Age-Friendly Health Systems

Becoming an Age-Friendly Health System

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
- Recognition of Becoming an Age-Friendly Health System
- Implementation at Stanford Health Care
- 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

Ankur Bharija, M.D.,
Medical Director, Inpatient Geriatrics Programs, Stanford Health Care, Clinical Assistant Professor, Primary Care and Population Health, Department of Medicine, Stanford Medicine

Amy Lu, M.D.
Associate Chief Quality Officer for Clinical Effectiveness, Stanford Health Care

Age-Friendly Health Systems

We Invite Your Questions

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

Age-Friendly Health Systems

Our Partners

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The John A. Hartford Foundation

Institute *for* Healthcare Improvement

CHA®
Catholic Health Association of the United States

Age-Friendly Health Systems

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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

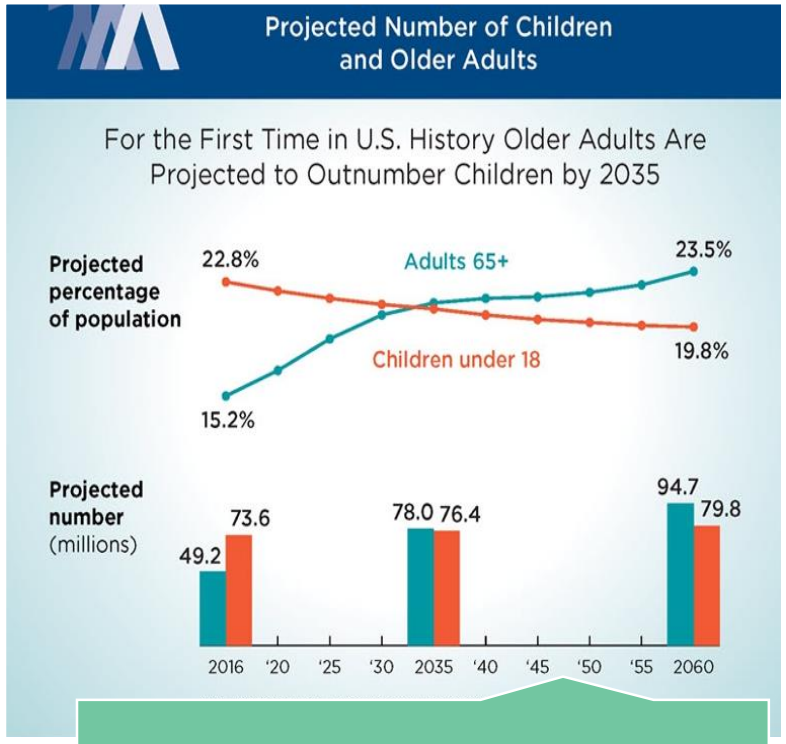
Affordability: The best care that adds value to lives

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

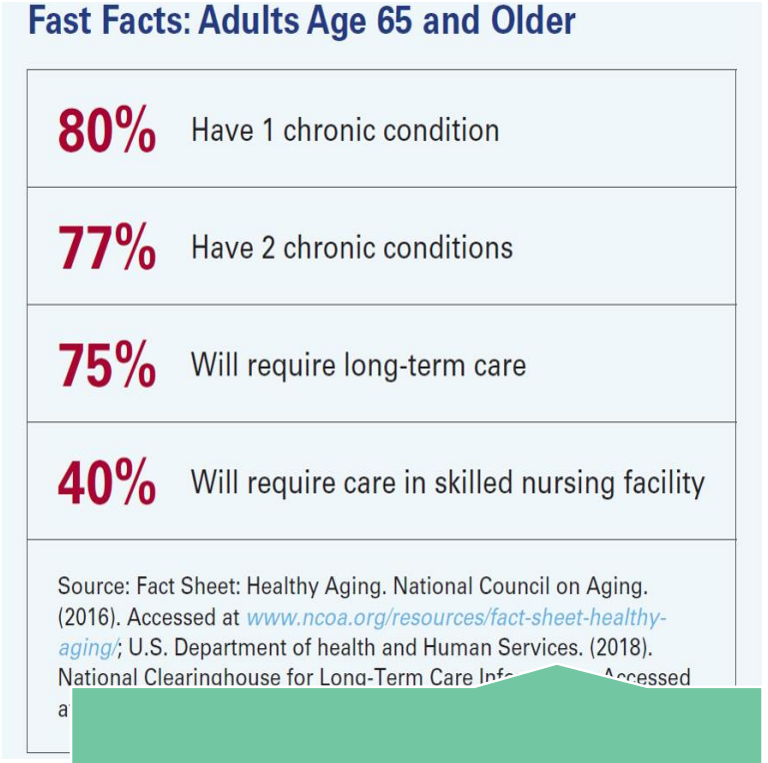
"H" of the future: Hospitals, **H**ealth systems and **H**ealth organizations are transforming and will continue to lead to provide a network of caring that improves the health of communities.

Age-Friendly Health Systems

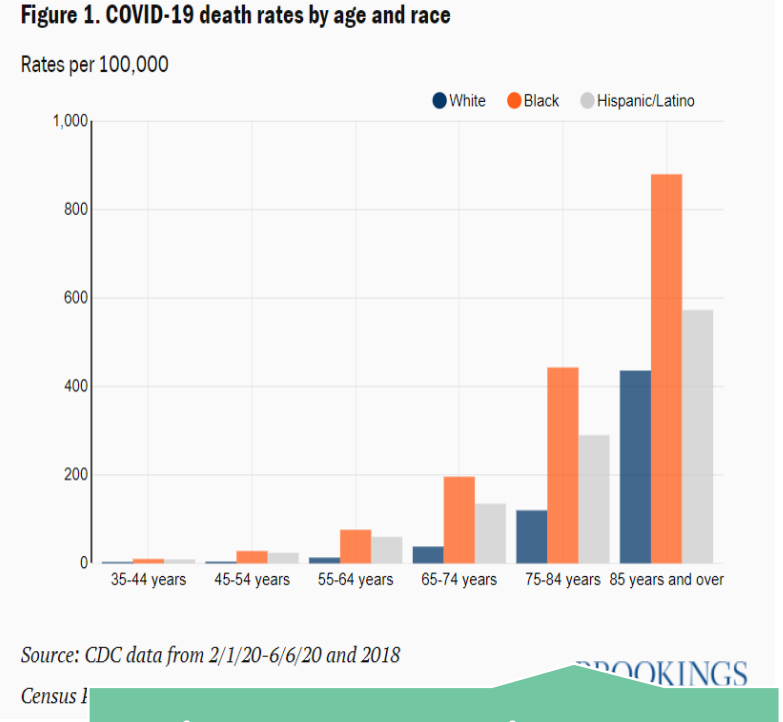
Why Age-Friendly Health Systems?



Demography



Complexity



Disproportionate Harm

Age-Friendly Health Systems

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.

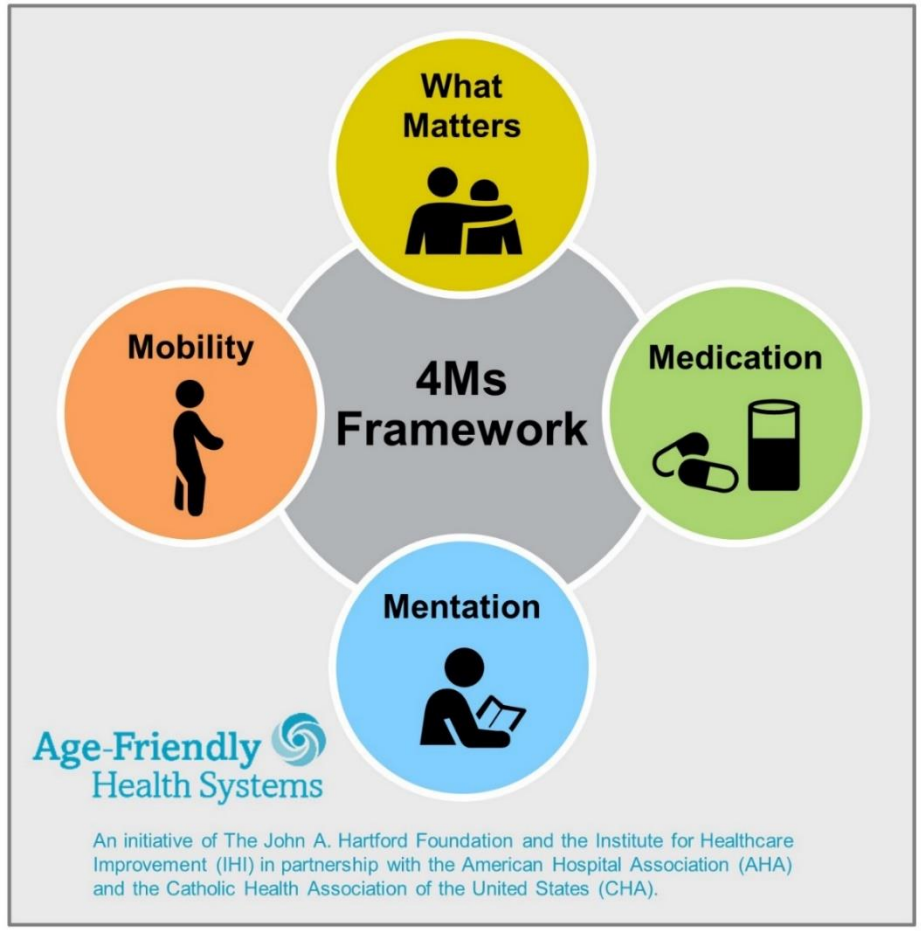
Specific Aims:

- 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

Age-Friendly Health Systems

What is an Age-Friendly Health System?

- 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



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.

