Walking Aids May Do More Harm Than Good

BY KEITH HAGLUND

The Centers for Disease Control and Prevention wanted to know how elderly people get around using walkers and canes. Not so well, CDC researchers found out—at least according to emergency department data.

After investigating 3,932 ED visits for fall-related injuries from 2001 to 2006, CDC researchers estimated that each year, 47,312 people aged 65 years and older go to EDs in the United States for mishaps associated with use of canes or walkers. One-third of those people are hospitalized.

The estimated yearly injuries total 17,856 fractures, 14,106 contusions or abrasions, 6,590 lacerations, 3,213 strains or sprains, 3,003 internal injuries, and 2,544 other.

"Injuries and hospital admissions for falls associated with walking aids were frequent in this highly vulnerable population," Judy A. Stevens, Ph.D., and her CDC colleagues wrote in the Journal of the American Geriatrics Society (2009;8:1464-9). The researchers suggested that the design of walkers and even canes could be improved. They also called for research into the physical and cognitive demands that walking aids put on users.

The team estimated fall injuries in both nursing homes (annually, 6,713 with walkers and 544 with canes) and public places (3,426 with walkers and 749 with canes). But, by far, the most falls associated with aids occur at home: 25,144 with walkers and 3,289 with canes, making up about 60% of all such injuries. About 12% of injuries occurred at unknown locations.

Many times walkers and canes aren't fitted to an individual's size and capability and, too often, users receive no instruction.

Older women appear to be particularly susceptible. Although they constitute 59% of the 65-and-older population, they suffered 77% of the fall injuries in the study. Most of those involved walkers.

The researchers wrote that other studies support the perception that walkers and canes help elderly people with balance and mobility, but the team added that some studies "suggest that they can be associated with greater fall risk because they can cause tripping or interfere with a person's balance control."

The numbers of injuries associated with the aids seem "higher than they should be," said Dr. Stevens. She suggested that many times walkers and canes aren't fitted to an individual's size and capability and that, too often, users receive no instruction. Especially for home use, she said, elders or family members tend to buy whatever device is in a nearby store when the need for a walking aid arises.

Even simple devices call for fitting and proper instruction, said Dr. Stevens. For instance, a cane user could benefit from advice on which side of the body needs the support and how tall the device should be, but those "bought at the corner drugstore" don't come with such instructions, she said.

On walkers, features such as wheels and seats can be inappropriate. Dr. Stevens said that falls commonly occur when a walker rolls away from a user or the person moves too far into a lightweight device and loses control of his or her center of gravity.

Dr. Hosam Kamel of the department of geriatrics at the University of Arkansas, Little Rock, said that, when used properly, the aids can greatly improve elders' quality of life but added, "If not used appropriately, they can cause more harm than benefit." He stressed the need to fit each elderly person with the proper device and then periodically reassessing the person's physical and cognitive abilities to handle that device. ■

Care Model Shores Up Satisfaction Among Elderly, Chronic Patients

BY SUSAN BIRK

CHICAGO — A primary care delivery model for older patients with multiple chronic illnesses increased physician understanding of the patients' clinical conditions and improved communication with patients and families, in a randomized trial at eight primary care practices.

The study findings, presented in a poster at the annual research meeting of AcademyHealth, add to a growing body of evidence that the model can improve outcomes, reduce costs, and enhance the quality of care for chronically ill older adults.

In the Guided Care model—an initiative developed by the Johns Hopkins Bloomberg School of Public Health, Baltimore—a Guided Care nurse works with three or four primary care physicians and a targeted population of 50-60 patients. The nurse receives additional training in patient education and coaching and in chronic disease management.

The nurse also develops a comprehensive care plan for each patient based on medical conditions, the home environment, and individual patient goals; monitors patients monthly; coordinates transitions between providers and sites of care; educates and supports caregivers; keeps an electronic health record; and provides physicians with detailed updates.

