Creating Age-Friendly Health Systems

AHA Action Community: An Invitation to Join Us

Age-Friendly Health Systems is 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).

Agenda

- Value of Age-Friendly Health Systems and 4Ms
- Overview of Action Community
- Sharing of Data & Learning
- Implementation at Cedars-Sinai Medical Center
- How to Join the Action Community
- Q&A

Age-Friendly
Health Systems

Speakers

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

Sonja Rosen, MD, FACP
Medical Director, Geriatrics for Cedars-Sinai Medical Network and Chief, Academic Section of Geriatrics at Cedars-Sinai

Kathleen Breda NP, MSN, BBA, AGACNP-BC, ONP-C
Nurse Practitioner Lead, Geriatric Fracture Program, Cedars-Sinai

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We Invite Your Questions

To submit a question, please type your question
on the left-hand side of your presentation screen.

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Our Partners

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The John A. Hartford Foundation

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:

- Age-Friendly Health Systems
- Family Caregiving
- Serious Illness & End of Life
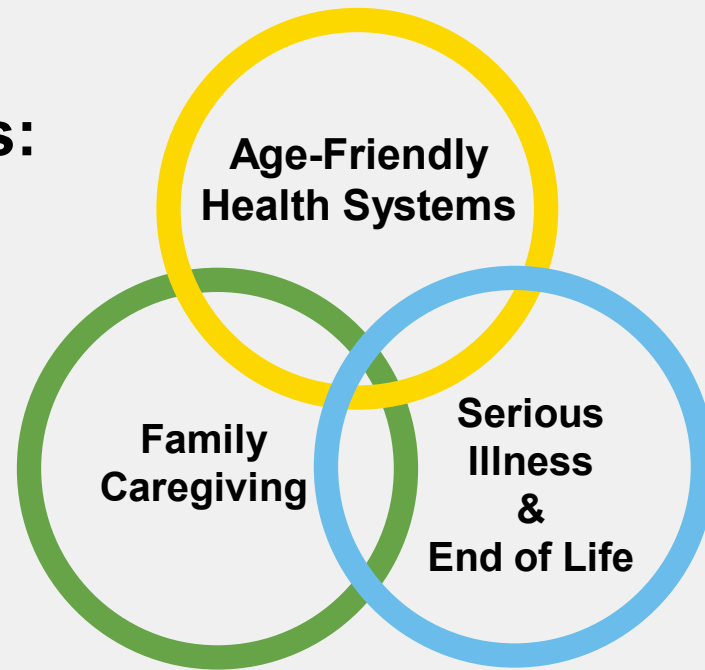
The Path Forward

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

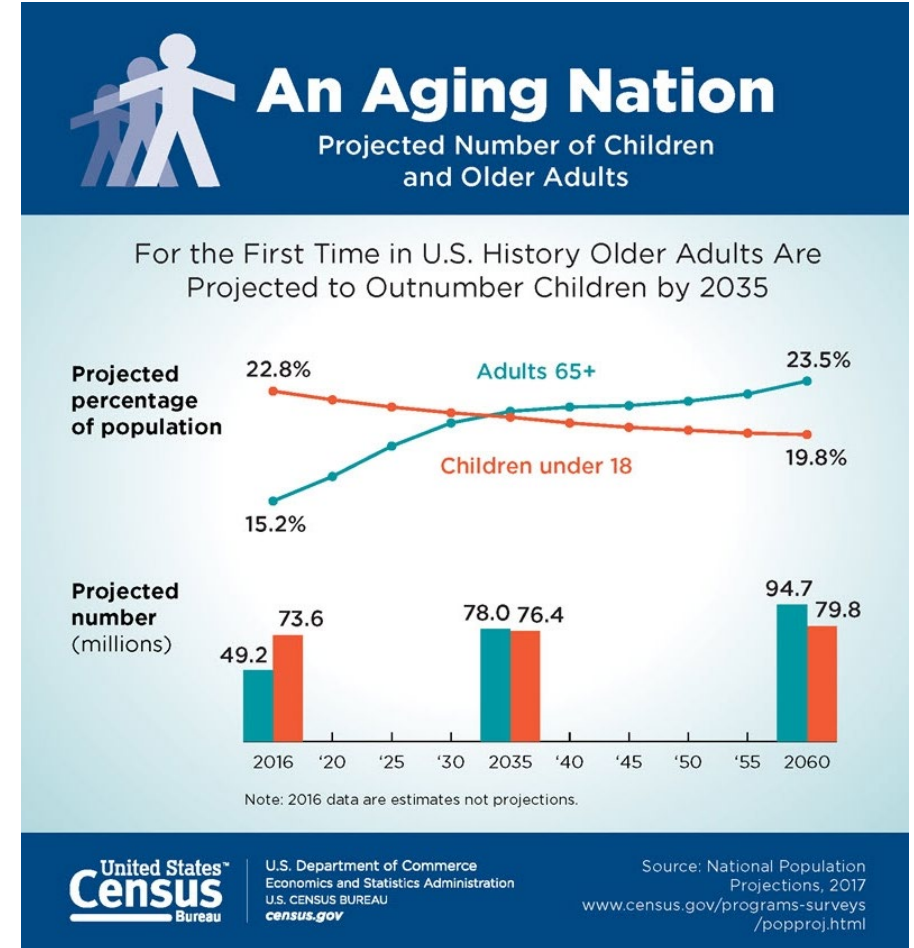**A**ffordability: The best care that adds value to lives

Individual As Partner: Recognize the diversity of individuals and serve as partners in their health

"H" of the future: Hospitals, Health systems and Health organizations are transforming and will continue to lead to provide a network of caring that improves the health of communities.
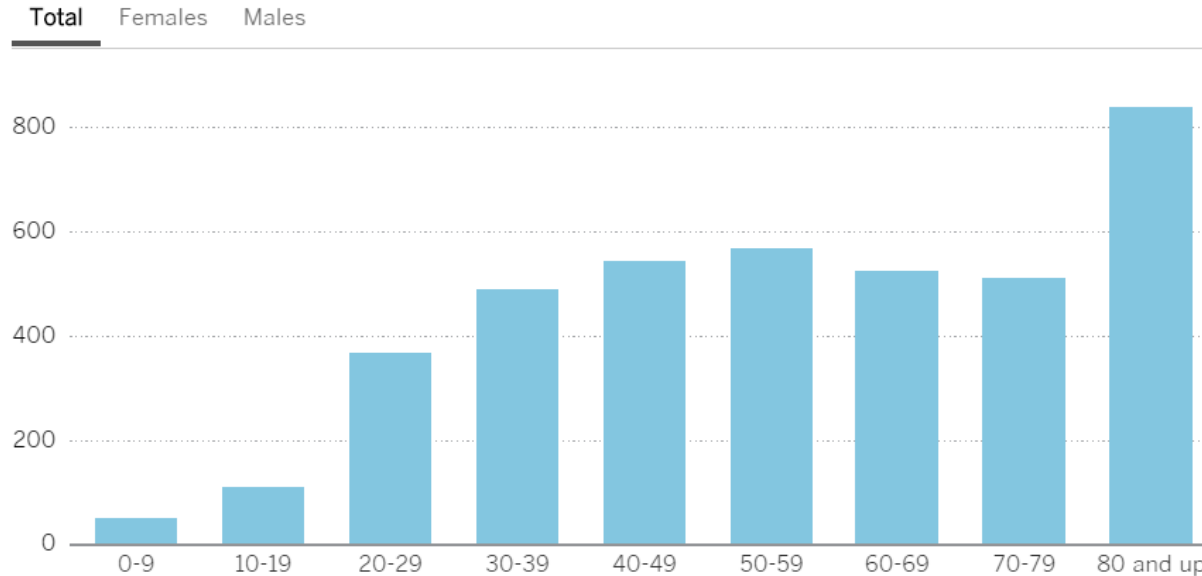
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Why Age-Friendly Health Systems?