Age-Friendly Health Systems

Spread and Scale AFHS – Action Communities

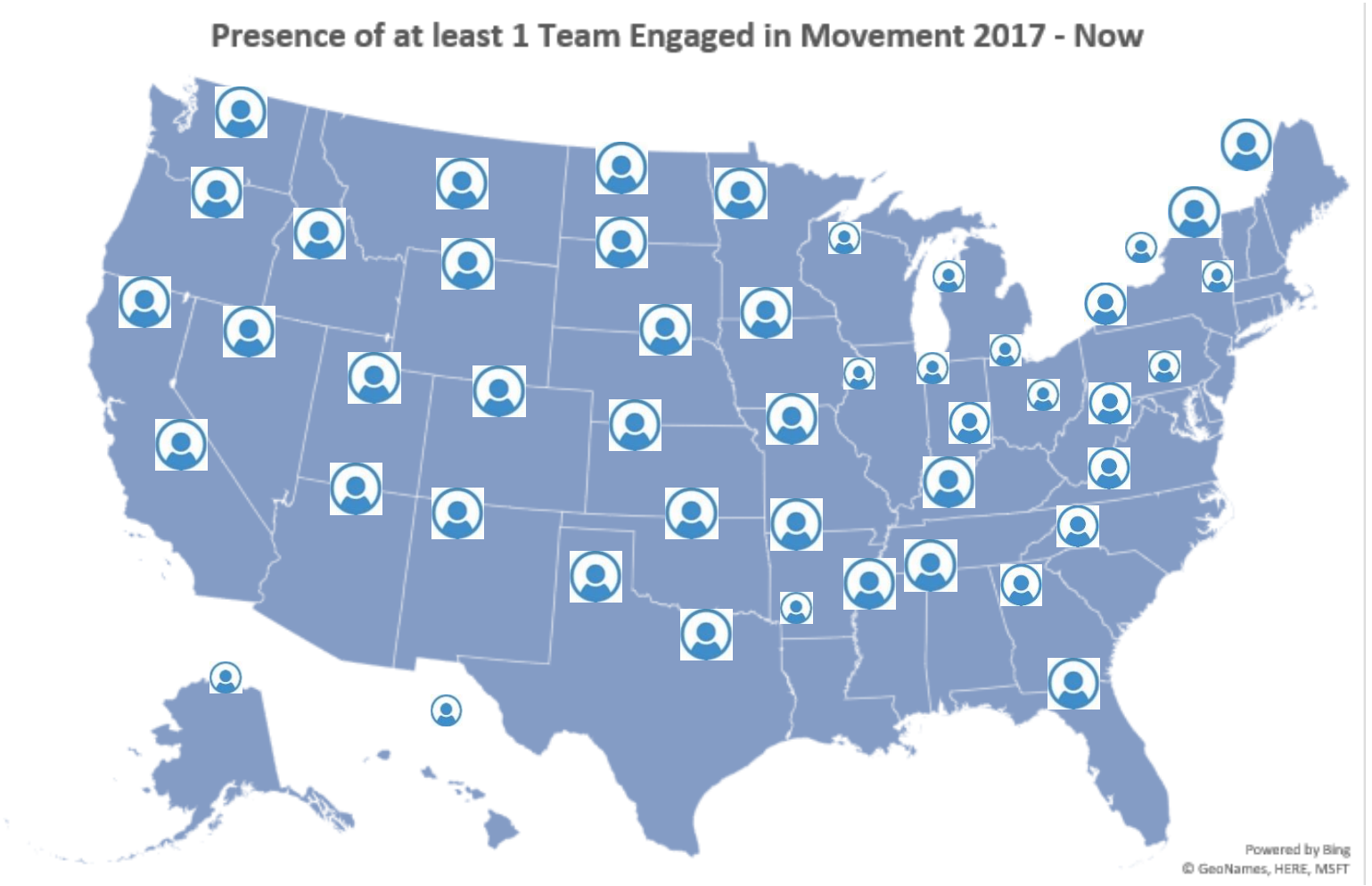
Anne Arundel Medical Center

ASCENSION

KAISER PERMANENTE®

Providence St. Joseph Health

Trinity Health



Age-Friendly Health Systems Pioneer

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

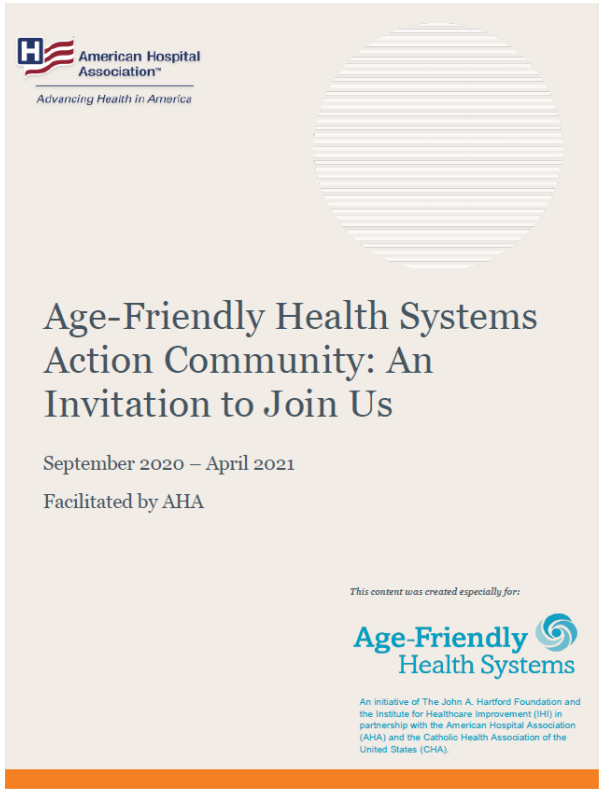
www.aha.org/AgeFriendly

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**
  - Starts Mid-September with 2 Kick off Calls
  - Starting October
    - Monthly all-team webinars
    - Scale-up leaders webinars
    - Listserv, sharing learnings
    - Monthly reports on testing and learnings
  - Celebration of joining the movement!

Enroll Today!



- **Download AHA's Invitation Guide**
- **Visit aha.org/agefriendly to learn more**
- **Email ahaactioncommunity@aha.org with any questions.**

AHA Action Community Activities

- 2 Kick Off Calls in September
- Test Age-Friendly interventions
- Monthly brief data submissions

Some of the 4Ms sometimes with some older adults

Webinar 1
October 2020

Learning & Action Period 1

Webinar 2
November 2020

Learning & Action Period 2

Webinar 3
December 2020

Learning & Action Period 3

Webinar 4
January 2020

Learning & Action Period 4

In-Person/Virtual Meeting 2021

Learning & Action Period 5

Webinar 5
March 2021

Learning & Action Period 6

Celebratory Webinar
April 2021

Reliable 4Ms implementation at the scale of the system

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

7 Months

Age-Friendly Health Systems

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

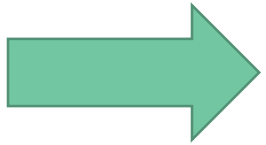
Resources

www.ihi.org/AgeFriendly

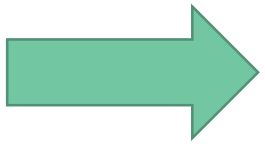
Age-Friendly Health System Recognition

An Age-Friendly Health System…

- **Defines** the 4Ms for its hospital and/or practice



- **Counts** the number of 65+ people whose care includes the 4Ms (reported by each site)



- **Scales** the work and **celebrates** recognition nationally

Age-Friendly Health Systems

Putting the 4Ms into Practice: A "Recipe"

1. Understand your current state
2. Describe what it means to provide care consistent with the 4Ms
3. Design/adapt your workflow to deliver care consistent with the 4Ms
4. Provide care consistent with the 4Ms
5. Study your performance
6. Improve and sustain care consistent with the 4Ms

Age-Friendly Health Systems

Customizing Putting the 4Ms into Practice: A "Recipe"

Age-Friendly Health Systems

4Ms Description Worksheet: Hospital

	What Matters	Medication	Mentation	Mobility
Aim	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	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	Prevent, identify, treat, and manage delirium across settings of care	Ensure that each older adult moves safely every day to maintain function and do What Matters
Engage / Screen / Assess Please check the boxes to indicate items used in your care or fill in the blanks if you check "Other."	List the question(s) you ask to know and align care with each older adult's specific outcome goals and care preferences: One or more What Matters question(s) must be listed. Question(s) cannot focus only on end-of-life forms.	Check the medications you screen for regularly: ☐Benzodiazepines ☐Opioids ☐Highly-anticholinergic medications (e.g., diphenhydramine) ☐All prescription and over-the-counter sedatives and sleep medications ☐Muscle relaxants ☐Tricyclic antidepressants ☐Antipsychotics ☐Other: _____ Minimum requirement: At least one of the first seven boxes must be checked.	Check the tool used to screen for delirium: ☐UB-2 ☐CAM ☐3D-CAM ☐CAM-ICU ☐bCAM ☐Nu-DESC ☐Other: _____ Minimum requirement: At least one of the first six boxes must be checked. If only "Other" is checked, will review.	Check the tool used to screen for mobility limitations: ☐TUG ☐Get Up and Go ☐ JH-HLM ☐ POMA ☐ Refer to physical therapy ☐Other: _____ Minimum requirement: One box must be checked. If only "Other"
Frequency	☐Once per stay ☐Daily ☐Other: _____ Minimum frequency is once per stay.	☐Once per stay ☐Daily ☐Other: _____ Minimum frequency is once per stay.	☐Every 12 hours ☐Other: _____ Minimum frequency is every 12 hours.	☐Onc ☐Dail ☐Oth Minimu stay.
Documentation	☐EHR	☐EHR	☐EHR	☐EHR
Act On Please describe how you use the information obtained from Engage/Screen/Assess to design and provide care. Refer to pathways or procedures that are meaningful to your staff in the "Other" field.	☐Align the care plan with What Matters most ☐Other: _____ Minimum requirement: First box must be checked.	☐ Deprescribe (includes both dose reduction and medication discontinuation) ☐Pharmacy consult ☐Other: _____ Minimum requirement: At least one box must be checked.	Delirium prevention and management protocol including, but not limited to: ☐Ensure sufficient oral hydration ☐Orient older adult to time, place, and situation on every nursing shift ☐Ensure older adult has their personal adaptive equipment (e.g., glasses, hearing aids, dentures, walkers) ☐Prevent sleep interruptions; use non-pharmacological interventions to support sleep ☐ Avoid high-risk medications ☐Other: _____ Minimum requirement: First five boxes must be checked.	☐Ambulate 3 times a day ☐Out of bed or leave room for meals ☐ PT intervention (balance, gait, strength, gate training, exercise program) ☐ Avoid restraints ☐ Remove catheters and other tethering devices ☐ Avoid high-risk medications ☐Other: _____ Minimum requirement: Must check first box and at least one other box.

