Creating Value with Age-Friendly Health Systems

June 24, 2020
Presenters

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Affordability Through Lens of Value

Value = Outcomes & Patient Experience

Cost
# Affordability Through Value-based Strategies

<table>
<thead>
<tr>
<th>Redesign the Delivery System</th>
<th>Improve Quality and Outcomes</th>
<th>Manage Risk and Offer New Payment Models</th>
<th>Implement Operational Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Coordination of care</td>
<td>• Address equity of care and health disparities</td>
<td>• Move to value-based payments</td>
<td>• New process improvements</td>
</tr>
<tr>
<td>• Clinically integrated networks</td>
<td>• Evidence-based care/analytics</td>
<td>• Population health management</td>
<td>• Cost reductions</td>
</tr>
<tr>
<td>• Primary Care Medical Homes</td>
<td>• Reduce clinical and operational variation</td>
<td>• Address social determinants</td>
<td>• Utilize cost accounting and data</td>
</tr>
<tr>
<td>• Chronic care management</td>
<td>• Eliminate unnecessary utilization</td>
<td>• High-need/high-cost approaches</td>
<td>• Support clinicians’ practices to their level of education</td>
</tr>
<tr>
<td>• Telehealth</td>
<td>• Advanced medical technologies</td>
<td>• Partner/own health plan</td>
<td>• Create a culture geared to value not volume</td>
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<td>• Community-based alternatives</td>
<td>• Personalized medicine</td>
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<tr>
<td>• Community partnerships including public health</td>
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The Value Initiative

Thought leadership on affordability

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

American Hospital Association

Advancing Health in America

Working to Make Health Care More Affordable
Members In Action

Value Initiative

Members in Action: Redesigning the Delivery System

Overview

The VA’s Members in Action series highlights hospitals and health systems that are pioneering new value-based strategies to improve health care affordability. This includes work to redesign the delivery system, manage risk and payment models, improve quality and outcomes, and implement operational solutions.

Impact

In Parkland’s fiscal 2011 the direct custodial care line showed $49.5 million in savings or 6.4% of the overall total. The care line achieved this through early discharge, reduced length of stays, and improved care transitions. This was a groundbreaking effort to reduce unnecessary hospitalizations and improve care transitions.

Impact

Russell (KS) Regional Hospital (RHR), a critical access hospital, was already leader in hospital care at a lower cost. They started an initiative to manage care - it is a new form of care delivery system where you have more scheduled visits and fewer hospitalizations.

Impact

RRH has an energy score of 100, which means their efforts performance better than all of its peer facilities. The facility reduced energy usage by a respectable 42 percent between 2010 and 2016. The energy services company measured and evaluated the savings as part of their work. RHR management staff independently verified the savings with ENERGY STAR's Pro Plus Audit.

The lowest cost projects with the quickest return on investment included replacing 712 and older 76 fluorescent lighting with energy efficient 75 lamps (1.5 years to recoup costs), replacing variable-speed pumping (1.5 years to recoup costs), and replacing condensing units (5.0 years to recoup costs).

The overall impact on patients, with targeted time frames to recoup costs, were the initial savings ($15,532,716) in energy cost savings (a more than $15,000,000 in addition to the broader replacements) 5 years on energy cost savings.

The overall savings are more than $15,000,000 annually for RHR.

• Behavioral changes: RHR staff started checking lights to make sure they were not left on unnecessarily. They also started changing back some pressure when it did not need to be high and adjusting back temperature when possible.

