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).
Our Time Together Today

• Welcome & Introductions
• Julie Trocchio, Catholic Health Association
• Why Age-Friendly Health Systems
• Overview of Action Community
• Sharing of Data & Learning
• Implementation at Providence St. Joseph Health
• How to Join the Action Community
• Q&A
Our Team

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Speakers

Julie Trocchio, MS,
Senior Director
Community Benefit and Continuing Care, CHA

Angela Fox, Director of Business Development and Implementation, Providence Health & Services
We Invite Your Questions

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

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Community Benefit and Continuing Care, CHA

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Catholic Health Care and Age-Friendly Health Systems

AHA Webinar
August 1, 2019

Julie Trocchio
Catholic Health Association
The Catholic Health Association

- More than 600 hospitals
- 1,600 long-term care and other health facilities in all 50 states
- Largest group of nonprofit health care providers in the nation
- Everyday more than one in seven patients in the U.S. is cared for in a Catholic hospital
Statement of Shared Identity

“Special attention to our neighbors who are poor; underserved, and most vulnerable”
Seniors Are Vulnerable

At risk of:

- Too many or wrong medications
- Falling (or bedrest)
- Delirium
- Dementia not being addressed in plan
Catholic Health Association Activity

- Annual meeting presence
- Catholic Health World
- Health Progress
- Website https://www.chausa.org/eldercare/creating-age-friendly-health-systems
CREATING AN AGE-FRIENDLY CONTINUUM IN BOISE, IDAHO

By Randy E. Mink, MD, MPP, and Karla E. McVeigh, MD

The Idaho Commission on Aging, assisted by the Catholic Health Association (CHA) of the United States and the Idaho Health Association, has undertaken a project to create an age-friendly continuum in Boise, Idaho. This article provides an overview of the project and its goals.

"It's time to think differently," said one of the project's leaders. "We need to focus on the needs of older adults, not just on their health." The project aims to create a system that recognizes the unique needs of older adults and provides them with the support they need to live independently.

The project is led by an interdisciplinary team of experts in health care, aging services, and community development. The team includes representatives from health care providers, local government agencies, and non-profit organizations.

The project's key components include:

1. Developing an age-friendly continuum that includes services for older adults, such as transportation, housing, and long-term care.
2. Engaging stakeholders from across the community to ensure that the continuum is responsive to the needs of all older adults.
3. Creating partnerships with local organizations to provide support services.
4. Developing a communication plan to raise awareness about age-friendly continuum services.

The project is expected to take several years to complete, but the team is committed to creating a sustainable system that will benefit older adults for many years to come.
Systems embark on making health care 'friendly' for the elderly
August 15, 2017
By JULIE TROCHIO

BOSTON — Three Catholic systems — Trinity Health, Ascension and Providence St. Joseph Health — are among five health care systems testing a prototype for creating a more age-friendly health system.

The Creating Age-Friendly Health Systems initiative is sponsored by the Institute for Healthcare Improvement and the John A. Hartford Foundation, which invests in research and practice innovations to improve the care of older adults. According to IHI, the goal of the initiative is to develop an age-friendly health systems model of care that can be in use in 20 percent of the nation’s hospitals and across the continuum of care in health systems by 2020.

The other systems participating in the first phase of the initiative are Anne Arundel Medical Center and Kaiser Permanente. Representatives from all five systems participated in a June 2-3 workshop here that brought together researchers, physicians, nurses and other health care professionals from academia and acute, long-term and primary care.

"Our goal is to close the gap between what we know and what we do when it comes to our older patients," said Ann Hendrich, senior vice president and chief quality/safety and nursing officer for St. Louis-based Ascension, a workshop faculty member. "We want to do the right thing for each patient, each time and we need to quantify this.