[Guide to Using the 4Ms]

4Ms Description Worksheet: Ambulatory

	What Matters	Medication	Mentation	Mobility
Aim	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	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	Prevent, identify, treat, and manage delirium across settings of care	Ensure that each older adult moves safely every day to maintain function and do What Matters
Engage / Screen / Assess Please check the boxes to indicate items used in your care or fill in the blanks if you check "Other."	List the question(s) you ask to know and align care with each older adult's specific outcome goals and care preferences: *One or more What Matters question(s) must be listed. Question(s) cannot focus only on end-of-life forms.*	Check the medications you screen for regularly: ☐ Benzodiazepines ☐ Opioids ☐ Highly-anticholinergic medications (e.g., diphenhydramine) ☐ All prescription and over-the-counter sedatives and sleep medications ☐ Muscle relaxants ☐ Tricyclic antidepressants ☐ Antipsychotics ☐ Other: _____ *Minimum requirement: At least one of the first seven boxes must be checked.*	Check the tool used to screen for delirium: ☐ UB-2 ☐ CAM ☐ 3D-CAM ☐ CAM-ICU ☐ bCAM ☐ Nu-DESC ☐ Other: _____ *Minimum requirement: At least one of the first six boxes must be checked. If only "Other" is checked, will review.*	Check the tool used to screen for mobility limitations: ☐ TUG ☐ Get Up and Go
Frequency	☐ Once per stay	☐ Once per stay	☐ Every 12 hours	

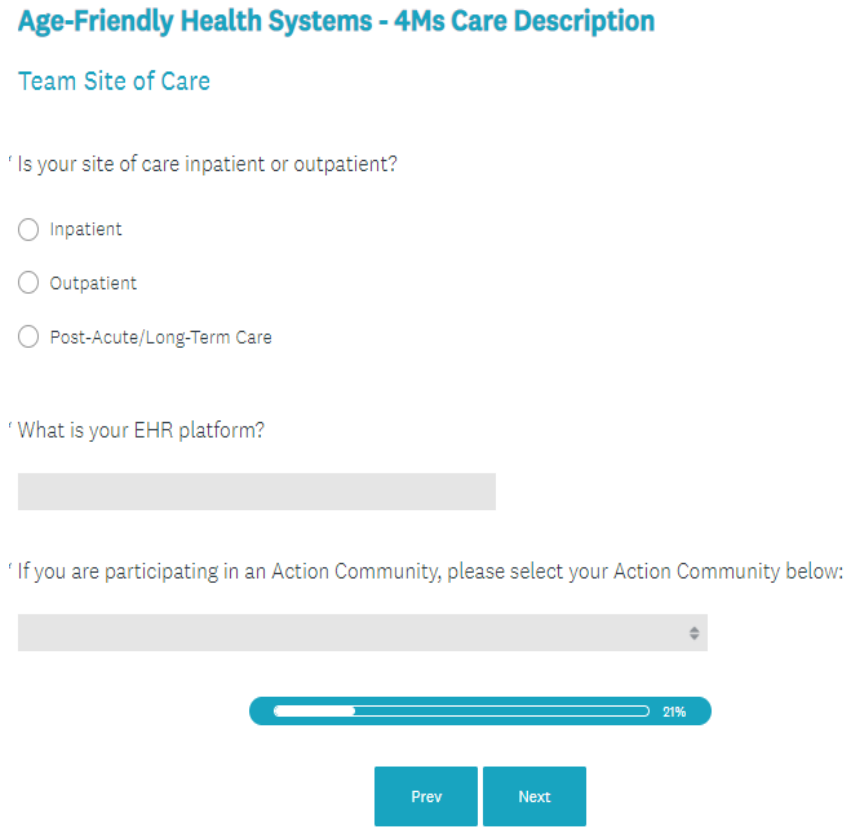
	What Matters	Medication	Mentation	Mobility
	☐ Daily ☐ Other: _____ *Minimum frequency is once per stay.*	☐ Daily ☐ Other: _____ *Minimum frequency is once per stay.*	☐ Other: _____ *Minimum frequency is every 12 hours.*	☐ Daily ☐ Other: _____ *Minimum frequency is once per stay.*
Documentation Please check the "EHR" (electronic health record) box or fill in the blank for "Other."	☐ EHR ☐ Other: _____ *One box must be checked; preferred option is EHR. If "Other," will review to ensure documentation method is accessible to other care team members for use during the hospital stay.*	☐ EHR ☐ Other: _____ *One box must be checked; preferred option is EHR. If "Other," will review to ensure documentation method is accessible to other care team members for use during the hospital stay.*	☐ EHR ☐ Other: _____ *One box must be checked; preferred option is EHR. If "Other," will review to ensure documentation method can capture assessment to trigger appropriate action.*	☐ EHR ☐ Other: _____ *One box must be checked; preferred option is EHR. If "Other," will review to ensure documentation method can capture assessment to trigger appropriate action.*
Act On Please describe how you use the information obtained from Engage/Screen/Assess to design and provide care. Refer to pathways or procedures that are meaningful to your staff in the "Other" field.	☐ Align the care plan with What Matters most ☐ Other: _____ *Minimum requirement: First box must be checked.*	☐ Deprescribe (includes both dose reduction and medication discontinuation) ☐ Pharmacy consult ☐ Other: _____ *Minimum requirement: At least one box must be checked.*	Delirium prevention and management protocol including, but not limited to: ☐ Ensure sufficient oral hydration ☐ Orient older adult to time, place, and situation on every nursing shift ☐ Ensure older adult has their personal adaptive equipment (e.g., glasses, hearing aids, dentures, walkers) ☐ Prevent sleep interruptions; use non-	☐ Ambulate 3 times a day ☐ Out of bed or leave room for meals ☐ PT intervention (balance, gait, strength, gate training, exercise program) ☐ Avoid restraints ☐ Remove catheters and other tethering devices ☐ Avoid high-risk medications

Guide to Using the 4Ms

Action Community Monthly Data Sharing

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

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



Age-Friendly Health Systems

Sites Recognized by the Movement

Age-Friendly Health Systems
Participant

805

Hospitals, practices, retail clinics 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

179*

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

Age-Friendly Health Systems

Connecting Age-Friendly Measures with Value

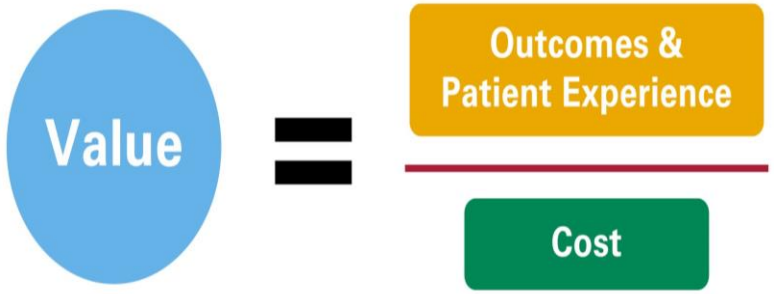


Figure 3: Age-Friendly Measures Contribute to Value

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

The Value Initiative

Age-Friendly Health Systems

Stanford HEALTH CARE

Becoming an Age-Friendly Health System: Stanford Health Care Improvement Journey

The American Hospital Association AFHS Action Community Forum - August 19th, 2020

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Associate Chief Quality Officer,

Stanford Health Care

Vice Chair, Department of Anesthesiology, Perioperative and Pain Medicine, Stanford School of Medicine