- Demography
- Complexity
- Disproportionate harm

An Aging Nation
Projected Number of Children and Older Adults

For the First Time in U.S. History Older Adults Are Projected to Outnumber Children by 2035

Projected percentage of population

22.8% — Adults 65+ — 23.5%

15.2%

Children under 18 — 19.8%

Projected number (millions)

49.2 / 73.6 (2016), 78.0 / 76.4 (2035), 94.7 / 79.8 (2060)

2016 '20 '25 '30 2035 '40 '45 '50 '55 2060

Note: 2016 data are estimates not projections.

United States Census Bureau
census.gov

U.S. Department of Commerce
Economics and Statistics Administration
U.S. CENSUS BUREAU

Source: National Population Projections, 2017
www.census.gov/programs-surveys/popproj.html

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Impact of COVID-19 on Older Adults

Incidence of COVID-19 cases in the U.S., by age

Total   Females   Males

Cases per 100,000 population that were laboratory-confirmed between Jan. 22 and May 30, 2020.

Centers for Disease Control and Prevention

A third of U.S. coronavirus deaths are linked to long-term care facilities.

Cases in long-term care facilities   All other U.S. cases

11%

Deaths in long-term care facilities   All other U.S. deaths

35%
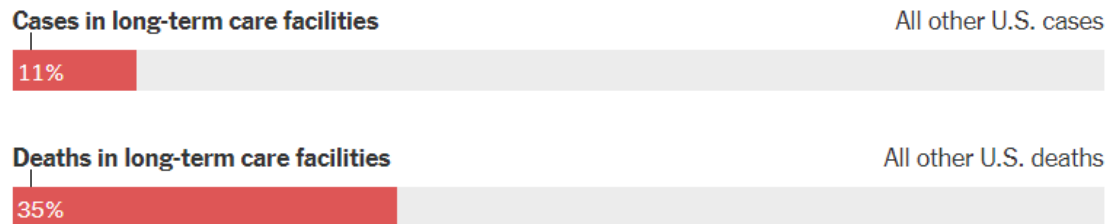
"The overall cumulative COVID-19 hospitalization rate is 89.3 per 100,000, with the highest rates in people aged 65 years and older: - CDC

Figure 1. COVID-19 death rates by age and race

Rates per 100,000

● White   ● Black   ○ Hispanic/Latino
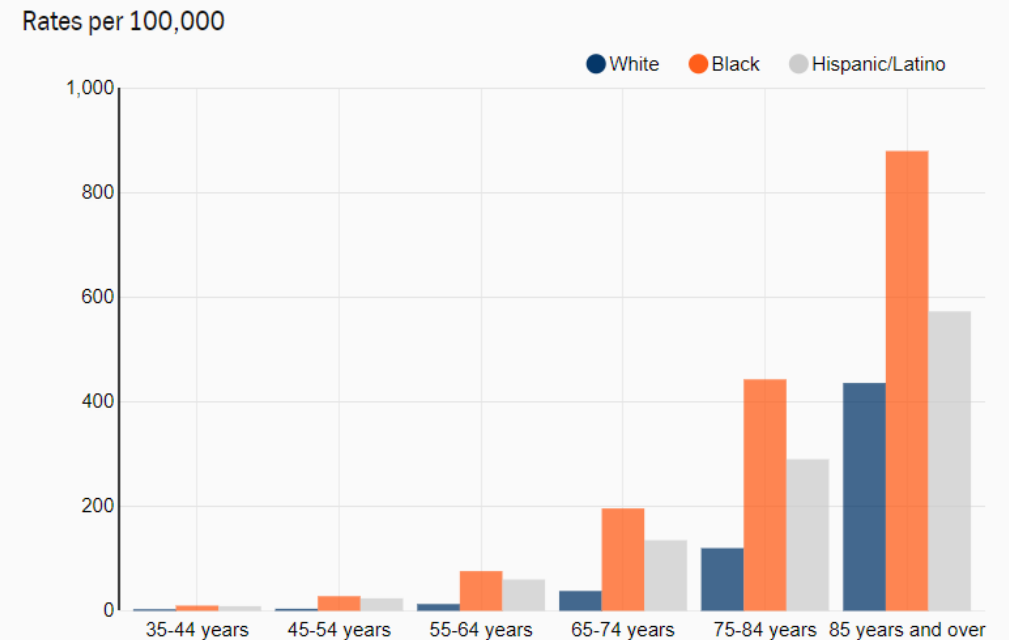
Source: CDC data from 2/1/20-6/6/20 and 2018 Census Population Estimates for USA

BROOKINGS

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

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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)

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What is an Age-Friendly Health System?
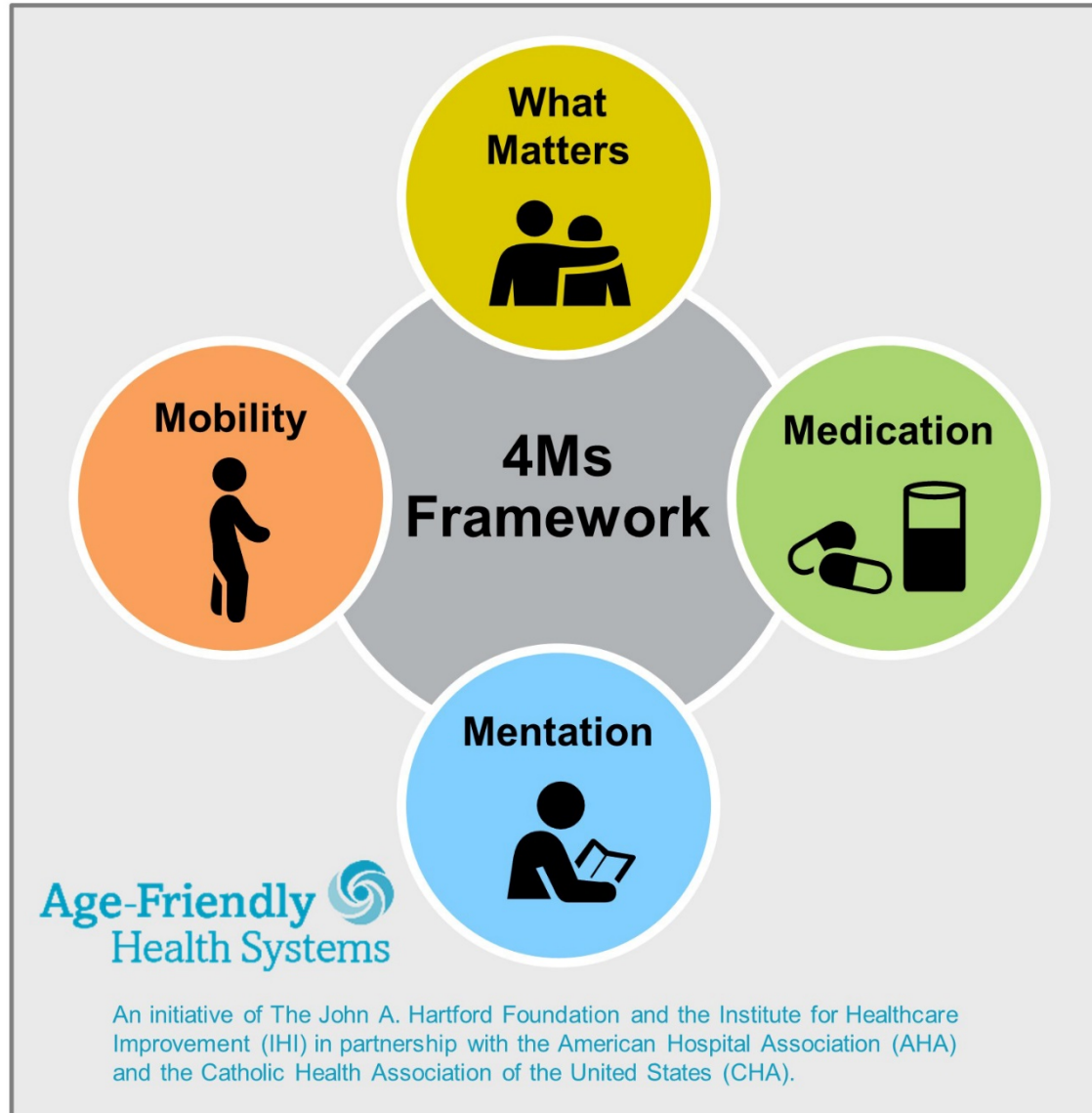
What Matters