Central to the age-friendly prototype is attention to four "Ms":
- mobility
- medication
- nutrition
- safety
Creating Age-Friendly Health Systems

Overview
The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI) are partnering on the Creating Age-Friendly Health Systems Initiative. The goal of the initiative is to develop an Age-Friendly Health Systems model and rapidly spread the model to 20 percent of U.S. hospitals and health systems by 2020.

Five U.S. health systems participating in the Creating Age-Friendly Health Systems Initiative will test and scale up the prototype model in their organizations. They include three Catholic ministries: Ascension, Trinity Health and Providence St. Joseph Health.

As this initiative takes shape, CHA will provide timely updates and articles on this page. For additional information, please contact Julie Trousdale, CHA’s senior director of community benefits and continuing care.

The Four Ms
The initial focus of the health systems participating in the initiative will be four high-level interventions (referred to as the “4 Ms”):

- **What Matters**: Understand and actively support what matters to older adults
- **Mobility**: Review mobility plans for each patient
- **Meaningful Care**: Improvement of end of life care
- **Mental Health**: Integration and optimization of mental health services

“Our goal is to close the gap between what we know and what we do, when it comes to our older patients. We want to do the right thing for each patient, each time and we need to quantify this.”

— Ann Hendrix, Senior Vice President and Chief Quality/Safety and Nursing Officer,
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 Leader in Improving Care of Older Adults

$565,000,000
amount invested in Aging and Health since 1982

- Building the field of aging experts
- Testing & replicating innovation

Photo by Julie Turkewitz
AHA’s Center for Health Innovation

Advancing Health in America

The Path Forward

Priorities Align With The AHA Path Forward and Playbook

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

Value: The best care that adds value to lives

Partners: Embrace diversity of individuals and serve as partners in their health

Well-being: Focus on well-being and partnership with community resources

Affordability

Performance Improvement

Population Health

New Delivery Models

Emerging Issues
Why Age-Friendly Health Systems?

• Demography
• Complexity
• Disproportionate harm
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.

Our first aim is to reach 20%: 1000 hospitals & 1000 primary care practices by December 31, 2020.
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)
4Ms Core of 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.
Celebration of Pioneers

Structuring Medicare Wellness Exams and Geriatric Consultations Around the “4Ms”

Deploying the 4Ms to Improve Outcomes in Healthy Older Adults

Finding Out What Matters to Older Patients: A Conversation Guide

Saint Alphonsus is Becoming Age Friendly

aha.org/AgeFriendly
Age-Friendly across the U.S

IHI Age-Friendly Health Systems Action Community Wave 1 In September 2018,

- September – March 2019
- 131 sites of care from 73 organizations

IHI Age-Friendly Health Systems Action Community Wave 2

- April – October 2019
- 153 sites of care from 94 organizations
Celebration of Age-Friendly Health Systems

Build a community for hospitals to share with one another.

“I really enjoyed all of the brain-storming and knowledge sharing. I also enjoyed seeing how a lot of our ideas aligned”
Join the AHA Action Community

• Visit www.aha.org/AgeFriendly to download invitation with more information

• Enroll through this link (see chat for hyperlink)

• Participate in AHA’s Action Community (Sept. 2019 - March 2020)
  - Monthly all-team webinars
  - Scale-up leaders webinars
  - Listserv, sharing learnings
  - Monthly reports on testing and learnings
  - Celebration of joining the movement!

• Email ahaactioncommunity@aha.org with any questions.
Engage in the AHA Action Community

- 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 Description of 4Ms Care at your site
  - Submit monthly qualitative feedback on your progress and description of 4Ms Care

- 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
AHA Action Community Schedule

Kick off
September 2019

Learning & Action Period 1

Learning & Action Period 2

Learning & Action Period 3

Learning & Action Period 4

Learning & Action Period 5

Learning & Action Period 6

Webinar 1
October 2019

Webinar 2
November 2019

Webinar 3
December 2019

Webinar 4
January 2020

Webinar 5
February 2020

Webinar 6
March 2020

In-Person 2019/2020

Some of the 4Ms sometimes with some older adults

Monthly Webinars and Drop-In Coaching on Measurement and Changes

Reliable 4Ms implementation at the scale of the system

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

What Matters to Me?