• Occupancy sensors: When light switches were replaced, the team replaced them with occupancy sensor switches instead. The switches were replaced at the same
Issue Briefs

- Frame the complex issue of affordability
- These briefs can be used to initiate conversations with stakeholders in your community
2020 Virtual Workshop Series

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

- Data on national health expenditures
- Describe the drivers and influencers of cost and value
- Track how value is perceived by various stakeholders
- State of Value Snapshot – measure value trends over time
Creating Value with 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
• Overview of Action Community
• Sharing of Data & Learning
• Implementation at Hartford Hospital
• How to Join the Action Community
• Q&A
Our Partners

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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

Dedicated to Improving the Care of Older Adults
The Path Forward

Hospitals and health care systems are committed to Advancing Health In America through:

- **Access**: Access to affordable, equitable health, behavioral and social services
- **Health**: Focus on holistic well-being in partnership with community resources
- **Innovation**: Seamless care propelled by teams, technology, innovation and data
- **Affordability**: The best care that adds value to lives

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

- Demography
- Complexity
- Disproportionate harm
Impact of COVID-19 on Older Adults

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

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

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

Specific Aims:

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

• What Matters:
  – Asking what matters and developing an integrated systems to address it lowers inpatient utilization (54% dec), ICU stays (80% dec), while increasing hospice use (47.2%) and pt satisfaction (AHRQ 2013)

• Medications:
  – Older adults suffering an adverse drug event have higher rates of morbidity, hospital admission and costs (Field 2005)
  – 1500 hospitals in HEN 2.0 reduced 15,611 adverse drug events saving $78m across 34 states (HRET 2017)

• Mentation:
  – Depression in ambulatory care doubles cost of care across the board (Unutzer 2009)
  – 16:1 ROI on delirium detection and treatment programs (Rubin 2013)

• Mobility:
  – Older adults who sustain a serious fall-related injury required an additional $13,316 in hospital operating cost and had an increased LOS of 6.3 days compared to controls (Wong 2011)
  – 30+% reduction in direct, indirect, and total hospital costs among patients who receive care to improve mobility (Klein 2015)
What is an Age-Friendly Health System?

4Ms Framework

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
Age-Friendly Health System Pioneers

Anne Arundel Medical Center
ASCENSION
KAISER PERMANENTE
Providence St. Joseph Health
Trinity Health

www.aha.org/AgeFriendly
Action Community – Starting in September

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

625 Teams (hospital-based teams, ambulatory care teams and long term) in all 50 states
Engage in the AHA Action Community

Leadership Track to Support Scale-Up

Participate in monthly interactive webinars
- Monthly content calls focused on 4Ms
- Opportunity to share progress and learnings with other teams

In-person meeting
- One in-person meeting (TBD)

Test Age-Friendly interventions
- Test specific changes in your practice

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

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

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

Monthly Webinars and Drop-In Coaching on Measurement and Changes

Reliable 4Ms implementation at the scale of the system
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

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
Definition of an Age-Friendly Health System

An Age-Friendly Health System...

1. **Defines** the 4Ms for its hospital and/or practice
   
   1. (e.g. Hospital: How it will screen for delirium every 12 hours; Practice: What tool will it use to screen for depression and how does the screen fit into the AWV flow)

2. **Counts** the number of older adults whose care includes the 4Ms (reported by each site)

3. **Shares** the information with the Action Community and AHA to be celebrated on aha.org
Level 1 & 2 Recognition

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

• Level 2 – Committed to Care Excellence
Sites Recognized by the Movement

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

**742**

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

**170***

*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

[www.ihi.org/AgeFriendly](http://www.ihi.org/AgeFriendly)  [www.aha.org/AgeFriendly](http://www.aha.org/AgeFriendly)
1. Definition of the how you are putting the 4Ms into practice

