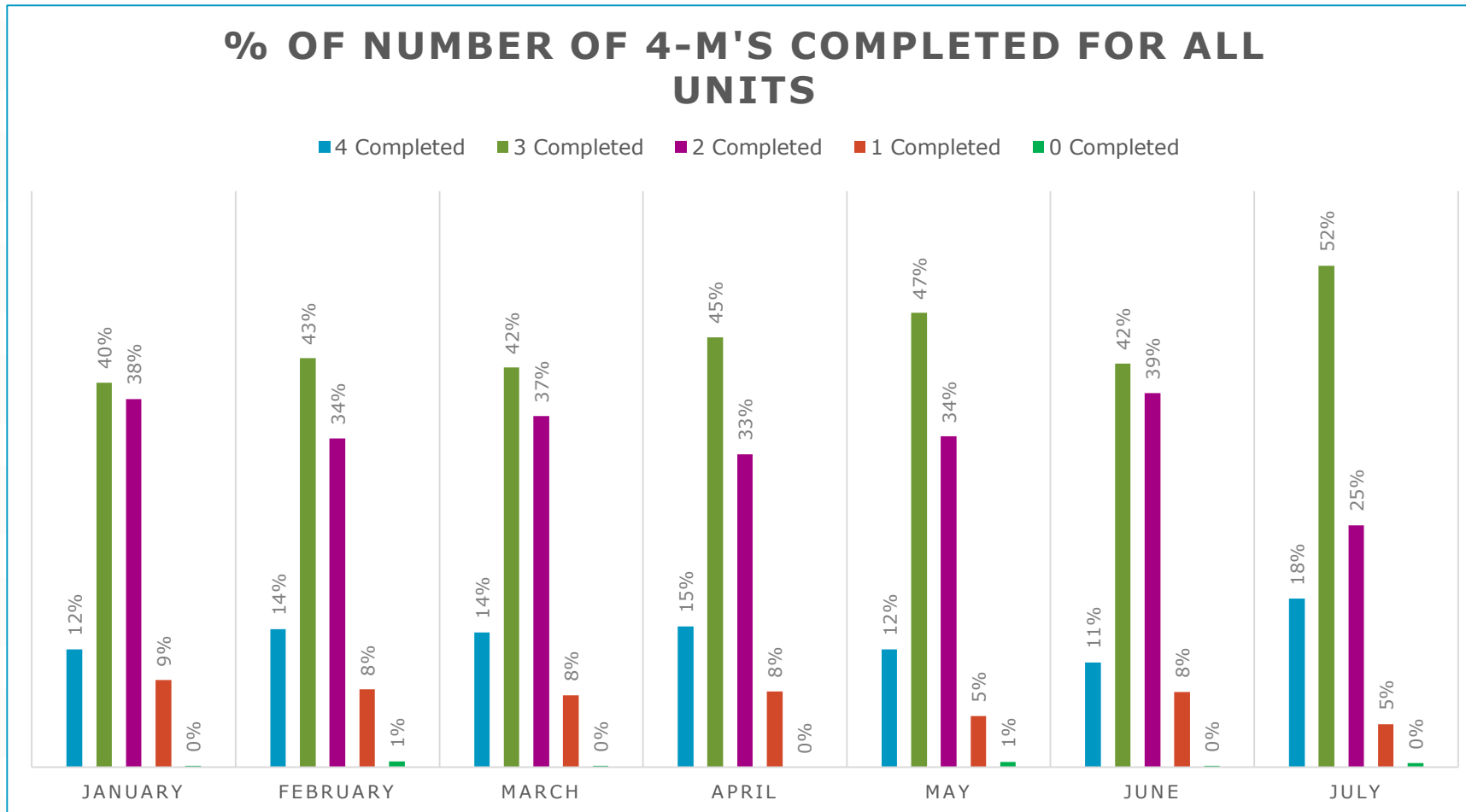
No effort

Every effort

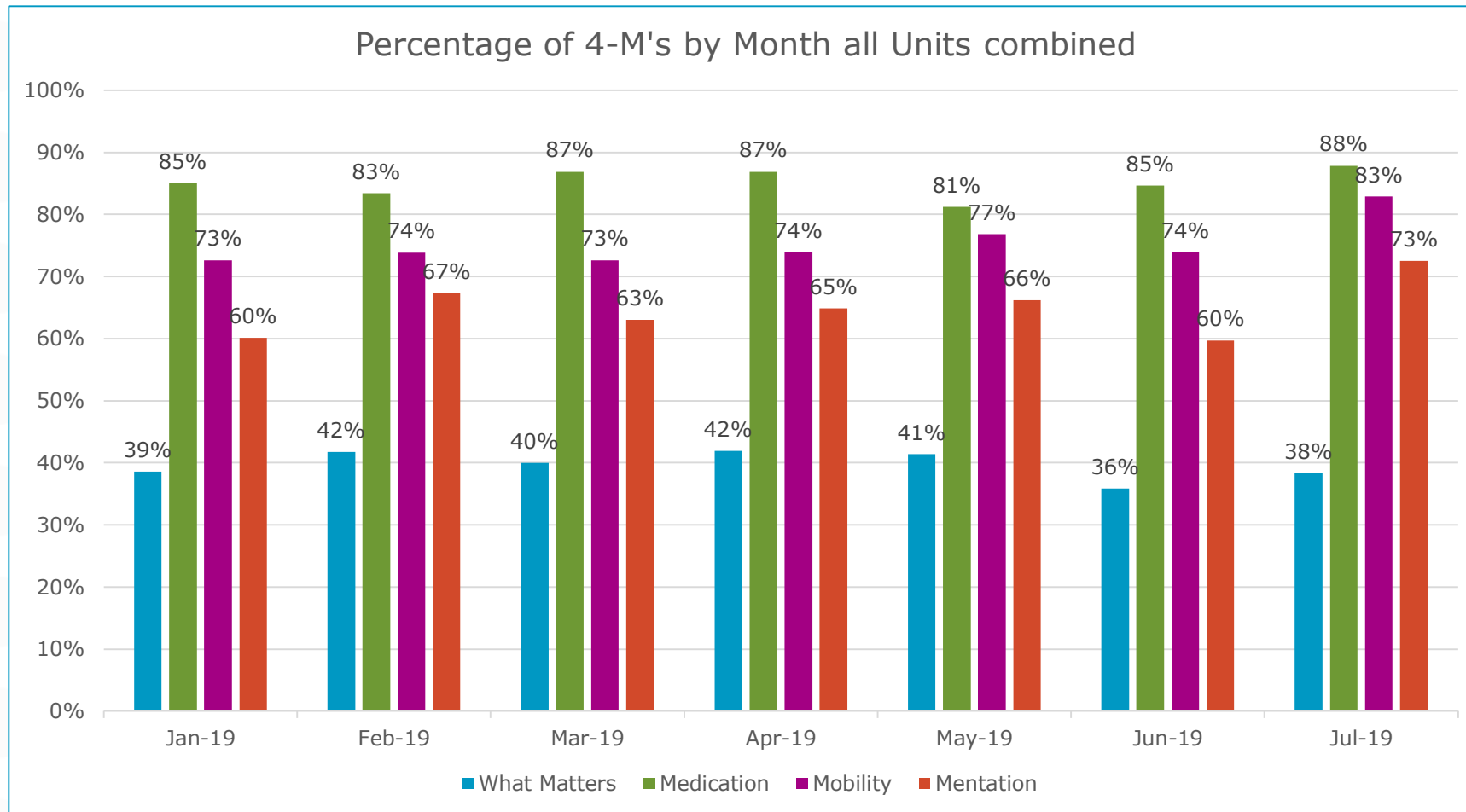
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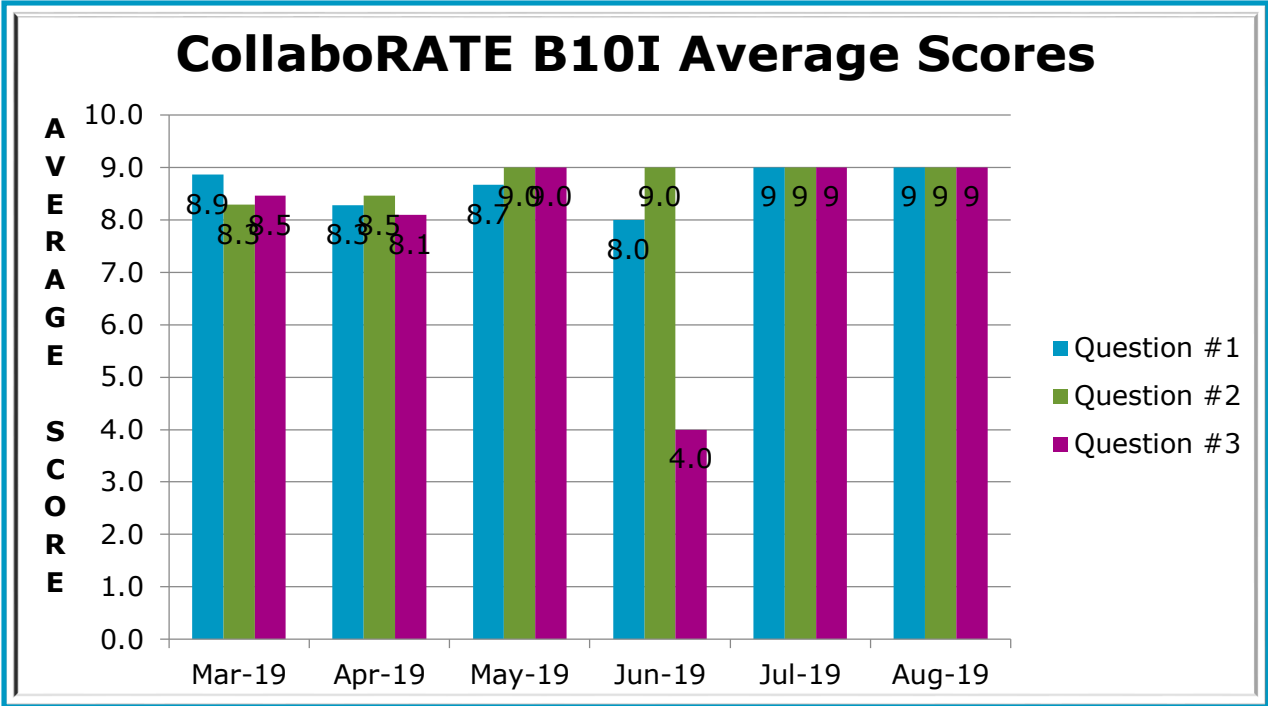
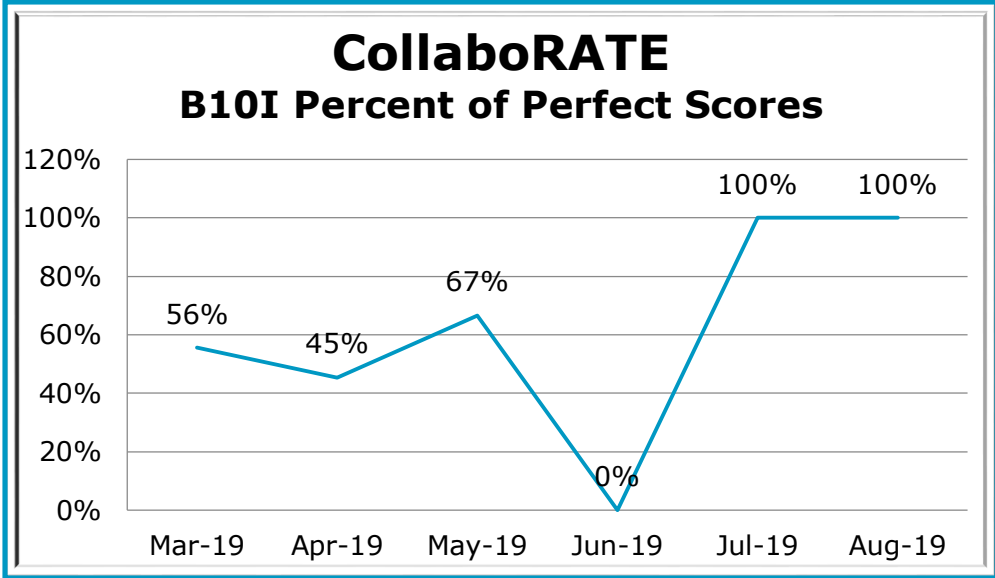
Return this form to: Christine Waszynski Fax: 860-972-3738 or via email *Thank you!!*

How are we doing addressing all 4 M's with all older adults?