The amount of time AAMC has given back to patients (65+) since FY17

**Time Saved Compared to FY17 Average**

- **Days**

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**Readmissions FY17-18**

8% Decrease

**ED Arrival to Departure (OP-18b) FY17-18**

3% Decrease

**Length of Stay FY17-18**

3% Decrease

What matters documented in record: 22,263 times since start of initiative

- **10.23 years**

- **Time with my family**

- **Time for new experiences**

- **Time to do the things I love**

- **Age-Friendly Health Systems**

- **Anne Arundel Medical Center**

- **LIVING HEALTHIER TOGETHER.**

- **Compassion > Trust > Dedication > Innovation > Quality > Diversity > Collaboration**
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

3. **Shares** the information with the Action Community and AHA to be celebrated
Guide to Using the 4Ms in the Care of Older Adults

- Action Community webinars will teach you how to test the 4Ms in your setting.

- Access resources to support your journey to become an Age-Friendly Health System on www.ihi.org/AgeFriendly.
Join the AHA Action Community

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Age-Friendly Health System: From Framework to Practice

Angela Fox
Director, Business Development and Implementation
Senior Health Program, Oregon

August 1, 2019
Overview

• Who is Providence St. Joseph Health
• How Providence Oregon is advancing the 4Ms
  • Geriatric Mini Fellowship
  • What Matters Conversations
  • Fall Risk Management Program
• Applying AFHS concepts
  • 4Ms as organizing constructs for interventions
  • Lessons Learned
Age-Friendly Health System Initiative in Oregon

- Providence Senior Health in Oregon selected to be one of five pioneering systems
- Started our work in January 2016
- Focused on outpatient interventions in primary care clinics and in the home
APPROACHES TO AN AGE-FRIENDLY HEALTH SYSTEM:
PROVIDENCE HEALTH & SERVICES OREGON
The Older Adult Population in Providence Oregon
2018 at a glance for patients age 65+

80,000 in Primary Care

150,000 in Hospitals*

The average 85-year-old with a PMG clinic visit in 2018:
Came to the clinic 6 times, is taking 9+ medications,
had a 40% chance of an ED visit or hospital admission

*150,000 seniors had an ED visit and/or Inpatient Stay
Tactic #1: Create Geriatric Champions in Primary Care

2019 Geriatric Mini-Fellowship

- April 8-12 Intro & Medication
- May 20-24 Mobility
- Sept 23-27 Mentation
- Oct 21-25 What Matters

“My practice is being transformed”

- 11 MD and 1 NP champions in 12 clinics serving 28,000 seniors
- 4-week, all-day classes; taught by Geriatrician, Geriatric NP, PharmD and guest faculty
- Nursing/PharmD/Care Management join provider for one full day each week
- Conversations underway on how to grow
Tactic #1: Key Performance Indicators

Pre/Post completion of Mini-Fellowship

For all Mini Fellowship Clinics combined:

25% Increase in documented dementia
(now more in line with national prevalence rates)

25% Decrease in patients on Skeletal Muscle Relaxants
(high risk medication that increases risk of falling for patients over 65)

35% Increase in PT referrals for patients with high fall risk

Continuing to Monitor:
ED/Hospital utilization overall and due to fall/fracture
Readmission Rates
Orthostatic Measurement
Documented Goals of Care
Tactic #2: Strengthen What Matters Conversations

What Matters Conversation Guide
7 Steps with how-to, resources and guiding questions

Clinician Steps  |  Content/Intent/Hints  |  Steps/Actions/Suggestions

1. Determine Need
2. Set up the Conversation to be a success
3. Invite the patient to the conversation
4. Ask more specific questions
5. Summarize & Action Planning
6. Next Steps
7. Document
Becoming An Adult

All adults 18+ should have Advance Care Planning discussion that ideally leads to completion of Advance Directive document.