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Ankur Bharija, MD

Clinical Assistant Professor, Geriatric Medicine

Division of Primary Care and Population Health,

Department of Medicine, Stanford Medicine

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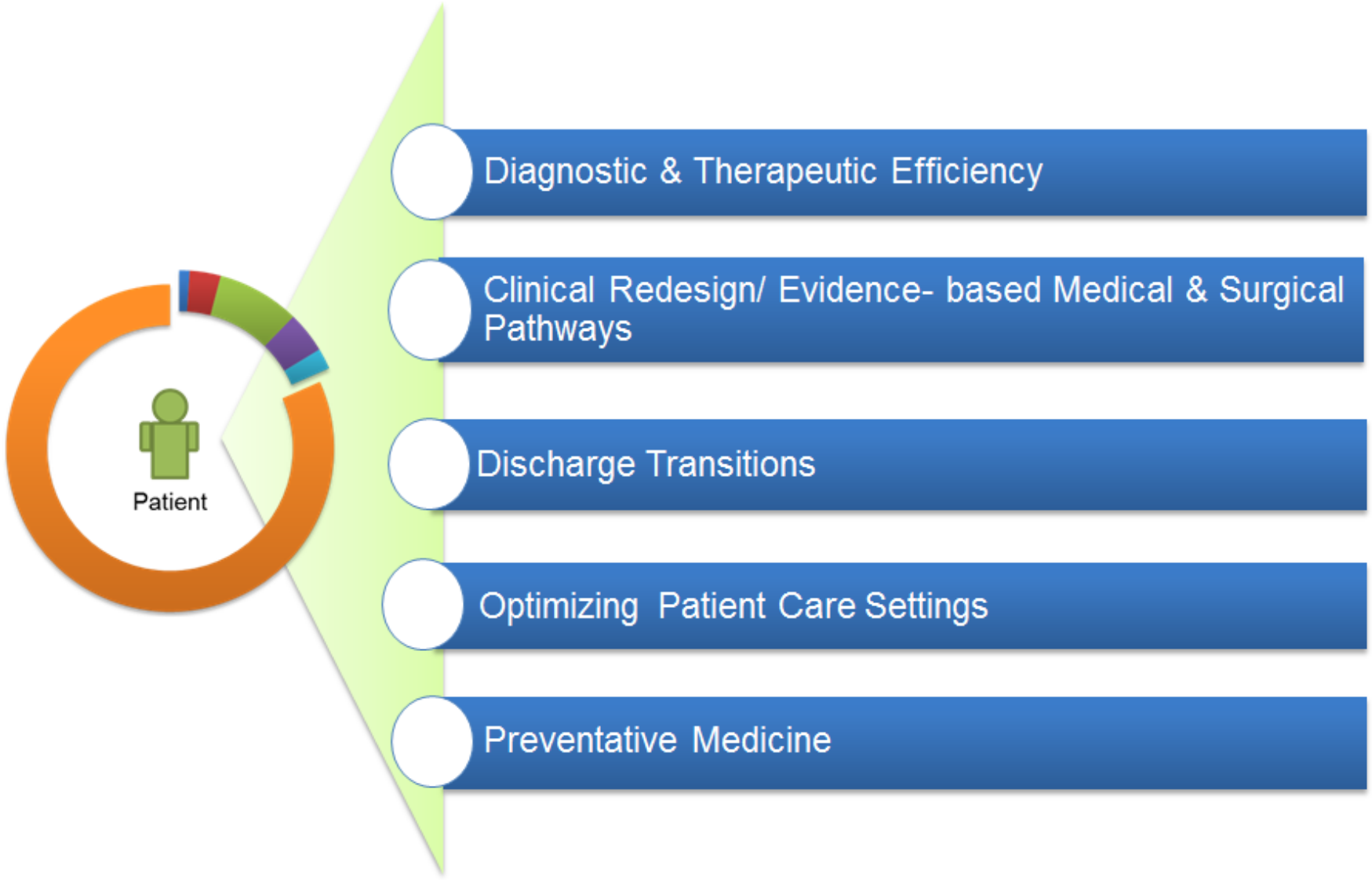
Twitter: @DrAnkurB

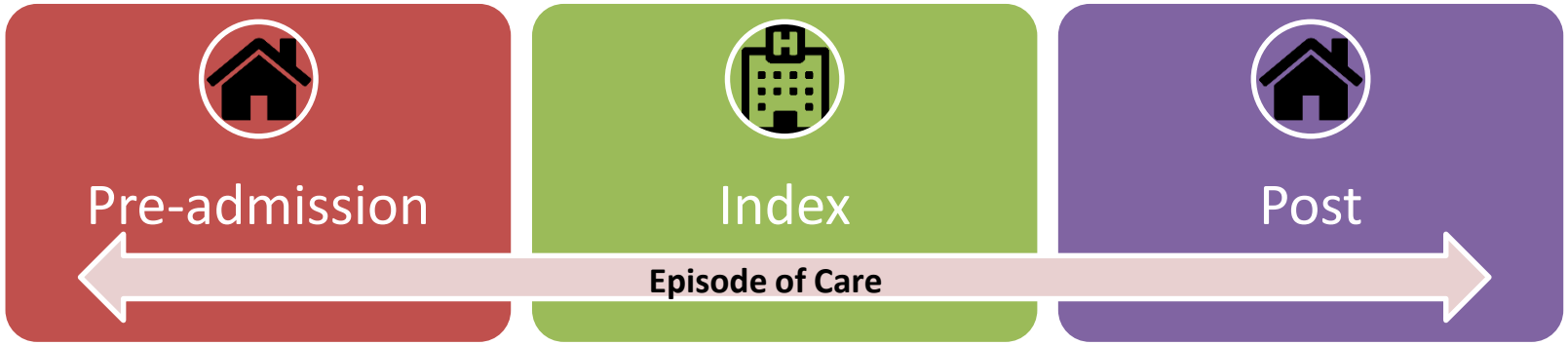
Stanford | MEDICINE

Stanford Health Care High Value Care Model

Integrated model of patient-centered and system-level performance



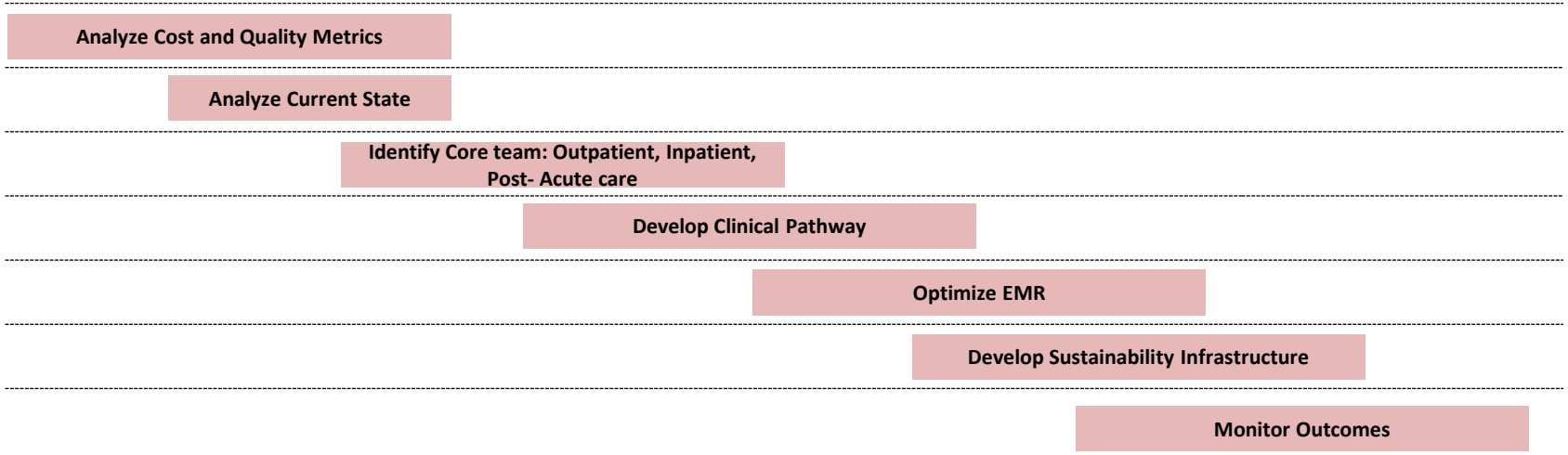
Clinical Pathways, Care Redesign, and Coordination