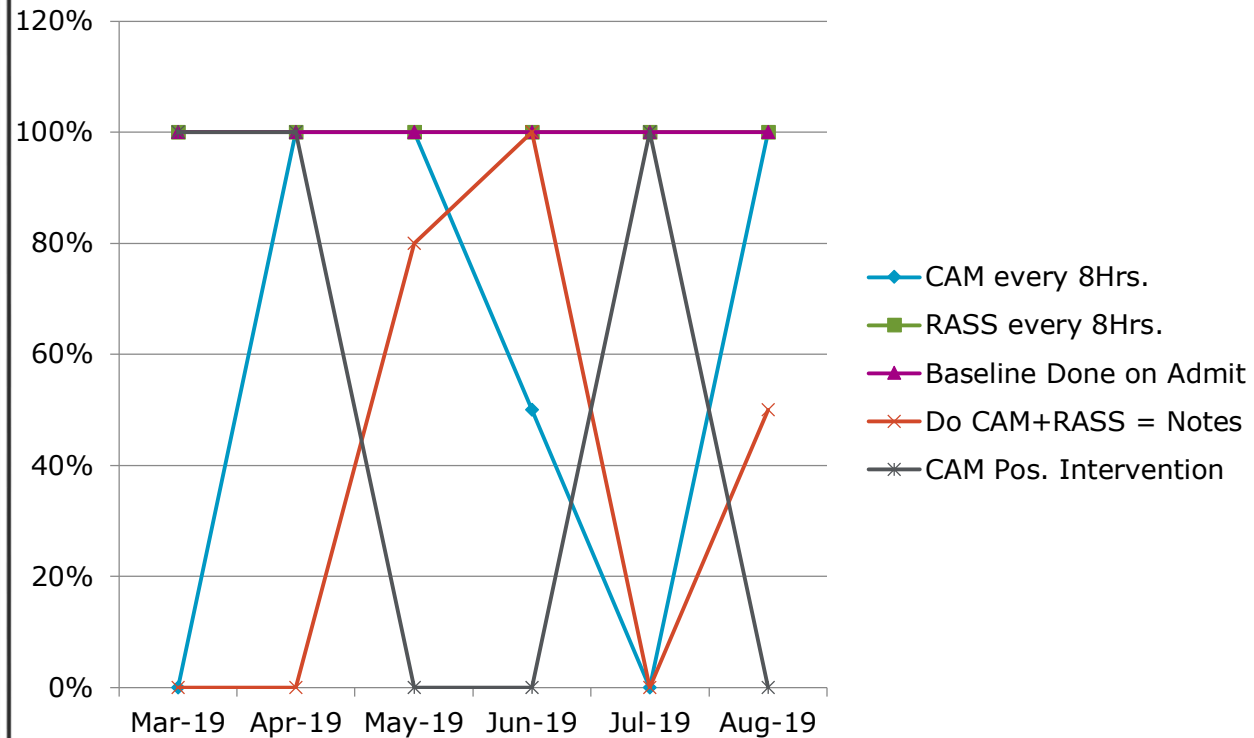
How are we doing with each of the M's with all older adults?

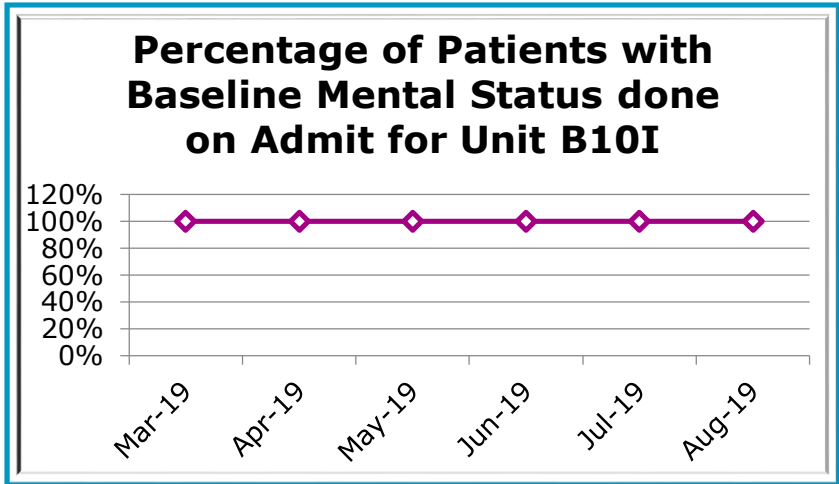
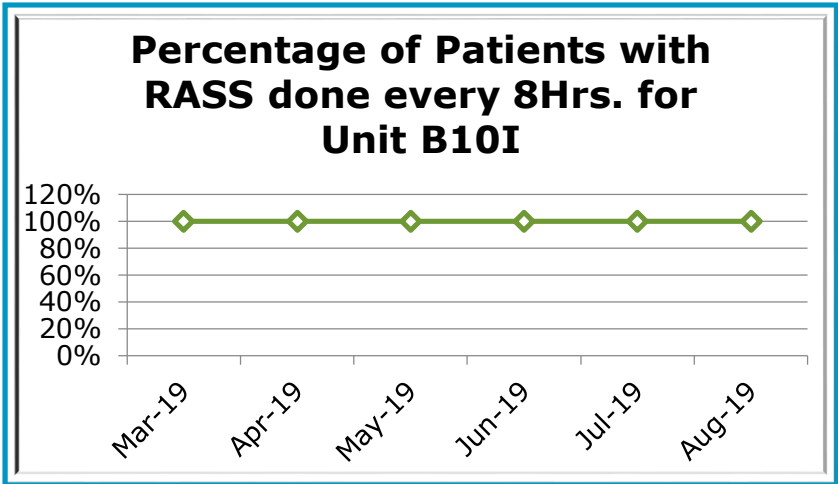
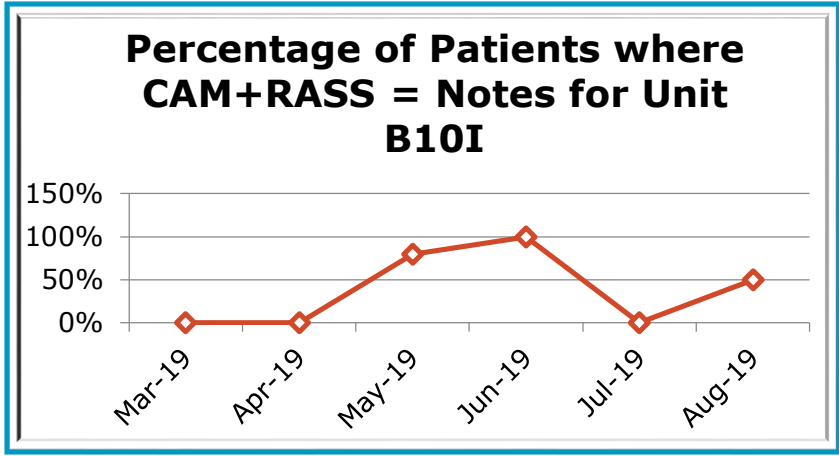
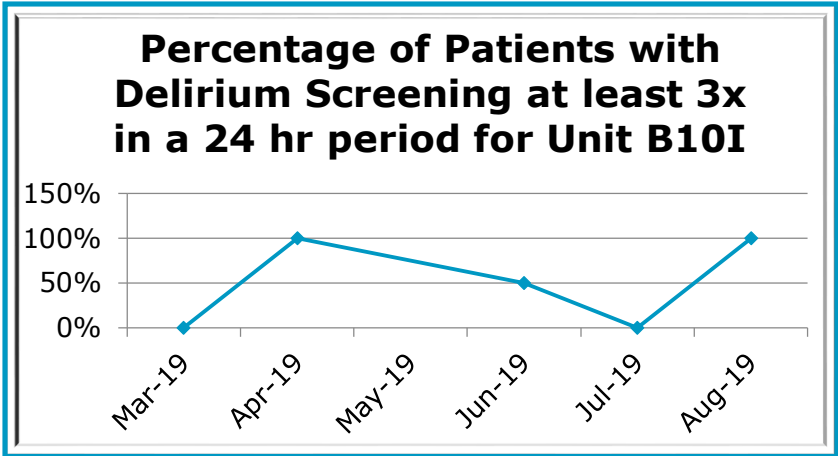