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.
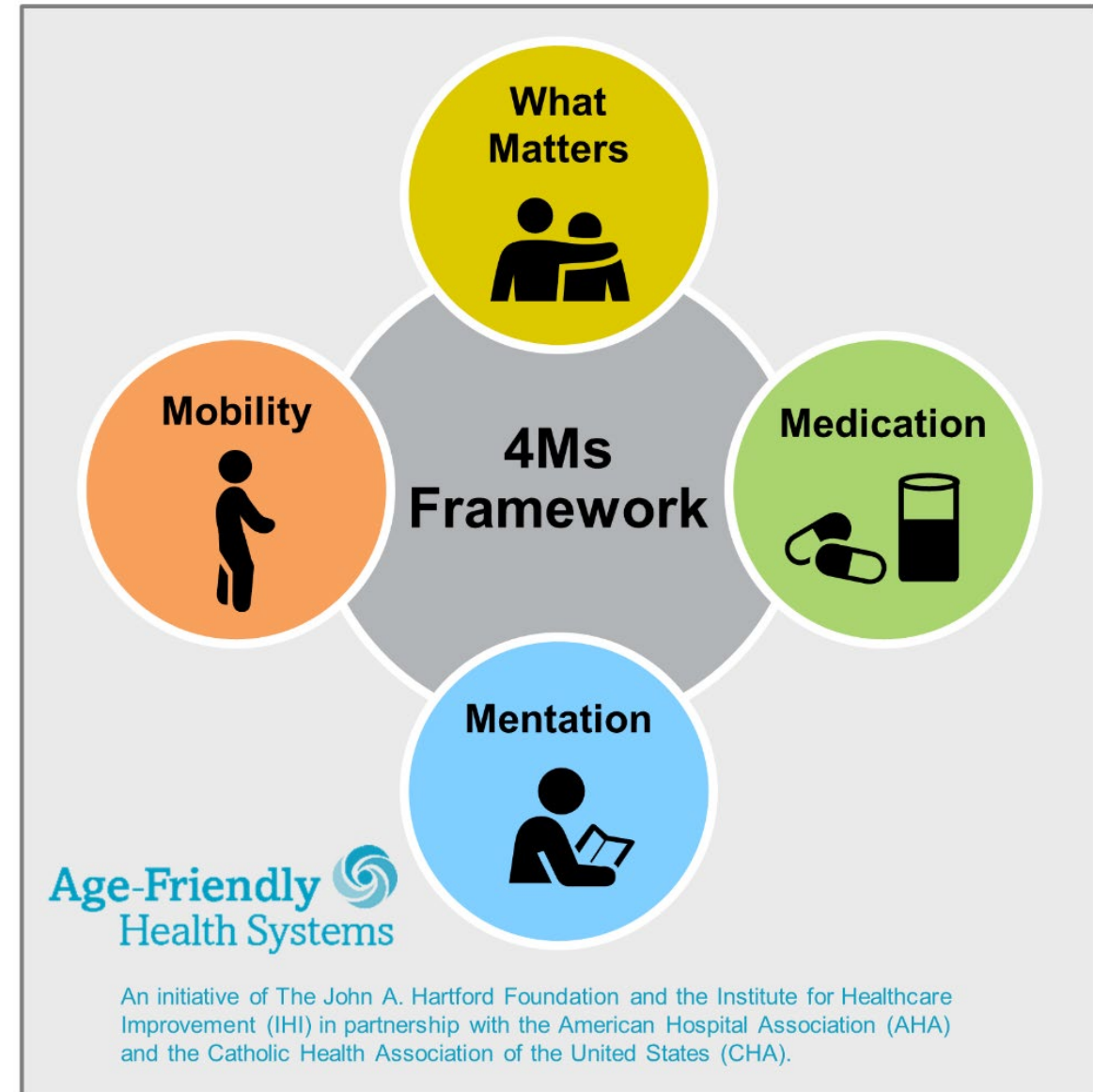
Mentation

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.

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

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

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

Presence of at least 1 Team Engaged in Movement 2017 - Now

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

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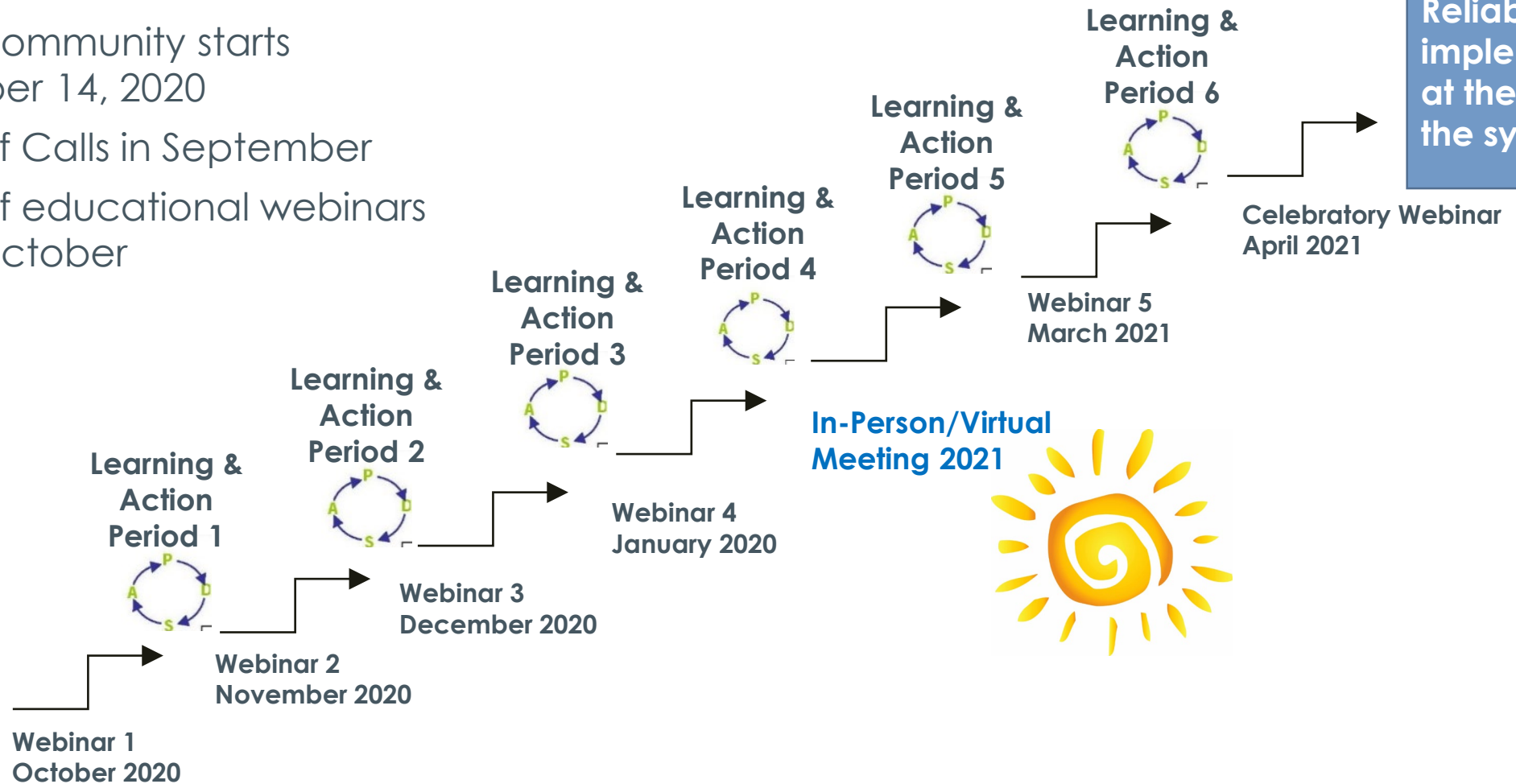- Leaders join monthly C-suite/Board level calls to set-up local conditions for scale up (Hosted by IHI)