- ❑ ED
- ❑ PCP/Specialty Clinic

- ❑ Acute Care Hospital
- ❑ Ambulatory Surgery
- ❑ Outpatient Clinic

- ❑ Home
- ❑ Skilled Nursing Facility
- ❑ Home Health
- ❑ PCP/ Specialty Clinic



Clinical Pathway and Care Redesign Development

1. Initial Design, Scoping, Target Cohort Identification

2. Detailed Data Analysis

3. Review of literature and evidence-based best practices

4. Pathway Development with Multidisciplinary Team with providers and patients

5.EPIC Optimization and Order Set Creation

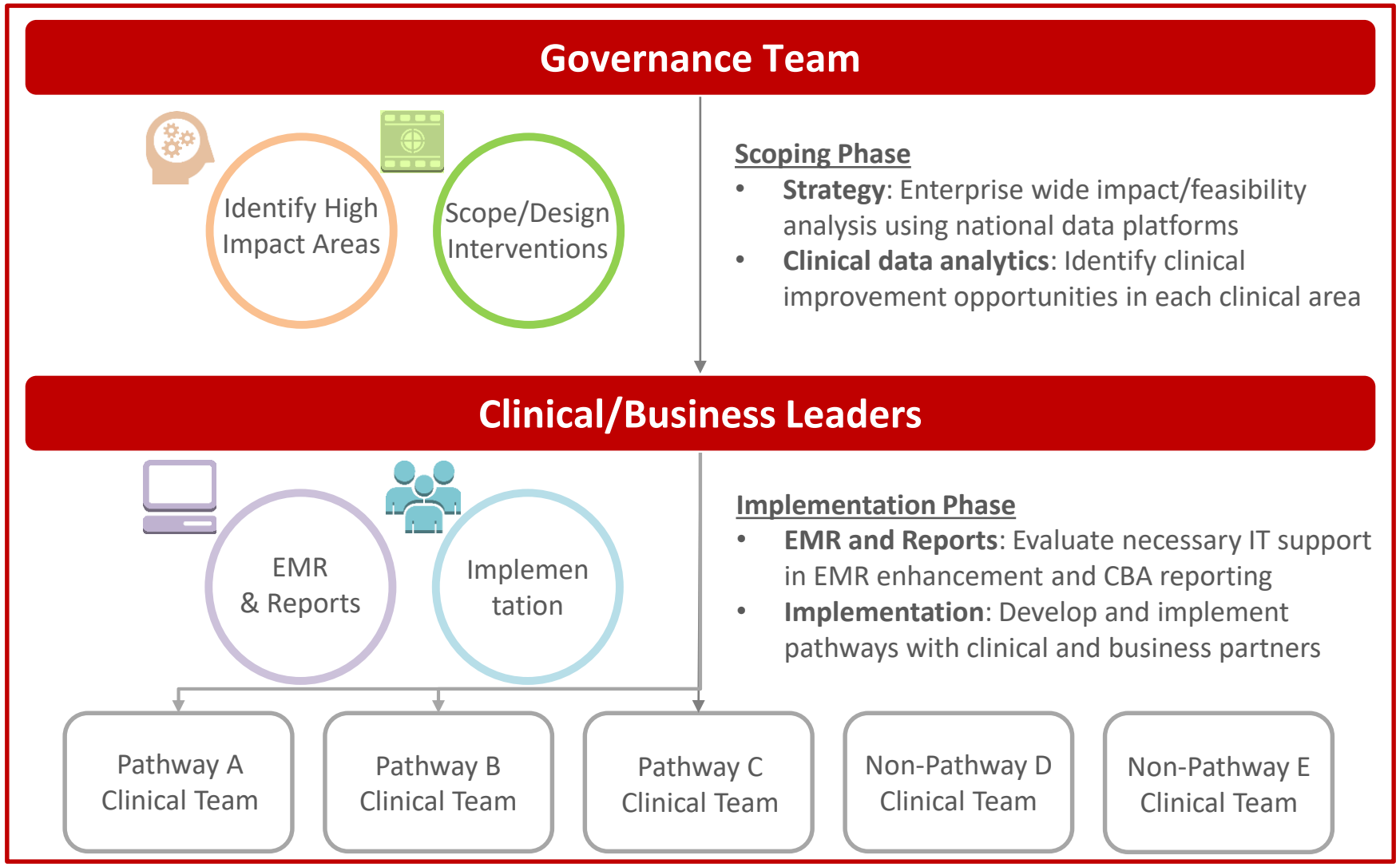
6. Automated Data Dashboard

7. Initial Implementation

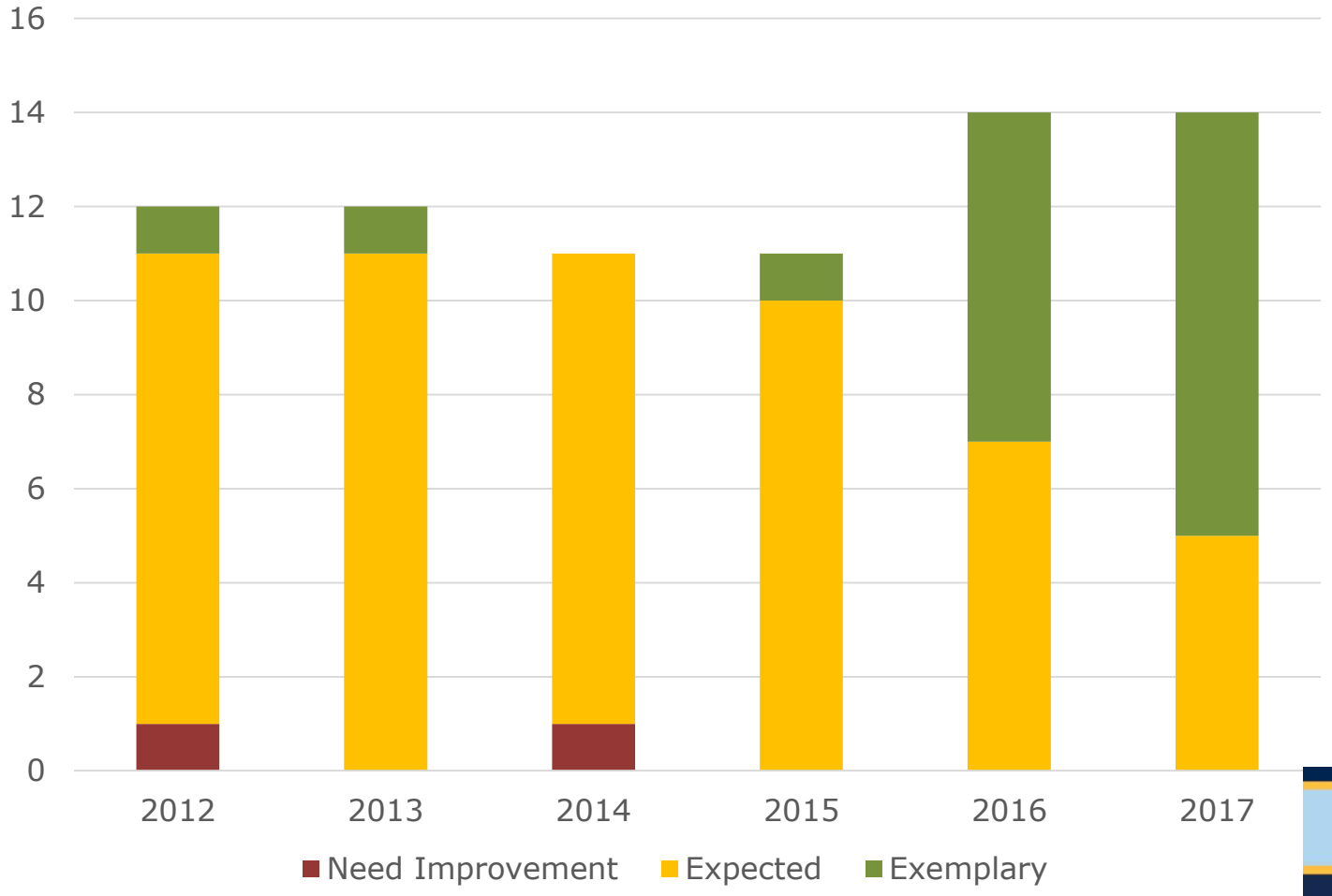
8. Patient Education Materials

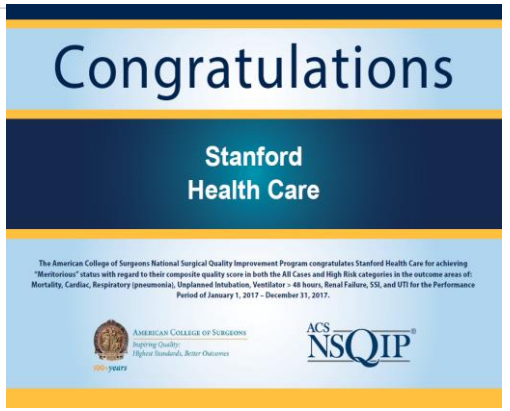
9. Iteration/ Sustainability Plan

Improvement Scoping and Implementation



NSQIP Risk-Adjusted Complication Rates for SHC





Objectives

- ✓ **Implementation** - Becoming an Age-Friendly Health Systems
- ✓ **Impact** - Value Improvement and Culture Change
- ✓ **Value** – Action Community and the Recognition

Geriatric Trauma at Stanford

- An increasing segment of trauma admissions - **24% increase** in admissions 65 and older from FY17 to FY18.
- Time-consuming, but **non-operative**, problems
- High rates of **ICU "bounce back",** complications
- Higher **direct cost** of care
- **Ground Level Falls - most common** mechanism of injury

Stanford Geriatric Trauma Initiatives

Targeted Geriatrics Consultation

October 2016

- **Frailty screening led by Trauma service** during Tertiary survey – GT65 Screen
- **1. Geriatrics to consult those who screen positive.**
- 2. Observations:
- - 23% had delirium
- - 50% had cog impairment
- - 70% had Med changes recommended

Geriatric Specific Order sets

May 2017

1. Admission order sets:

Trauma admission order sets reviewed and updated for senior-friendly pharma and non-pharma interventions

2. Elderly Rib Fracture pain Mx protocol

- Standardized pain evaluation and management protocols created by Pain service, Geriatrics and Trauma.

Acute Care for Elders Unit (Trauma)

October 2017

ACE unit model launched on the Trauma (Non-ICU) unit.

1. **Nursing-driven screening** at admission and daily report-out for geriatric syndromes based on 'SPICES' format.

2. **Geriatric APP driven** guidance to IDT regarding geriatric syndromes as barriers to discharge during daily IDT rounds.

Continuous Process Improvement

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Geriatric Trauma High-Value Care Pathway

November 2018

Multi-disciplinary (Nursing, Rehab, CM/SW, Geriatrics and Trauma) care pathway for all 65+ admitted under Trauma service – built with attention to the AFHS '4M care' framework for all.

Continuous Process Improvement

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

AIM: To provide age-friendly care consistently to at least 80% of the geriatric trauma population.

AFHS SMART GOAL: To improve the consistent delivery of “4M care bundle” from 60% to 80% in the geriatric trauma population from Nov 2018 to Nov 2019.

Stanford HEALTH CARE

Multidisciplinary Workshop

- Brainstorming session with multidisciplinary team in May 2018

- Trauma Team- surgeons, APP
- Geriatric Medicine- Providers, CNS
- ED PCM
- Nursing- C2, E2 ICU
- Case Management & Social Worker
- Pharmacy
- Rehab
- Patient-Family Advisor
- High Value Care

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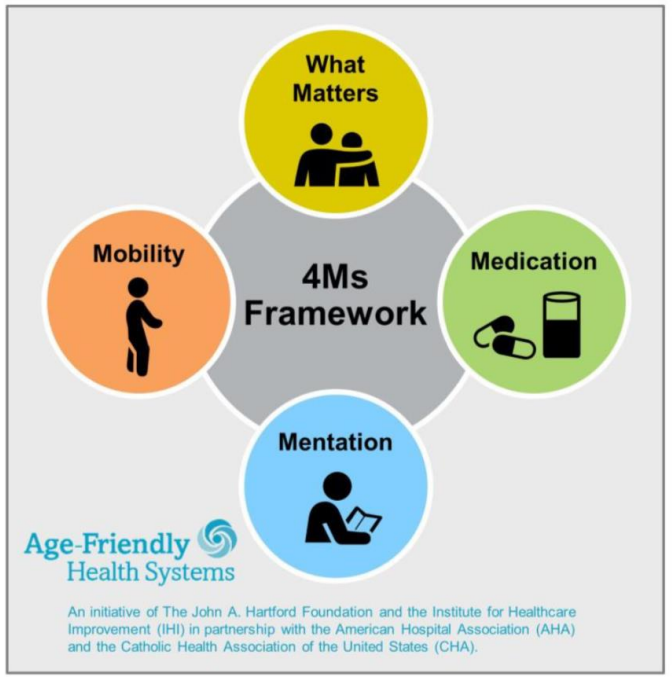
Integrating Age-Friendly Care