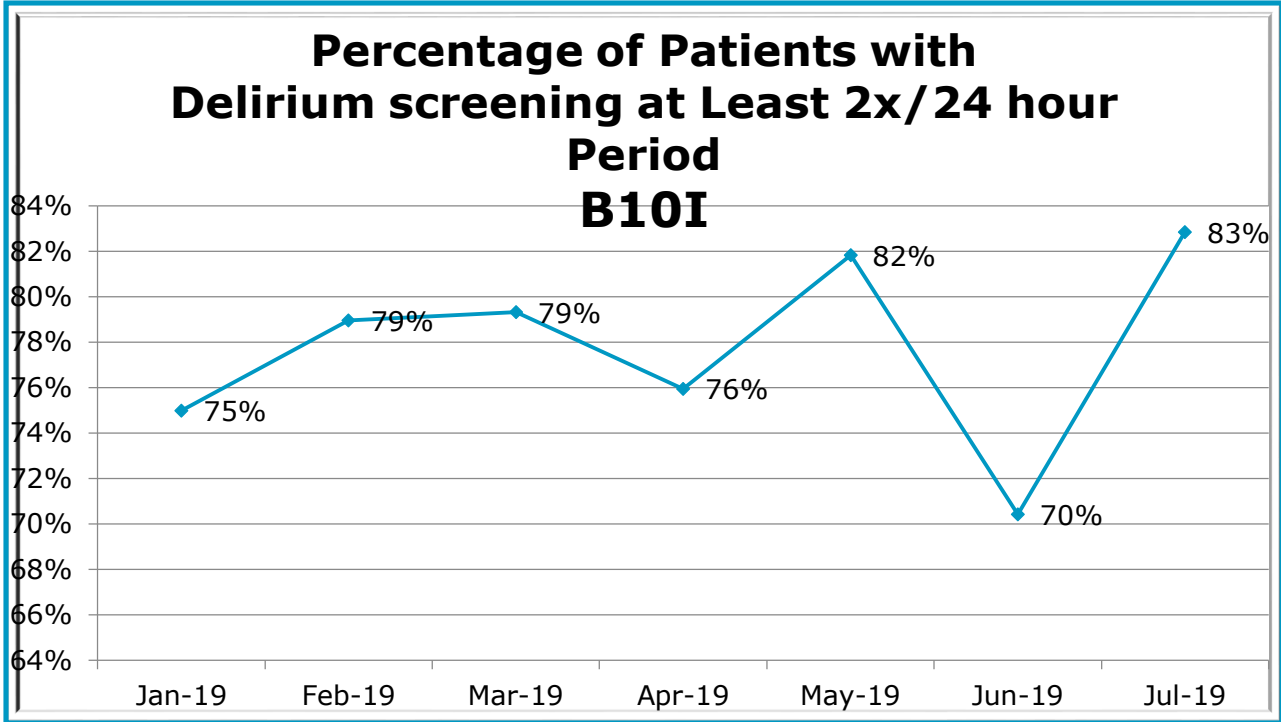
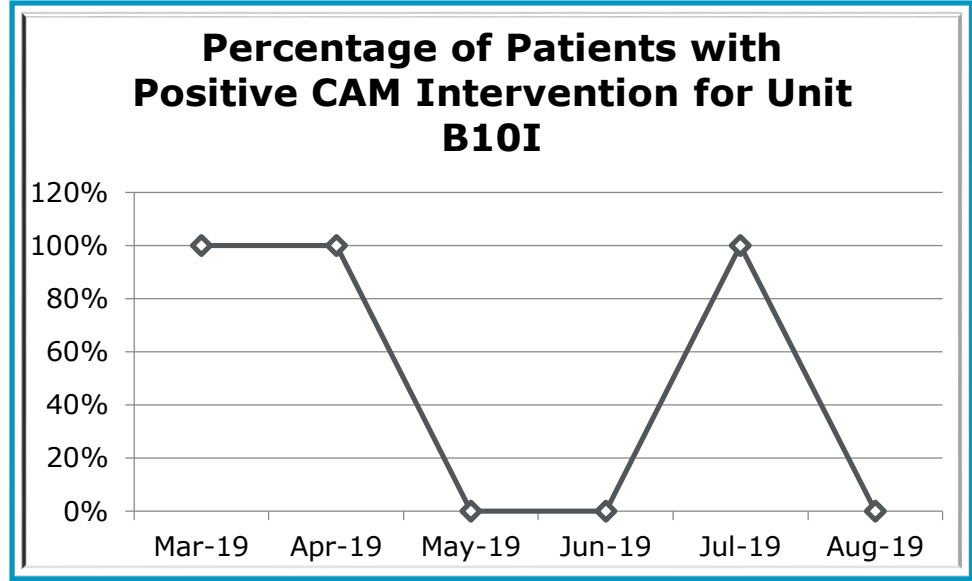


Mentation

Mentation Protocol Completion for Unit B10I

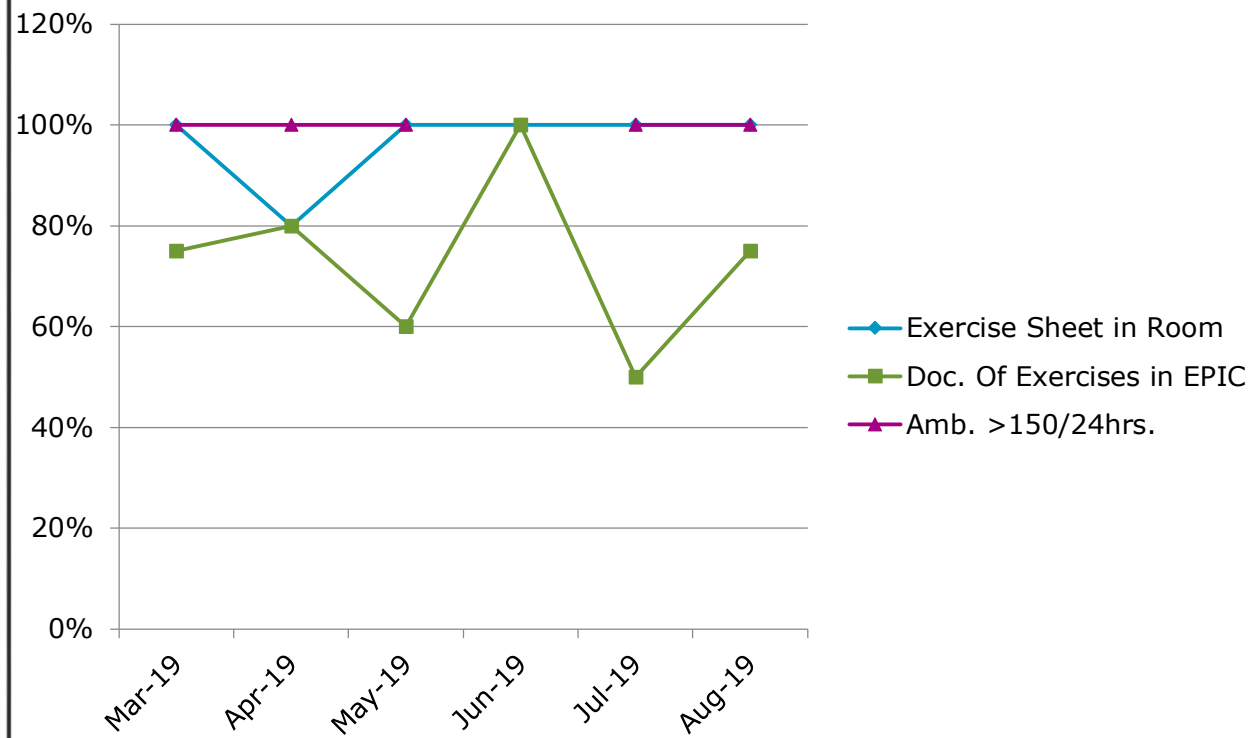


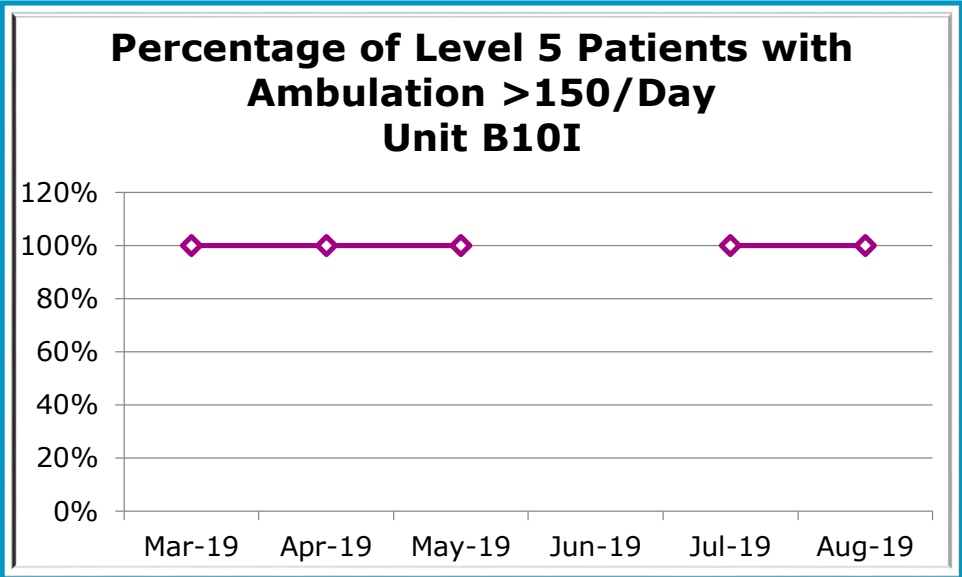
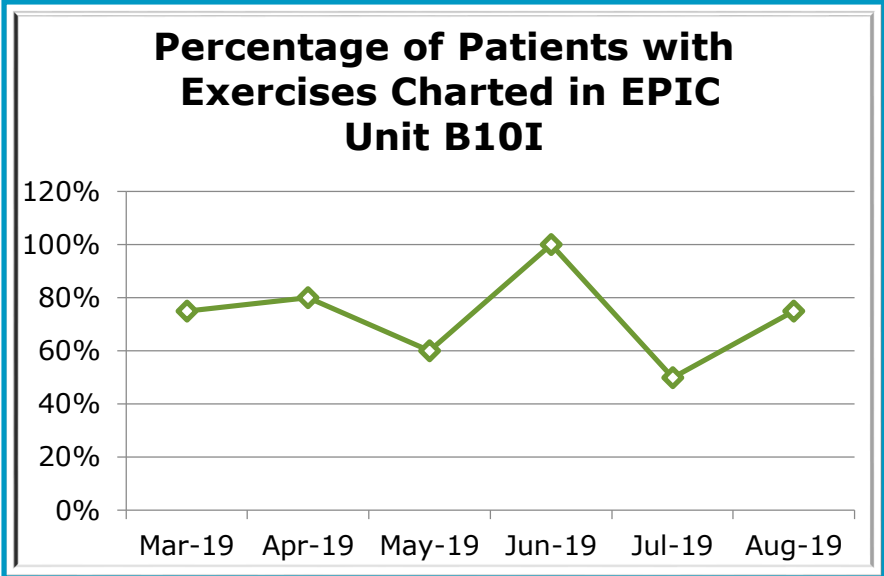
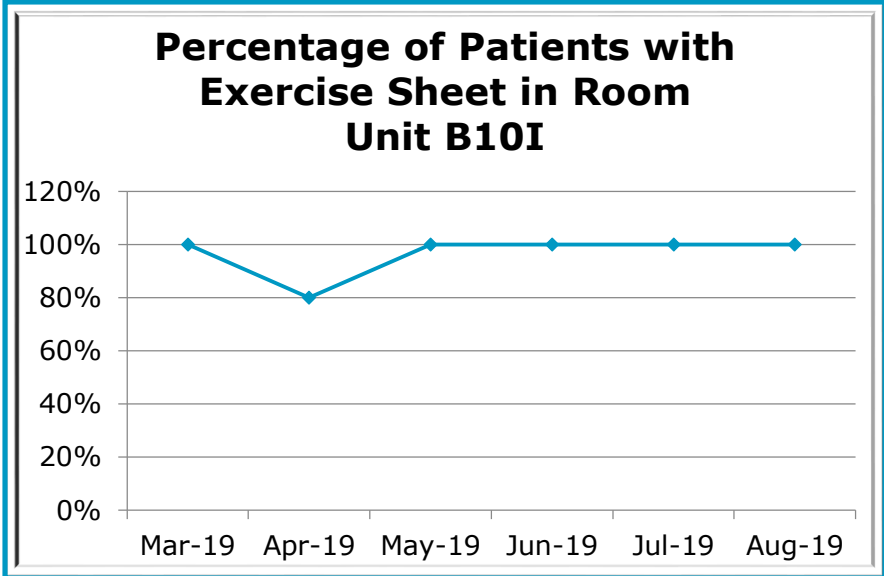