2. Count of 65+ people whose care includes the 4Ms
Connecting Age-Friendly Measures with Value

<table>
<thead>
<tr>
<th>Age-Friendly Measures</th>
<th>The Value Equation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic Outcome Measures</strong></td>
<td><strong>Hospital Setting</strong></td>
</tr>
<tr>
<td>30-day readmission</td>
<td>X</td>
</tr>
<tr>
<td>Emergency department utilization</td>
<td></td>
</tr>
<tr>
<td>Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey</td>
<td>HCAHPS</td>
</tr>
<tr>
<td>Length of stay</td>
<td>X</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Advanced Measures</th>
<th>Hospital Setting</th>
<th>Ambulatory/Primary Care Setting</th>
<th>The Value Equation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delirium</td>
<td>X</td>
<td>N/A</td>
<td>Patient outcomes, cost</td>
</tr>
<tr>
<td>CollaboRate (or similar tool to measure goal concordant care)</td>
<td>X</td>
<td>X</td>
<td>Patient outcomes, Patient experience</td>
</tr>
</tbody>
</table>
Join AHA Action Community 2020-2021

• Join and get your Age-Friendly Recognition. It’s FREE

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

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

• Download AHA’s Invitation Guide and visit aha.org/agefriendly to learn

• Email ahaactioncommunity@aha.org with any questions.
Hartford HealthCare Geriatric Continuum of Care

- Hospital Inpatient Consults & Programs
- APRN Home Visits/REACH
- PPN SNFs/SNF programs
- Home
- Outpatient Geri Consults
  - Primary Care
  - Geriatric oncology
  - Co-management

- Serve 13 towns
- 1 of 7 hospitals
- 8 sites
- 9 sites
- 13 towns

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- 13 towns
Integration of AFHS into Hartford HealthCare

HHC Mission: To improve the health and healing of the people and communities we serve

Core Values
• Caring-individualized care; dignity
• Safety – promoting safe mobilization
• Excellence-evidence based practice
• Integrity-trust

4 M’s
• What Matters
• Medications
• Mobility
• Mentation

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

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

GRN Champs
GRNs
GPCAs

Keeping In Touch
Activity Cart
Meal Mates
Mobility
Safety
VOLUNTEERS
Geriatric Education

**Nursing Staff**

**Nurses**
- General Nursing Orientation
- Nurse Residency
- Annual Competency
- Geriatric Resource Nurse Program
- GRN Champ Program
- Fellowships/rotation

**Nursing Assistants**
- General orientation
- Annual Competency
- Geriatric PCA

**Other Staff**

**Providers**
- New hire orientation
- Grand rounds
- Geriatric consults
- Geriatric rotation

**Rehab**
- Inservices
- Mobility volunteer rotations

**All hospital staff**
- Annual competency
ADAPT (2011-present)

**Actions to enhance Delirium Assessment Prevention and Treatment**

- Screening all patients (improve recognition)
- Preventative measures for high risk patients (40% cases are preventable)
- Quick response by health care team to a positive delirium screen (cause; safety; preservation of function) decreases severity and duration of delirium
- Evidence based interventions to improve outcomes
**1 Deter**
- No harmful drugs*
- Avoid abrupt discontinuation* (Drugs, ETOH, nicotine)
- Avoid/limit Devices (catheters, lines, leads)

**2 Detection**
- Review CAM/CAM-ICU & RASS/mRASS Scores
- Daily cognitive assessment
- Determine baseline mental status

**3 Diagnosis / Do**
- Physical exam
- Med review
- Determine potential causes*
- Differential diagnosis
- Document acute encephalopathy
- Activate Delirium order set in EPIC

**4 Discuss**
- Provider + Nursing
- +/- Pharmacist
- Huddle
- Make Plan

**5 Daily Visit**
- Cognitive assessment
- F/U Diagnostics
- Review meds-adjust prn

**6 Daily Dialogue**
- Provider + Nursing
- +/- Family
- Progression Rounds
  - Is Patient Improving?

**7 Discharge**
- Document course and cause of Delirium if known
- Degree of resolution
- Discontinue unnecessary psychotropics
- Follow up for Delirium if not resolved
- Document on W10/After Visit Summary

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**Risk Factors**
- Age > 65
- Dementia
- Substance Dependency
- Hx Delirium
- ICU/SD
- Impaired vision/hearing