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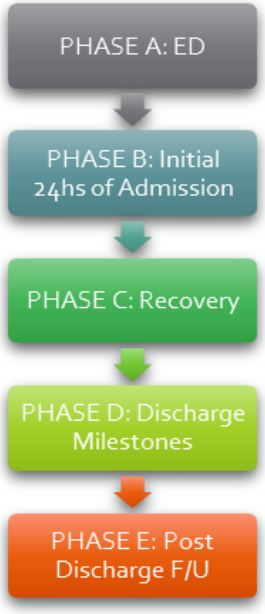

Recovery Milestones

Geriatric Trauma Non-Surgical Clinical Pathway

Geriatric
Last Updated 10/16/18_PK

Provider	Pharmacy	Case Management	Spiritual Care
Nursing	Rehab	Social Worker	

Categories	Primary Owner	Phase A: ED	Phase B: Initial 24 hrs of admission	Phase C: Recovery	Phase D: Discharge Milestones	Phase E: Post Discharge Follow-Up
Goal		• Acuity assessment • Identify injuries • Review past medical history • Hemodynamic stability • Pain control • Keep patient & family informed of plan and test results • Identift next of kin/ surrogates • Prevent or treat delirium • Bleed risk assessment - if fall (possible	• Trauma Tertiary Survey (TTS) • Have complete characterization and final reads on all injuries • Prevent or treat delirium	• Patient and family to prepare for long-term care • Discharge to safe preferred living situation • Progress to baseline hemodynamic status	• Baseline hemodynamic status • Improved exercise tolerance • Transition of care- Discharge summary to	• Patient & family prepared for post discharge care
Labs	Provider	• BMP, CBC • PT/ INR • Repeat HCTs for Traumatic Brain Injury patients • Therapeutic drug levels (eg. digoxin				
Diagnostics	Provider	• EKG • Chest XRay • CT Head, Chest, or Abdomen- dependi on injuries • Imaging to determine weight bearing precautions • If fall or mecahnism of injury concernin syncope: 12 Lead EKG, Troponin, Transt Echo				
Pulmonary (For thoracic trauma)	Provider	• Determine pulmonary function • Aggressive pulmonary toilet • O2 Therapy				
Consults	Provider	• Trauma Service • Pain Service • PT/OT consult • Social Work (SW) consult, if APS report needed.				
Pain Management	Provider	Aggressive pain control measures: Goal P Score <4 For thoracic trauma: • Pain/ Anesthesia team consult for epid paravertebral nerve block				

Categories	Primary Owner	Phase A: ED	Phase B: Initial 24 hrs of admission	Phase C: Recovery	Phase D: Discharge Milestones	Phase E: Post Discharge Follow-Up
			• Document pain scores • Massage therapy/ guided imagery/ meditation • Application of Ice		• Completed OT and/or PT evaluations with safe discharge recommendations in place	
Goals of Care (GOC)	Provider	• Trauma provider to clarify goals of care for next 24 hours • Check Epic for POLST	• MD: Discuss & document preliminary goals of care;	• MD: Discuss & document revised goals of care		
Mind/ Mentation	Nursing					
Nutrition/ Hydration	Nursing	• Bedside swallow eval • Maintain diet • SLP: If h/o dysphagia, • MD: IV fluids, if signs				
Elimination	Nursing	• Urine output monitor • Document last BM				
Wound Care/ Skin Integrity	Nursing	• Treatment of wounds • Initiate pressure relie applicable				
Education	Nursing	• Patient and family ed and next steps • Importance of pulmo				

Categories	Primary Owner	Phase A: ED	Phase B: Initial 24 hrs of admission	Phase C: Recovery	Phase D: Discharge Milestones
Medications	Pharmacy	• Admitting MD: Medication reconciliation with home meds; Assess interaction of new meds with home meds.	• Complete med reconciliation • Restart home meds • Place order for "PO to feeding tube per pharmacy" order, as needed	• Geriatrician to assess med list using Beers Criteria • Transition to PO Meds • Transition to non-opiods alternatives • Finalize recommendations from consulting services • Finalize meds for discharge	• Trauma team to complete discharge med education
			• Review side effects with the patient and family	• Confirm patient's outpatient pharmacy	• Meds education, as needed • Confirm delivery of meds or sign up patient for home med delivery
				• SW: Obtain prior authorization for meds	
Activity	Rehab	• Activity order, if appropriate (clarify precautions)	• Early Mobility Protocol • Head of Bed at 30 degrees (unless contraindicated by spinal precaution) • Out of Bed to chair- 3 x daily for all meals • PT Eval to determine baseline function and progress mobility • OT Eval to address ADLs, IADLS, cognition and non-pharmacologic pain management techniques • SLP Eval for swallow assessment, when needed • Provide initial recommendation on disposition, DME, Transport	• Ambulate at least 3x daily, as appropropriate • OT consult for sleep hygiene	
			• **Nursing:** document activity in Epic every shift; activity checklist on the whiteboard		
Discharge planning	Case Management	• Utilization review- Inpatient vs Observation; Home Health, vs SNF; DME needs • Discharge education and after care, if discharged from ED with skilled needs	• Provide list of SNFs that family can visit prior to dc • Patient goals for discharge; Confirm EDD with treatment team; assess psychosocial needs; involve family; Complete Admission Assessment- Insurance, living environment, baseline mobility, DME at home, caregiver, PT/OT eval, transportation	• Confirm disposition: Home, SNF, Acute Rehab, Home with Home Health • Ensure prior authorization for medications are completed • Case manager to ensure DME is authorized • Call receiving facilities for eval, if to return within 48hrs	• Arrange home care, if appropriate • Discharge meds are available for pickup or delivery • Call Pharmacy to verify coverage/ availability if medication is rare or needs prior auth
Psycho-Social	Social Worker	• Substance abuse screening, abuse neglect screening, psychosocial history • Notify next of kin and/or surrogate decision maker of ED visit and/or hospitalization • Identify and document DPOA and/or surrogate decision maker	• Substance abuse screening, abuse neglect screening, psychosocial history • Identify and document DPOA, surrogate decision maker • Assess financial counselor needs; f/u on PT/OT recommendations	• Insurance/housing/transportation needs and medication access • Arrange for appropriate therapeutic interventions	• Arrange community services and resources as appropriate • Assist with medications when uninsured and medication vouchers for Medi-Cal patients • Assist with transportation as appropriate

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AFHS 4M Care Definition – SHC Geriatric Trauma

4Ms	Definition	Role	Frequency	Measure
What Matters	1. ***"What's most important to you during this hospital stay?"*** 2. HC proxy/ Surrogate 3. Previous Advance Directive	Geriatrics team	Once per stay for all and recurrent if needed	% receiving GOC note Time to complete first GOC note (Goal – 48 hrs)
Medications	Screen home and current medication list for potentially inappropriate medications	Geriatrics team	Admission and Daily	Admission med rec within 48 hrs.
Mentation	Screen for Delirium by CAM	Nursing	Every shift	% of positive CAM and/or Delirium DRG code during admission.
Mobility	Screen for mobility and proactive ambulation	Rehab and Nursing	Admission and Daily	# of hours (Time) to first mobility from admission.

Nursing Orientation – Trauma ICU and Non-ICU unit

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GERIATRIC TRAUMA (NON-SURGICAL) CARE PATH

OVERVIEW

- **Situation:** The Trauma and Geriatric service lines are implementing geriatric trauma care path for non-surgical trauma patients with age 65 and above. Care path and updated order sets will define standardized care across different phases of care and thereby will improve efficiency and reduce LOS. The go-live date is 11/5/18.

- **Background:** Trauma, in geriatric populations, increases with age and is a leading cause of disability. The presence of comorbidities and drug therapies increases the risk of trauma in the elderly. The use of multidisciplinary clinical pathway tends to be effective and is associated with reduced complications and length of stay.

- **Assessment:** The Trauma and Geriatric service line in partnership with High Value Care, organized a clinical workgroup in April 2018 to evaluate geriatric trauma cases and optimize care using multidisciplinary clinical pathway. Variation noted in surgical vs non-surgical trauma patients with opportunities both in length of stay and cost. It was decided to scope out the project in two phases by developing separate clinical pathways for Non-Surgical and Surgical trauma patients. The clinical workgroup identified evidence-based guidelines to advance care of the patients and clarify roles of each discipline.