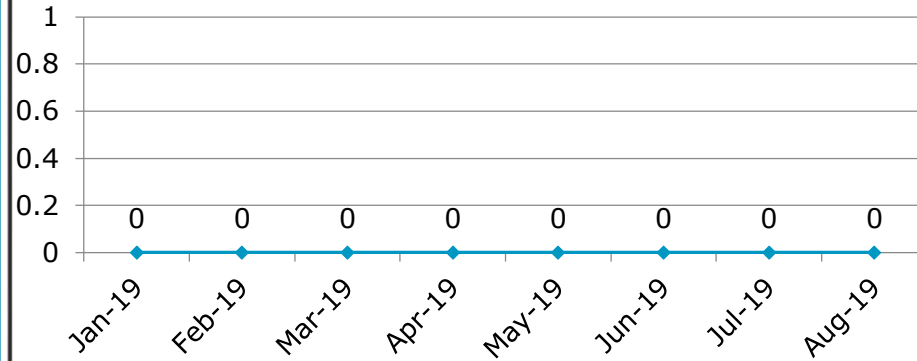
Mobility

Mobility Protocol Completion Unit B10I

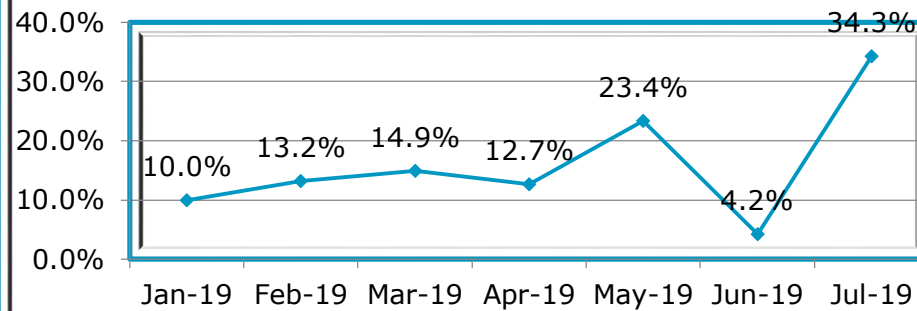




Number of Patients with Assisted Falls Without a Gait Belt B10I

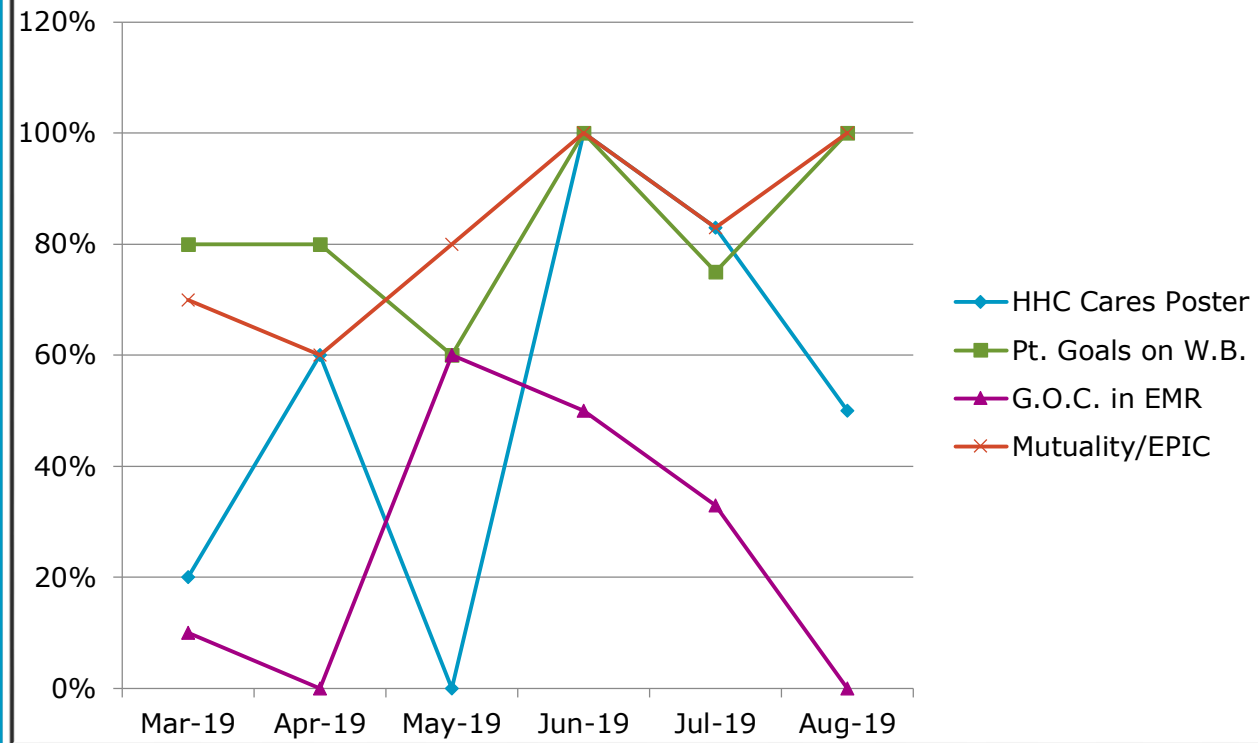


Percentage of Patients with Documented Mobility Screening (Progressive mobility Level) B10I

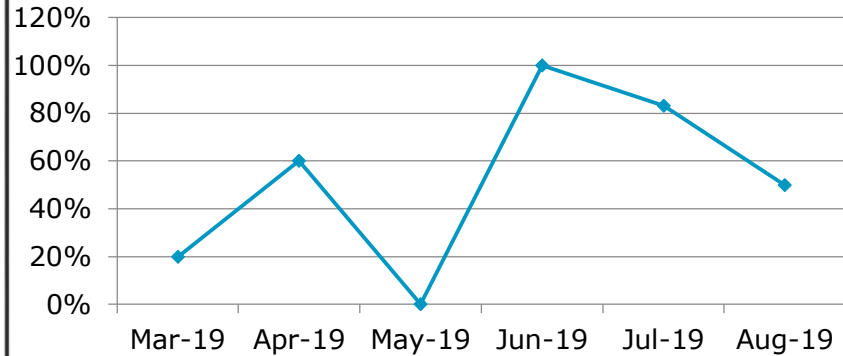


What Matters

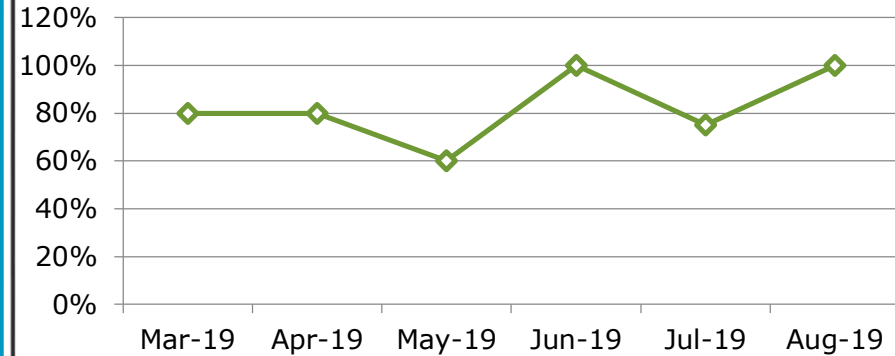
"What matters" Protocol Completion for Unit B10I



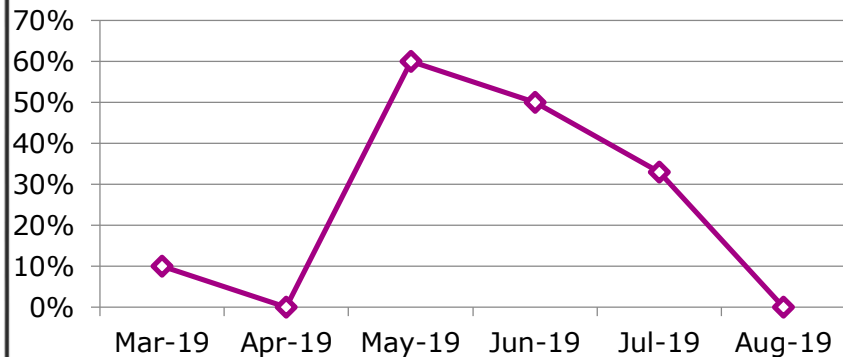
Percentage of Patients with HHC Cares About Me Poster in Room for Unit B10I



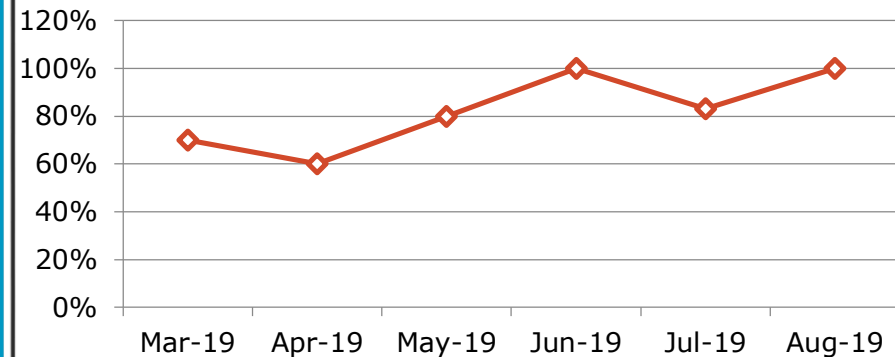
Percentage of Patients with Patient Friendly Goals on White Board for Unit B10I



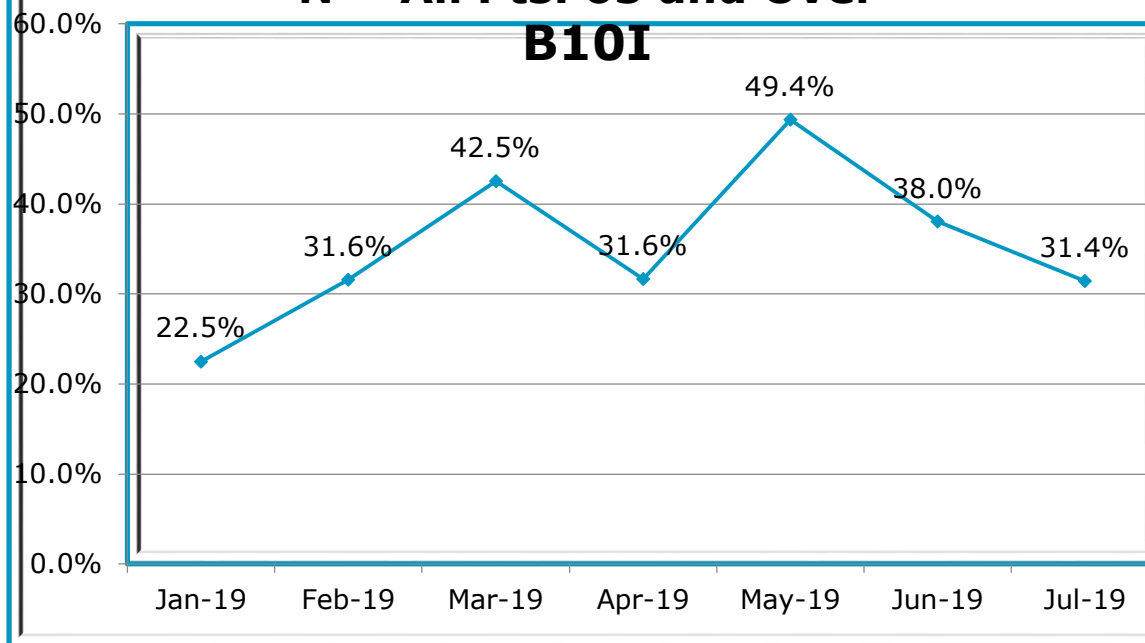
Percentage of Patients with Advanced Directive/Goals of Care in EMR for Unit B10I



