American Hospital Association™

Advancing Health in America

Creating Value with Age-Friendly Health Systems

June 24, 2020

THE Value Initiative

Age-Friendly Health Systems

An initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI) in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA).

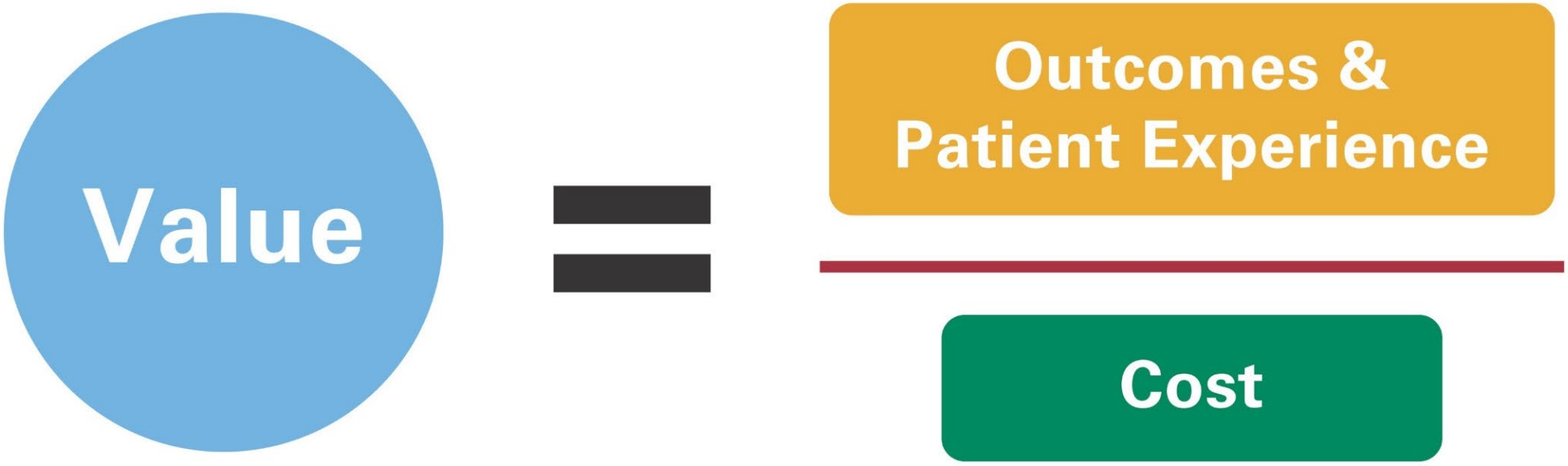
Presenters

Marie Cleary-Fishman, MS, MBA
Vice President, Clinical Quality, American Hospital Association

Christine Waszynski, DNP, APRN
Geriatric Nurse Practitioner, Hartford Hospital

AHA Activities

Affordability Through Lens of Value



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Affordability Through Value-based Strategies

Redesign the Delivery System

- Coordination of care
- Clinically integrated networks
- Primary Care Medical Homes
- Chronic care management
- Telehealth
- Community-based alternatives
- Community partnerships including public health

Improve Quality and Outcomes

- Address equity of care and health disparities
- Evidence-based care/analytics
- Reduce clinical and operational variation
- Eliminate unnecessary utilization
- Advanced medical technologies
- Personalized medicine

Manage Risk and Offer New Payment Models

- Move to value-based payments
- Population health management
- Address social determinants
- High-need/high-cost approaches
- Partner/own health plan

Implement Operational Solutions

- New process improvements
- Cost reductions
- Utilize cost accounting and data
- Support clinicians' practices to their level of education
- Create a culture geared to value not volume

THE Value Initiative

Thought leadership on affordability

- **Issue Briefs:** Start the conversation
- **Executive Forums:** Perspectives and strategies
- **Innovative Activities:** Real solutions that promote value
- **Members in Action Series:** Success stories from the field
- **Voices on Value:** Expert insights from outside the field
- **Data:** Trends and support for federal policy solutions

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Easy-to-Use Presentations

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Members In Action

THE Value Initiative

Members in Action: 2018 Summary

The AHA's Members in Action series spotlights hospitals and health systems that are implementing new value-based strategies to improve health care affordability. This includes work to redesign the delivery system, manage risk and new payment models, improve quality and outcomes, and implement operational solutions. Below is a synopsis from 2018; read the full case studies at www.aha.org/value-initiative.

Redesigning the Delivery System

University of Mississippi Medical Center, Jackson, MS – Remote Patient Monitoring

University of Mississippi Medical Center initiated a Diabetes Telehealth Network pilot program to treat patients in the Mississippi Delta region, one of the most impoverished areas in the country.

Meadville Medical Center, Meadville, PA – Care Coordination for Adults and Children

Meadville Medical Center created the Community Care Network to engage patients and improve community well-being. This program uses an interdisciplinary team to improve care coordination for residents with chronic disease conditions such as hypertension, diabetes, hyperlipidemia and depression.

Illinois Rural Community Care Organization, Princeton, IL – Statewide Rural ACO

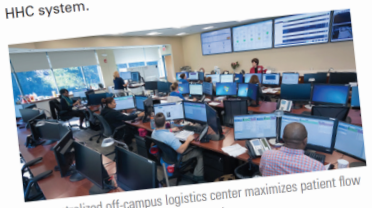
Illinois Rural Community Care Organization builds the structure necessary for rural providers to be successful Accountable Care Organizations. The organization has been able to decrease hospital readmission rates and increase visits to primary care offices for follow-up care and closer monitoring.

Allina Health, Minneapolis, MN – LifeCourse Program

The LifeCourse program helps patients and their families and friends navigate the complexities of serious illnesses, such as cancer, Parkinson's disease and advanced heart failure. Allina patients report an improved quality of life, and the program offers proven savings.

Hartford HealthCare, Hartford, CT – Centralized Logistics Center

Hartford HealthCare instituted a centralized logistics center to maximize patient flow among its flagship academic medical center and five other hospitals. Since its launch, the center has decreased the time it takes to get patients to the next level of care and increased the number of patients staying within the HHC system.



The centralized off-campus logistics center maximizes patient flow among all Hartford HealthCare hospitals.

Brigham and Women's Hospital, Boston, MA – Home Hospital Program

Home hospital patients receive hospital-level care while in the comfort of their own homes. The program has helped to lower costs and readmissions. In addition, patients in the program experienced fewer clinical interventions, more physical activity and comparable patient satisfaction scores as those being cared for in the hospital.

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Members in Action: Redesigning the Delivery System

Meadville Medical Center – Meadville, PA
Care Coordination for Adults and Children

THE Value Initiative

Members in Action: Improving Quality & Outcomes

Parkland Health & Hospital System – Dallas, TX
Self-Care IV Therapy Program

In the *Members in Action* series, AHA will highlight how hospitals and health systems are implementing new value-b strategies to improve health care affordability. This includes work to redesign the delivery system, manage risk and payment models, improve quality and outcomes and implement operational solutions.

Overview

When Leaders at Parkland Health & Hospital System, a safety-net hospital in Dallas, launched a program for administering long-term antibiotics to patients, they were seeking to address two problems: disparities in the delivery of health care services and the inappropriate use of health care resources. Kavita Bhavan, M.D., medical director of Parkland's Infectious Diseases Outpatient Parenteral Antimicrobial Therapy (OPAT) Clinic, worked with a multidisciplinary team to address this issue by creating a new delivery of care model for patients requiring long-term intravenous antimicrobial therapy for the treatment of serious infections stemming from illness or injury.

Historically, insured patients have various options for outpatient IV antibiotic therapy within a number of locations: an infusion center, a physician's office, a skilled nursing facility or, most frequently, at home with support from home health services. Uninsured patients, however, typically cannot access these services so they have been treated as inpatients at Parkland or discharged to another location, such as skilled nursing facility, for example, with the hospital paying for outpatient treatment.

"It wasn't unheard of to be here 42 days getting IV antibiotics," said Bhavan, who also serves as associate professor of internal medicine at the University of Texas Southwestern Medical Center. "And they were medically stable and doing fine with the sole reason for extended hospitalization being administration of IV antibiotic therapy."

That meant inpatient beds were being tied up by patients who could be treated at home, while Parkland was constantly challenged with bed availability for acutely ill patients presenting daily through the emergency department. At the same time, patients receiving long-term antibiotics in the hospital wanted to go home to resume activities of daily living and get back to work, etc. Further, spending weeks as a hospital inpatient comes with the risk of nosocomial infections.

"Instead of asking for more resources, we wanted to find a way to maximize the potential we have in front of us," said Bhavan. That potential: the ability of patients to perform care traditionally provided by medical professionals. Bhavan and her colleagues developed a program to train those patients to self-administer IV antibiotics at home by using a simple wire coat hanger to hang the medication above

Impact

In Parkland's fiscal 2015 the direct costs associa with the S-OPAT progra were $957,933, or $3,574 per patient. During that year, the program freed up 5,893 inpatient bed days, translating into direct cost avoidance of more than $7.5 million in unreimbursed care. Bhava attributes the patients' se care performance to their personal motivation. Whil most provider organizatio fall short of 100 percent hand-hygiene compliance an individual patient strivi to recover from a life-threatening infection is hig motivated.

"For health care providers hand hygiene is an essen part of our job to prevent infection, and we should be doing it because it is the right thing to do," said Bhavan. "But patients do think of it that way. It's not a job – it's their body and they have assumed ownership in their care to help achieve better clinical outcomes."

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Members in Action: Managing Risk & New Payment Models

Sharp Grossmont Hospital – La Mesa, CA
Care Transitions Intervention Program

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Members in Action: Implementing Operational Solutions

Russell Regional Hospital – Russell, KS
Achievement of ENERGY STAR® 100

In the *Members in Action* series, AHA will highlight how hospitals and health systems are implementing new value-based strategies to improve health care affordability. This includes work to redesign the delivery system, manage risk and new payment models, improve quality and outcomes and implement operational solutions.

Overview

Russell (KS) Regional Hospital (RRH), a critical access hospital, was already a leader in hospital energy performance when it embarked on a journey to make additional improvements. RRH's goal was to make strategic energy-related investments that would reduce operating expenses while increasing system reliability. Now they have an ENERGY STAR® 100 rating.

The 1 – 100 ENERGY STAR score is a screening tool that helps assess a building's energy performance and compares it with similar buildings nationwide. Developed by the Environmental Protection Agency and stakeholders, the tool helps identify which areas to target for improvement or recognition. A score of 50 is the median: If a building scores below 50, it means it's performing worse than 50 percent of similar buildings nationwide, while a score above 50 means it's performing better than 50 percent of its peers. A score of 75 or higher means it's a top performer and may be eligible for ENERGY STAR certification.

The RRH maintenance team started by implementing strategies to reduce energy in-house. They started with the small things first, because it would result in savings that could be used for larger initiatives. For example, they initially focused on:

- Behavioral changes – RRH started checking lights to make sure they were not left on unnecessarily. They also started dialing back steam pressure when it did not need to be high and dialing back temperatures where possible.
- Occupancy sensors – When light switches needed replacing, the team replaced them with occupancy sensor switches instead. The switches were replaced slowly, a

Impact

RRH has an energy score of 100, which means that it performs better than all of its peer facilities. The facility reduced energy use by a spectacular 43 percent between 2013 and 2016. The energy services company measured and verified the savings as part of their work. RRH's maintenance staff independently verified the savings with ENERGY STAR Portfolio Manager®.

The lowest cost projects with the quickest returns on investment included replacing T12 and older T8 fluorescent lighting with energy-efficient T8 lamps (4.5 years to recoup costs), installing variable-speed pumping (3.8 years to recoup costs), and replacing condensing units (5.0 years to recoup costs). The most expensive projects, with the longest time frames to recoup costs, were the chiller replacements (15.2 years on a more than $300,000 investment) and the boiler replacements (4.3 years on a nearly $475,000 investment). In total, projected savings are more than $120,000 annually. So far, the savings predicted have been verified as above the guaranteed savings value. The hospital replaced old equipment, improved patient comfort and safety, and reduced operating expenses.

American Hospital Association

Issue Briefs

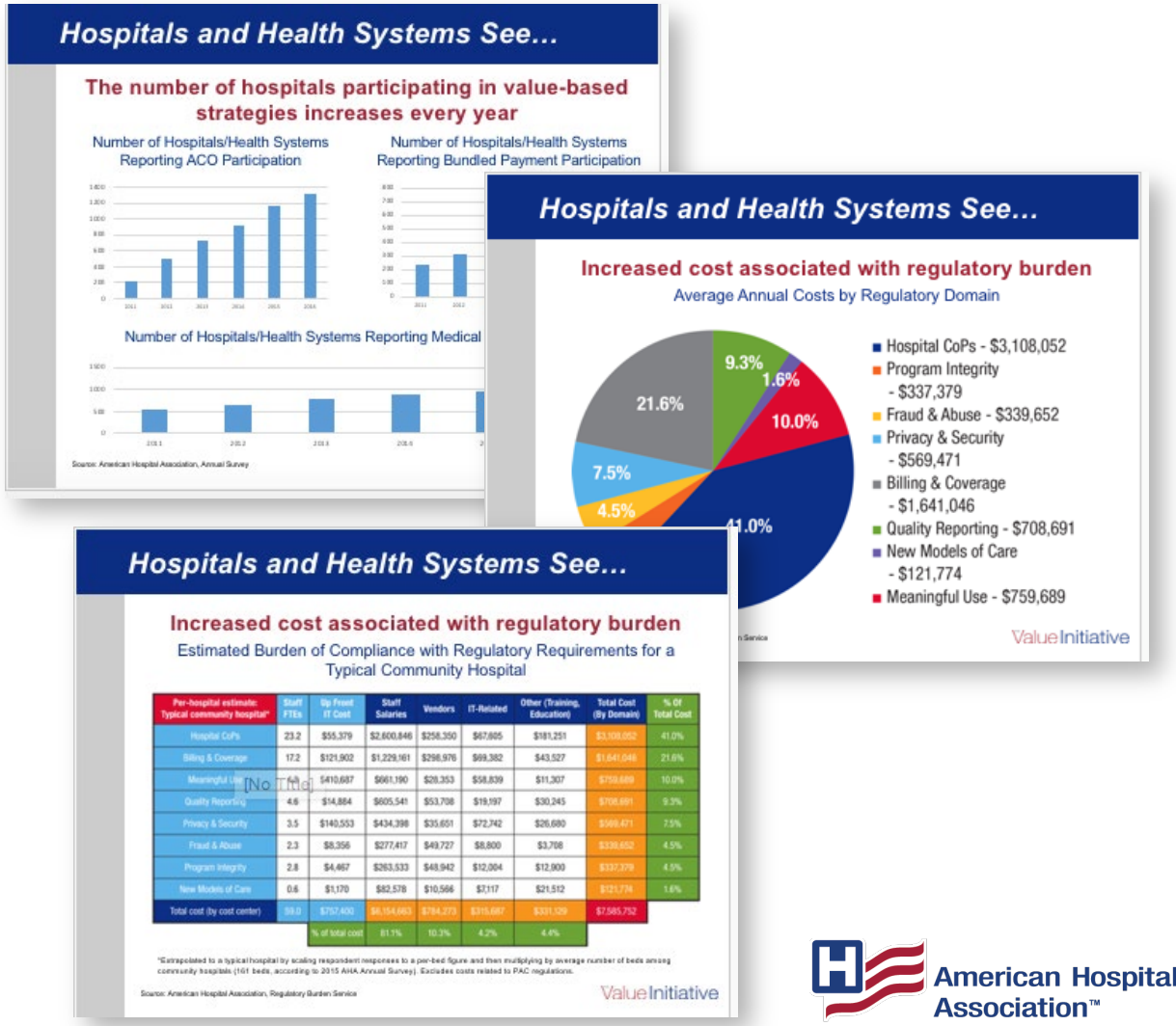
- Frame the complex issue of affordability
- These briefs can be used to initiate conversations with stakeholders in your community