**CAM or CAM-ICU Positive**
- ED screen of pts age >65
- Attention screen
- SQID?

**1 Deter**
- Mobilize to maximum
- Uninterrupted night-time rest (noise, bundle care, eye shields, earplugs)
- Eyeglasses/hearing aids
- Whiteboard up to date
- Daily goals of care
- Calendar/clock/familiar items
- Assist with food/fluids
- Comfort
- "HHC Cares About Me" poster
- Family as partners
- Volunteers for social interaction

**2 Detection**
- CAM every 8 hours and prn
- Determine baseline mental status
- Notify provider immediately of first positive CAM or CAM-ICU and activate “Acute Confusion” CPG

**3 Do**
- Fall prevention
- Discontinue/ Disguise devices
- Family teaching - brochure
- Provide Distractors (music, flashball, animal)
- T-A-D-A (Tolerate, Anticipate, Don’t Agitate)1
- Reassurance
- Individualize plan of care in EPIC
- Nurse - Nurse handoff
- Nurse - PCA handoff

**4 Discuss**
- Provider + Nursing
- +/- Pharmacist
- Huddle
- Make Plan

**5 Daily Care**
- CAM or CAM-ICU every 8 hours + prn
- Comfort/calm/consistent
- Toileting
- Feed/hydrate
- Mobilize to maximum
- Maintain normal sleep/wake cycle
- Touch/backrub
- Assess response to medications
- Family & volunteer involvement
- Alternative therapies (Reiki, Pet, Art, Music)
- Document progress

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**Document Successful Strategies**

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*see back of brochure for more information 1 Flaherty, 2011*
Outcome: Decreased Length of Stay In Patients with Delirium
30 Day All Cause Readmission Rates Over Time

Hartford HealthCare
Senior Services
Delirium Attributable Days

ADAPT Data

Year

2013 2014 2015 2016 2017 2018

Total Days

0 5000 10000 15000 20000 25000 30000 35000 40000 45000
### ROI Calculator Applied to ADAPT

#### 1. Start
- Acute Care for Elderly

#### 2. Population & 4M Period
- Number of annual admissions: 30,000
- Amortization period (Years): 5

#### 3. 4M Costs
- Launch - one time only expenses: $10,000
- Total annual cost of program: $620,000

#### 4. Estimates/Values
- Delirium: 12.6%
- HAPU’s: 0.0%
- Other Condition: 0.0%

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

#### Results
- **Total Cost Avoided**: $622,000
- **Net Benefit**: $334,123
- **ROI**: 334.1%
- **Years Given Back**: 12.23

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

#### Simulation Results (ROI)
- **Max**: 388.5%
- **Min**: 578.2%
- **Average**: 431.5%
- **% Below Target**: 0.0%

#### HA Condition
- **Type of stay**: Normal
- **Length of stay**: 5.0
- **Cost per day**: $2,000
- **Length of stay**: 5.0
- **Cost per day**: $2,000

#### Extended due to condition
- **Length of stay**: 5.2
- **Cost per day**: $260
- **Length of stay**: 4.0
- **Cost per day**: $40

#### Ded hospital case cost
- **Cost per day**: $13,052
- **Cost per day**: $0

#### - hospital and PAC combined
- **Costs avoided**: $6,432,066.00
- **Costs adjusted for revenue offset**: $11,527
Safe Mobilization

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

- Implemented Gait belt and walker for all mobilization of high fall risk patients
Bed Exercises - increase patient engagement in care