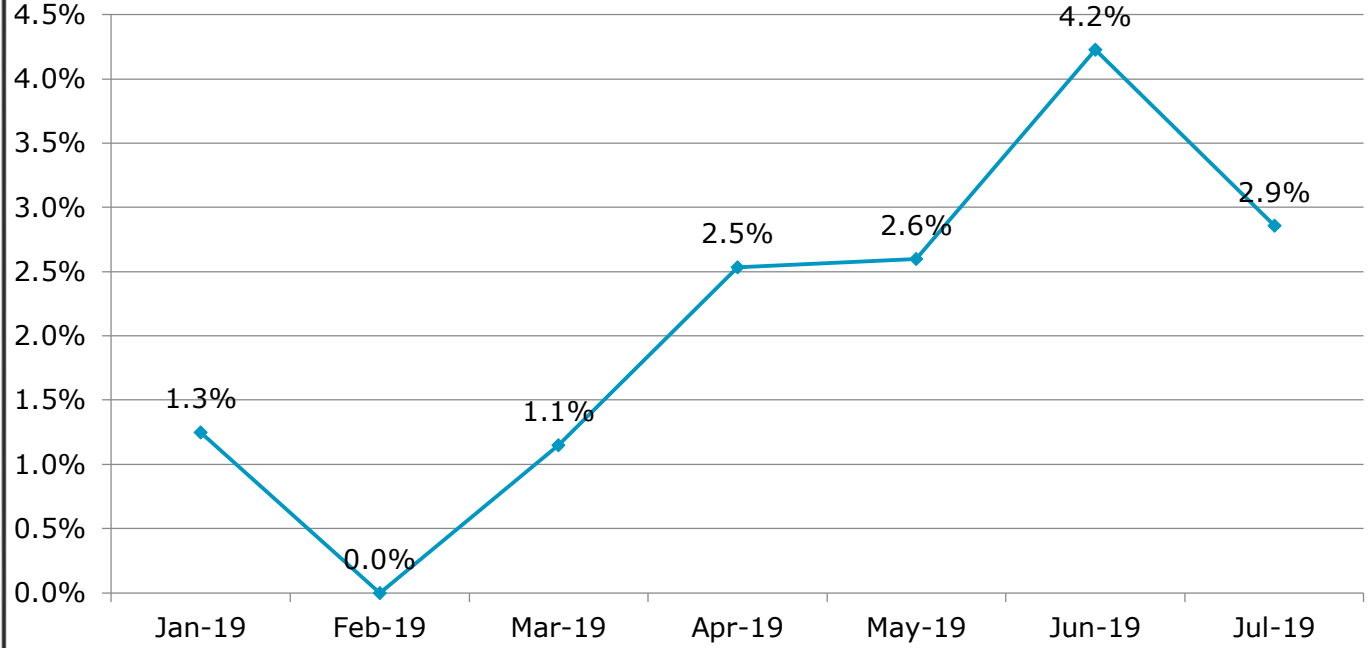
Percentage of Patients with Mutuality/Individualization in EPIC for Unit B10I



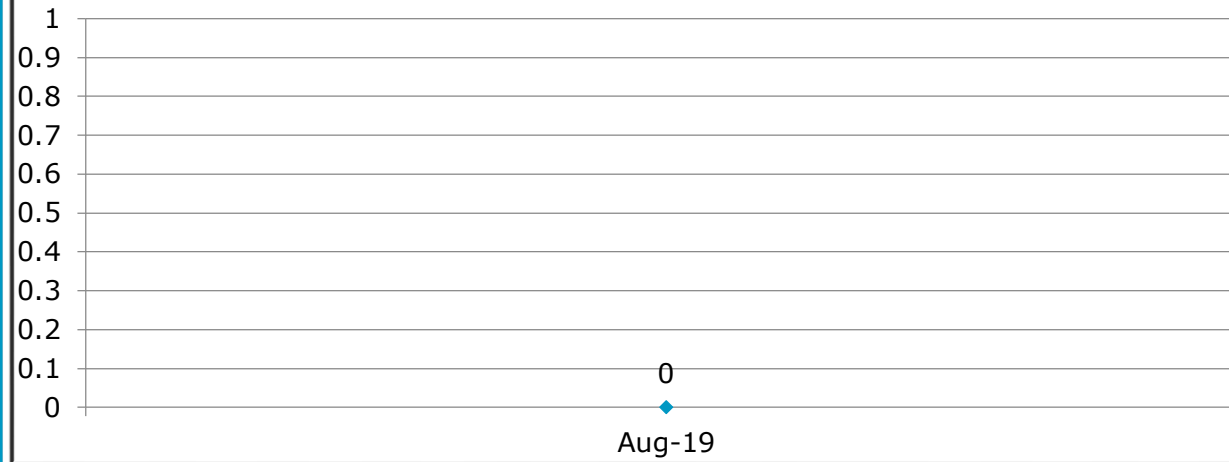
**Percentage of Patients with
Advanced Directive/Goals of Care in
EMR
N = All Pts. 65 and Over**



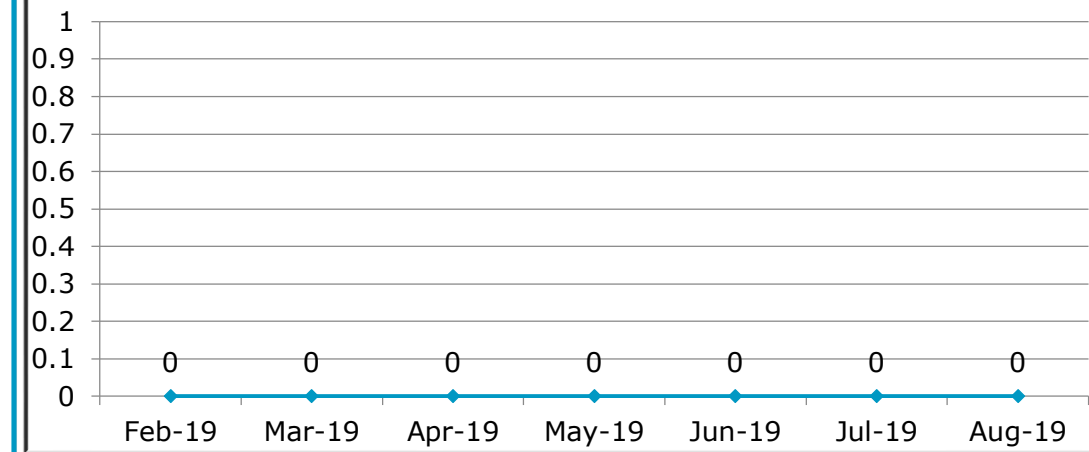
**Percentage of Patients with
Mutuality/Individualization in EMR
N = All Pts. 65 & Over
B10I**



of Patients with K.I.T. Visits B10I

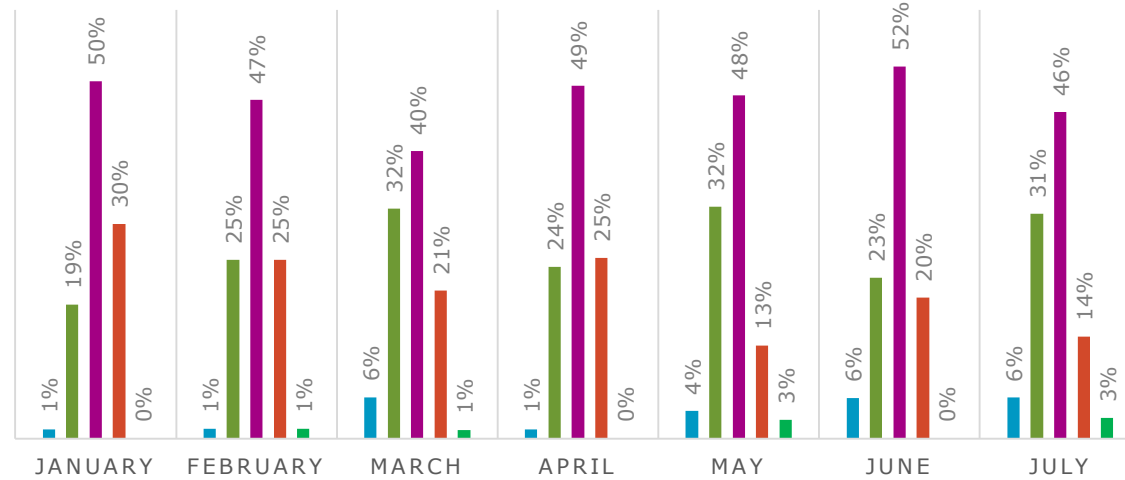


of Patients with Visits to Therapeutic Hub B10I



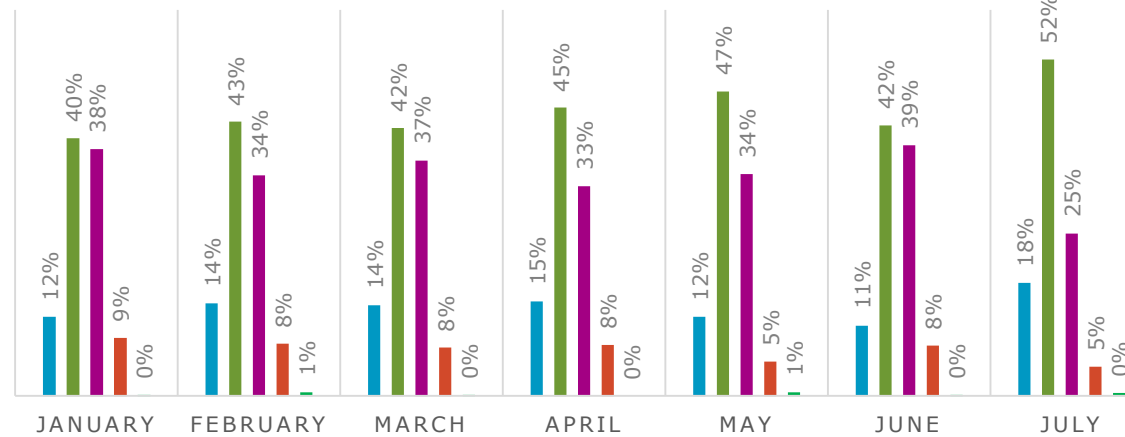
% OF NUMBER OF 4-M'S COMPLETED FOR UNIT B10I