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Action
Community

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AHA Action Community Schedule

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

Some of the 4Ms sometimes with some older adults

Learning & Action Period 1

Webinar 1
October 2020

Webinar 2
November 2020

Learning & Action Period 2

Webinar 3
December 2020

Learning & Action Period 3

Webinar 4
January 2020

In-Person/Virtual Meeting 2021

Learning & Action Period 4

Webinar 5
March 2021

Learning & Action Period 5

Celebratory Webinar
April 2021

Learning & Action Period 6

Reliable 4Ms implementation at the scale of the system

← Monthly Webinars and Drop-In Coaching on Measurement and Changes →

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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

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

Act | Plan

Study | Do

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.]

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Resources

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

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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 www.aha.org/agefriendly

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Level 1 & 2 Recognition

- Level 1 – Be recognized as an Age-Friendly participant

- Level 2 – Committed to Care Excellence

Action Community Monthly Data Sharing

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

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Participant

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

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Care Excellence
for Older Adults**

Age-Friendly Health Systems - 4Ms Care Description

Team Site of Care

' Is your site of care inpatient or outpatient?

○ Inpatient

○ Outpatient

○ Post-Acute/Long-Term Care

' What is your EHR platform?

' If you are participating in an Action Community, please select your Action Community below:

21%

Prev   Next

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Sites Recognized by the Movement

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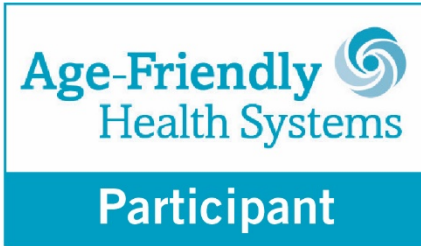
742

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

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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

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Connecting Age-Friendly Measures with Value

Value = $\dfrac{\text{Outcomes \& Patient Experience}}{\text{Cost}}$
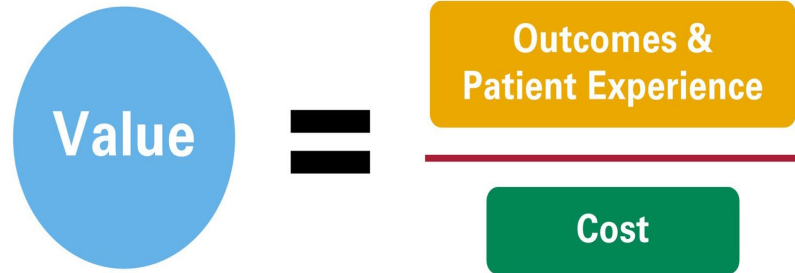
Age-Friendly Measures			The Value Equation
Basic Outcome Measures	**Hospital Setting**	**Ambulatory/Primary Care Setting**	**Components**
30-day readmission	X		Patient outcomes, cost
Emergency department utilization		X	Patient outcomes, cost
Consumer Assessment of Healthcare Providers and Systems (CAHPS) 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

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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 Webinar**

  - 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!

H American Hospital Association™
Advancing Health in America

Age-Friendly Health Systems
Action Community: An
Invitation to Join Us

September 2020 – April 2021

Facilitated by AHA

This content was created especially for:

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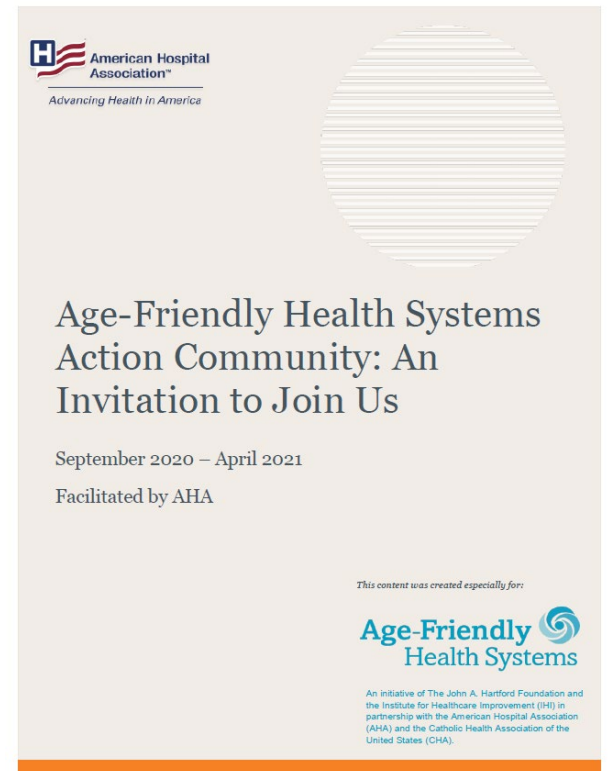
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Putting the 4Ms into Practice: Geriatric Fracture Program

Cedars-Sinai Health System

Sonja Rosen, MD, FACP

Chief, Geriatric Medicine, CSHS

Medical Director, Geriatrics, Cedars-Sinai Medical Care Foundation

Professor of Medicine, UCLA David Geffen School of Medicine

Kathleen Breda NP, MSN, BBA, AGACNP-BC, ONP-C

Nurse Practitioner Lead, Geriatric Fracture Program, CSHS

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Background

Cedars-Sinai Medical Center
- Nonprofit, acute, tertiary teaching hospital, Los Angeles, CA
- 886 licensed beds
- Level I trauma center
- *CSMC cares for more patients over the age of 80 than any other academic tertiary health care system in the country*
- FY19: 22,356 inpatient discharges > 65yo (46.6% of all discharges)
- GFP Launched in July 2018; expanded in September 2019
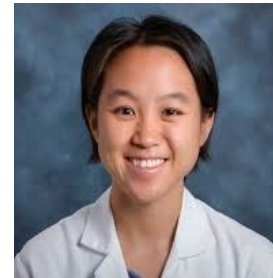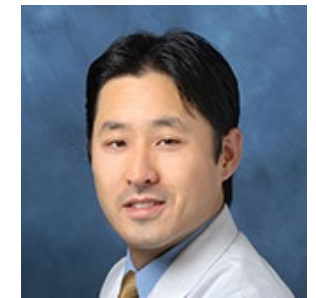
Carol Lin, MD

Kathy Breda, CNP
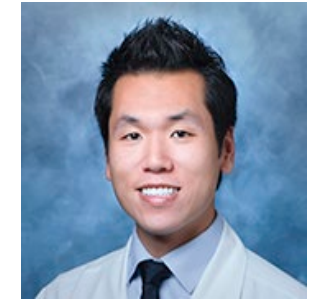
Aaron Chiang, MD

Sonja Rosen, MD

Jae Lee, MD

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Why This Work Matters to Me

- The baby boomers are aging in. The number of people over 65 will more than double by 2030, from 35 million now to > 70 million in 2030. Cedars is at the epicenter of this growth.
- Growing both our workforce of geriatricians and geriatric models of care are critical steps to preparing for this growing demographic.