2020 Virtual Workshop Series

- Opportunities for members to learn about the issues impacting affordability and value
- To register for a workshop, visit www.aha.org/calendar

Data, Metrics & Infographics

- Data on national health expenditures
- Describe the drivers and influencers of cost and value
- Track how value is perceived by various stakeholders
- State of Value Snapshot – measure value trends over time



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Age-Friendly Health Systems

Creating Value with Age-Friendly Health Systems

AHA Action Community: An Invitation to Join Us

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Agenda

- Value of Age-Friendly Health Systems
- Overview of Action Community
- Sharing of Data & Learning
- Implementation at Hartford Hospital
- How to Join the Action Community
- Q&A

Our Partners

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Institute *for* Healthcare Improvement

CHA®
Catholic Health Association of the United States

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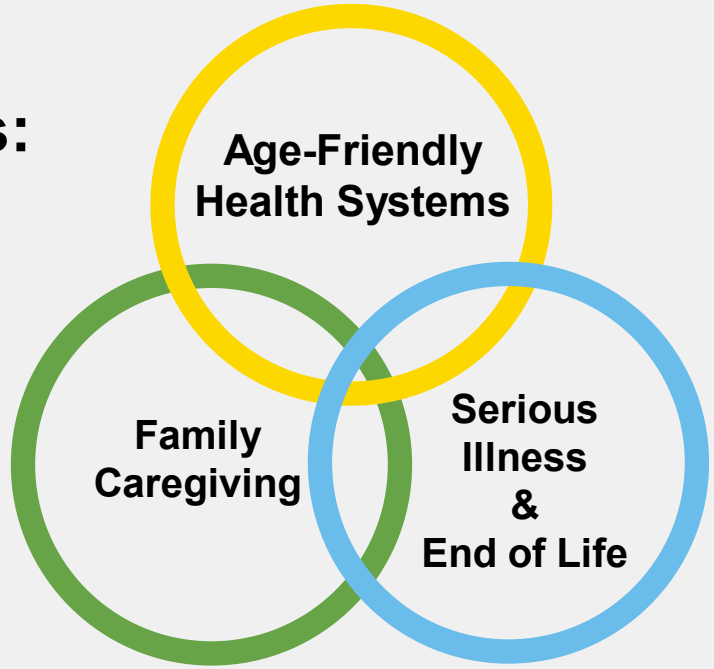
The John A. Hartford Foundation

A private philanthropy based in New York, established by family owners of the A&P grocery chain in 1929.

Dedicated to Improving the Care of Older Adults

Priority Areas:



The Path Forward

Hospitals and health care systems are committed to **A**dvancing **H**ealth **I**n **A**merica through:

Access: Access to affordable, equitable health, behavioral and social services

Health: Focus on holistic well-being in partnership with community resources

Innovation: Seamless care propelled by teams, technology, innovation and data

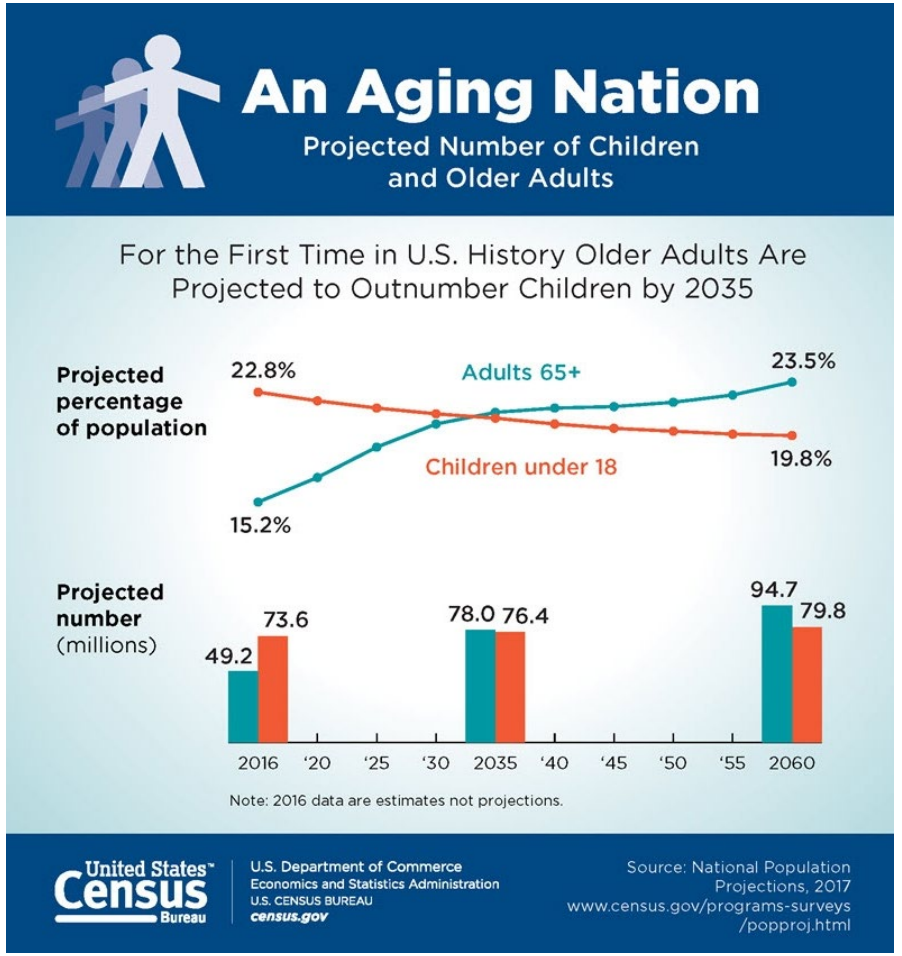
Affordability: The best care that adds value to lives

"H" of the future: Hospitals, **H**ealth systems and **H**ealth organizations are transforming and will continue to lead to provide a network of caring that improves the health of communities.

Age-Friendly Health Systems

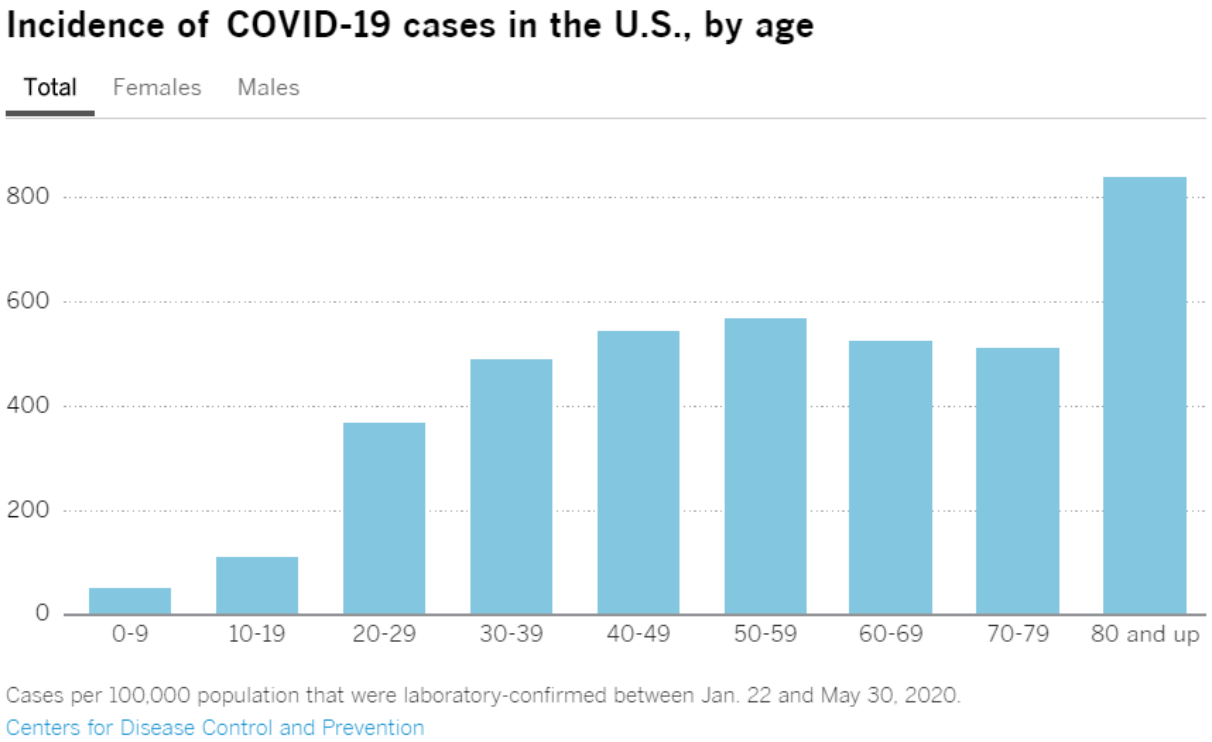
Why Age-Friendly Health Systems?

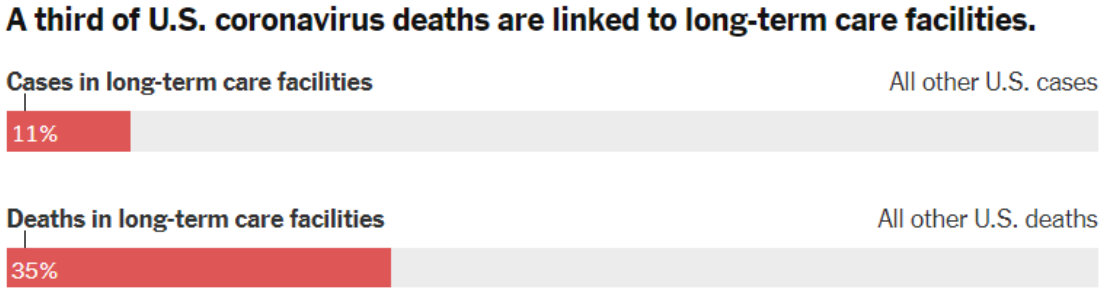
- Demography
- Complexity
- Disproportionate harm



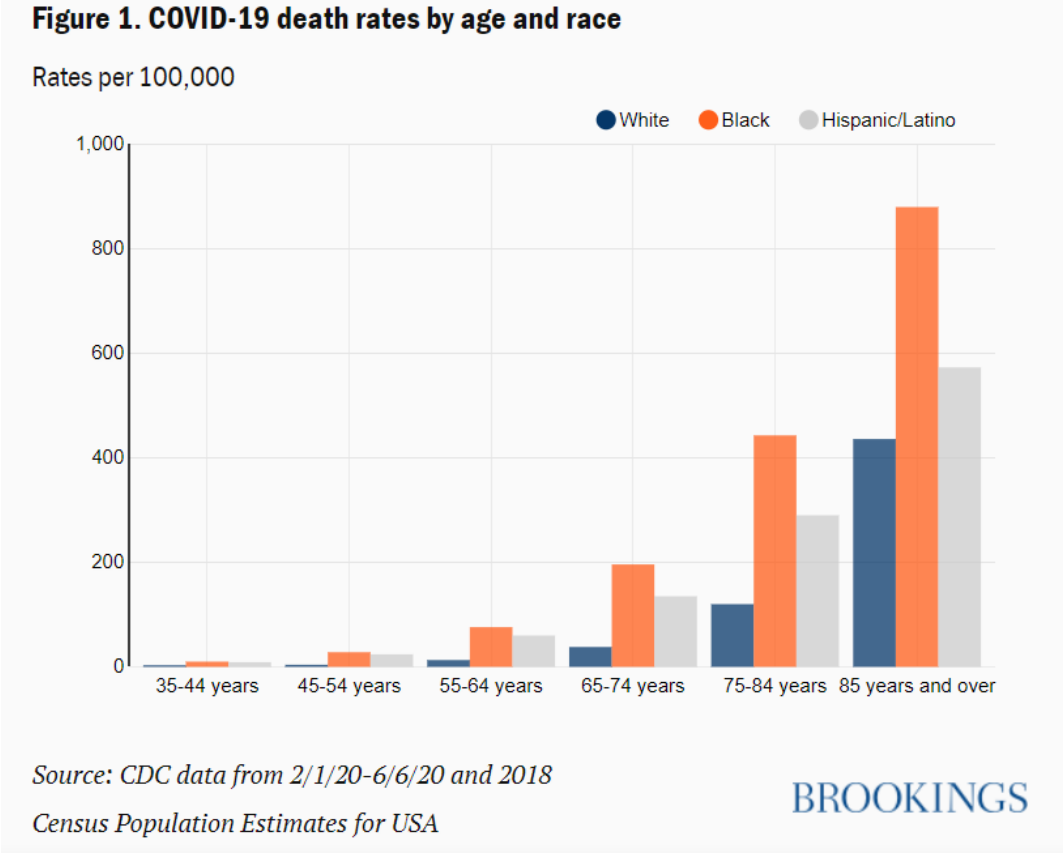
Age-Friendly Health Systems

Impact of COVID-19 on Older Adults





"The overall cumulative COVID-19 hospitalization rate is 89.3 per 100,000, with the highest rates in people aged 65 years and older: - CDC



What is Our Goal?

Build a social movement so ***all care*** with older adults is ***age-friendly care***:

- Guided by an essential set of evidence-based practices (4Ms);
- Causes no harms; and
- Is consistent with What Matters to the older adult and their family.