■ 4 Completed ■ 3 Completed ■ 2 Completed ■ 1 Completed ■ 0 Completed

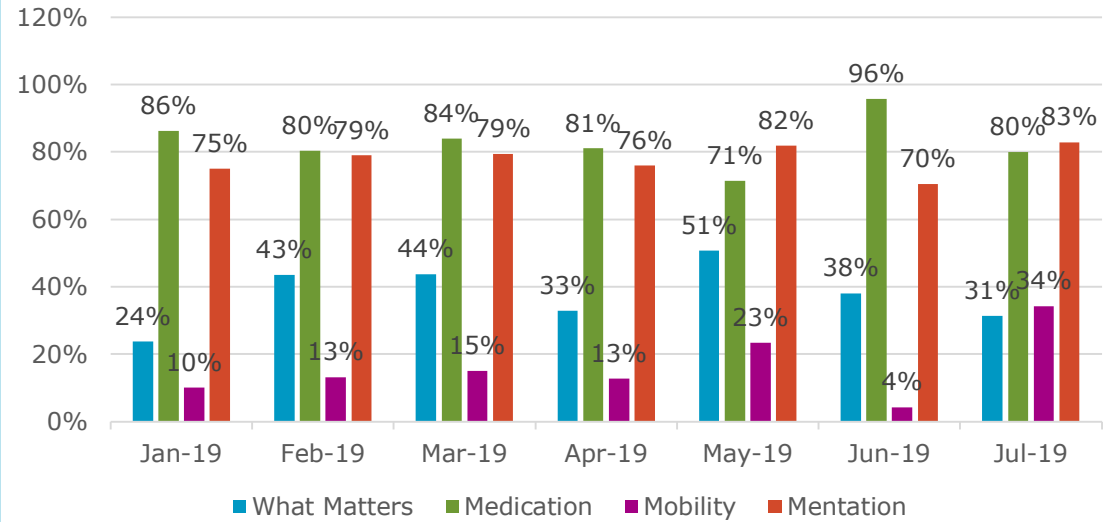


% OF NUMBER OF 4-M'S COMPLETED FOR ALL UNITS

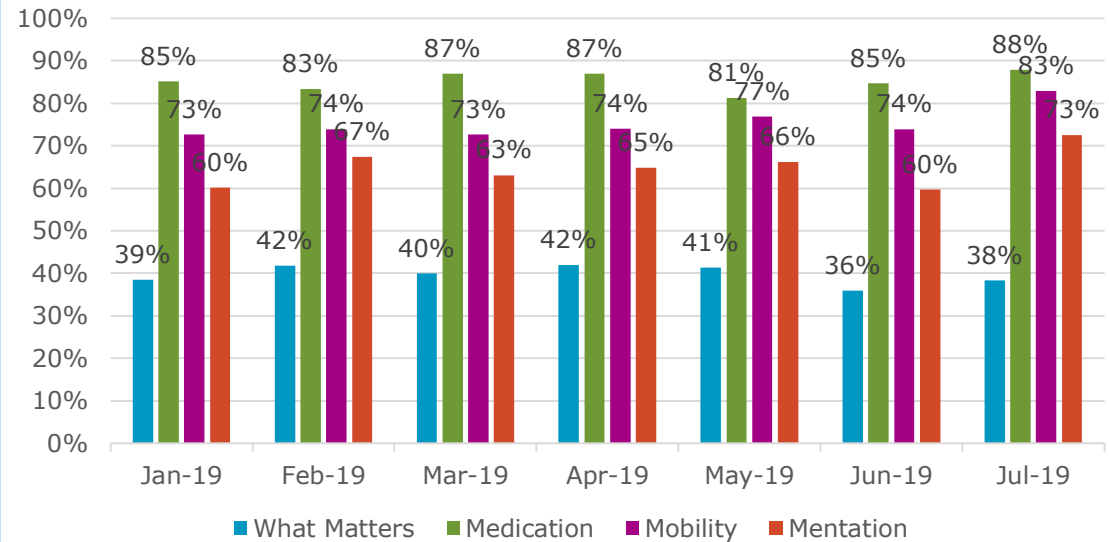
■ 4 Completed ■ 3 Completed ■ 2 Completed ■ 1 Completed ■ 0 Completed



Percentage of 4-M Completion for Unit B10I

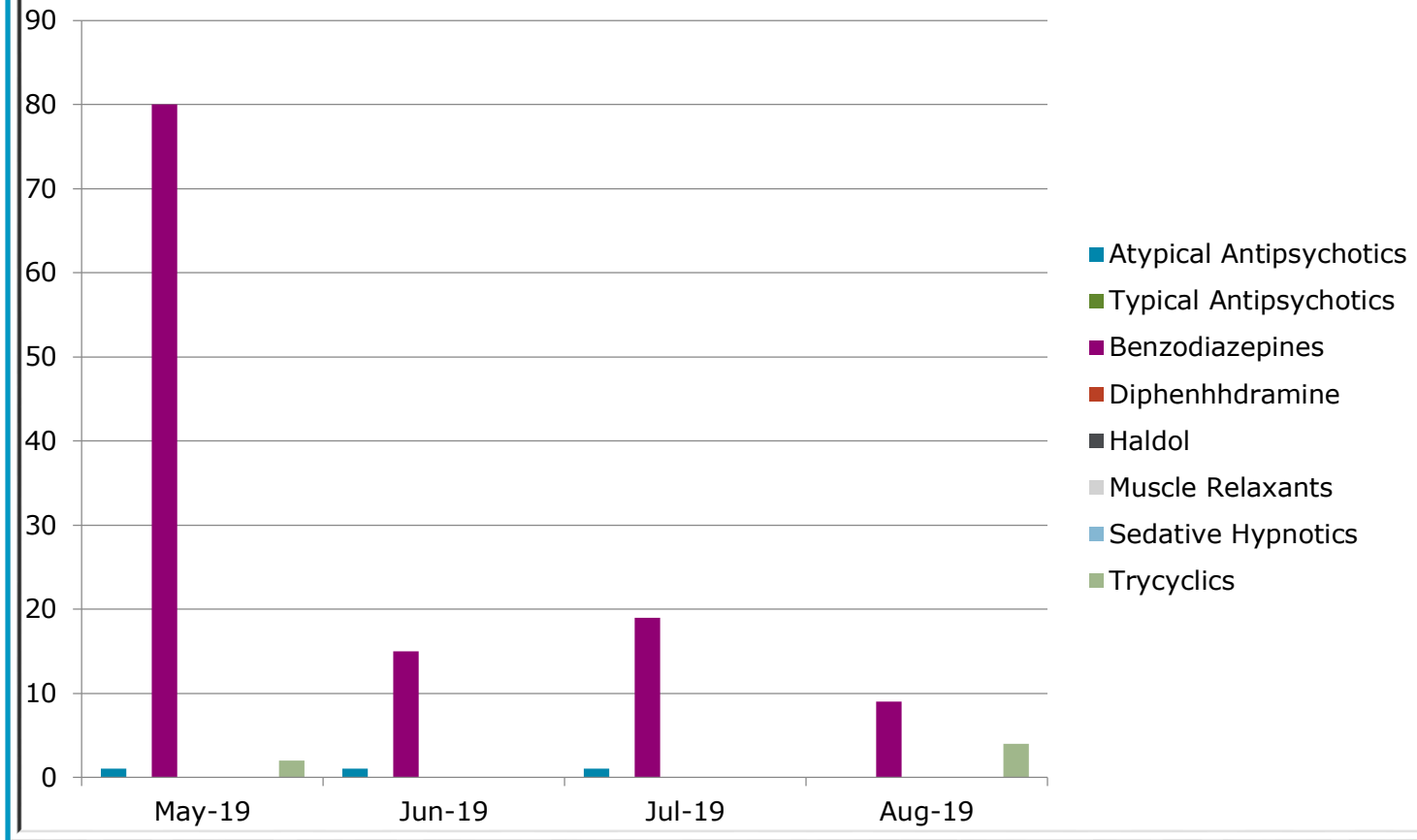


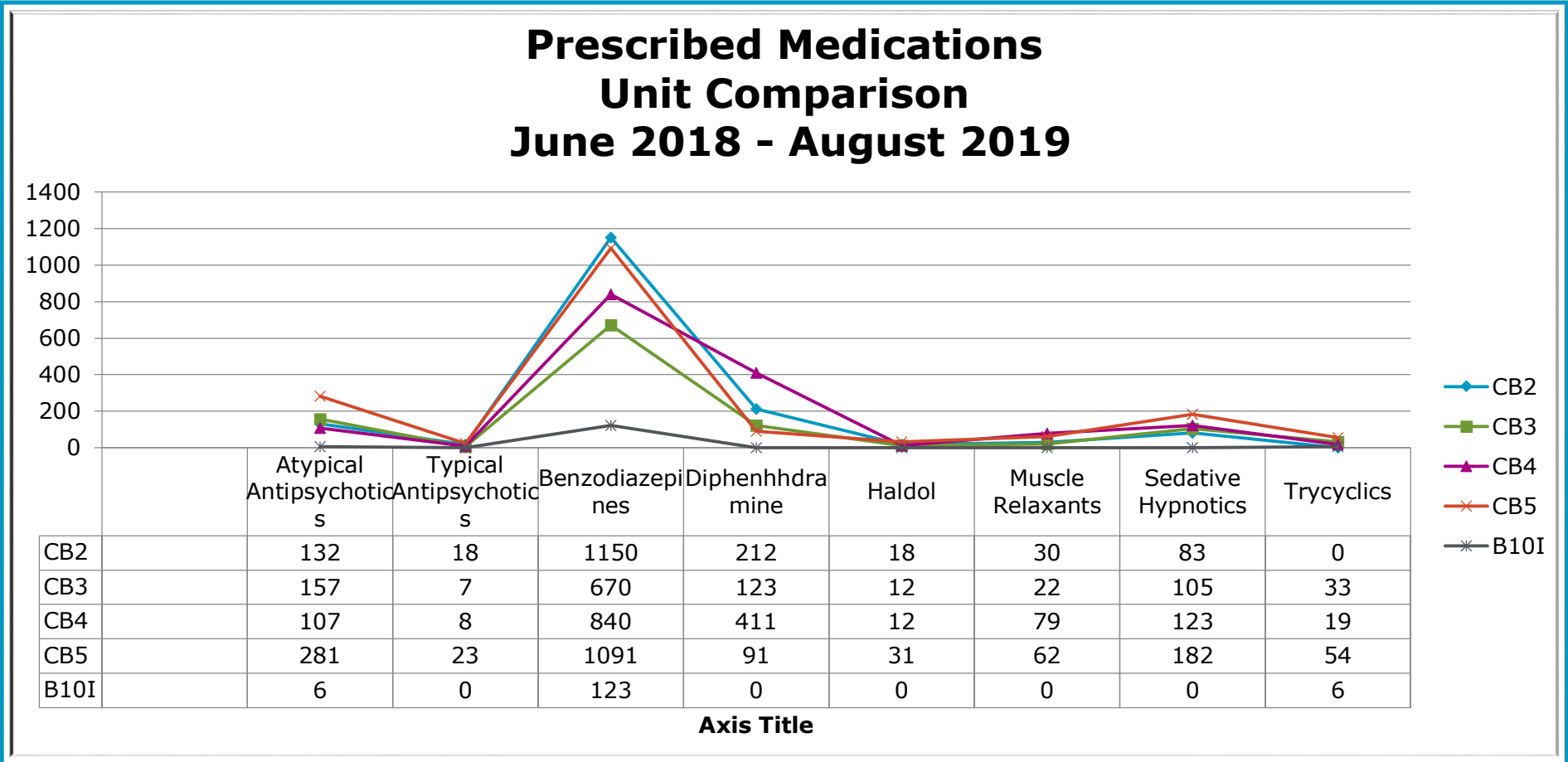
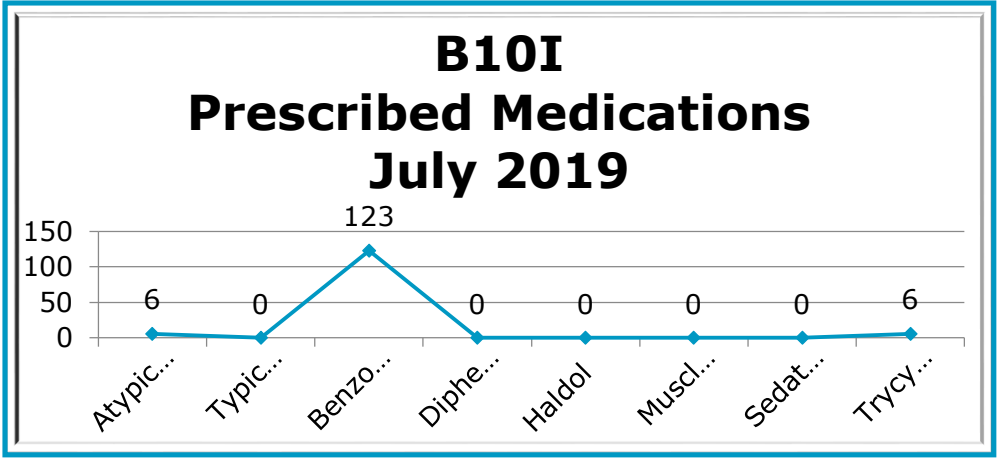
Percentage of 4-M's by Month all Units combined