Diagnosis of Serious Illness

Goals of Care conversations about meaningful life in the context of illness. Explicit discussion of future goals/hopes, worries/fears, and potential tradeoffs.

Worsening of Illness

Current goals in context of worsening illness, including consideration of completing POLST form to codify wishes.

Tactic #2: What Matters: Crucial Conversations

March 2018

December 2015

October 2016
Tactic #2: ACP Summary Report - Current State

Advance Care Plan

- Yes - EPOLST 2/1/2018
- Yes
- Yes
- No Code
- Yes

Advance Directive

- Yes
- Yes
- No Code
- Yes

Code Status

- Yes
- ACP Note: 1/19/2018
- Goal of Care Note: 3/21/2018

Notes

POLST

- Current State
- 02/15/18
- POLST ORS
- 02/15/18
- POLST ORS

Advance Directive

- Power of Attorney
- N/A
- N/A
- N/A
- N/A

Code Status

- Yes
- N/A
- N/A
- N/A

Current Code Status

- Yes
- N/A
- N/A
- N/A

Prior Code Status

- Yes
- N/A
- N/A
- N/A
Tactic #3: Build Integrated Fall Risk Management Program

Implementing the 4Ms through the lens of Mobility

**Community-Based Education**
- Hospitals, Community locations (centers, churches), Spanish Falls Classes, Focus on National Fall Prevention Awareness Day

**Clinic-Based Fall Risk Management Models**
- PMG/Rehab STEADI screening, Fall Risk f/u Visit: RN only, Shared, Provider; Fall Risk Shared Medical Appointment

**High Risk Fallers**
- ED Frequent Fallers, Home Safety Evaluation, Osteoporosis Bundle, Paramedicine curriculum
Tactic #3 Highlight: Frequent Fallers Program
Implementing the 4Ms through the lens of Mobility
Tactic #3: Frequent Fallers Program Key Performance Indicators

**Operational Metrics** - *Is this do-able?*
- Number of patients through the program
- % patients with a Geri consult

**Leading Indicators** – *Are we doing the things that will improve outcomes?*
- PT referrals
- Medication modifications
- Home safety assessments

**Outcome Measures** – *Have we made an impact?*
- ED/Hospital utilization due to fall/fracture
- Mortality
IMPLEMENTATION OF THE AGE-FRIENDLY HEALTH SYSTEM FRAMEWORK ACROSS SETTINGS AND POPULATIONS
CARING RELIABLY: IMPROVING OUTCOMES AND MAKING IT STICK

CORE BEHAVIORS OF HIGH RELIABILITY

Toolbox for Everyone
- Pay Attention to Detail (STAR, peer check)
- Communicate Clearly (SBAR, repeat back, clarifying questions)
- Have a Questioning Attitude (know why and comply, validate and verify)
- Operate as a Team (brief, execute and debrief)
- Speak Up for Safety (CUS, event reporting systems)

Toolbox for Leaders
- Message on the Mission (reflection/safety message, safety first in every decision, stand up for those who speak up for safety)
- Lead Reliable Operations (daily huddles including experience, top 10 lists)
- Build Engagement, Accountability (5:1 feedback, fair and just accountability, round to influence)
- Foster Teamwork (display unit-based results, learning boards, action plans)

Tones for Respect
- Smile and greet others: say hello
- Introduce using preferred names and explain roles
- Listen with empathy and intent to understand
- Communicate positive intent of our actions
- Provide an opportunity for others to ask questions

INPATIENT SAFETY: CARE BUNDLES

Prevent Infections
- Expect scrupulous hand hygiene
- Use standard precautions and appropriate PPE for isolation
- Conduct case reviews immediately when infections occur
- Assist patient in maintaining personal and hand hygiene
- Ensure comprehensive environmental cleaning