Specific Aims:

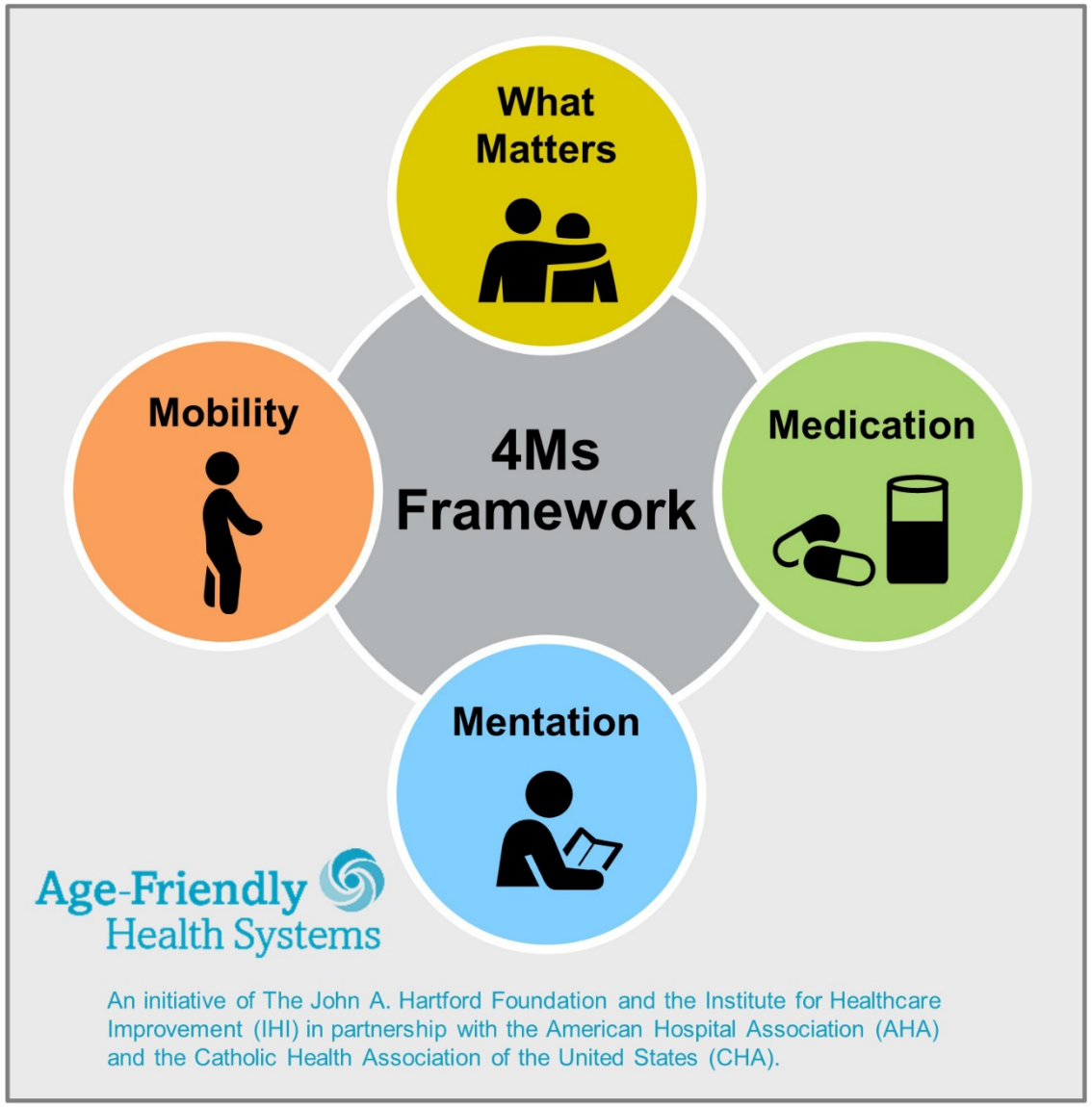
- By 12/31/20: Reach older adults in 1000 hospitals and practices recognized as Age-Friendly Health Systems
- By 6/30/23: Reach older adults in 2500 hospitals and practices, and 100 post acute communities recognized as Age-Friendly Health Systems

Evidence-base

- **What Matters**:
  - Asking what matters and developing an integrated systems to address it lowers inpatient utilization (54% dec), ICU stays (80% dec), while increasing hospice use (47.2%) and pt satisfaction (AHRQ 2013)
- **Medications:**
  - Older adults suffering an adverse drug event have higher rates of morbidity, hospital admission and costs (Field 2005)
  - 1500 hospitals in HEN 2.0 reduced 15,611 adverse drug events saving $78m across 34 states (HRET 2017)
- **Mentation:**
  - Depression in ambulatory care doubles cost of care across the board (Unutzer 2009)
  - 16:1 ROI on delirium detection and treatment programs (Rubin 2013)
- **Mobility:**
  - Older adults who sustain a serious fall-related injury required an additional $13,316 in hospital operating cost and had an increased LOS of 6.3 days compared to controls (Wong 2011)
  - 30+% reduction in direct, indirect, and total hospital costs among patients who receive care to improve mobility (Klein 2015)

Age-Friendly Health Systems

What is an Age-Friendly Health System?



For related work, this graphic may be used in its entirety without requesting permission.
Graphic files and guidance at ihi.org/AgeFriendly

What Matters

Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.

Medication

If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

Mentation

Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Mobility

Ensure that older adults move safely every day in order to maintain function and do What Matters.

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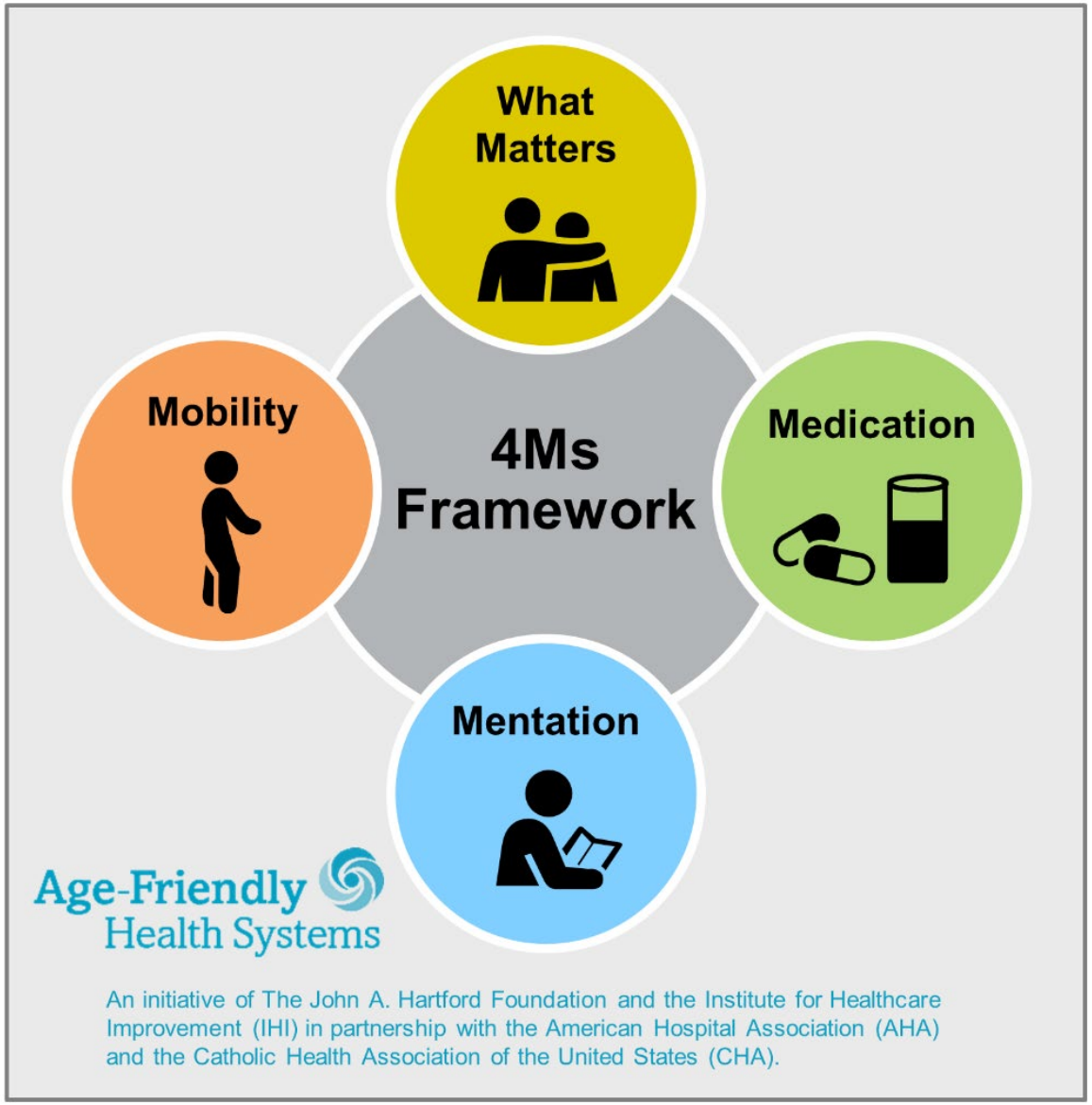
Why the 4Ms?

- Represents core health issues for older adults
- Builds on strong evidence base
- Simplifies and reduces implementation and measurement burden on systems while increasing effect
- Components are synergistic and reinforce one another



Age-Friendly Health System Pioneers

Age-Friendly Health Systems
Pioneer

Anne Arundel Medical Center

ASCENSION

KAISER PERMANENTE®

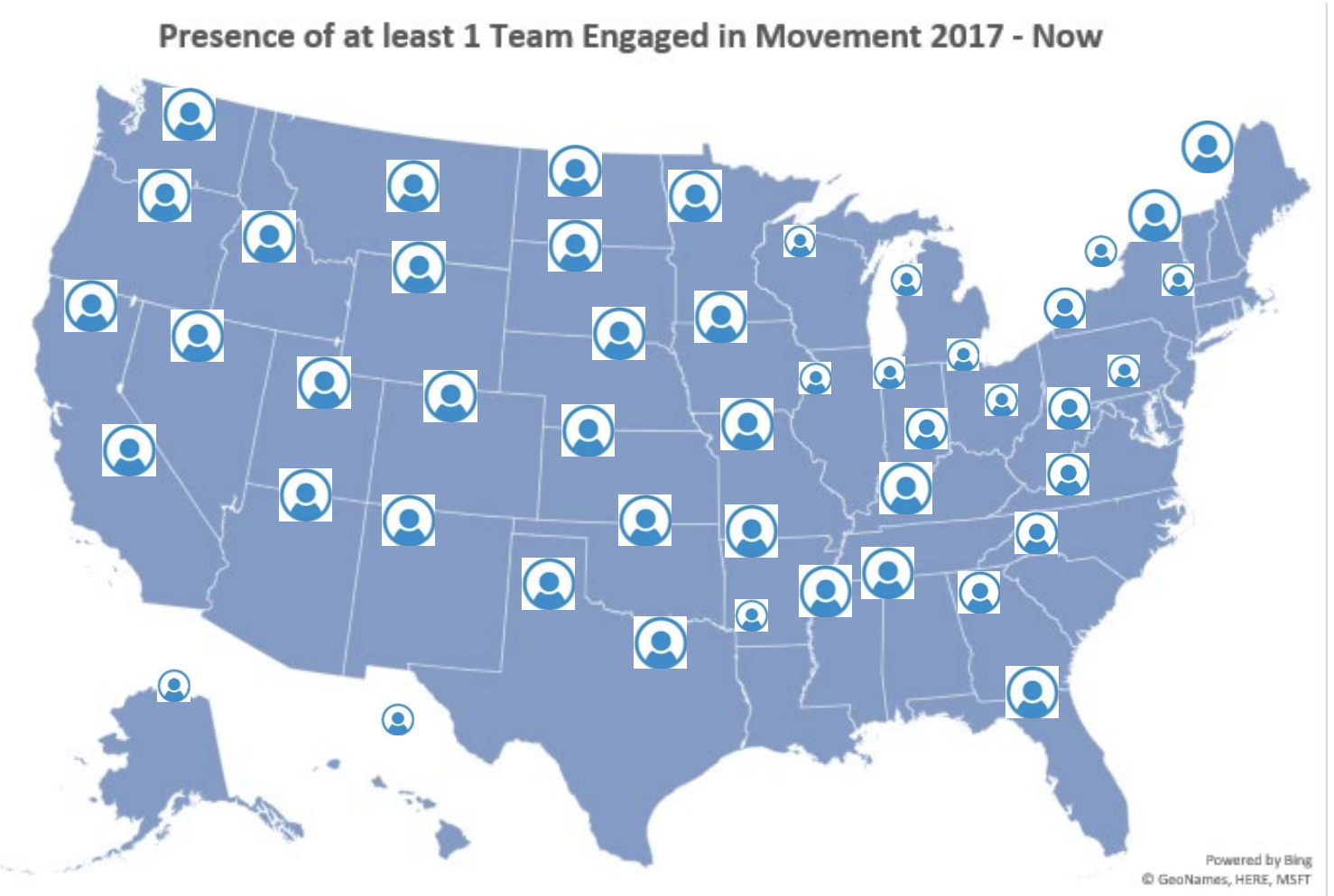
Providence St. Joseph Health

Trinity Health

www.aha.org/AgeFriendly

Age-Friendly Health Systems

Action Community – Starting in September



625 Teams (hospital-based teams, ambulatory care teams and long term**)**
in <u>all 50</u> states

Age-Friendly Health Systems

Engage in the AHA Action Community

7 Months

Participate in monthly interactive webinars

- Monthly content calls focused on 4Ms
- Opportunity to share progress and learnings with other teams

In-person meeting

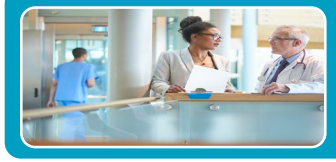
- One in-person meeting (TBD)

Test Age-Friendly interventions

- Test specific changes in your practice

Share data on a standard set of Age-Friendly measures

- Submit a data dashboard on a standard set of process and outcome measures



Join one drop-in coaching session

- Join other teams for measurement and testing support in monthly drop-in coaching sessions

Leadership track to support system-level scale up

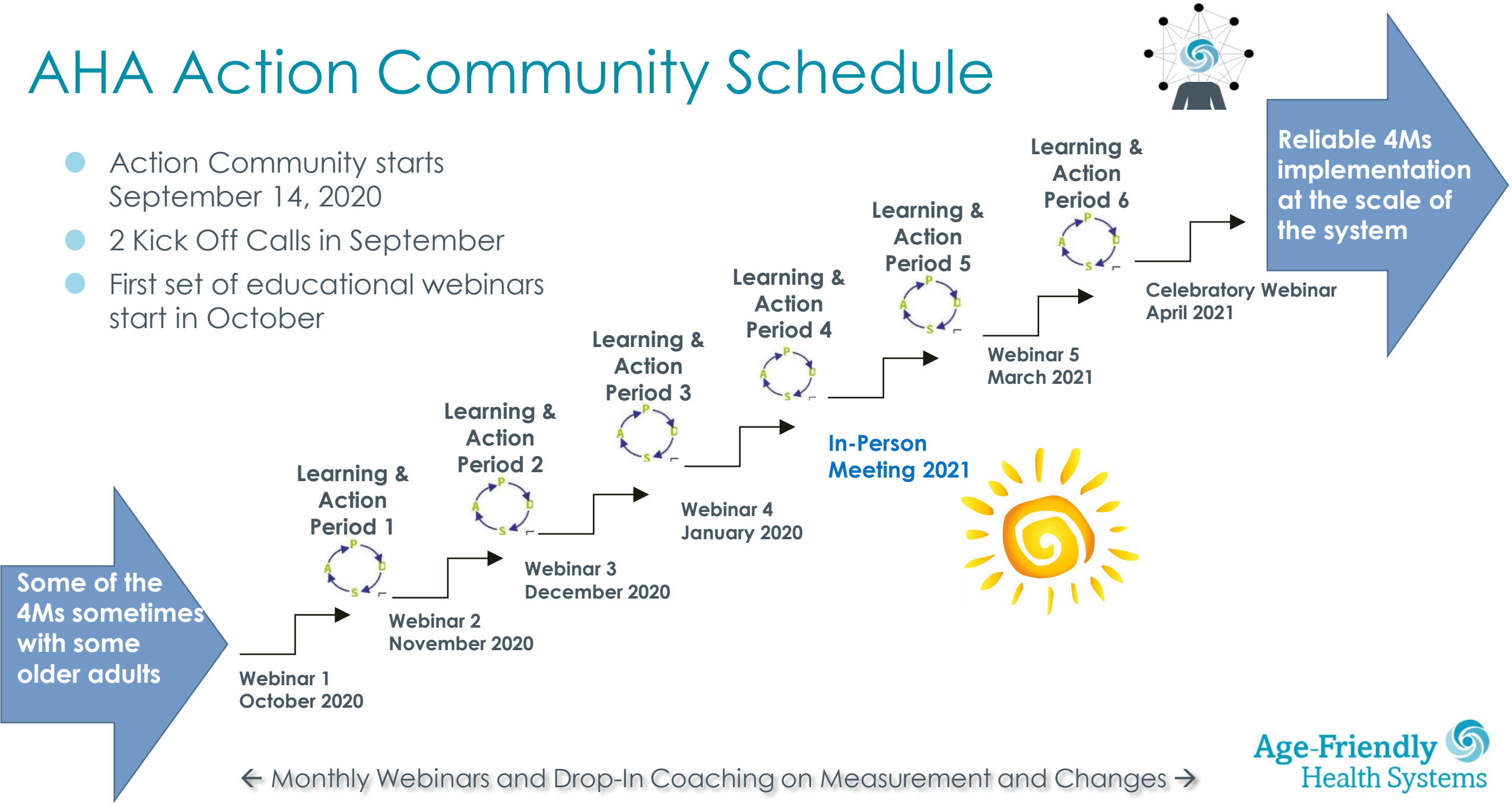
- Leaders join monthly C-suite/Board level calls to set-up local conditions for scale up (Hosted by IHI)