Supine Therapeutic Exercises

<table>
<thead>
<tr>
<th>Exercise</th>
<th>Position</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANKLE PUMPS</td>
<td>Laying on your back</td>
<td>Point foot up towards your nose then point down as far as you can, keep leg straight</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10-15x times 2-3x a day</td>
</tr>
<tr>
<td>QUAD SETS</td>
<td>Laying on your back with your leg straight</td>
<td>Squeeze thigh pushing knee down toward bed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10-15x times 2-3x a day</td>
</tr>
<tr>
<td>GLUTE SETS</td>
<td>Laying on your back with your leg straight</td>
<td>Squeeze buttocks together</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10-15x times 2-3x a day</td>
</tr>
<tr>
<td>HIP SLIDES</td>
<td>Laying on your back with legs straight</td>
<td>Slowly slide heel up towards hips with knee then return to starting position</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10-15x times 2-3x a day</td>
</tr>
<tr>
<td>SHORT ARCH QUADS (TERM KNEE EXTENSION)</td>
<td>Laying on your back with towel roll under knee or LE/knees elevated position on bed</td>
<td>Lift heel off bed straightening lower leg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10-15x times 2-3x a day</td>
</tr>
</tbody>
</table>

LEG ABDUCTION/ADDUCTION

<table>
<thead>
<tr>
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<th>Action</th>
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</thead>
<tbody>
<tr>
<td>on your back with leg straight</td>
<td>keep knee straight and toes toward ceiling, slide leg out as far as possible then return to starting position</td>
</tr>
<tr>
<td>10-15x times 2-3x a day</td>
<td></td>
</tr>
<tr>
<td>ADDUCTOR SQUEEZE</td>
<td>place pillow between legs, squeeze legs together then relax</td>
</tr>
<tr>
<td>10-15x times 2-3x a day</td>
<td></td>
</tr>
<tr>
<td>STRAIGHT LEG RAISE</td>
<td>lay on your back, keep leg straight</td>
</tr>
<tr>
<td>10-15x times 2-3x a day</td>
<td>lift leg off bed then back down</td>
</tr>
</tbody>
</table>

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

Hartford HealthCare
Senior Services
Chair Exercises

Chair Exercises

Side Bends
Modified Dionne’s Egress Test ™

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

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

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

**Test 3**
- **Step forward**
  1. From comfortable stance width, advance and retreat each foot
  2. May use assistive device
  3. Heel must advance past toes of other stance foot without buckling of stance leg

**Test 4**
- **Step to the Side**
  1. Standing with legs in contact with edge of bed.
  2. Take 3 side steps to left and right. (If knees buckle, patient is not safe for stepping transfer to chair)
Safer Mobilization

Safety Assessment Fall Evaluation Risk

Reviewed: (Date) (Time) (Pt. Initials) (Staff Initials)

Recent Procedure/Surgery
- Medication
- Poor Vision
- Poor Hearing
- Low Blood Pressure

Your Fall Risk Score:

4 or more = High Fall Risk

Your Safe Mobility Plan
- Bed/chair alarm
- Gait belt
- Walker
- Assistance by ___ or ___ staff members
- Wheelchair follow
- Low bed
- Other _______

Mobility Level
- Low
- Medium
- High

Sit at Edge of Bed with Staff Assistance
- Exercises as directed

Your Responsibilities
(for a Score of 4 or More)
- Avoid Sitting on Edge of Bed Alone
  - Permit Staff To.......... Use a Gait Belt and Walker for mobilization
  - Stay with You During Toileting
  - Set Exit Alarm

Toileting Plan
- Urinal
- Commode
- Bed Pan
- At Bedside
- Bathroom

Rehab Recommendations

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

Notes:
**Safer Mobilization**

**Safety Assessment Fall Evaluation Risk**

---

**Your Safe Mobility Plan**

- Bed/chair alarm
- Gait belt
- Walker
- Assistance by Ṣ or Ṣ staff
- Wheelchair follow
- Other ____________

**Mobility Level**

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

**Toileting Plan**

- Urinal
- Incontinent
- Bed Pan
- Bathroom
- Commode
- Commode
- At Bedside
- over toilet