- **Recommendation:** Optimize care of non-surgical geriatric trauma patients by following the evidence-based clinical pathway. The care path link is attached below.
  Geriatric Trauma Non-Surgical Pathway

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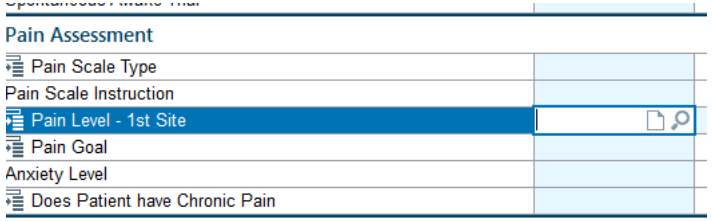
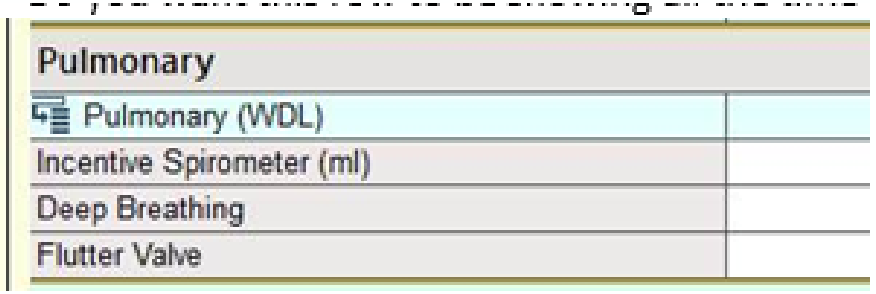
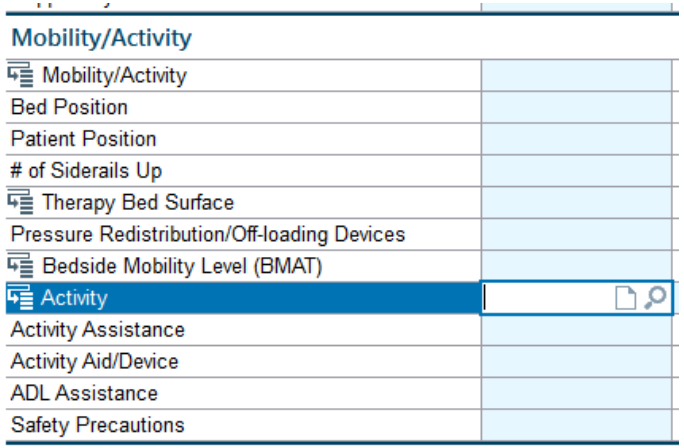
Standardized EPIC Documentation







Geriatric Trauma (Non-Surgical) Care Path

Frequently Asked Questions

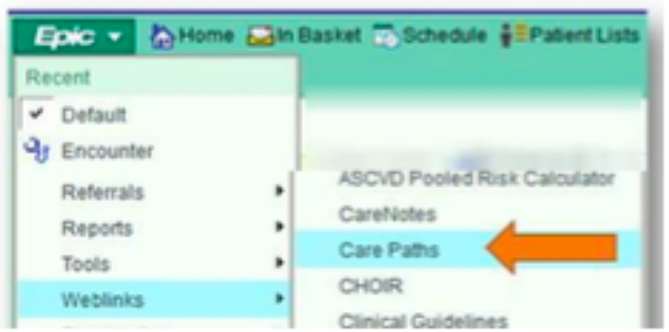
Does THE PATHWAY apply to all patients?

- ✓ The following cases will be excluded from the care path: All major surgical procedures
- ✓ Following cases will be flagged as "Off the target LOS": Insertion of pacemaker & defibrillator, Cardiac assist device- IABP, ECMO, VAD, patients on hemodialysis or CRRT, prolonged vent>24 hrs

Where to find the Geriatric Trauma Non-Surgical Care Pathway?

- ✓ The Care Path link is available here:
  Geriatric Trauma Non-Surgical Pathway
- ✓ The link is also available for reference in Epic (see screenshots below) and in order sets.

Reference Link is located in "WebLinks"



Selection launches the SHC Care Path repository web site

Which order set to use?

- ✓ The following order sets are updated and are available to use in Epic:
  - *IP SUR General Admit*
  - *IP GEN/ICU Rib Fracture*

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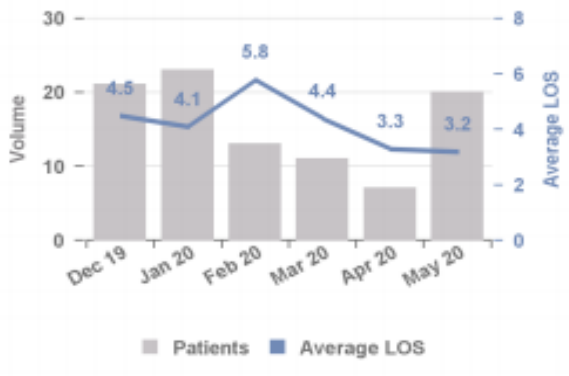
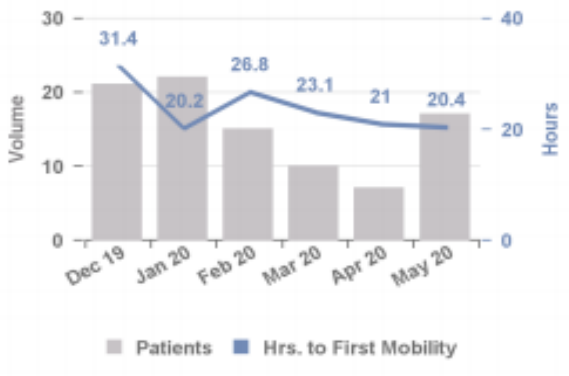
Geriatric Trauma Non-Surgical Outcomes

Volume and Average LOS



Note: Average # days patient spent in hospital (Length of stay is discharge - admit).

Average # of Hours to First Mobility

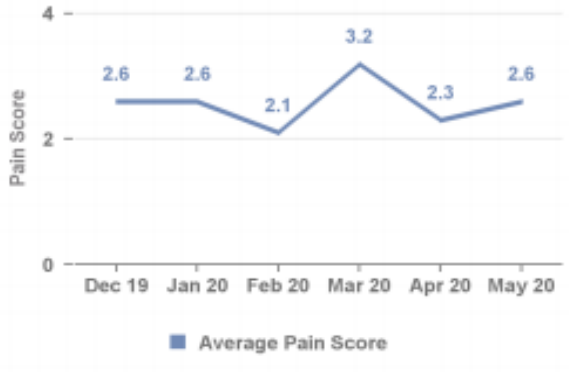


Note: Averages are computed for all patients WITH a recorded first mobility time.

Average # of Hours to First Goals of Care Note

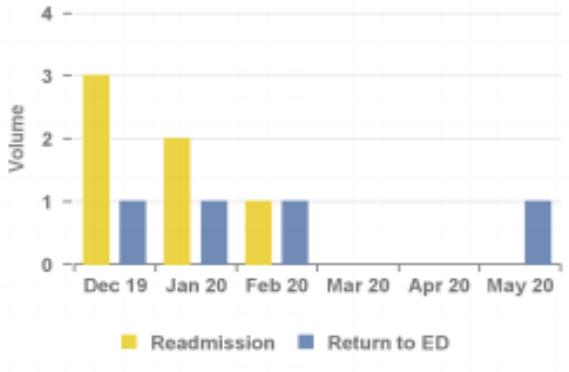
Note: Averages are computed for all patients WITH a recorded goals of care note.

Average Pain Score, Last 24 Hours



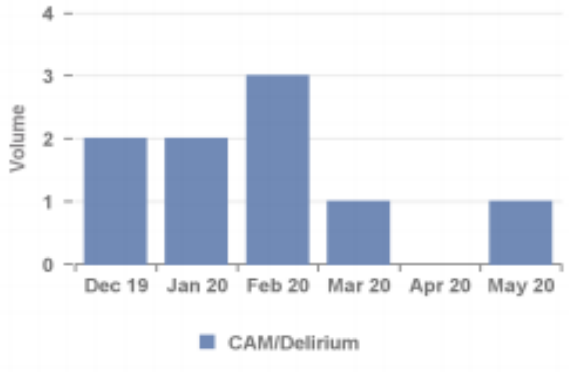
Note: Average pain score 24 hours prior to discharge is determined per patient first and then averaged per month.

Unplanned Care



Note: Readmission and ED are returns within a 30 day period.

CAM/Delirium



Number of patients with positive CAM and/or delirium diagnosis during the encounter (Delirium ICD-10 codes 'R41.0', 'R41.82', 'F05', 'F10.231', 'F11.221', 'F13.231', or 'F13.921')

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Geriatric Trauma Care Pathway Dashboard (updated monthly)

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Value Improvement

$$\text{Value} = \text{Team Engagement} \times \left[\frac{\text{Quality} + \text{Service}}{\text{Cost}} \right]$$

Voice of the Team		Voice of the Patient					Voice of the System	
Employee Sat.	Provider Sat.	Mortality O:E	Readmits	Excess Days	Complications - Delirium etc.	Patient Sat.	Direct Cost	Length of Stay

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Outcomes and Process Metrics (Improving Value)

		FY17 (Pre-Implementation)	FY18 (Implementation)	FY19 (Post-Implementation)	FY20 (-Jan20) (Sustainability)
	Number	193	214	**249**	**101**
4M Care Process Implementation	What Matters: Time to first ACP/GOC note and % completed	50hrs	38hrs (60%)	**32hrs (70%)**	**(70%)**
	Mobility: Average time to first mobility		48hrs	**23hrs (99%)**	**(99%)**
	Medications: Admission Med Review		60%	**(70%)**	**(70%)**
	Mentation: Nursing CAM Assessments		90%	**(99%)**	**(99%)**
Utilization/ Cost	LOS (Non-Surgical) (days)	4.55	4.13	**4.1**	4.33
	LOS (CAM+ vs CAM-) (days)	6.7 vs 3.6	5.7 vs 3.4	6.1 vs 3.5	6.2 vs 3.8
	Direct cost/ patient	BL	(-$3,100)		
	30-day Readmission Rate (%)	6	1	7	**5**
	30-day Return to ED (%)	5	4	8	**3**
Quality/ Safety	Mortality (%)	5.8	4.8	**2.5**	**3**
	Delirium Incidence (%) (CAM + DRG)	32%	34%	**24%**	**22%**
Patient Experience	What number would you use to rate this hospital? (Top Box)	58.7%	63.5%	**67.3%**	
	Would you recommend this hospital to your friends and family?	69.6%	63.5%	**66.7%**	

Stanford Geriatric Trauma: Stories

Care:

A very **elderly lady with dementia being admitted for fall-related** injuries. She was seen in the ED within 24 hours by rehab and the geriatrics team. We **walked her around the ED and met with son to discuss GOC/ ACP priorities**. She was **downgraded from ICU to the regular floor** (ACE unit). Her pain was controlled early, she was taking PO and moving bowels, so was able to go home Day 3, **avoiding delirium and disability from a protracted ICU** and hospital stay.