Eliminate CAUTI
- Know the evidence-based indications for catheter use and only use when met
- Insert catheter aseptically
- Ensure catheter is secured
- Perform appropriate catheter hygiene daily, and following fecal incontinence
- Remove at earliest opportunity, no later than 48 hours unless otherwise indicated

Eliminate C. difficile
- Avoid excess and inappropriate antibiotic use
- Isolate and test early on suspicion of infection
- Only test symptomatic patients where infection is suspected
- Terminally clean room with sporidial disinfectant at discharge

Eliminate CLABSI
- Verify appropriate indications for placement
- At insertion, utilize maximal barrier precautions & sterile technique
- Change dressing/tubing every 7 days or when integrity is breached
- Flush the central line at least once every 12 hours
- Verify justification for continuing central line daily

Eliminate Surgical Site Infections
- Establish and maintain glycemic control targets (pre, peri, post)
- Maintain temperature at 36 degrees C or above (pre, peri, post)
- Conduct post-procedure pause to document wound class and skin closure
- Ensure weight-based, appropriate dosing of antibiotics
- Counsel for smoking cessation, at least for duration of wound healing

Eliminate Falls with Injury
- Universal assessment & safety protocol for all patients
- Interventions based on risk assessment
- Plan shared with patients, family and care team
- Team debriefs every fall identified
- Pharmacy reviews medication regimen post fall

INPATIENT HEALTH: CARE BUNDLES

Make Hospitals Healthier
- Provide goal-aligned care (focus on what matters to the patient)
- Assess and support nutritional status
- Minimize night-time noise, enable undisturbed sleep
- Encourage exercise & staying out of bed
- Ensure 24-7 family access and support for patients

Care Compassionately
- Nurse rounding using specific compassion-based behaviors
- Greeting and immediate intervention with patients

Reduce Sepsis Mortality
- Initiate blood cultures on suspicion of sepsis
- Fluid Resuscitation with 30 mL/kg over 1 hour
- Administer antibiotics within 3 hours
- Repeat lactate at 6 hours

Prevent Readmissions
- Med reconciliation at discharge and follow up
- Ensure safe discharge with concise instructions and flu hotline
- Schedule flu within 5 days (high risk) or 14 days (moderate risk)
- Conduct follow-up call within 48 hours (high risk)
- Same day d/c summary for transitions, warm handoff in high risk
Screen adults and adolescents for depression

Assign a proxy decision maker in the event of not being able to make care decisions during crisis or grief
Ensure older adults have completed an advance directive

Encourage physical activity and complete an annual health assessment

Other Conditions
- Screen adults and adolescents for depression
- Guide and manage reported suicidal ideations safely and appropriately
- Treat Chronic Obstructive Pulmonary disease with appropriate inhaler therapies

Atherosclerotic Cardiovascular Disease
- Prescribe appropriate intensity statin for risk patients
- Manage blood pressure to treatment goals
- Treat underlying conditions for Heart Failure to slow disease progression

Health and Wellness
- Identify and close adolescent health and wellness care gaps
- Encourage physical activity and complete an annual health assessment
- Provide the necessary tools and resources to achieve weight management goals

Age Friendly Health System
- Assign a proxy decision maker in the event of not being able to make care decisions during crisis or grief
- Ensure older adults have completed an advance directive

Primary Care Redesign
- Maximize the health and well-being of our communities through partnership to deliver the best outcomes, patient experience and caregiver experience at the highest value, one person at a time.