1/3 of community dwelling older persons fall every year	→	Complications from falls are the leading cause of death from injury in persons > 65 years of age	→	Of these falls, 300,000 persons are hospitalized every year with hip fractures

These patients are at higher risk for delirium, and subsequent functional decline and dementia	→	The 1-year mortality after sustaining a hip fracture is 14% - 58%, the first year after fracture is critical	→	Falls among older adults are costly: $50 billion annually for Medicare & Medicaid in 2015

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Prior State

- *Pre-GFP (prior July 2019)*
- *Pluralistic academic tertiary health care system: 3 different hospitalist services & private physicians*
- *Baseline data FY 18: 612 fracture patients (hip 343)*
- *Average age 82*
- *Average TTS: 36 (33 hip) hours*
- *Average LOS: 5 (5.2 hip) days*

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Designing, Testing, and Studying our Performance

- Genesis of the GFP program
  - How can a complex, pluralistic medical environment implement a geriatric fracture program?

  - How will the program impact time to surgery (TTS), Length of Stay (LOS) and readmissions?

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Geriatric Fracture Program Tenets

The Cedars-Sinai
Geriatric Facture Program (GFP)
Launched July 2018

Committed Inter-professional team

Defined goals, scope and communica-tion

Geriatric Training of MDs, Nurses and CPs

Standard. geriatric-centric pre-operative assessments

Standard. geriatric-centric in-patient interventions

Daily project data collection and regular reporting
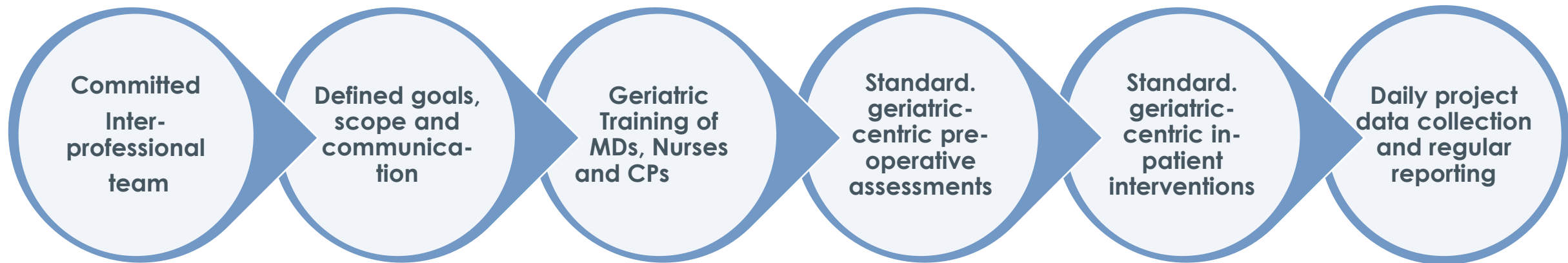
Continuous review, assessment and intervention

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Cedars-Sinai Geriatric Fracture Program Goals