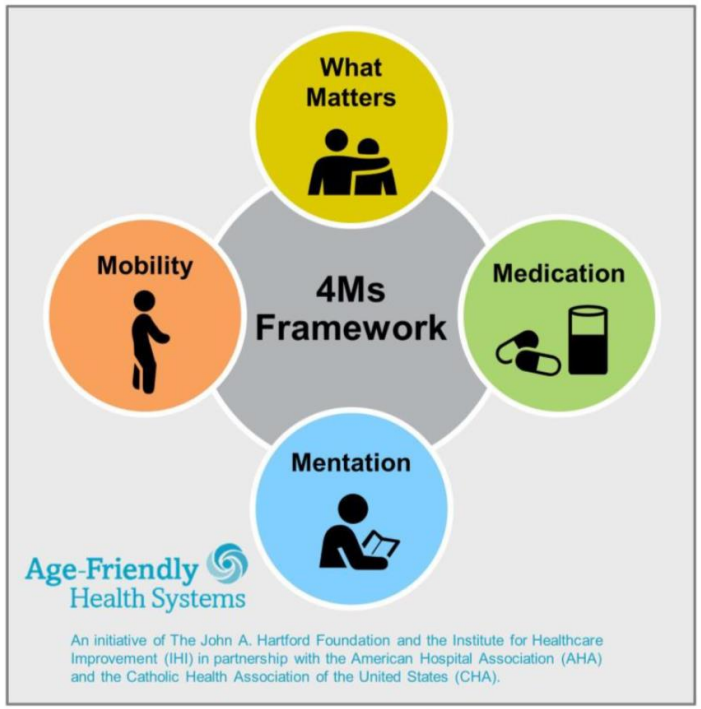
Culture:

Surgical team residents/ attendings now thinking about ACP (capacity, surrogate decision makers and goals) early for frail elders. **ICU nurses** are becoming comfortable with working with rehab for **early mobilization in the ICU**. **Floor nurses are recognizing more polypharmacy** issues and escalating NPO and bed rest orders ASAP.

Age-Friendly Health Systems Initiative

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

Stanford Geriatric Trauma Program recognized nationally November 2019



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

Medication
If medication is necessary, use Age-Frienc medication that does not interfere with Wh 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.

Institute for Healthcare Improvement

The John A. Hartford Foundation
Dedicated to Improving the Care of Older Adults

American Hospital Association

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Value of the AFHS Initiative

- **Access to a community** of experts in process improvement and others implementing 4M care.
- **Designing and Measuring -** key processes based on 4M care framework, value improvement
- **Messaging and Scaling** – Recognition has helped with key stakeholder buy-in from Nursing and Rehab leadership, resource allocation from hospital quality/EMR/CBA teams.

Opportunities for system-wide Age-Friendly Care

- **System-wide multi-disciplinary AFHS governance structure** – led by SHC nursing leadership in partnership with Geriatrics
- **New ACE unit(s)** - New Hospital (medicine and surgery)
- **Emergency Room** - Geri-ED – Level 2 certification.
- **Multi-disciplinary AFHS Care Pathways** - Geriatric Hip-Fractures
- **Future** initiatives to include measuring **provider engagement**, variation in care and outcomes based on **ethnic diversity/ caregiving needs**.

…AND culture change, value improvement, advancing health equity!

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On behalf of the – Stanford Geriatric Trauma Team

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Case Management and Social Work

Pharmacy

Janjiri Desai

Patient-Family Advisory Council

Alka

Thanks to the IHI-John A. Hartford AFHS community

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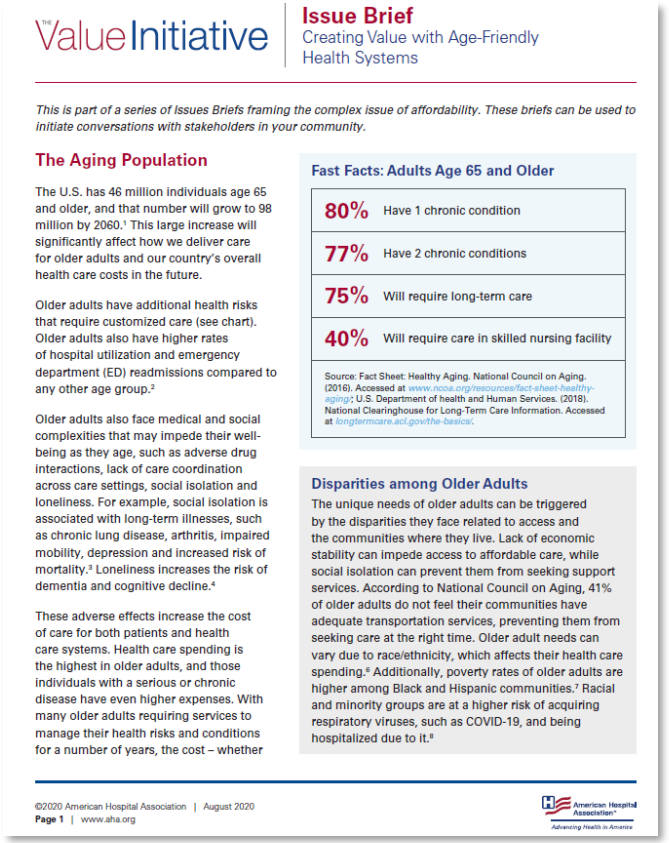
Discussion/Q & A

Type in the chat!

Age-Friendly Health Systems

New Resources!

Issue Brief: Creating Value with Age-Friendly Health Systems



The Value Initiative

Issue Brief
Creating Value with Age-Friendly Health Systems

This is part of a series of Issues Briefs framing the complex issue of affordability. These briefs can be used to initiate conversations with stakeholders in your community.

The Aging Population

The U.S. has 46 million individuals age 65 and older, and that number will grow to 98 million by 2060.[1] This large increase will significantly affect how we deliver care for older adults and our country's overall health care costs in the future.

Older adults have additional health risks that require customized care (see chart). Older adults also have higher rates of hospital utilization and emergency department (ED) readmissions compared to any other age group.[2]

Older adults also face medical and social complexities that may impede their well-being as they age, such as adverse drug interactions, lack of care coordination across care settings, social isolation and loneliness. For example, social isolation is associated with long-term illnesses, such as chronic lung disease, arthritis, impaired mobility, depression and increased risk of mortality.[3] Loneliness increases the risk of dementia and cognitive decline.[4]

These adverse effects increase the cost of care for both patients and health care systems. Health care spending is the highest in older adults, and those individuals with a serious or chronic disease have even higher expenses. With many older adults requiring services to manage their health risks and conditions for a number of years, the cost – whether

Fast Facts: Adults Age 65 and Older

80%	Have 1 chronic condition
77%	Have 2 chronic conditions
75%	Will require long-term care
40%	Will require care in skilled nursing facility

Source: Fact Sheet: Healthy Aging. National Council on Aging. (2016). Accessed at www.ncoa.org/resources/fact-sheet-healthy-aging/; U.S. Department of health and Human Services. (2018). National Clearinghouse for Long-Term Care Information. Accessed at longtermcare.acl.gov/the-basics/.

Disparities among Older Adults

The unique needs of older adults can be triggered by the disparities they face related to access and the communities where they live. Lack of economic stability can impede access to affordable care, while social isolation can prevent them from seeking support services. According to National Council on Aging, 41% of older adults do not feel their communities have adequate transportation services, preventing them from seeking care at the right time. Older adult needs can vary due to race/ethnicity, which affects their health care spending.[6] Additionally, poverty rates of older adults are higher among Black and Hispanic communities.[7] Racial and minority groups are at a higher risk of acquiring respiratory viruses, such as COVID-19, and being hospitalized due to it.[8]

American Hospital Association
Advancing Health in America

Case Study: Kent Hospital

Case Study: Rush University Medical Center

www.aha.org/AgeFriendly

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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

Age-Friendly Health Systems

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

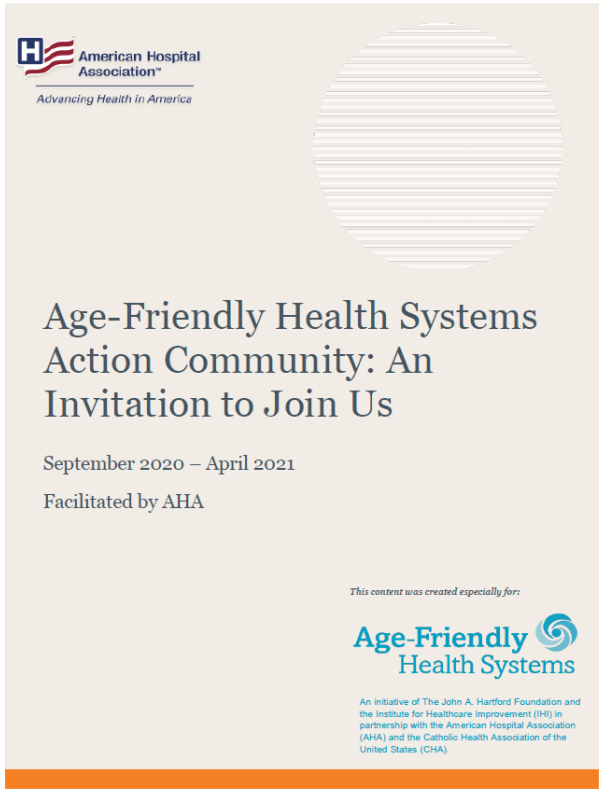
For questions, email AFHS@ihi.org

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**
  - Starts Mid-September with 2 Kick off Calls
  - Starting October
    - Monthly all-team webinars
    - Scale-up leaders webinars
    - Listserv, sharing learnings
    - Monthly reports on testing and learnings
  - Celebration of joining the movement!

Enroll Today!



- **Download AHA's Invitation Guide**
- **Visit aha.org/agefriendly to learn more**
- **Email ahaactioncommunity@aha.org with any questions.**

Evaluation Survey

- Share your feedback

Age-Friendly Health Systems