---

**Rehab Recommendations**

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

**Patient Responsibilities**

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

---

**Permit Staff To...**

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

### Cares About Me...

<table>
<thead>
<tr>
<th>I like to be called:</th>
<th>What I do or used to do for work:</th>
<th>What I do for fun and activity:</th>
<th>My favorite TV shows, music, books are:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My family, friends, pets names are:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My favorite food:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I brought with me:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentures: No / Yes: Upper / Lower / Both</td>
</tr>
<tr>
<td>Glasses: No / Yes</td>
</tr>
<tr>
<td>Hearing Aides: No / Yes: Right / Left / Both</td>
</tr>
</tbody>
</table>
Personalized activities for patients with cognitive impairment

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

**Response During Therapeutic Activity**

- Positive Response: 73%
- No Change: 27%

**Response One Hour After Compared to Prior**

- Positive Response: 36%
- No Change: 64%
Family Video Messaging

- Non pharmacological intervention to:
  - Provide comfort and connection to agitated patients with altered mental status
  - Engage families in care
  - Provide comfort to families
  - Offer a personalized intervention for staff
Example of Family Video Message
% of Participants Experiencing a Decrease in Agitation
The Therapeutic HUB

Healing
Understanding
Belief in patient as person
The Therapeutic HUB multi-sensory stimulation environment
Patients may feel safer and more “normalized” in a controlled, multisensory environment compared to a clinical, hospital room.
Findings to date Jan 2018-2020

- Approximately 400 patients worked with a nurse in the HUB
- Most have altered mentation (dementia/delirium/both)
  - Agitated patients become more calm
  - Withdrawn patient become more engaged
  - Improved eating
  - Improved mobilization
  - Improved mood

Families express increased satisfaction
Opportunities for education

Staff implement bedside activities
Items brought to bedside for those who can not visit the HUB

- Qualitative data: “Feels like home”
  “I feel more normal”

Pilot study suggests the HUB improves cognition and normalizes arousal levels.
Voice over powerpoint with video: Therapeutic HUB

- [https://vimeo.com/266874016/f693ff3a99](https://vimeo.com/266874016/f693ff3a99)
Our 4 M Age Friendly Health System Focus

- Focused on 5 inpatient units
  - 2 medical units
  - 1 medical oncology unit
  - 1 transplant medical unit
  - 1 cardiac ICU
## What You Can Do

<table>
<thead>
<tr>
<th>What Matters</th>
<th>Nurse</th>
<th>PCA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discuss goals of care in rounds</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Patient friendly goals on white board</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Ask pt what matters to them today</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Mutuality/individualization in EPIC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HHC Cares About Me poster in room</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Identify pts for Therapeutic HUB</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Identify pts for Keeping in Touch</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Mobility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mobilize level 5 ambulatory patients to maximum and document distance</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Give exercise sheet to patients and encourage them to do them</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Mentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screen CAM and RASS every 8 hours</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Notify nurse of any changes in patient’s behavior</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Activate Acute Confusion CPG for CAM + pts</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify new high risk meds and discuss with provider/pharmacist</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Teach pts not to take OTC “PM” meds</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
Unit based data collection tool

UNIT __________ DATE __________ PTS AGE ______ DATA COLLECTOR ______________

Make the following observations when you assume care of the patient for your shift:

HHC Cares About Me Poster completed Yes No
Patient Friendly Goals On Whiteboard Yes No
Exercise Sheet in the Room Yes No

Is a gait belt being used during mobilization Yes No

Review the patient’s EMR for the following:

Goals of Care documented in EPIC Yes No
Individuality/ mutualty section populated in EPIC Yes No

Does the patient have a progressive mobility level charted within the past 24 hours Yes No
Documentation of exercises in EPIC in past 24 hours Yes No

Has the patient walked more than 150 feet in past 24 hours if capable Yes No N/A
CAM done every 8 hours Yes No
RASS done every 8 hours Yes No

Has baseline mental status been done this admission? Yes No
Do the CAM and RASS match the notes or verbal report? Yes No