Goal #1
Reduce time to surgery

≤24 hours

Goal #2
Reduce average length of stay

≤5 days

Goal #3
Reduce post-operative delirium

Goal #4
Improve follow-up osteoporosis care

Goal #5
Reduce readmissions

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ED to 7N

24 hours
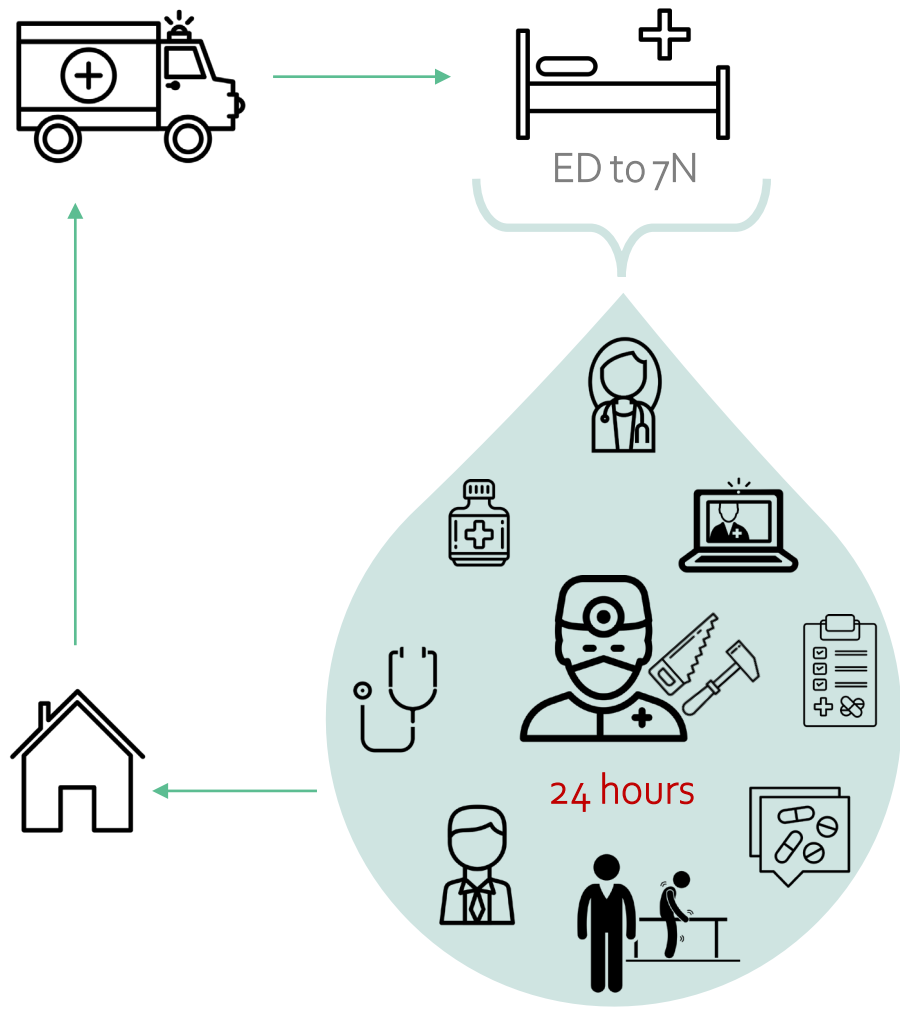
Key Elements of GFP

1. Timely Assessment and Evaluation

2. Minimization of Unnecessary Testing

3. Coordination Among the Care Team

4. Post-Discharge Geriatric Assessment

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Multi-professional Team

Anesthesia

Geriatrician

Emergency
Medicine

RN

Pharmacy

Geriatric NP

Orthopaedic
Trauma Surgeon

Hospitalist

Therapy

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GFP Daily Activities

Geriatric NP

- GFP Huddle
- Geri-centric Pain protocol
- Delirium Assessment Prevention/Mitigation
- Geri-centric Epic templates, order sets
- Osteoporosis and Falls Patient Education
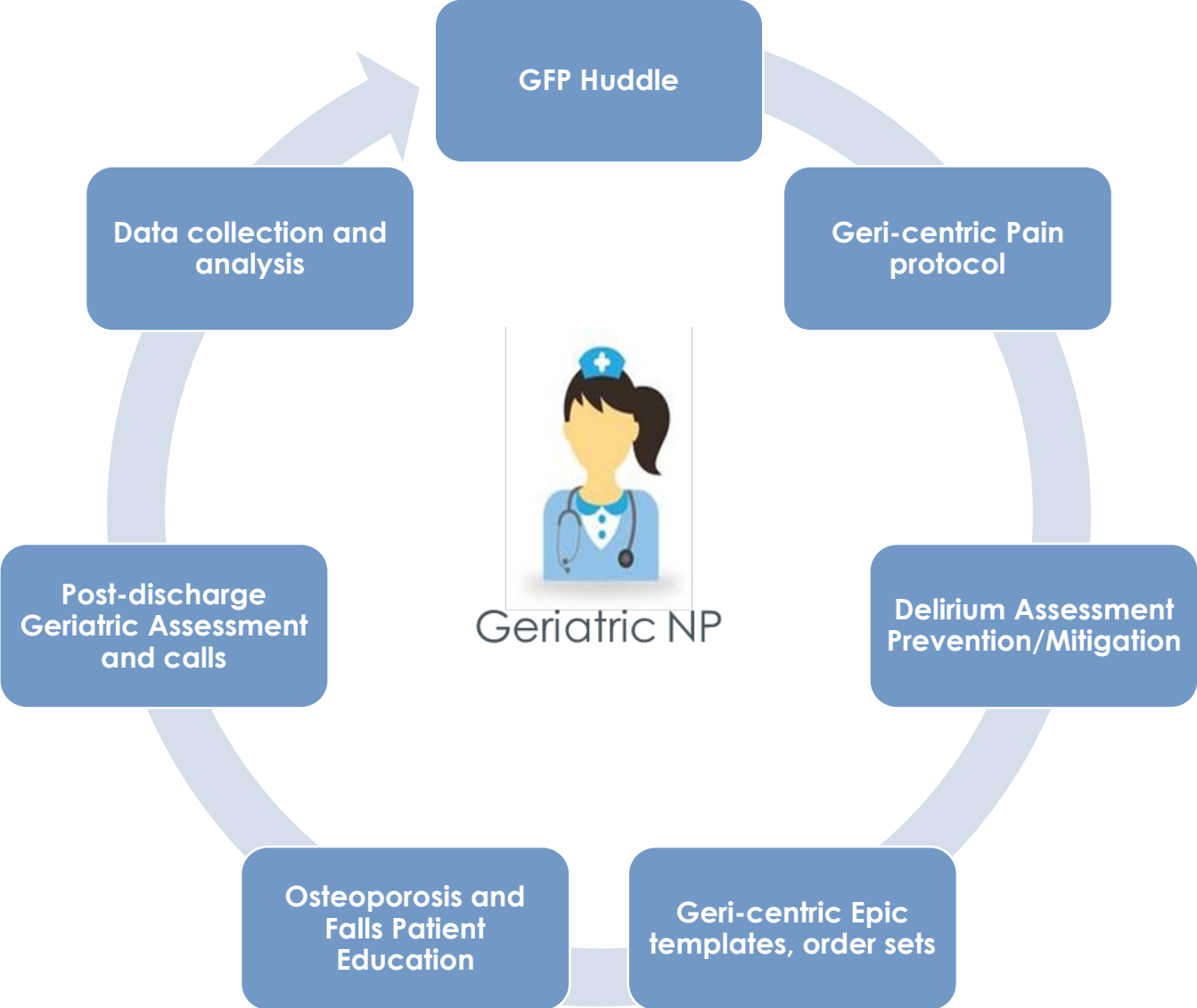- Post-discharge Geriatric Assessment and calls
- Data collection and analysis

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Typical Cedars-Sinai Geriatric Fracture Patient

- Female (70%) / Male (30%)
- Operative Cases (75%)
- Hip Fracture Cases (60%)
- Often frail
- Majority of patients discharge to SNF, followed by ARU and Home Care

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Step 5: Studying Your Performance – First year results

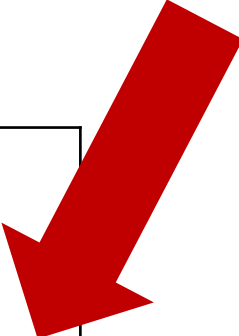|	Pre-GFP FY 18		Non-GFP FY 19		GFP FY 19	
Average Age (Years)	82		82		81	
Operative + Non-Operative Fractures	**n**	**%**	**n**	**%**	**n**	**%**
Total	612		407		153	
Hip	343	56%	214	53%	71	46%
All Other Non-Hip Fractures	269	44%	193	47%	82	54%

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Step 5: Studying Your Performance – First year results

Average Time to Surgery (TTS) for Operative Fractures (Hours)	Pre-GFP FY 18	Non-GFP FY 19	GFP FY 19
All Fractures	36*	24.3	21.1
Hip	33*	22.7	20.7

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Step 5: Studying Your Performance – First year results

Average Length of Stay (ALOS) (Days)	Pre-GFP FY 18	Non-GFP FY 19	GFP FY 19
All Fractures	5	5.7	4.5
Hip	5.2	5.8	4.5
All Other Non-Hip Fractures	4.7	5.5	4.3
Vizient LOS Index	0.93	1.03	0.76

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Step 5: Studying Your Performance – First year results

Financial Impact

Pre-GFP compared to GFP

Pre-GFP FY18 average direct cost	GFP FY19 average direct cost	Δ costs	# of FY19 GFP patients	1 year of 'Savings' with GFP
$17,048	$14,884	$2,164	153	$330,000 less spent in direct costs

Potential savings with GFP expansion

# of non-GFP patients FY19	Avg direct cost delta: GFP vs non-GFP	Potential savings over one year
407	$1,940	$790,000 less spent in direct costs

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Cedars-Sinai GFP Results Roll-Up (before:after)

Exceeded Goal of < 24 hours to surgery	• A 45% improvement in Time to Surgery
Exceeded Goal of Length of Stay < 5 days	• A 38% improvement in reduced Length of Stay
Increased delirium assessment, prevention and mitigation by staff nurses	• Delirium assessment performed every shift
Reduced average direct costs by $330,000	• $1,000,000 in potential average direct cost savings with expansion
Decreased 30-day admissions	• Better or equal to non-GFP readmissions
Bone health follow-up	• 20% of our patients seen for bone health & fall prevention assessment by the Division of Geriatrics post discharge

Cedars Sinai

# Steps 3 – 5: Designing, Testing, and Studying Your Performance

- *Challenges*
  - *All hospitalists following agreed upon pre-operative assessments for cardiac/pulmonary issues*
  - *Ensuring education of new hospitalists and nurses*
  - *Preventing drift in practice*
  - *Ensuring follow-up for ambulatory Geriatrics bone health & fall prevention*

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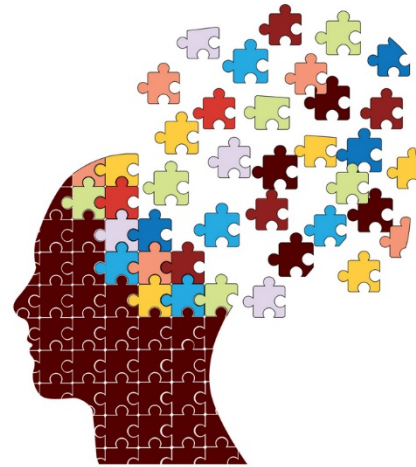Health Systems

Step 5: Studying Your Performance - Patient Impact Story

If you can't explain it **simply**, you don't understand it well enough.