"Physicians don't have a lot of time to do these things for every one of their complex patients," Jill Marsteller, Ph.D., noted in an interview. "The nurse helps very much in terms of having a close personal relationship with these people who are so complex, and can provide them with the guidance that they need to access community resources and help them keep track of all the different visits." The nurse also summarizes the information for the physician.

The nurse visits the patient's home when Guided Care begins, making a connection that can yield valuable insights that might not come out in a medical interview.

A randomized trial of Guided Care has shown that this heightened attention to patients and support for physicians improves outcomes and increases patient satisfaction with their care. In the trial, 49 primary care physicians at eight community-based medical practices in the Baltimore and Washington region and 904 of their patients aged 65 years or older with multiple comorbidities were randomly assigned to Guided Care or usual care.

After 6 months, patients receiving Guided Care were twice as likely as patients receiving usual care to rate the quality of their care as high (J. Gerontol. A Biol. Sci. Med. Sci. 2008;63:321-7). After 8 months, Guided Care patients spent 24% fewer days in the hospital, and had 29% fewer home health visits and 15% fewer emergency department visits (Am. J. Manag. Care 2009;15:555-9).

The most recent phase of the study, presented at the AcademyHealth meeting, focused on physician satisfaction and perceptions after participating in the project for 1 year.

On a six-point scale ranging from "very dissatisfied" to "very satisfied," physicians in the control group gave mean ratings of 4.25 and 3.94, at baseline and at 1 year, respectively, for satisfaction with patient/family communication, while physicians in the Guided Care group gave mean ratings of 4.03 and 4.40. On a four-point scale measuring clinical knowledge of patients, with responses ranging from "definitely not" to "definitely," physicians in the control group gave mean ratings of 2.70 and 2.77 at baseline and 1 year, respectively, while physicians in the Guided Care group gave mean ratings of 2.85 and 3.17.

The study was funded by the John A. Hartford Foundation and the Roger C. Lipitz Center for Integrated Health Care of the Bloomberg School of Public Health. ■

A Third of Elderly Patients Readmitted Within 30 Days

BY PATRICE WENDLING

CHICAGO — Nearly one-third of elderly general medicine patients were readmitted within 30 days in a retrospective analysis of 164 patients.

Neither inpatient providers nor a standardized algorithm accurately predicted which patients would be readmitted, Dr. Nazima Allaudeen and her associates reported in a poster at the annual meeting of the Society of Hospital Medicine.

"My take-home from this is [that] all of our patients are at risk," she said in an interview. "Whatever intervention you're going to put in place—whether it be educating your patients more, making sure they have better social support, better patient medication—you really need to do it for everyone."

Among 159 patients aged 65 years or older, discharged from the general medicine service at the University of California San Francisco Medical Center during a 5-week period beginning March 17, 2008, 52 (32.7%) were readmitted within 30 days. Five patients died during the 30-day postdischarge period.

The rate is much higher than was identified in a recent Northwestern University study in which nearly 20% of 11,855,702 Medicare beneficiaries were rehospitalized within 30 days (N. Engl. J. Med. 2009;360:1418-28).

The higher rate could be explained by the fact that data on unscheduled readmissions to other hospitals were captured—data often missed in other studies, said Dr. Allaudeen, of the Veterans Affairs Palo Alto (Calif.) Health Care System. The researchers reviewed electronic medical records at the local county hospital as well as their own institution, and telephoned patients or caregivers to determine readmission to outside hospitals. They also excluded patients who died during the 30-day postdischarge period.

In the current study, attending physicians did the best job of predicting who would be readmitted. Their mean predicted readmission rate of 32.5% fell just shy of the actual 32.7% rate. The predicted readmission rate was 41.5% using the probability of repeat admission (Pra) algorithm, which was calculated using eight variables extracted during chart review.

Readmissions cause significant distress to patients and caregivers, and are associated with considerable financial costs. The authors contend that it is especially critical for hospitals to have in place systematic interventions targeting general medicine patients now that Medicare may be changing reimbursement policies for hospital readmissions.

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