Age-Friendly Health System Action Community

Age-Friendly Health Systems

AHA Action Community Schedule

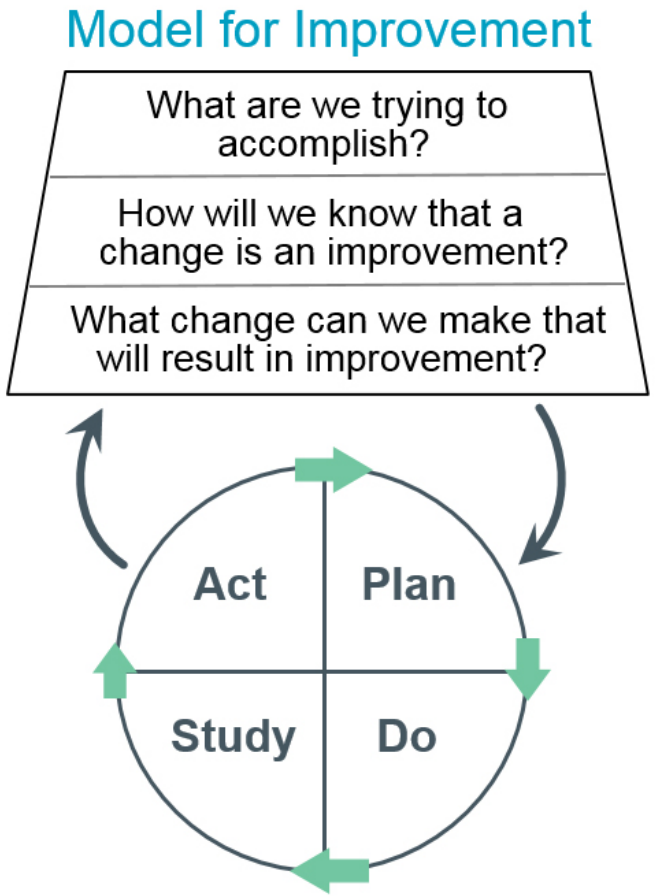
- Action Community starts September 14, 2020
- 2 Kick Off Calls in September
- First set of educational webinars start in October



Age-Friendly Health Systems

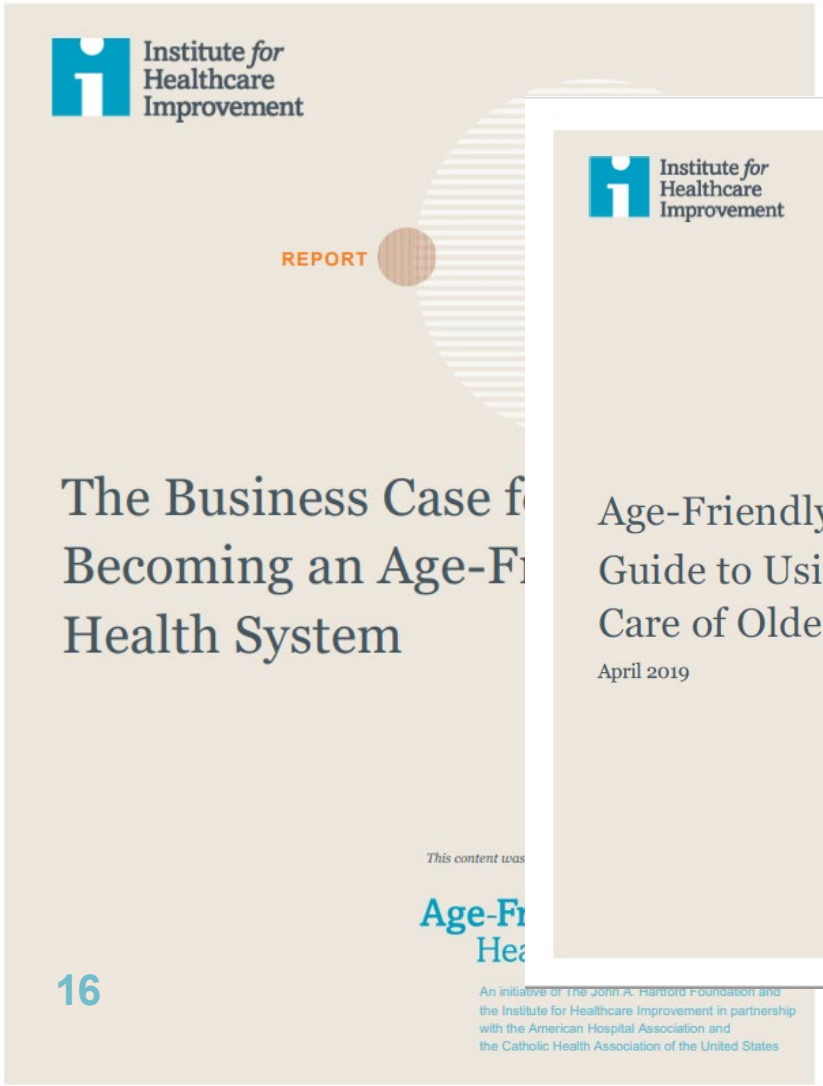
What's the Work of Each Participating Team

- Know where and how the 4Ms are already in practice and secure leadership support and commitment
- Define what it means to provide care consistent with the 4Ms
- Design/adapt your workflow to deliver care consistent with the 4Ms, including how you will assess, document and act on the 4Ms
- Provide care consistent with the 4Ms
- Study your performance. Measure and share – how reliable is your care? What impact does your care have?
- Improve and sustain care consistent with the 4Ms and share learnings with others



The Model for Improvement was developed by Associates in Process Improvement. [Source: Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009.]

Resources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REPORT
The Business Case f
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Institute for Healthcare Improvement
Age-Friendly Health System
Guide to Using the 4Ms in t
Care of Older Adults
April 2019
This content was created especially for:
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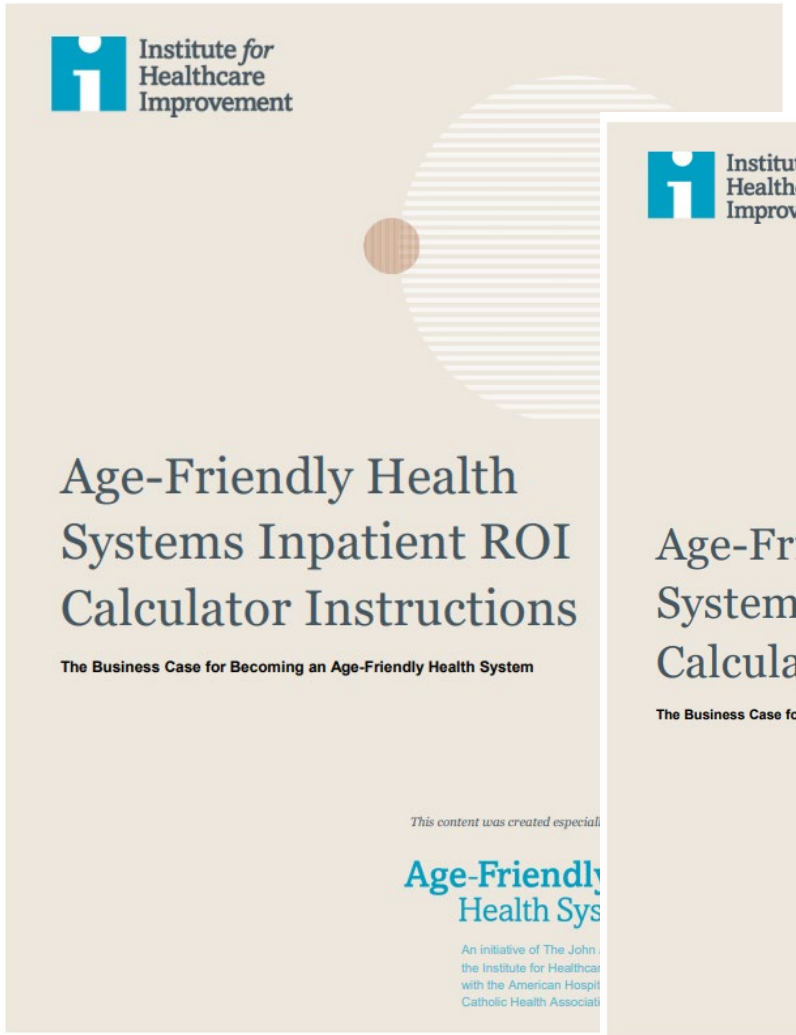
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Age-Friendly Health Systems Inpatient ROI Calculator Instructions
The Business Case for Becoming an Age-Friendly Health System
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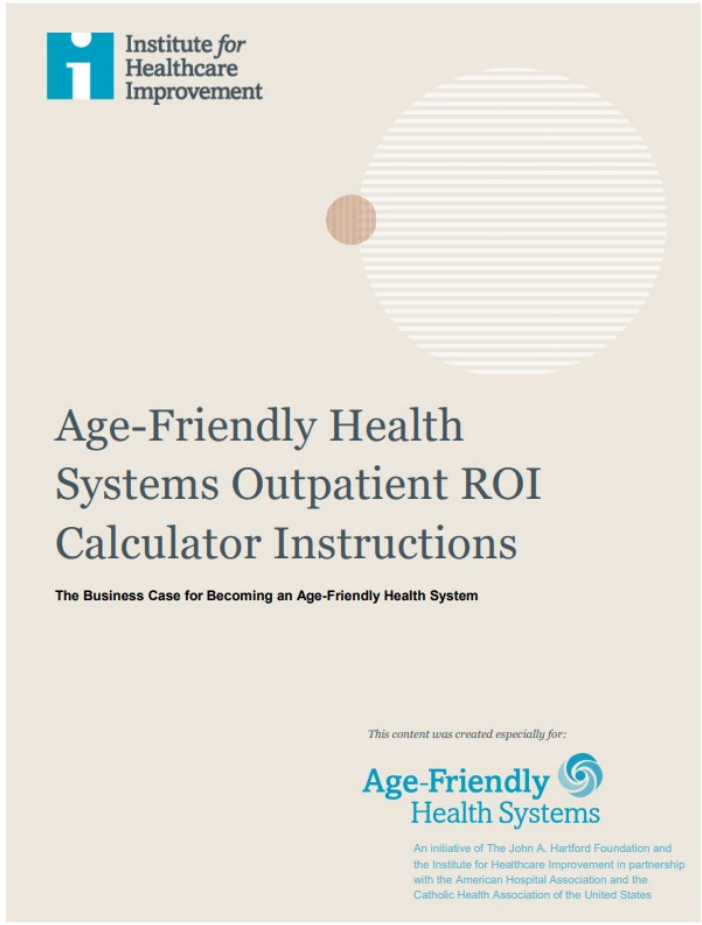
Institute for Healthcare Improvement
TOOLKIT
"What Matters" to Older Adults?
A Toolkit for Health Systems to Design Better Care with Older Adults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Age-Friendly Health Systems Outpatient ROI Calculator Instructions
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Practical Ideas for Changing the "Way we do it"

- Convert the white board to a "what matters" board
- Mobility check upon check-in
- Blood draw to 6am instead of 4am
- Mobility place mats; Brain games on flip side
- My Story with every chart
- Add a mobility check to a vitals check
- Use Straws instead of pitchers
- COVID-19 Telehealth visits

Age-Friendly Health Systems

Definition of an Age-Friendly Health System

An Age-Friendly Health System…

1. **Defines** the 4Ms for its hospital and/or practice
    1. (e.g. Hospital: How it will screen for delirium every 12 hours; Practice: What tool will it use to screen for depression and how does the screen fit into the AWV flow)
2. **Counts** the number of older adults whose care includes the 4Ms (reported by each site)
3. **Shares** the information with the Action Community and AHA to be celebrated on aha.org

Age-Friendly Health Systems

Level 1 & 2 Recognition

- Level 1 – Be recognized as an Age-Friendly participant
- Level 2 – Committed to Care Excellence

Age-Friendly Health Systems
Participant

Age-Friendly Health Systems
Committed to Care Excellence for Older Adults

Age-Friendly Health Systems

Sites Recognized by the Movement

Age-Friendly Health Systems
Participant

742

Hospitals, practices and post-acute communities have described how they are putting the 4Ms into practices (4Ms Description Survey)

Age-Friendly Health Systems
Committed to Care Excellence for Older Adults

170*

Hospitals, practices and post-acute communities have shared the count of older adults reached described how they are putting the 4Ms into practices

www.ihi.org/AgeFriendly

www.aha.org/AgeFriendly

**Age-Friendly Health System-Participants* count is inclusive of hospitals and practices that went on to be recognized as *Age-Friendly Health Systems-Committed to Care Excellence as of June 1, 2020*

Age-Friendly Health Systems

Action Community Monthly Data Sharing

1. Definition of the how you are putting the 4Ms into practice

Age-Friendly Health Systems
Participant

2. Count of 65+ people whose care includes the 4Ms

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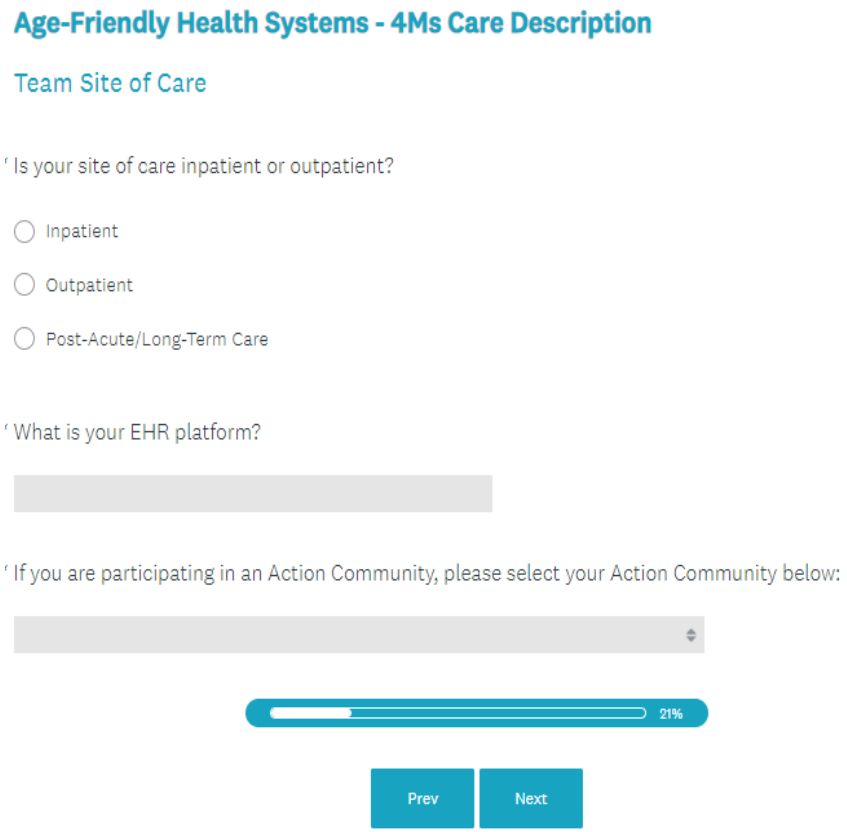
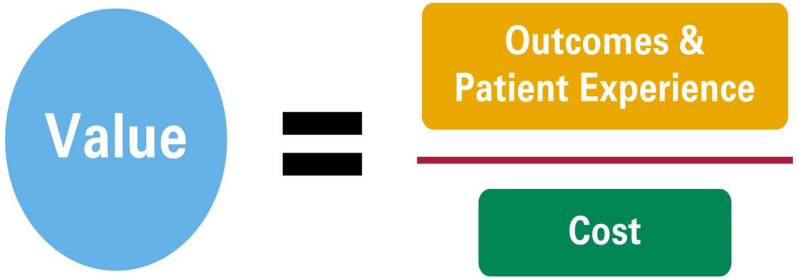
Committed to Care Excellence for Older Adults