-Albert Einstein

QuotesEverlasting.com

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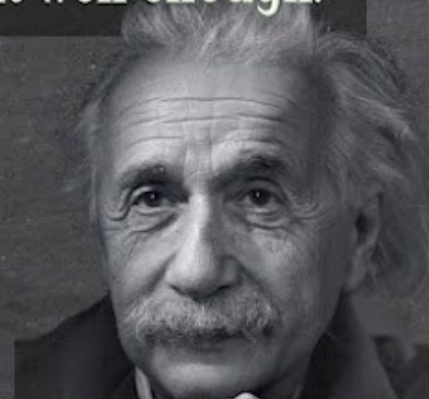
Step 5: Studying Your Performance - Staff Impact Story

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Impact

The Geriatric Fracture Program optimizes the care of inpatient geriatric fracture patients to minimize potential complications and help them return to their homes and meaningful lives

Incorporating the 4Ms during Covid-19 Pandemic

I. Cedars-Sinai Ambulatory Clinical Geriatrics Program

II. Multidisciplinary Total Care Management Program for Medicare Advantage

III. LEAP Exercise Program to Combat Social Isolation

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Cedars-Sinai Ambulatory Clinical Geriatrics Program, Pre-Covid

- 4 Faculty Geriatricians – Mix of full-time clinician educators and clinician scientists
- Dedicated Geriatrics Suite – "geri-friendly space"
- Multidisciplinary team with Geriatric Pharmacist and Exercise Health Coach; case management & social work available as needed
- Primary care ~3000 patients, majority Medicare FFS
- Consults and Co-management for geriatric syndromes
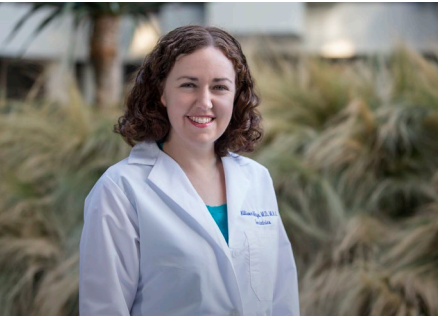
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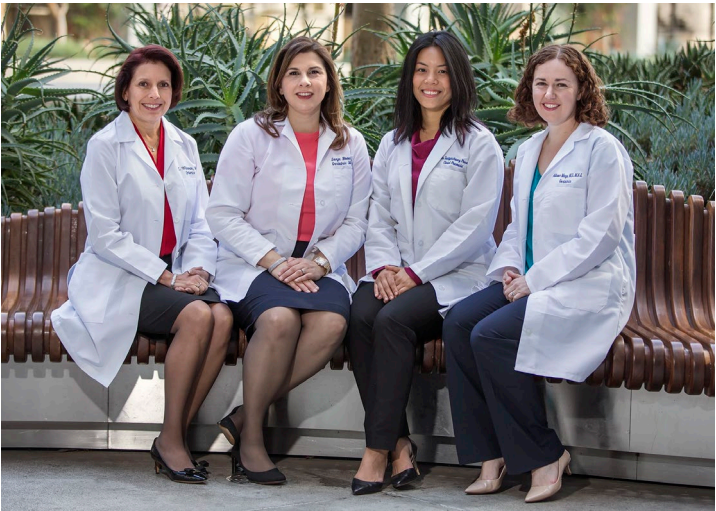# Cedars-Sinai Ambulatory Geriatrics Program

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Cedars-Sinai Geriatrics offers primary care for patients over 75 years of age, as well as consultations for those with geriatric syndromes, such as bone health, dementia, functional decline and fall prevention.

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March 19 – Safer at Home implemented in LA County

- Geriatrics moved out of our clinical space in order to allow for the Urgent Care to become a bifurcated space, and ensure safety for our patients in a "non-Covid" space to a pod in the CS primary care home
- Started virtual care on Monday March 16 from our homes
- Potentially infectious patients that required in office evaluation were redirected to UC or ER, as appropriate, after discussion with PCP
- Modalities: Telephone & Video
- Residency rotation was put on hold
- Vehicle: Doximity, CS Link (EPIC), FaceTime, Skype

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Every geriatric visit:

- 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 medications that do 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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Institutional support

- Physicians and staff allowed to work from home
- Medical network daily huddles for leadership; geriatrics huddles – varying frequency
- Billing support and education
- Telephone and video templates provided
- Key was to include time spent, consent to visit

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Benefits of telephone visits

- All patients and / or caregivers have the ability to talk on the phone – (what matters most)

- Physicians and pharmacists review medications on phone (medications)

- Informed decision making for necessity of in person visits or ED / hospital admission (what matters most)

- Access - patients (and physicians) are available (mobility)

- Ability to conference call (what matters most, medications, mentation)

- Patients love to feel connected; appreciative; report feeling more access to their physicians on patient satisfaction surveys

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Additional benefits of video visits

- Visual benefit of a virtual physical exam (mobility, mentation)
- Visual review of medications by physicians or pharmacists (medications)

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Challenges of virtual visits

- Ability to manage the technology - need a Smart Phone
- Delays in accessing the technology (e.g.; Doximity) – delays in starting visit
- Video visits were the minority of our virtual visits
- Labs / x-rays – have to be ordered separately. Use of a variety of mobile agencies for phlebotomy, radiology as well as private radiology centers and Home Health. Fidelity of follow up
- Patients want to be seen and examined

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Outcomes

- Enabled continuity of care and management of both acute and chronic medical conditions, thereby preventing avoidable admissions and directing access of care for higher level of care when appropriate

- Maintained patient satisfaction

- Ability for physicians and staff work from home during Covid pandemic

- Increased productivity to 130% of Pre-Covid productivity

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Next steps

- Began seeing patients in our "new" space June 15
- No staggered schedule at this juncture, but seeing virtual visits in between in office visits
- Potentially infectious patients will continue to be redirected to Urgent Care
- RE-incorporate residents into workflows July 24. Will shadow pharmacist and LEAP classes virtually; SNF rounds on hold for now. Expanded to inpatient experience with Geriatric Fracture Program.

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Medicare Advantage: Total Care Management

- Multidisciplinary team proactively managing MA patient population across different transitional levels of care, with goals to:
  - Caring for the whole patient, helping to keep them healthy in their residence and "catching them" before they fall.
    - Preventing unnecessary ("potentially avoidable") admissions ("ACEs") and reducing readmissions ("reACEs")
    - Decreasing length of stay (LOS)
    - Appropriate level of care
    - Addressing goals of care

- Already a virtual program incorporating 4Ms

- Falls risk, high risk medication screening; AD discussed in outreach calls, identification of patient goals

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AARP Foundation Grant: Leveraging Exercise to Age in Place (LEAP)

- AARP Foundation Strategic Objectives:
1. Increase ability of individuals served to age-in-place
2. Demonstrate sustained improvement in social connectedness as measured by the Duke Social Support Index
- Three year grant $750,000, Dr. Allison Mays, MD, MAS is Principal Investigator
- ~450 patients enrolled in first year
- 7 parallel evidence-based programs (Tai Chi, OA, Enhanced Fitness & Chronic disease management)
- 2 non-profit community partners (JFS & PICF)
- Program coordinator ("health coach")
- Measuring DSSI and UCLA 30-item loneliness scale
- Measuring utilization for MA subset