Medications

Types of Prescriptions by Month Unit B10I





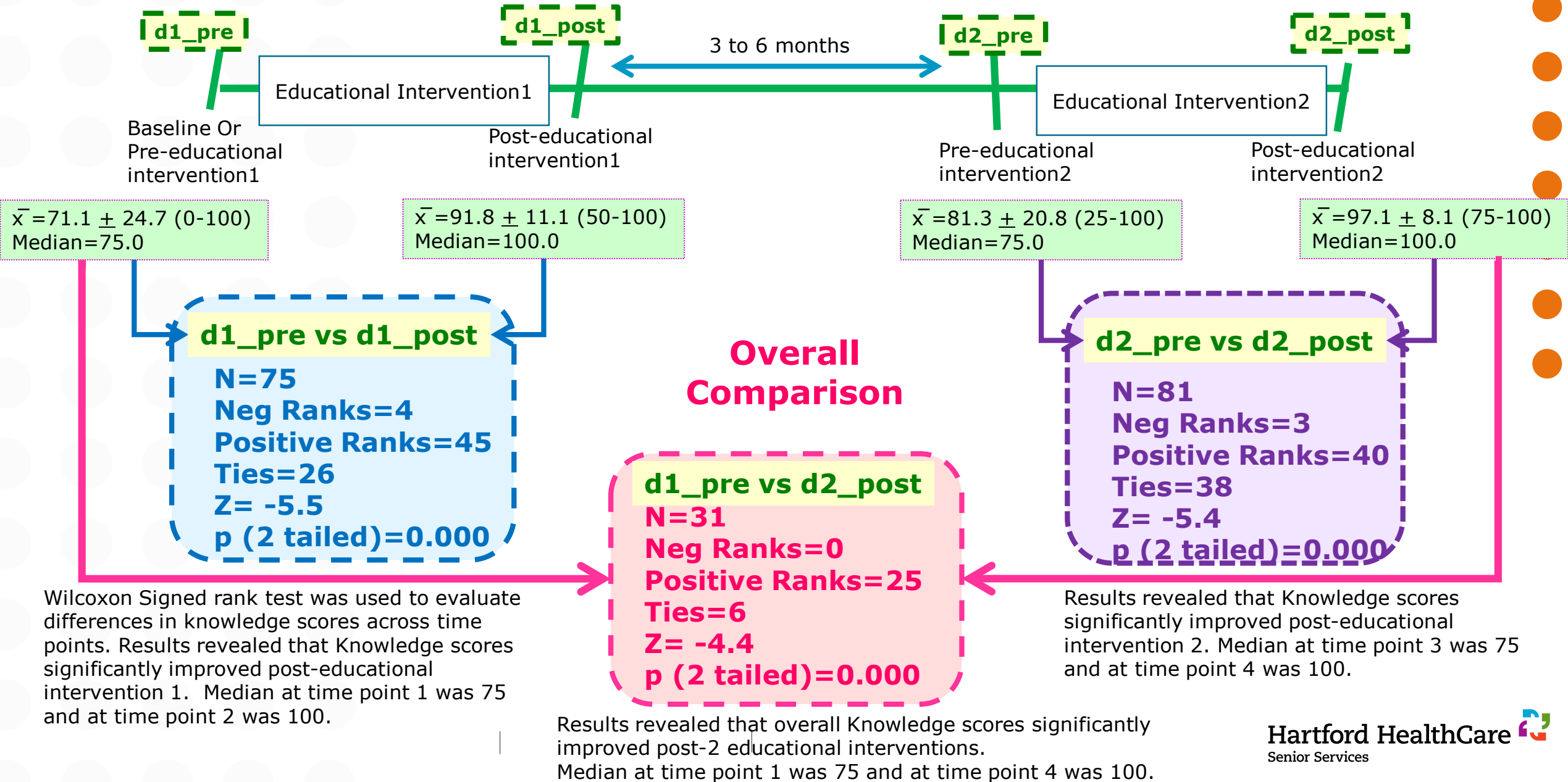
The CESI mobile program



Post-Acute Care (PAC) experience

- 16-23% patients in sub-acute care enter with or develop delirium
- Poor progress toward standard goals
 - ***D/E impairs participation***
 - ***SNF generally lack skills and strategy to rehabilitate and successfully convalesce a delirious patient. No systematic studies to date.***
- Sparse programming/expertise for cognitive rehabilitation
- Complicated by management 'missteps'
 - ***Medication choices that worsen confusion***
 - ***Inappropriate goal setting***
 - ***Avoidable complications: UTI, dehydration, falls, dysphagia, behavioral incidents, readmissions.***
- Disposition dilemma

KNOWLEDGE scores- compared across time points within individuals



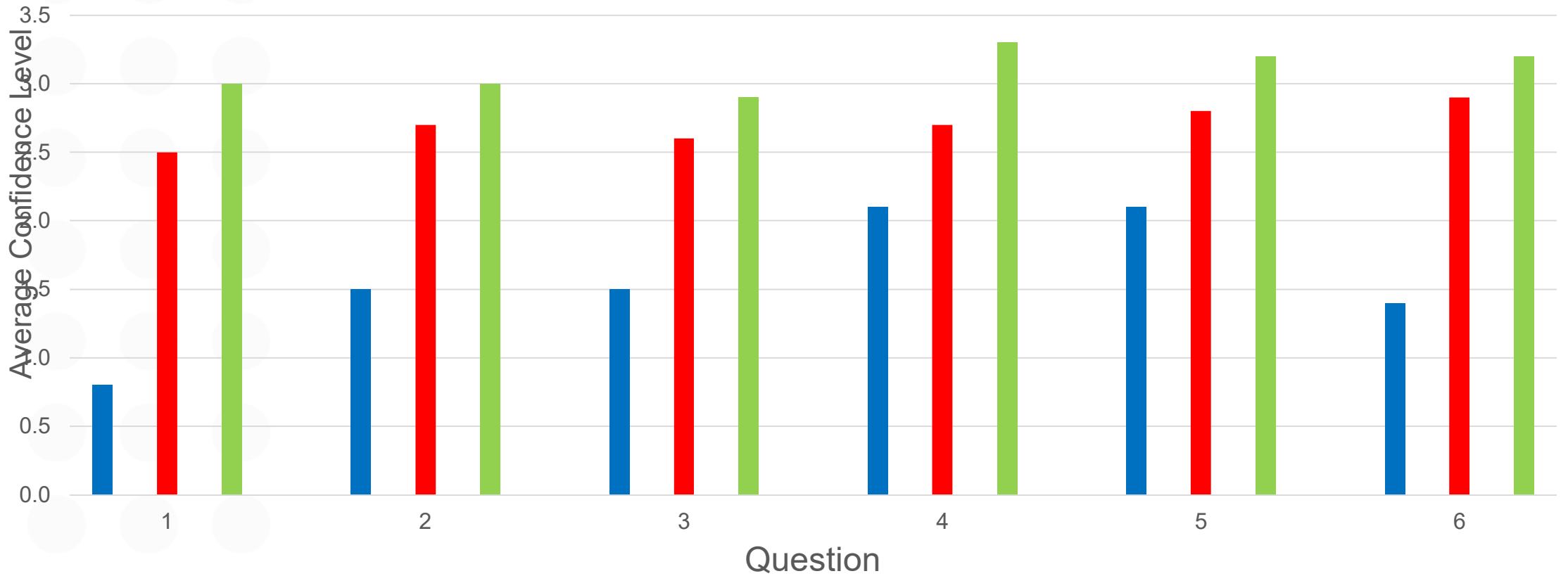
Confidence questions

How confident are you:

1. Screening for delirium
2. Assessing for acute onset/fluctuating course of mental status different from baseline
3. Assessing for inattention
4. Assessing for altered level of consciousness
5. Assessing disorganized thinking
6. Notifying the provider of a positive CAM

Confidence scores– compared across time points within individuals

The Effects of Training on Average Confidence



Brownstone- Annual Wellness

Population health project:

- Underserved older adults (2x the rate of cognitive impairment than surrounding community)
- Operationalizes Annual wellness visit
- integrates 4Ms
- Universal cognitive screening using mini-Cog and CDR
- Focused cognitive assessment using BrainCheck
- Structured assessment of Modifiable Factors
- Wellness intervention
- Fitness Program, cognitive and physical

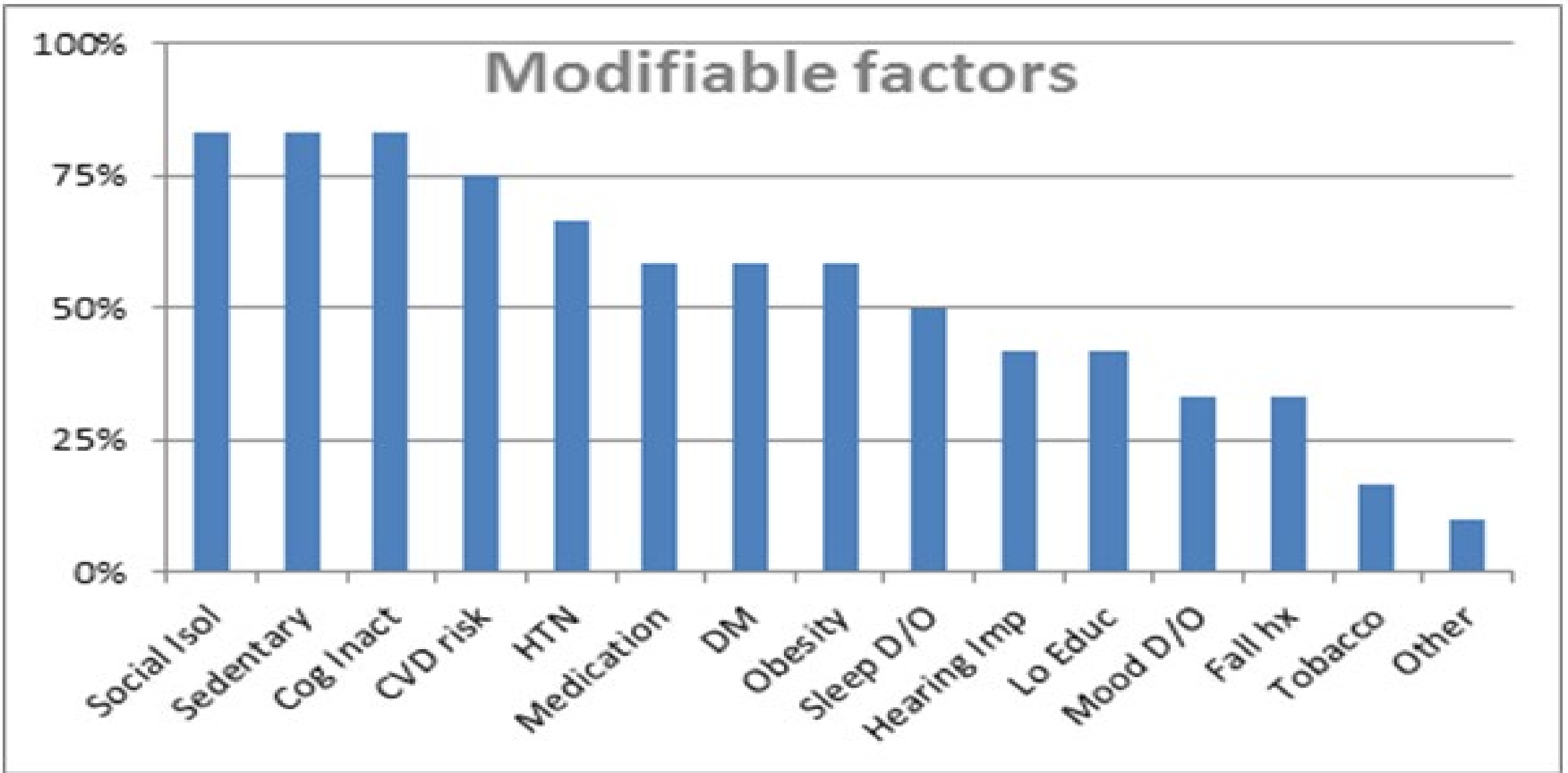
Brownstone Population seen

24 patients seen for focused cognitive assessment

- - 17 non English speaking, 5 english, 1 korean, 1 chinese
- - Mean age 75 (57-99)
- - 18 female, 6 male
- - 13 referred because of Annual Wellness Visit Screen fail; remainder referred because of family concerns or observed compliance concerns (missed appointments, medications, other)