Age-Friendly Health Systems

Connecting Age-Friendly Measures with Value



Age-Friendly Measures			The Value Equation
Basic Outcome Measures	**Hospital Setting**	**Ambulatory/Primary Care Setting**	**Components**
30-day readmission	X		Patient outcomes, cost
Emergency department utilization		X	Patient outcomes, cost
Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey	HCAHPS	CGCAHPS	Patient outcomes, Patient experience
Length of stay	X		Patient outcomes, cost
Advanced Measures	**Hospital Setting**	**Ambulatory/Primary Care Setting**	**The Value Equation**
Delirium	X	N/A	Patient outcomes, cost
CollaboRate (or similar tool to measure goal concordant care)	X	X	Patient outcomes, Patient experience

The Value Initiative

Age-Friendly Health Systems

Join AHA Action Community 2020-2021

- **Join and get your Age-Friendly Recognition. It's FREE**

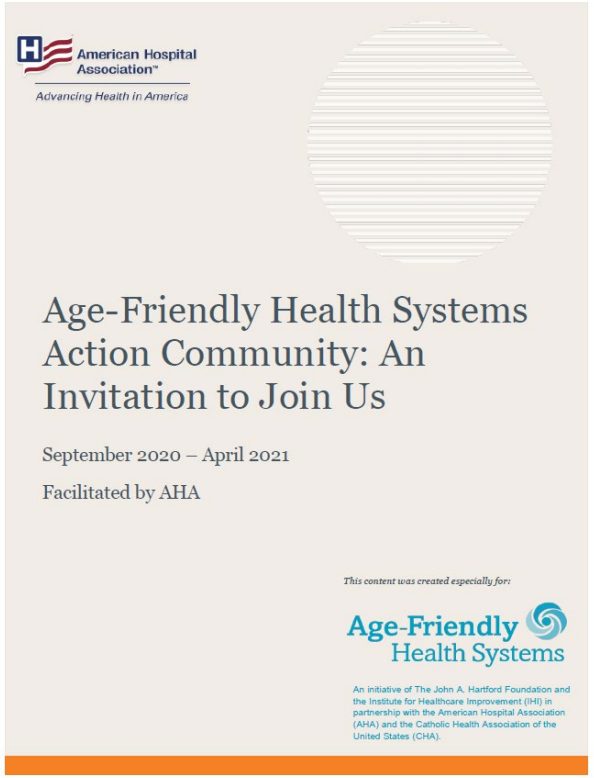
- **AHA AFHS Action Community is from September 2020 – April 2021**
  - Monthly all-team webinars
  - Scale-up leaders webinars
  - Listserv, sharing learnings
  - Monthly reports on testing and learnings
  - Celebration of joining the movement!

- **Register for Upcoming Webinars**
  - July 15, 2020 (12:00 – 1:00 PM ET) - Register here
    - Featuring Cedars-Sinai Medical Center
  - August 19, 2020 (12:00 – 1:00 PM ET) - Register here
    - Featuring Stanford Health Care

- **Download AHA's Invitation Guide and visit aha.org/agefriendly to learn**

- **Email ahaactioncommunity@aha.org with any questions.**

Enroll Today!



Age-Friendly Health Systems

Hartford HealthCare

Senior Services

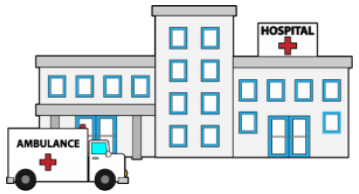
Christine Waszynski DNP, APRN, GNP-BC, FAAN
Hartford Hospital June 24, 2020

Hartford HealthCare Geriatric Continuum of Care

APRN Home Visits/ REACH

Serve 13 towns

Home



1 of 7 hospitals

Hospital Inpatient Consults & Programs

8 sites

Outpatient Geri Consults
Primary Care
Geriatric oncology
Co-management

PPN SNFs/SNF programs

9 sites

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

4 M's

- What Matters
- Medications
- Mobility
- Mentation

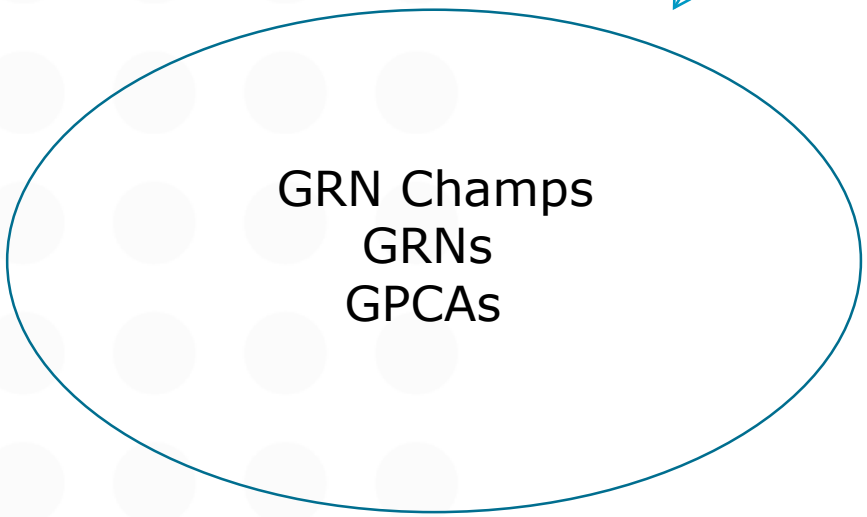
Goal: To provide an integrated, seamless, comprehensive care system linking seniors and their families to the services required and requested to maintain and restore health in alignment with expressed patient goals/wishes.

Hartford Hospital
Hartford CT

Hartford HealthCare
Senior Services

Inpatient Geriatric Team Players

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



Hartford HealthCare
Senior Services

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 (2011-present)

Actions to enhance **D**elirium **A**ssessment **P**revention and **T**reatment

- 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

PROVIDER

PATIENT

NURSES

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?**

YES

NO

YES

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 Distracters (doll, animal)
- Discuss follow-up with family
- Document individualized care needs on W10/After Visit Summary

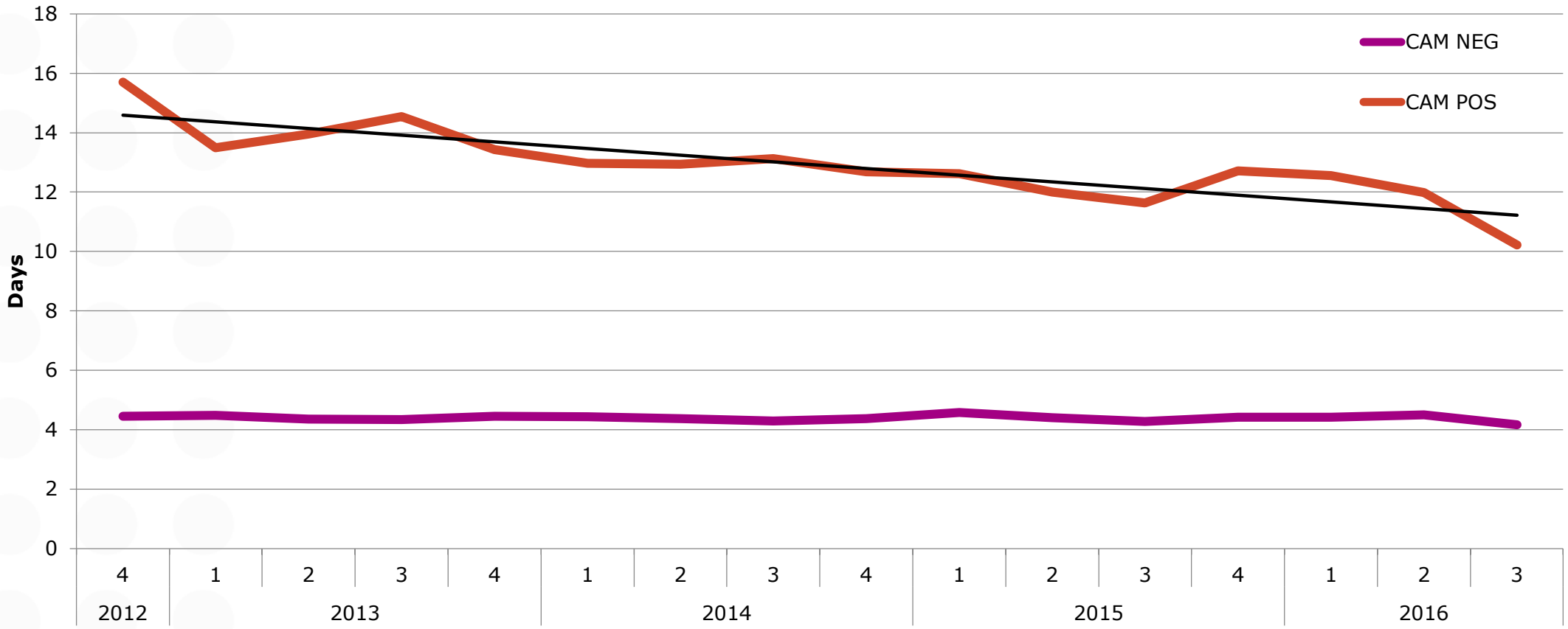
*see back of brochure for more information

[1] Flaherty, 2011

tford HealthCare
Services

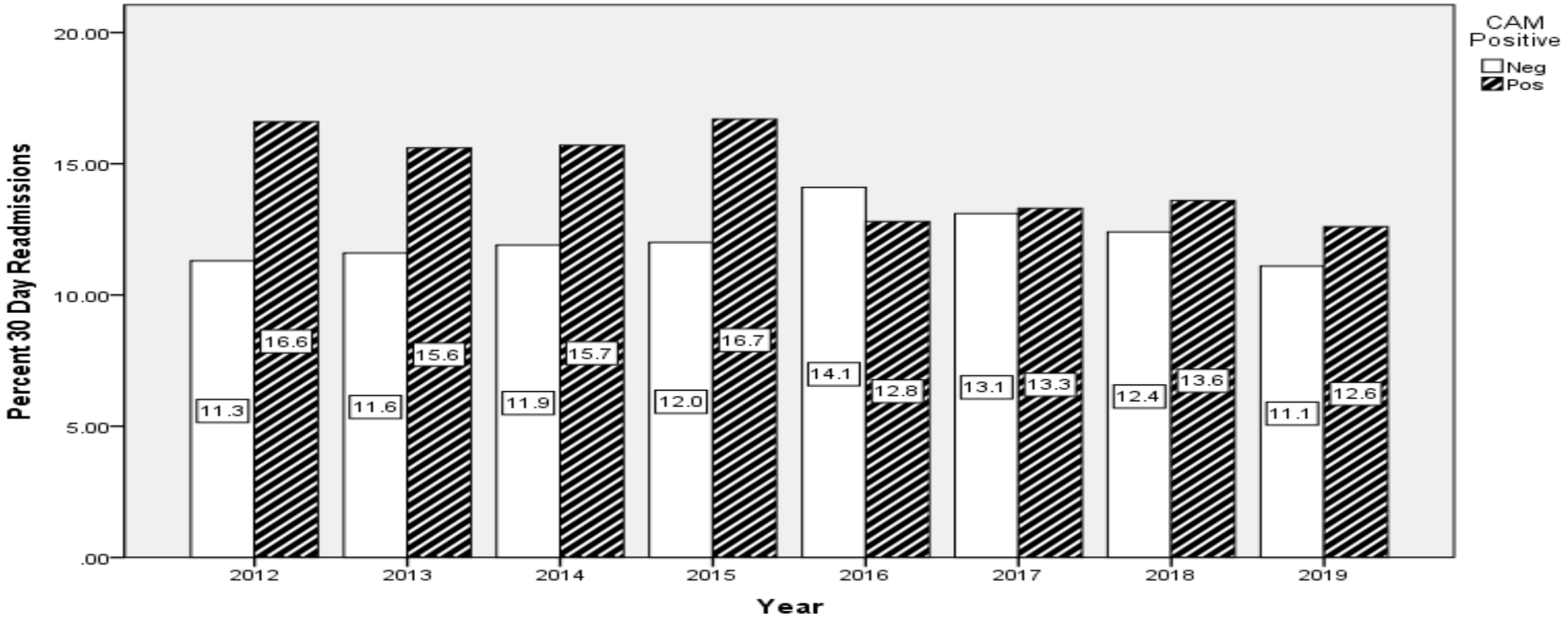
Outcome: Decreased Length of Stay In Patients with Delirium

ADAPT DATA



Hartford HealthCare
Senior Services

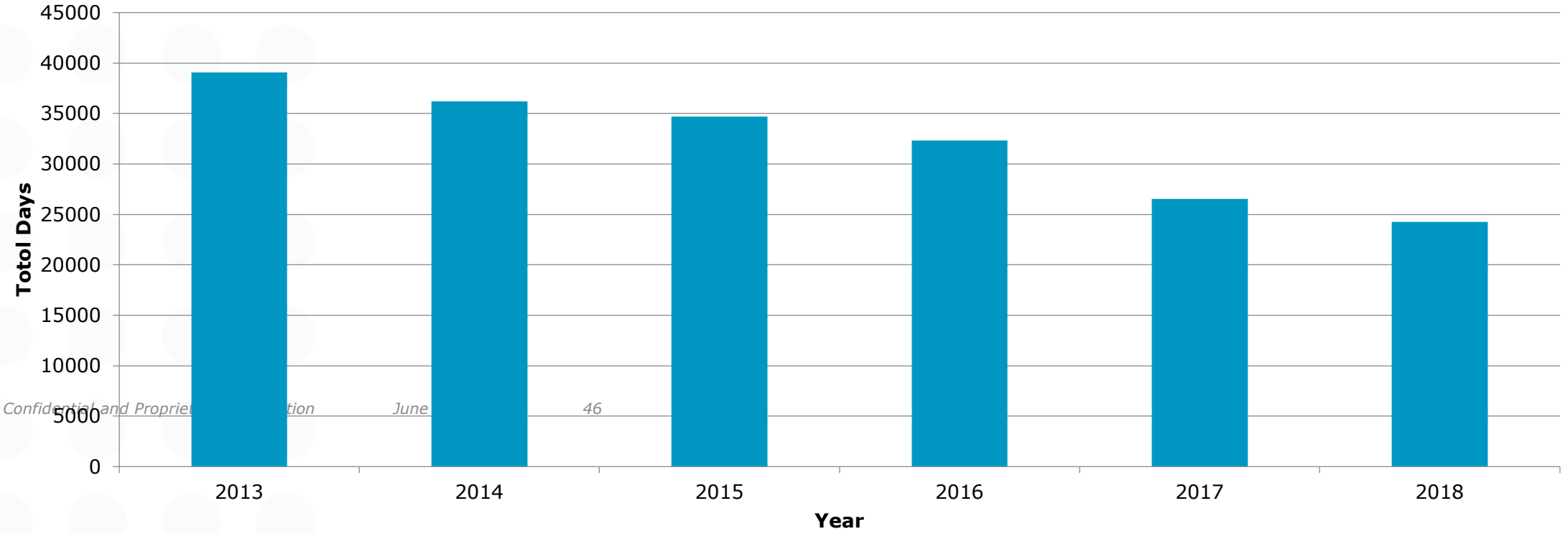
30 Day All Cause Readmission Rates Over Time