Other Conditions
- Screen adults and adolescents for depression
- Guide and manage reported suicidal ideations safely and appropriately
- Treat Chronic Obstructive Pulmonary disease with appropriate inhaler therapies

Data
- Use value based data to identify care gaps and target approaches to bridge needs
- Utilize patient reported outcomes and information to close care gaps
- Use claim data to identify and address care gaps

Innovation
- Identify and evaluate new approaches to deliver care
- Explore digital technologies to improve the delivery of care
## Age-Friendly Health System 4M Bundle

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<th>What Matters:</th>
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<tr>
<td>Know and act on each older adult’s specific health outcome goals and care preferences across all settings</td>
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<tr>
<td>Know the health outcome goals and care preferences for current and future use, including but not limited to end of life</td>
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<td>Align all care goals and preferences with the older adult’s specific goals and care preferences</td>
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<td>If medications are necessary, use Age-Friendly medications that do not interfere with What Matters, Mentation, or Mobility</td>
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<tr>
<td>Engage the older adult and the health care team in determining whether medications are impacting the older adult’s Mobility, Mentation, and/or What Matters; if so, create a shared responsibility to de-prescribe or adjust the dosage</td>
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<td>Make medication decisions in partnership with the older adult, family, and health care team, and identify options that support What Matters, Mentation, and Mobility</td>
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<th>Mentation:</th>
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<td>Identify and manage depression, dementia, and delirium across care settings</td>
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<td>Know if an older adult has dementia and/or delirium</td>
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<tr>
<td>Manage the factors that contribute to delirium</td>
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<tr>
<td>Treat and manage dementia by understanding the underlying needs of older adults with dementia to keep them safe</td>
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<tr>
<td>Know if an older adult is depressed, and treat and manage depression</td>
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<td>Ensure that older adults at home and in every setting of care move safely every day in order to maintain function and do what matters</td>
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<td>Create an environment and culture that enables, supports, and encourages mobility</td>
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<td>Identify and treat underlying contributors to immobility and fall injuries</td>
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## Organization Key Stakeholders

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<td>Clinic Caregivers (MAs, Nurses, Team Coordinators, Front Desk)</td>
</tr>
<tr>
<td>Specialists Providers and teams</td>
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<tr>
<td>Pharmacy</td>
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<tr>
<td>Fall Risk Prevention Team</td>
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<tr>
<td>ED</td>
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<tr>
<td>Hospitalists</td>
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<tr>
<td>Rehab – OT and PT</td>
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<tr>
<td>Home Services (home health, DME, hospice)</td>
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<tr>
<td>Palliative Care</td>
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<tr>
<td>System Office Leadership</td>
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<tr>
<td>Nursing</td>
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<tr>
<td>Community Partners</td>
</tr>
<tr>
<td>Health Plan / Payors</td>
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</tbody>
</table>
Lessons Learned

• Initiative needs to be on an organizational strategic plan
• Executive leadership is crucial to spread within your organization
• Providers as champions
• Nail your value proposition
• Use the 4M framework
• Measures are HARD but absolutely necessary
• SIMPLIFY
Summary and Next Steps

• Implementation of the Age-Friendly Health System provides rich opportunities to improve care to older adults across the continuum
• IHI supports implementation of the Age-Friendly Health System through ongoing Improvement Collaboratives and a growing library of resources – Get the *Start up & Measurement* guides
• Population and setting-targeted interventions are exemplars of 4M-focused improvement
• The Age-Friendly 4M Framework is complementary with top-of-license practice across the continuum of care and will benefit all patients
• There are multiple internal and external resources to assist in identifying tactics and defining metrics – Join Now!
THANK YOU!

QUESTIONS?
PLEASE EMAIL:
ORSENIORHEALTHPROGRAM@PROVIDENCE.ORG
Q & A

To submit a question, please type your question on the right-hand side of your presentation screen.
Join the AHA Action Community

- Visit www.aha.org/AgeFriendly to download invitation with more information
- Enroll through this link (see chat for hyperlink)
- Participate in AHA’s Action Community (Sept. 2019 - March 2020)
  - Monthly all-team webinars
  - Scale-up leaders webinars
  - Listserv, sharing learnings
  - Monthly reports on testing and learnings
  - Celebration of joining the movement!
- Email ahaactioncommunity@aha.org with any questions.