Cognitive Diagnoses:

- 14 MNCD, 7 mild, 5 moderate, 2 severe
- 14 no previous NCD dx
- 11 no previous focused medical work up for treatable causes
- 3 had core lab done in anticipation of the consultative visit
- 2 MCI
- 2 Clinical Depression
- 6 NO NeuroCognitive Disorder



Geriatric Oncology Program at HHC Cancer Institute

- Increased education for staff
 - GRN and GPCA classes for in and outpt staff
 - Annual geriatric oncology conference
- Geriatric assessment for newly diagnosed pts
- Geriatric case management
 - Integrating the 4 Ms

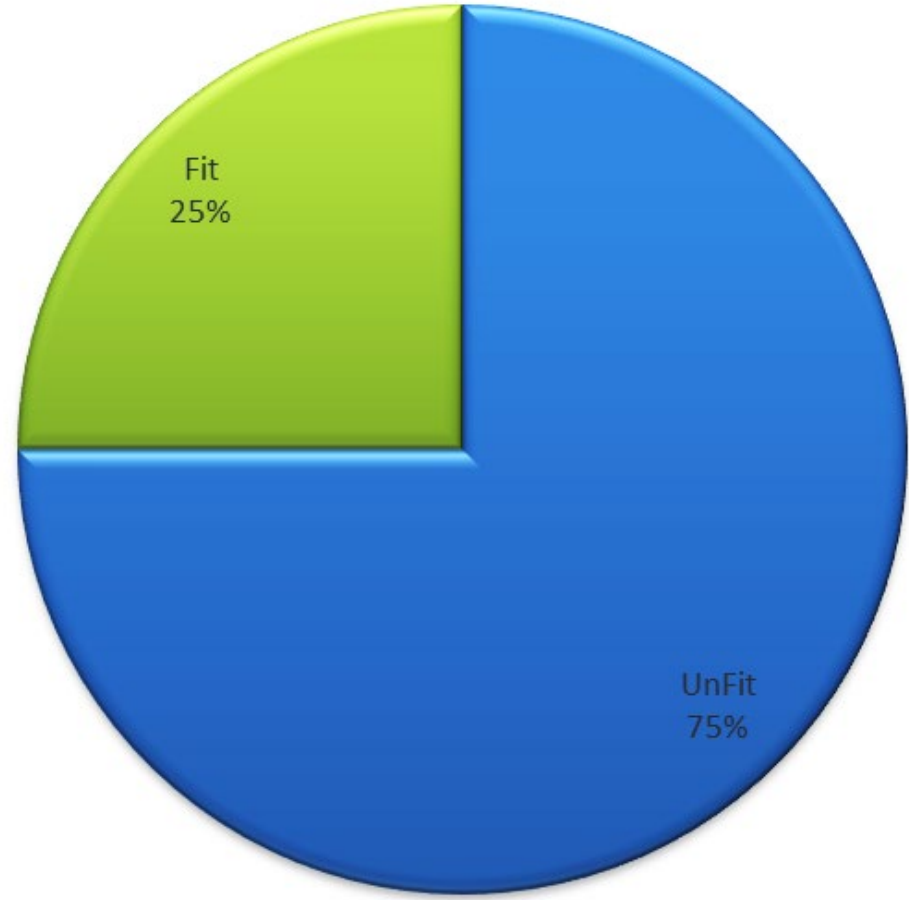
Geriatric Oncology Program at HHC Cancer Institute

- Screen all older adults with a new cancer diagnosis using the G8 to determine cognitive and function fitness
- Provide focused care by geriatric oncologist and geriatrician
 - Determine patient wishes and goals
 - Assess risks
 - Intervene for modifiable risks
 - Make recommendations for treatment/care based upon patient fitness and individualized goals



**November
2018: mG8
Pilot**

Pilot Subjects - Frailty Screening by mG8 Score

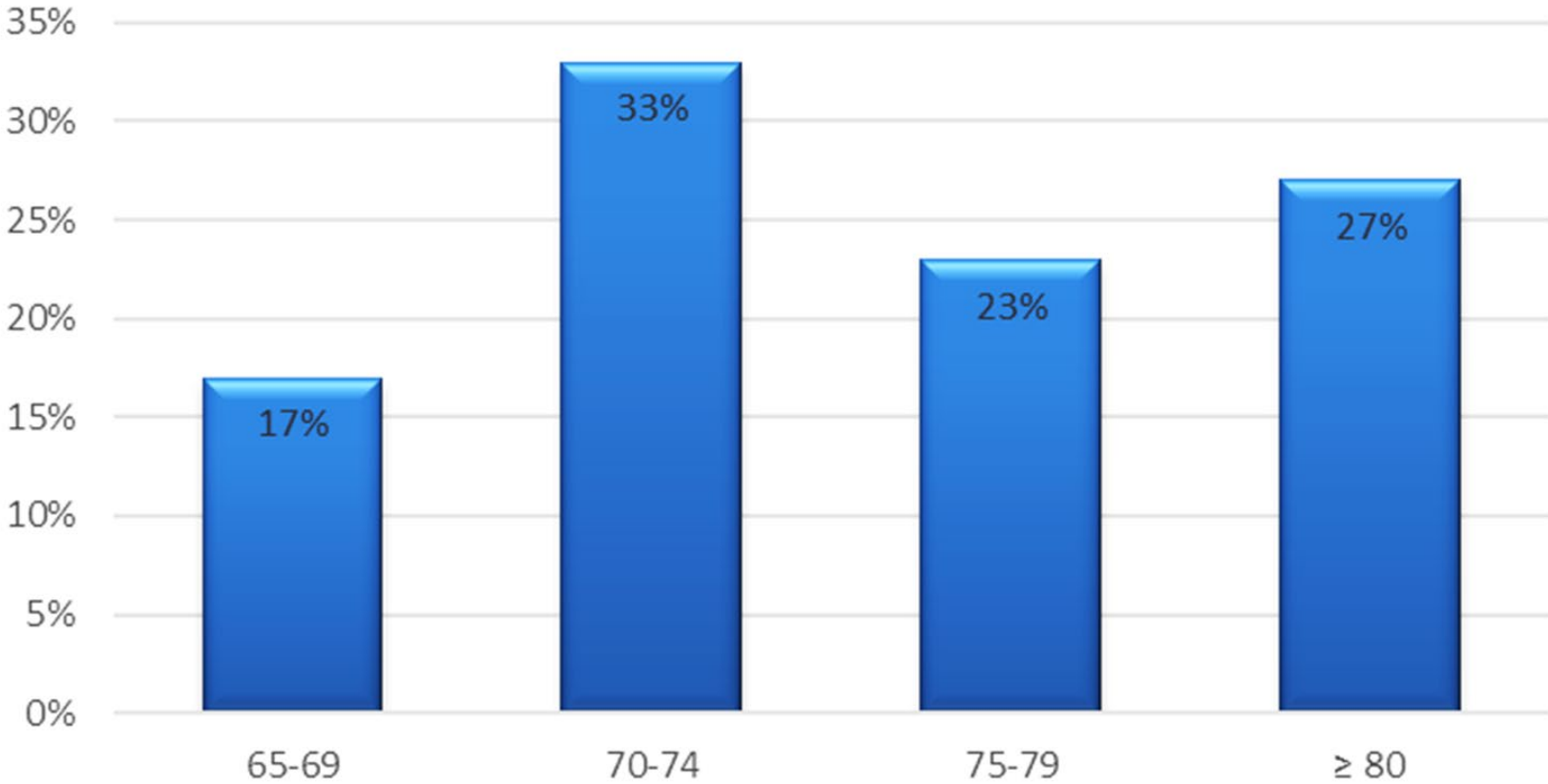


■ UnFit ■ Fit



**November
2018: mG8
Pilot**

UnFit Patients - Distribution by Age



Center For Healthy Aging Services



Outcomes- Quality Data for TCNs

TCN Identified:

- 92% Medication discrepancies
- 82% High risk for readmission/hospitalization
- 16% Moderate risk for readmission/hospitalization
- 91% Fall risk
- 35% of patients were hospitalized within 12 months prior to seeing TCN
- 43% of patients live alone

Link to Community Services

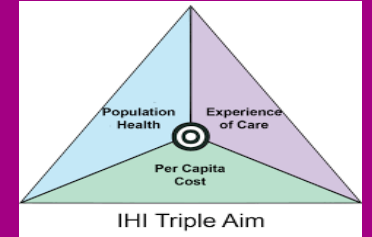
- 57% referred to certified homecare services
- 41% connected to provider
- 23% linked to caregiver services
- 71% required referral to social work/resource coordination
- 24% connected to dementia specialists
- 17% linked to behavioral health services
- 7.4% required referral to elderly protective services

Readmission rate: 3.7%
Hospitalization 12.6%

Benefits of Dementia Education

Training for caregivers of people with dementia improves:

- Caregiver confidence
- Ability to manage daily care challenges
- Supports caregivers in their role and relationship



Caregiver education and support has delayed Skilled Nursing Facility (SNF) placement by approx. 1.5 years

- **N=198**
- **Annual CT SNF =\$144,000/year**
- **18 Months CT SNF= \$216,000**
- **Possible healthcare cost savings \$42,768,000**

REACH Data

Measurement	Value
Total patients referred to REACH	222
Referred by HHCMG provider	200
Referred by non-HHCMG provider	18
Active REACH patients	170
Index hospitalization rate	29.3%
30 day readmission rate	5.9%
Referrals from REACH to HHC	59.9%
Referred to or utilizing home health	83.8%
Referred to or utilizing HHC at Home	41.4%
Referred to or utilizing hospice	32.9%
Have an advance directive on file	24.8%
Code status is DNR	32.9%
ICP involved	63.5%
Passed away	23.0%
% on Hospice among pt's who passed away	83.0%
Passed away at home	60%
Passed away in hospital	40%

Questions and Comments