Hartford HealthCare
Senior Services

Delirium Attributable Days

ADAPT Data



Hartford HealthCare
Senior Services

ROI Calculator Applied to ADAPT

1 2 3 4 5 | Scenarios | Scenario Name: No PAC | Find Levels (Target ROI)

1. Start	Acute Care for Elderly

2. Population & 4M Period	
Number of annual admissions	31,000
Amortization period (Years)	5

3. 4M Costs		Per Year
Launch - one time only expenses	$10,000	$2,000
Fixed expenses		$0
Variable cost per admission	$20	$620,000
Total annual cost of program		*******

5. Case cost from coding & payment for HAC	
Revenue per case detected (code modification)	$3,050
Detection & coding effectiveness (% cases)	50.0%
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

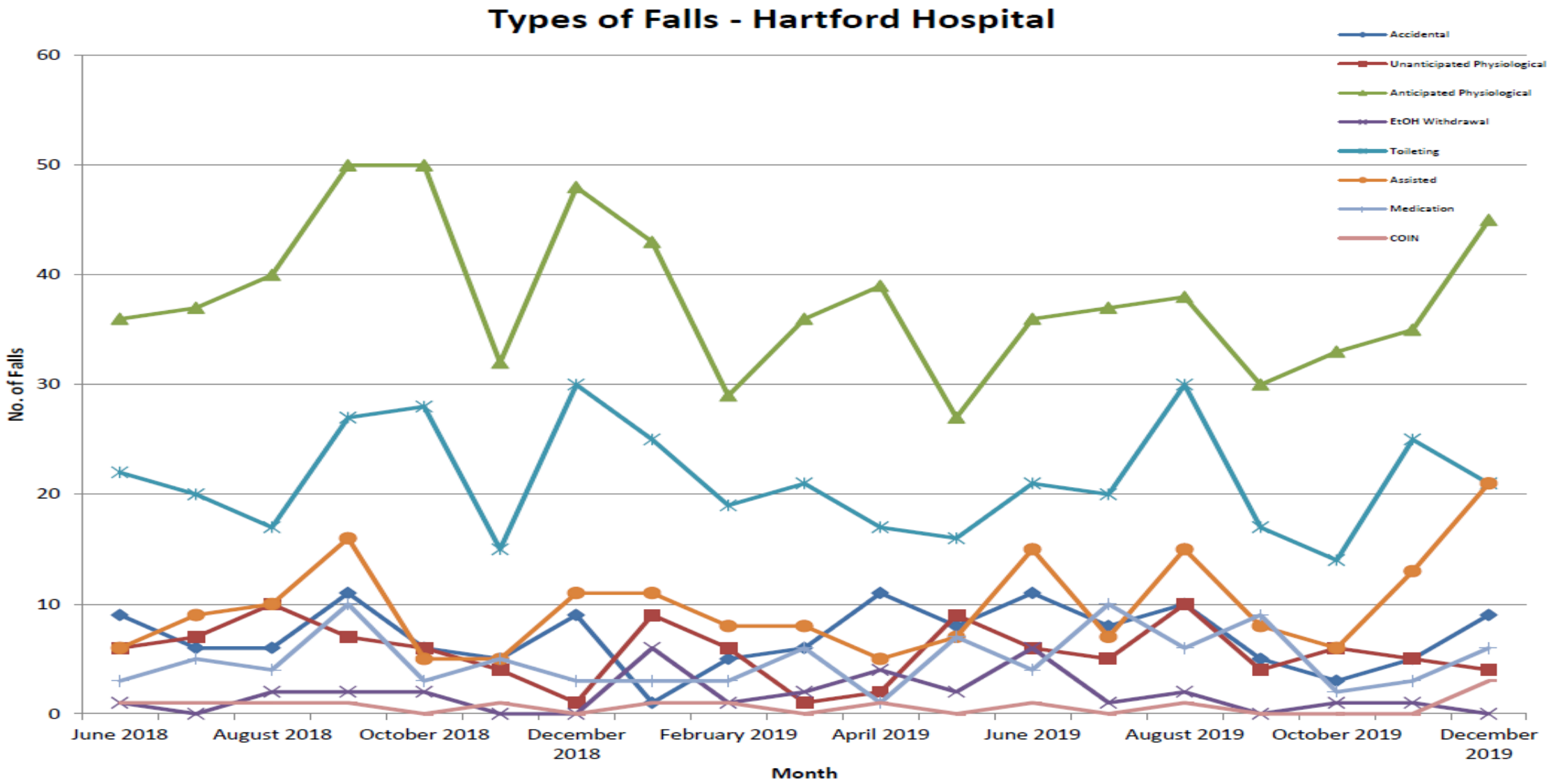
Levels	
Target ROI	300%
Delirium Effectiveness	20.4%
Delirium Incidence (%)	10.1%
Total Program Cost	$686,249

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%	0.0%	0.0%
	Total cases	3720	0	0
	4M program effectiveness	15.0%	0.0%	0.0%
	Cases avoided	558	0	0

	Type of stay	Length of sta	Cost per day	Length of sta	Cost per day	Length of sta	Cost per day
HA Condition	Normal	5.0	$2,000	5.0	$2,000	5.0	$2,000
	Extended due to condition	5.2	$260	0.0	$0	0.0	$0
	ded hospital case cost		**$13,052**		**$0**		**$0**

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

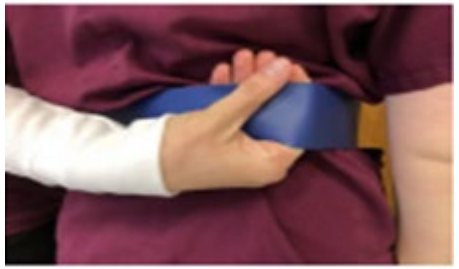


Hartford HealthCare
Senior Services

Safe Mobilization

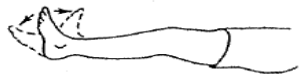
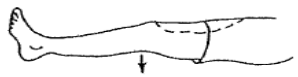
- Mobility volunteers since 2011 (PT or other health profession students)
- 17,500 mobility episodes

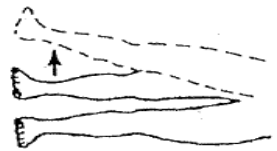
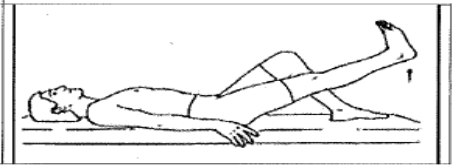
- Implemented Gait belt and walker for all mobilization of high fall risk patients



Bed Exercises- increase patient engagement in care

Supine Therapeutic Exercises

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 **10-15x times 2-3x a day**	
QUAD SETS **Position**: laying on your back with your leg straight **Action**: Squeeze thigh pushing knee down toward bed **10-15x times 2-3x a day**	
GLUT SETS **Position**: Laying on your back with your leg straight **Action**: squeeze buttocks together **10-15x times 2-3x a day**	
HEEL SLIDES **Position:** laying on your back with legs straight **Action:** slowly slide heel up towards hips with knee then return to starting position **10-15x times 2-3x a day**	
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 **10-15x times 2-3x a day**	

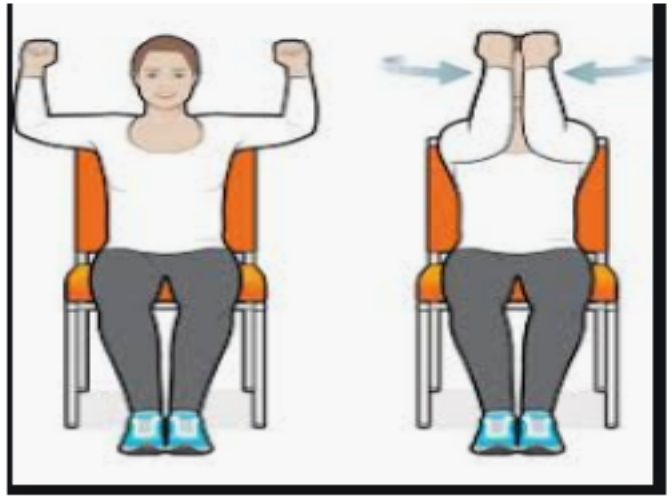
LEG ABDUCTION/ADDUCTION **Position**: laying on your back with leg straight **Action**: keep knee straight and toes toward ceiling, slide leg out as far as possible then return to starting position **10-15x times 2-3x a day**	
ADDUCTOR SQUEEZE **Position**: laying on your back, knees bent **Action:**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

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

Hartford HealthCare
Senior Services

Chair Exercises

Chair Exercises



Side Bends

Modified Dionne's Egress Test ™

Hartford Hospital
A Hartford HealthCare Partner

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

Test 1

- Rise sit-to-stand
  1. From sitting position, feet flat on floor, able to stand with minimal/moderate assistance of one person
  2. Remain standing

Test 2

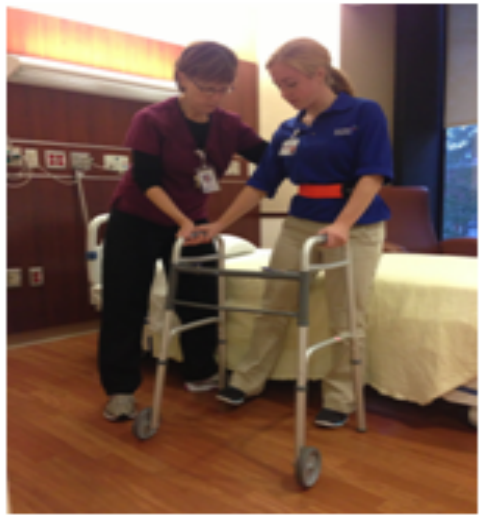
- Step in place
  1. Three steps in place with each foot. Must clear the floor without buckling of the supporting leg
  2. May use an assistive device
  3. Stay standing after last step

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.
  2. 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
- 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 _____

Low
Medium
High

Toileting Plan

Urinal
Bed Pan

Commode
At Bedside

Bathroom

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

Rehab Recommendations

Date:_____

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

Notes:

Care

Safer Mobilization

Safety Assessment Fall Evaluation Risk


Recent Fall


Dizziness

Weakness

Toileting Urgency


Forgetful/ confusion

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


Poor Vision


Poor Hearing


Recent Procedure/Surgery


Medication


Low Blood Pressure

Your Safe Mobility Plan

- ❑ Bed/chair alarm
- ❑ Gait belt
- ❑ Walker
- ❑ Assistance by 1 or 2 staff
- ❑ Wheelchair follow
- ❑ Other _____

Toileting Plan

Urinal	Incontinent
Bed Pan	Bathroom
Commode At Bedside	Commode over toilet

Mobility Level

- ❑ Sit at Edge of Bed with Staff Assistance
- ❑ Stand/pivot to chair
- ❑ Walk with Staff Assistance
- ❑ Independent

Rehab Recommendations

Date:_____

Notes:

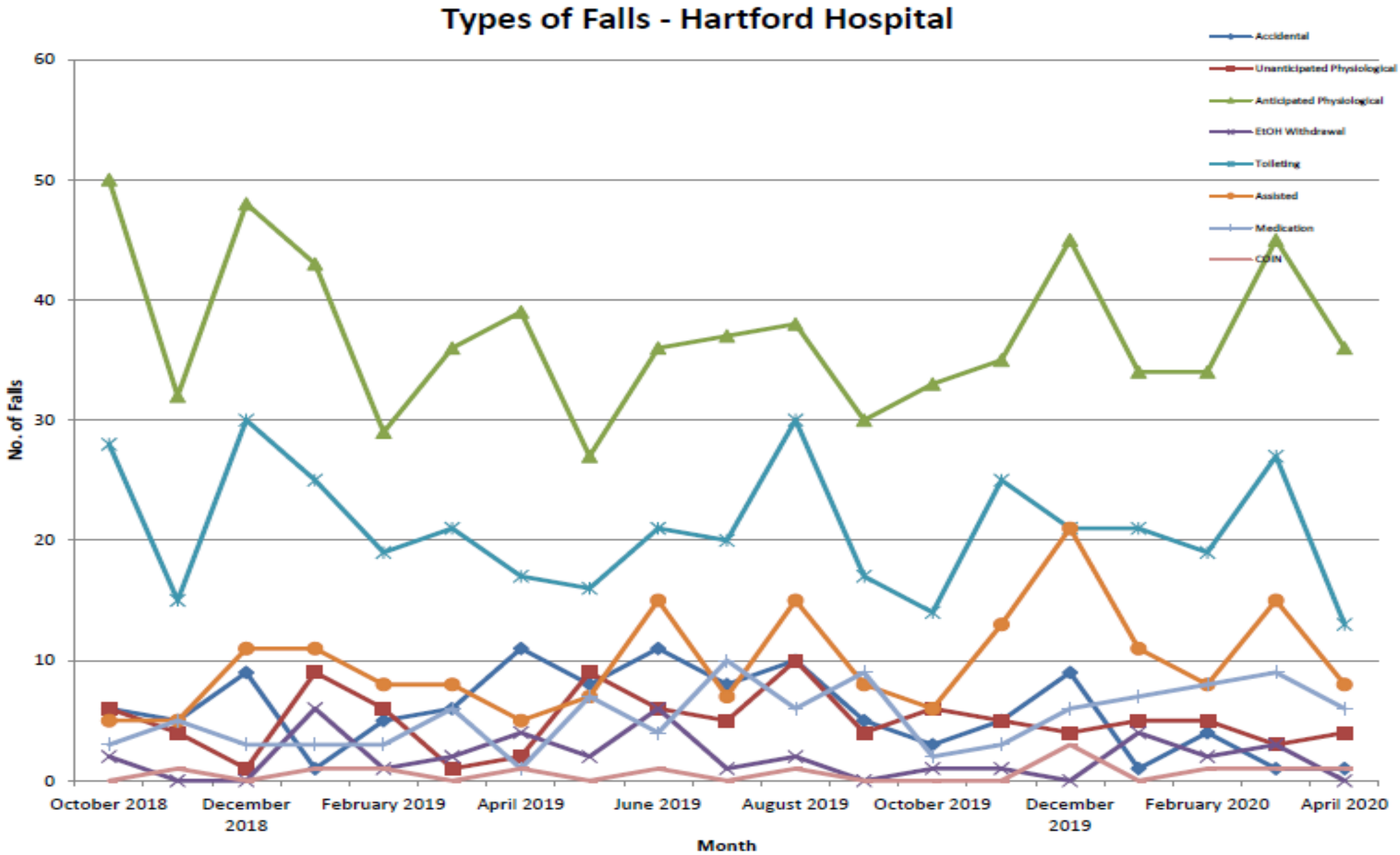
- ❑ Advance patient per Progressive Mobility Protocol
- ❑ Do not progress pt. without prior approval from rehab staff