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First Virtual LEAP Class: Arthritis Exercise
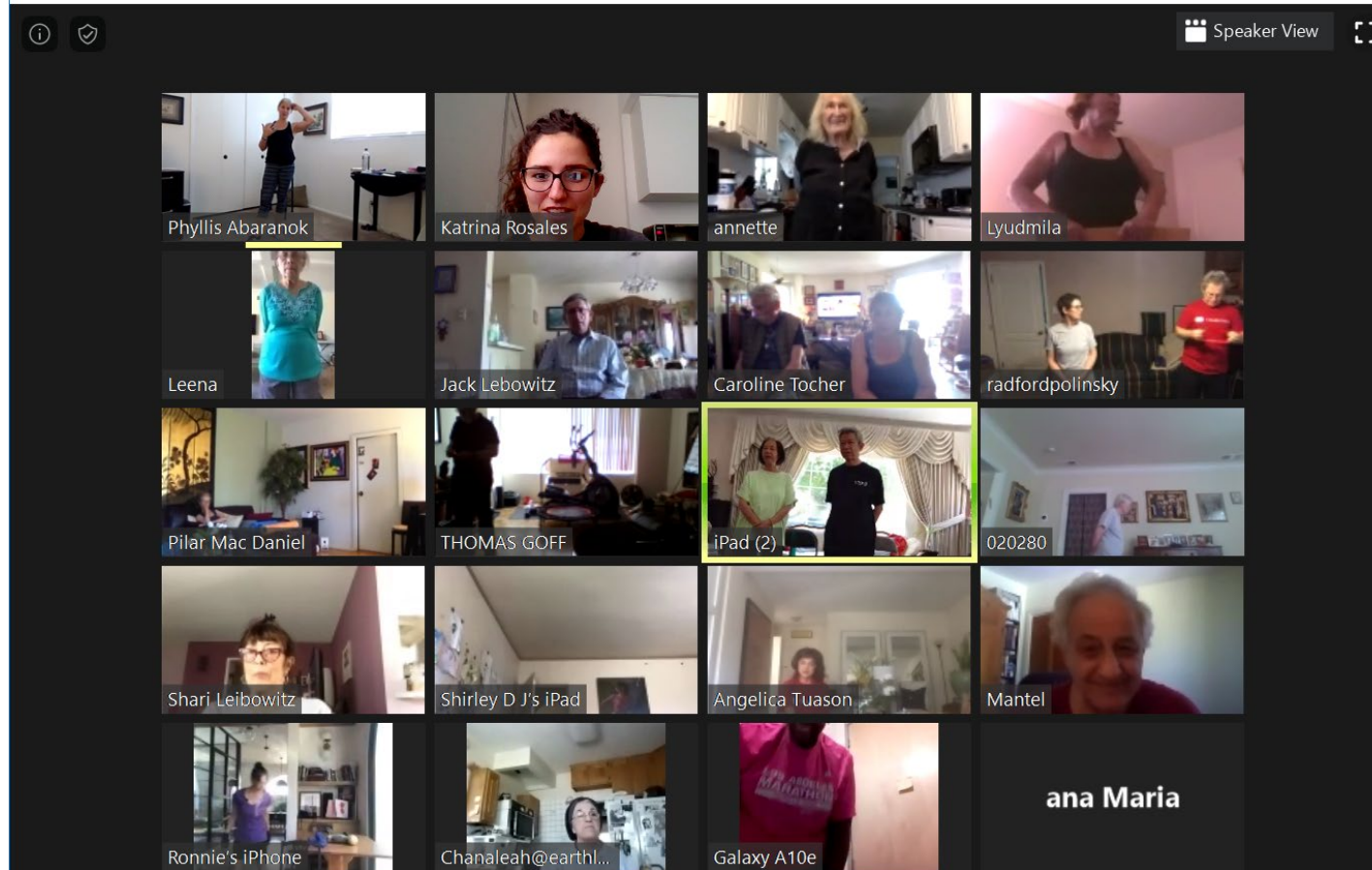
LEAP transitions to Virtual LEAP

- AARP Foundation granted a no-cost extension; goal to enroll up to 150 new participants over the next year
- Online platform to Zoom with both community partners
- First Arthritis exercise class with 22 participants!

- 1 participant Zoomed in from Michigan (3 hour time difference).

- Class instructor uses a specialized webcam that rotates using a handheld remote control. She instructs participants to adjust their screens so that she can monitor and ensure their safety.

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Appendix

Describe Care Consistent with the 4Ms - **Assess**

4Ms	Description
What Matters	• Ask the patient what they are concerned about • Ask the patient what are their goal(s) for recovery • Make sure that a person's individual, personally meaningful health outcomes, goals, and care preferences are reflected in treatment plans
Medication	• Pre-Admission medication review • Beers Criteria review of all inpatient medications • Anticholinergic burden for medications • Reduce polypharmacy & Interactions • De-prescribing unnecessary medications
Mentation	• Mini-Cog on admission • CAM every 12-hours by nurse • ADL and iADL Assessment • Frailty Assessment
Mobility	• Falls Assessment • Frailty Assessment • ADL and iADL Assessment • PT / OT assessment POD1

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Describe Care Consistent with the 4Ms - **Act On**

4Ms	Description
What Matters	• Discuss these goals in daily multidisciplinary care huddle • Educate patient about details of their hospital course and how we plan to meet their goals
Medication	• Geriatric pain protocol developed by multidisciplinary team • Patient medications reviewed daily for appropriateness, side-effects and interactions • Medication concerns, issues or changes discussed during daily multidisciplinary huddle
Mentation	• MD and nurse training on delirium prevention, assessment and mitigation • Delirium care checklists and electronic order sets available to clinicians • Hospital-wide delirium treatment protocol developed • Mental status discussed during daily multidisciplinary huddle and at nursing handoffs
Mobility	• All patients expected to be out of bed to chair – mobility protocol for all patients • Goal for patients to eat meals out of bed • Nurses and Care Partners are trained on patient mobility • Physical therapy sees patient Post-Op Day 1 or day after admission for non-operative weight bearing patients • Educate patients on need for mobility and what to expect as they recover

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Discussion/Q & A

Type in the chat!

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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

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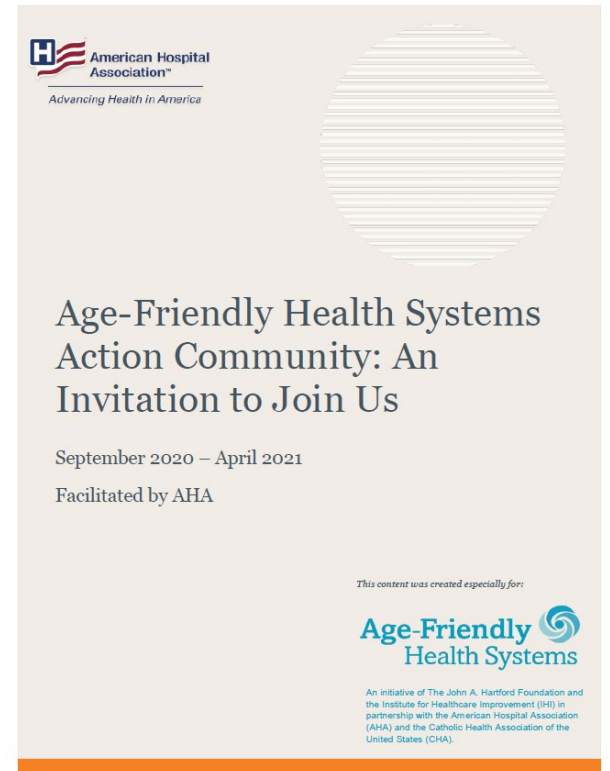# Join the Friends of Age-Friendly Community

- 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

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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**

  - 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!

American Hospital Association™
Advancing Health in America

Age-Friendly Health Systems
Action Community: An
Invitation to Join Us

September 2020 – April 2021

Facilitated by AHA

This content was created especially for:

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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).

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Evaluation Survey

- Share your feedback