Patient Responsibilities

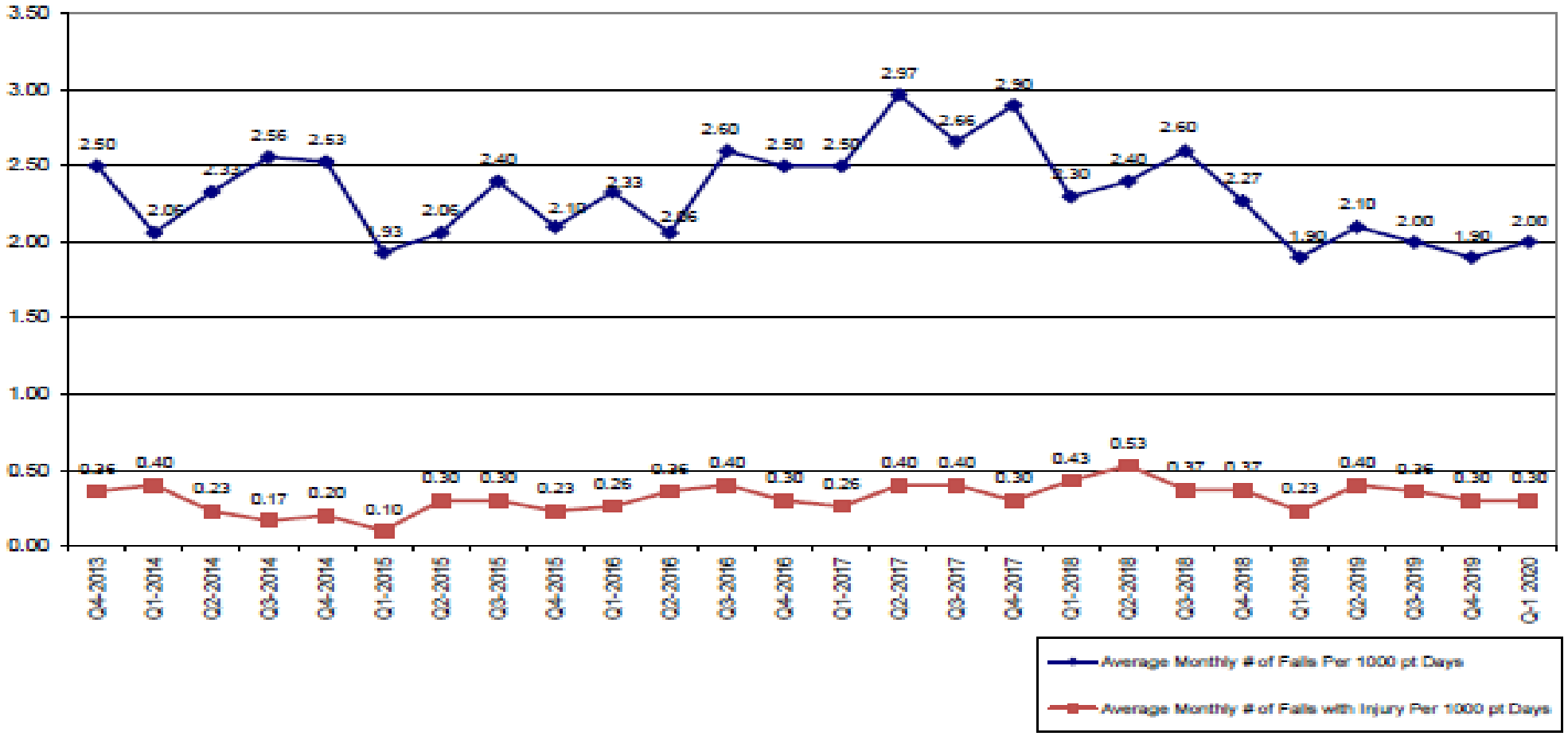
- Avoid sitting on edge of bed alone
- Call for staff assistance
- Participate in mobility activities
- Exercise as directed

Permit Staff To...

- Use a gait belt and walker as needed
- Stay during toileting
- Set exit alarm


Types of Falls - Hartford Hospital
Accidental
Unanticipated Physiological
Anticipated Physiological
EtOH Withdrawal
Toileting
Assisted
Medication
COIN
No. of Falls
60
50
40
30
20
10
0
October 2018
December 2018
February 2019
April 2019
June 2019
August 2019
October 2019
December 2019
February 2020
April 2020
Month

Average Quarterly Falls



Hartford HealthCare Cares About Me...

I like to be called:

What I do or used to do for work:

What I do for fun and activity:

My favorite TV shows, music, books are:

My family, friends, pets names are:

My favorite food:

I brought with me:

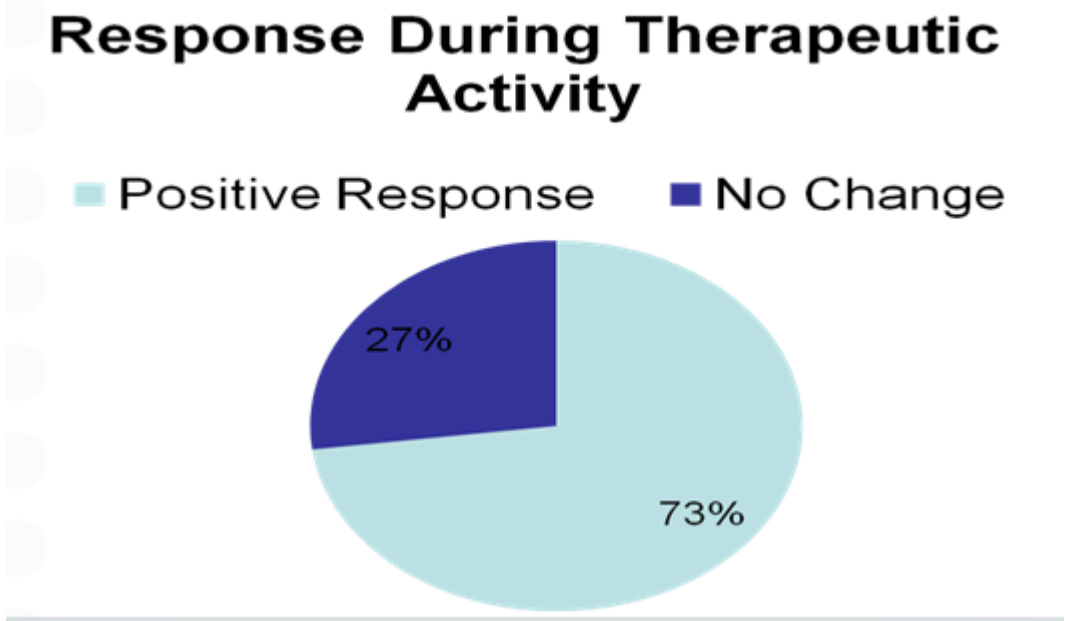
Dentures: No / Yes: Upper / Lower / Both

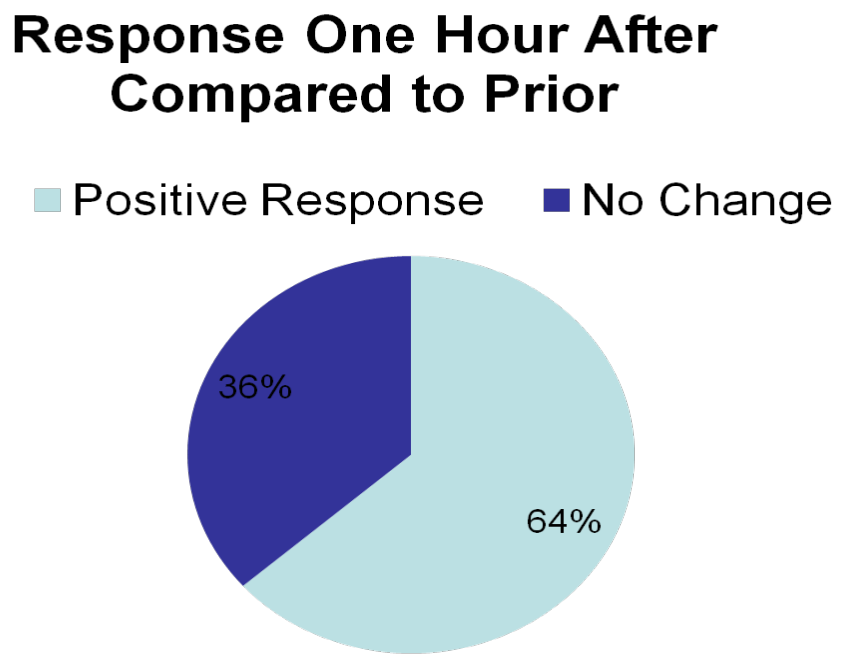
Glasses: No / Yes

Hearing Aides: No / Yes: Right / Left / Both

Personalized activities for patients with cognitive impairment

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





Hartford HealthCare
Senior Services

Family Video Messaging

- Non pharmacological intervention to:

➢Provide comfort and connection to agitated patients with altered mental status

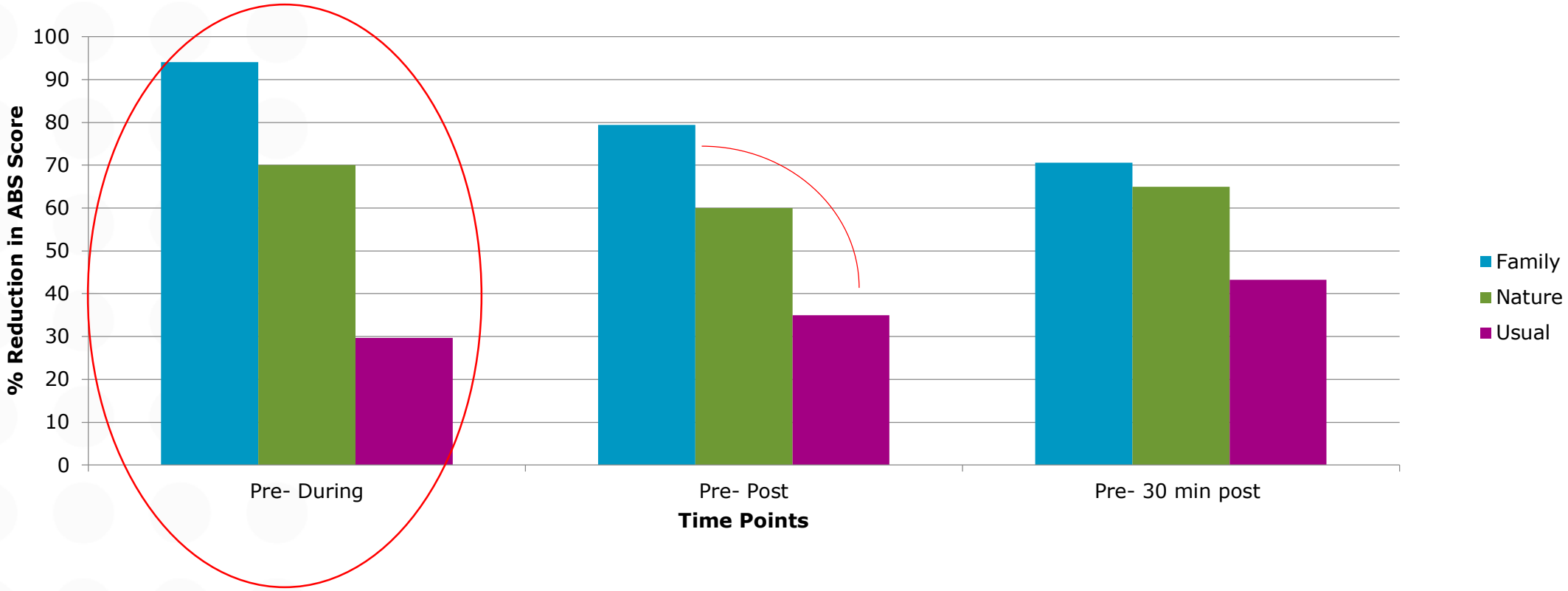
➢Engage families in care

➢Provide comfort to families

➢Offer a personalized intervention for staff

Example of Family Video Message

% of Participants Experiencing a Decrease in Agitation



Hartford HealthCare Senior Services

The Therapeutic HUB

Healing

Understanding

Belief in patient as person

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Senior Services

The Therapeutic HUB multi-sensory stimulation environment

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Senior Services

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.

Hartford HealthCare
Senior Services

Voice over powerpoint with video: Therapeutic HUB

- **https://vimeo.com/266874016/f693ff3a99**

Hartford HealthCare
Senior Services

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?* ___

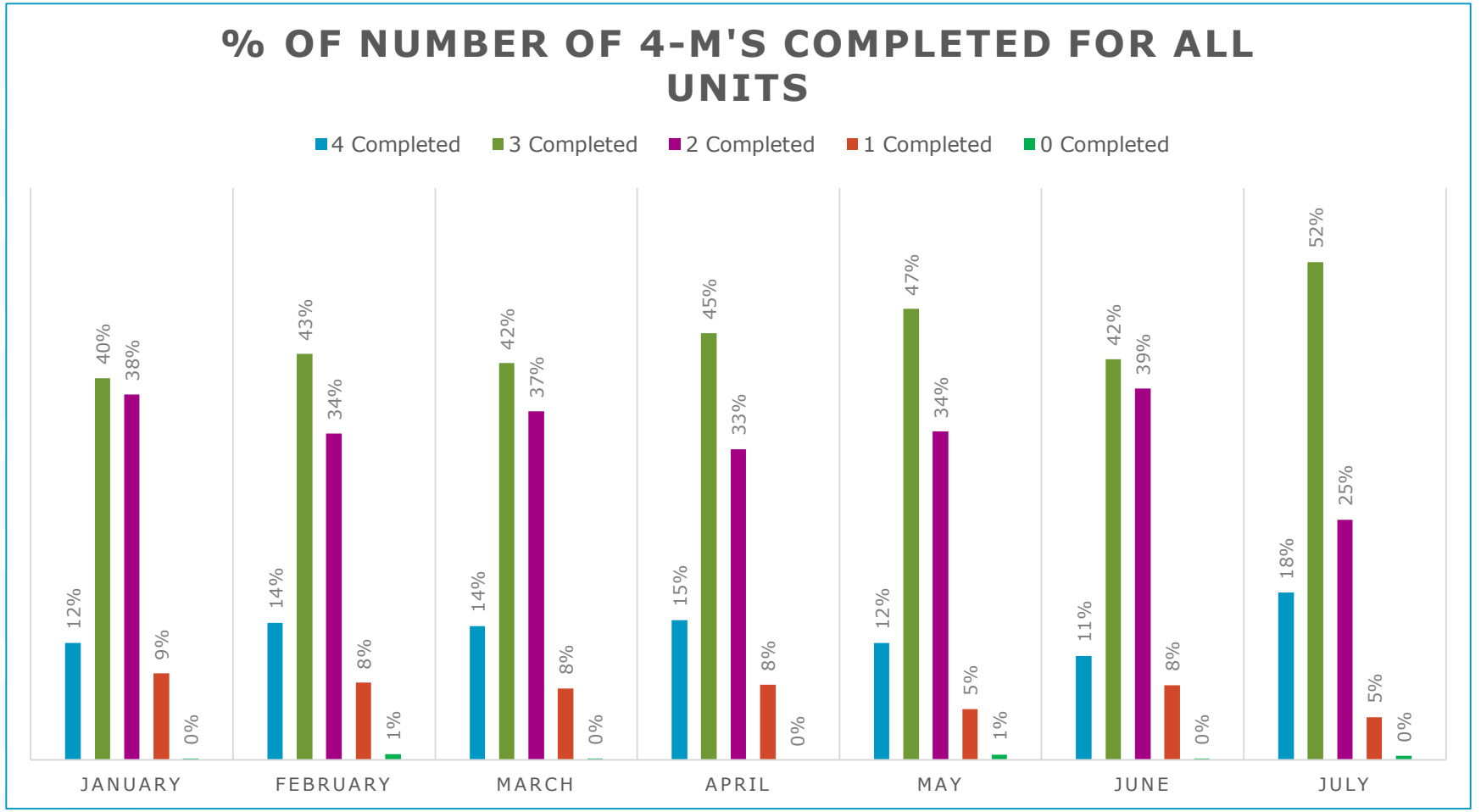
No effort Every effort

0 1 2 3 4 5 6 7 8 9

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

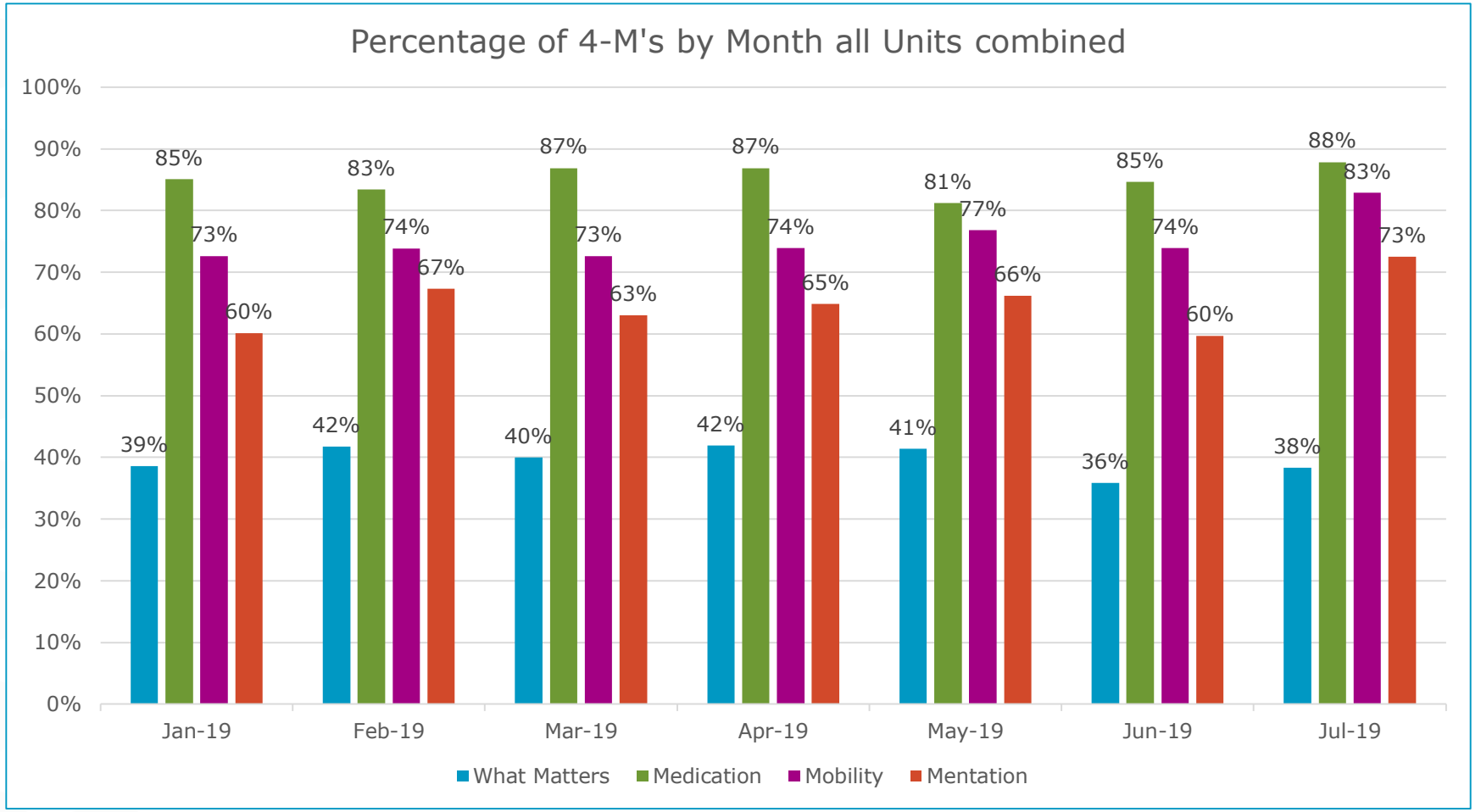
Hartford HealthCare Senior Services

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



Hartford HealthCare
Senior Services

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



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The CESI mobile program- Post Acute Care ADAPT

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Confidence questions

How confident are you:

1. Screening for delirium

2. Assessing for acute onset/fluctuating course of mental status different from baseline

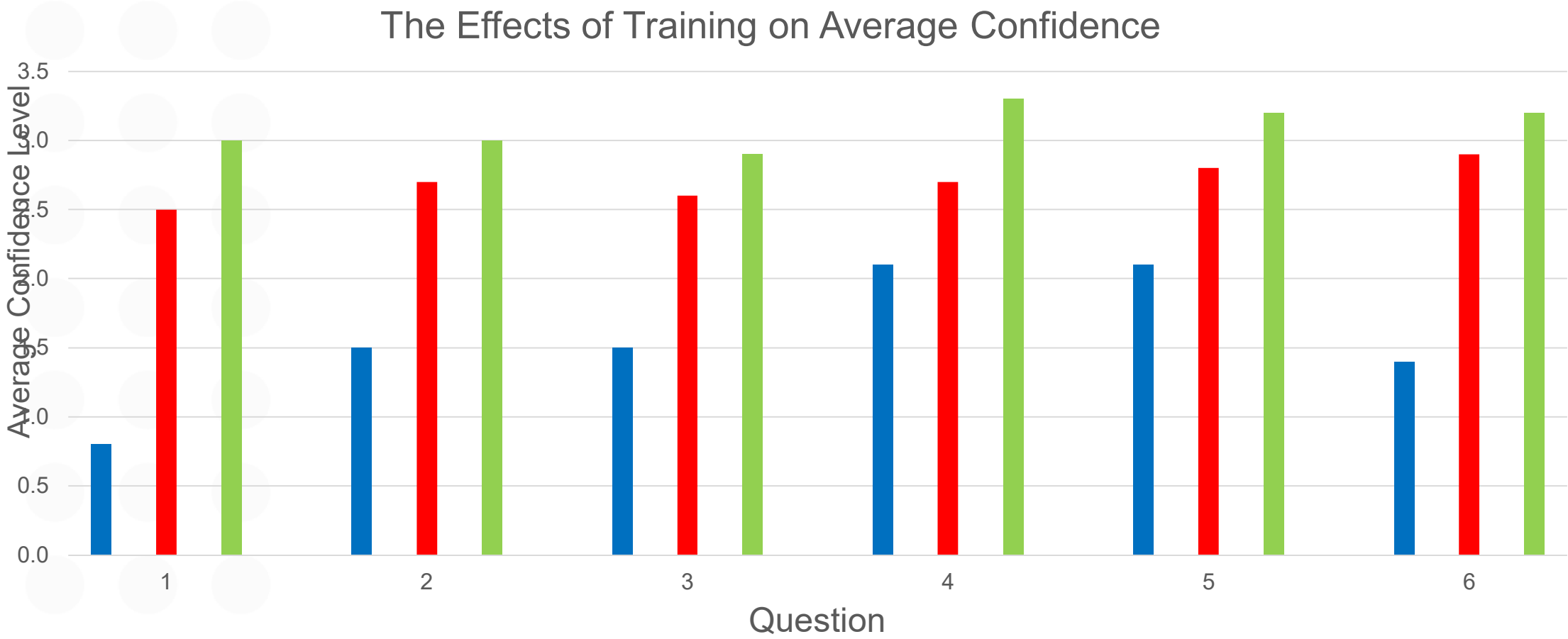
3. Assessing for inattention

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



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Brownstone- Annual Wellness

Population health project:

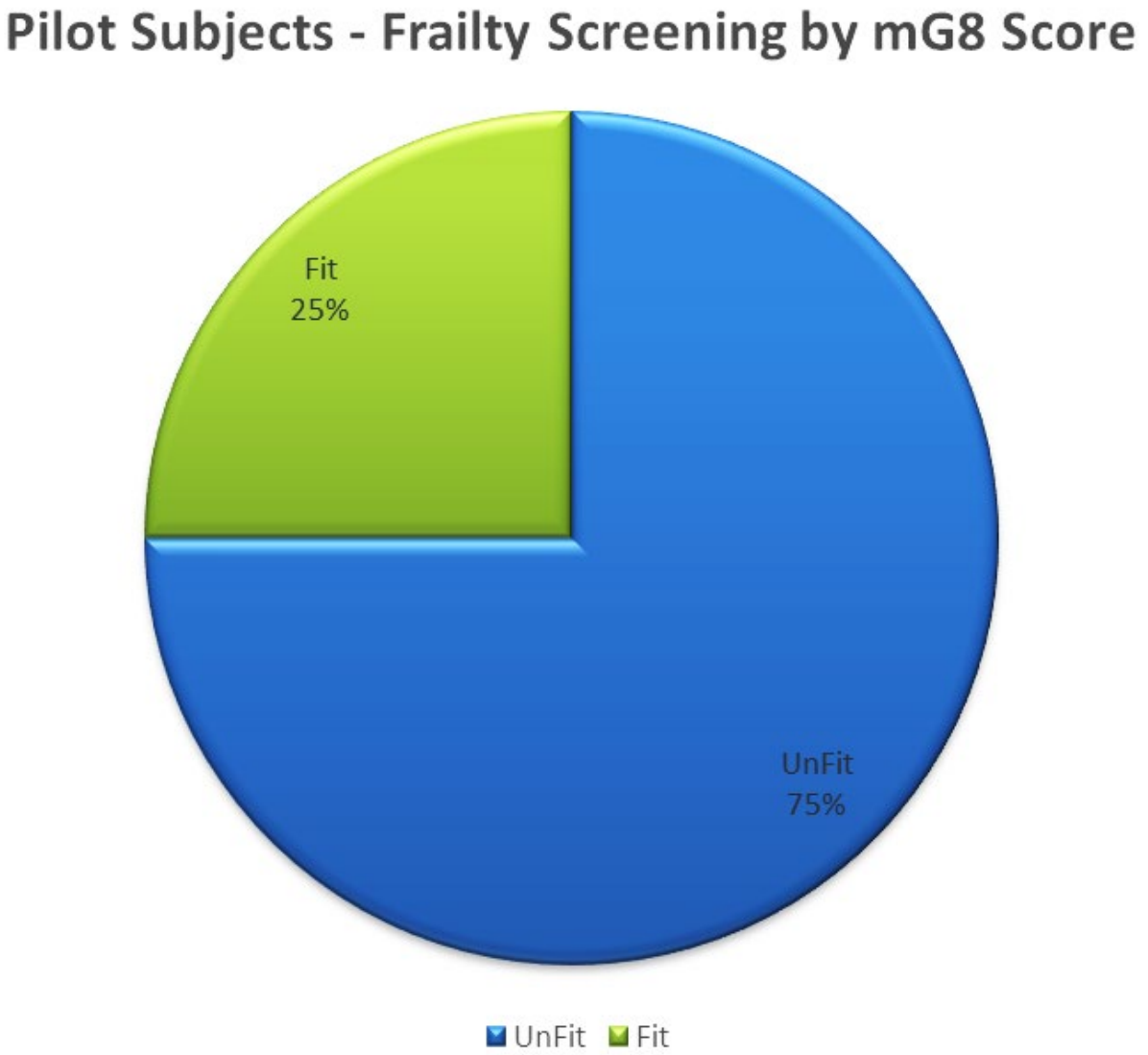
- Underserved older adults (2x the rate of cognitive impairment than surrounding community)
- Operationalizes Annual wellness visit
- integrates 4Ms
- Universal **cognitive screening** using mini-Cog and CDR
- Focused **cognitive assessment** using BrainCheck
- Structured assessment of **Modifiable Factors**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

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



Center For Healthy Aging Services

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Senior 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%

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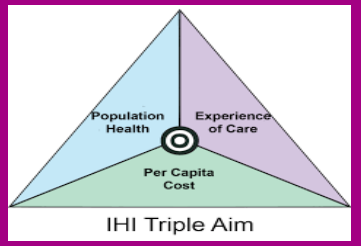
Benefits of Dementia Education

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**

*Mittleman, M.S., Haley, W.E., Clay, O.J., Roth, D.L. Neurology 2006;67:1592-1599 DOI: 10.1212/01.wnl.0000242727.81172.91

Hartford HealthCare Senior Services

Discussion/Q & A

Age-Friendly Health Systems

2020 TVI Virtual Workshops

- Opportunities for members to learn about the issues impacting value and affordability
- The Value Initiative Virtual Platform: https://www.linkedin.com/groups/13705163/

You are invited to explore The Value Initiative at:
www.aha.org/TheValueInitiative

COVID-19 Resources

- AHA: Latest Updates and Resources on COVID-19
- The John A. Hartford Foundation and COVID 19
- IHI: COVID-19 Resources: Care of Older Adults
- CDC: Information for Healthcare Professionals
- CDC: Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings
- CDC: Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19)
- American Geriatrics Society (AGS): Coronavirus Disease 2019 (COVID-19): Information for Internists
- Post-acute and senior living communities: LeadingAge and AHCA (American Health Care Association)
- Resource to help older adults locate community based resources (e.g. food and shelter) Eldercare Locator

Join the Friends of Age-Friendly Community

- Join the Friends of Age-Friendly Community
- Receive communications with tools and resources to accelerate the adoption of the 4Ms
- Opportunities to join quarterly webinars to connect with hundreds of organizations across the movement

For questions, email AFHS@ihi.org

Age-Friendly Health Systems

Join AHA Action Community 2020-2021

- **Join and get your Age-Friendly Recognition. It's FREE**

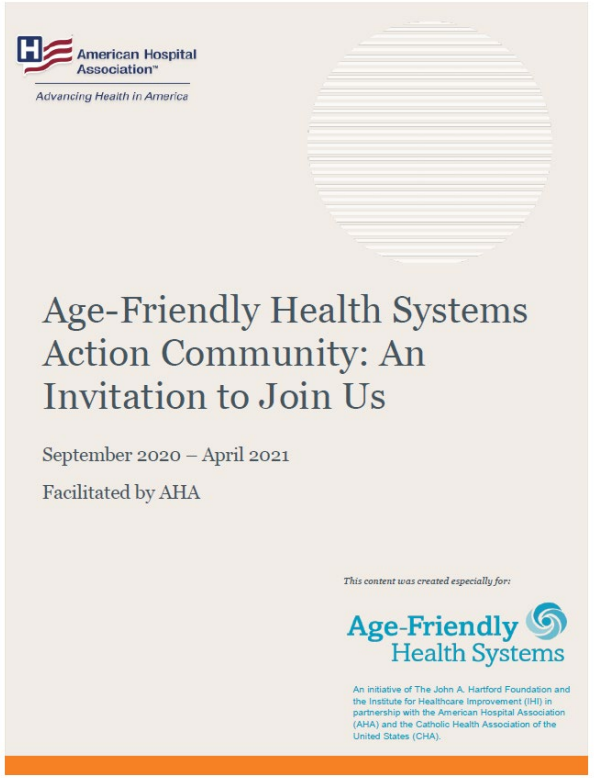
- **AHA AFHS Action Community is from September 2020 – April 2021**
  - Monthly all-team webinars
  - Scale-up leaders webinars
  - Listserv, sharing learnings
  - Monthly reports on testing and learnings
  - Celebration of joining the movement!

- **Register for Upcoming Webinars**
  - July 15, 2020 (12:00 – 1:00 PM ET) - Register here
    - Featuring Cedars-Sinai Medical Center
  - August 19, 2020 (12:00 – 1:00 PM ET) - Register here
    - Featuring Stanford Health Care

- **Download AHA's Invitation Guide and visit aha.org/agefriendly to learn**

- **Email ahaactioncommunity@aha.org with any questions.**

Enroll Today!



Age-Friendly Health Systems

Evaluation Survey

- Share your feedback

Age-Friendly Health Systems