Is there a specific intervention charted in the care plan if pt is CAM positive? Yes No N/A

Collaborate Assessment: [Ask the patient to answer each of these 3 questions, on a scale of 0-9]

Thinking about this hospitalization______

1. How much effort was made to help you understand your health issues? Score = ______
2. How much effort was made to listen to the things that matter most to you about your health issues? Score = ______
3. How much effort was made to include what matters most to you in choosing what to do next? ______

No effort Every effort

0 1 2 3 4 5 6 7 8 9

Return this form to: Christine Waszynski Fax: 860-772-5788 or via email Thank you!!

Confidential and Proprietary Information | June 24, 2020 | 69
How are we doing addressing all 4 M’s with all older adults?

% OF NUMBER OF 4-M’S COMPLETED FOR ALL UNITS

- 4 Completed
- 3 Completed
- 2 Completed
- 1 Completed
- 0 Completed

JANUARY
- 12% (4 Completed)
- 9% (3 Completed)
- 1% (2 Completed)
- 0% (1 Completed)
- 0% (0 Completed)

FEBRUARY
- 43% (4 Completed)
- 34% (3 Completed)
- 8% (2 Completed)
- 1% (1 Completed)
- 0% (0 Completed)

MARCH
- 42% (4 Completed)
- 37% (3 Completed)
- 8% (2 Completed)
- 0% (1 Completed)
- 0% (0 Completed)

APRIL
- 45% (4 Completed)
- 33% (3 Completed)
- 8% (2 Completed)
- 0% (1 Completed)
- 0% (0 Completed)

MAY
- 47% (4 Completed)
- 34% (3 Completed)
- 5% (2 Completed)
- 1% (1 Completed)
- 0% (0 Completed)

JUNE
- 42% (4 Completed)
- 39% (3 Completed)
- 8% (2 Completed)
- 0% (1 Completed)
- 0% (0 Completed)

JULY
- 52% (4 Completed)
- 25% (3 Completed)
- 18% (2 Completed)
- 5% (1 Completed)
- 0% (0 Completed)
How are we doing with each of the M’s with all older adults?

<table>
<thead>
<tr>
<th>Month</th>
<th>What Matters</th>
<th>Medication</th>
<th>Mobility</th>
<th>Mentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan-19</td>
<td>39%</td>
<td>73%</td>
<td>60%</td>
<td>0%</td>
</tr>
<tr>
<td>Feb-19</td>
<td>42%</td>
<td>74%</td>
<td>67%</td>
<td>10%</td>
</tr>
<tr>
<td>Mar-19</td>
<td>40%</td>
<td>73%</td>
<td>63%</td>
<td>20%</td>
</tr>
<tr>
<td>Apr-19</td>
<td>42%</td>
<td>74%</td>
<td>65%</td>
<td>30%</td>
</tr>
<tr>
<td>May-19</td>
<td>41%</td>
<td>77%</td>
<td>56%</td>
<td>40%</td>
</tr>
<tr>
<td>Jun-19</td>
<td>36%</td>
<td>74%</td>
<td>60%</td>
<td>50%</td>
</tr>
<tr>
<td>Jul-19</td>
<td>38%</td>
<td>74%</td>
<td>60%</td>
<td>50%</td>
</tr>
</tbody>
</table>

Percentage of 4-M’s by Month all Units combined
The CESI mobile program- Post Acute Care ADAPT
**Confidence questions**

How confident are you:

1. Screening for delirium

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

3. Assessing for inattention

4. Assessing for altered level of consciousness

5. Assessing disorganized thinking

6. Notifying the provider of a positive CAM
Confidence scores– compared across time points within individuals

The Effects of Training on Average Confidence

Average Confidence Level

Question

1 2 3 4 5 6
Brownstone- Annual Wellness

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

• Screen all older adults with a new cancer diagnosis using the G8 to determine cognitive and function fitness

• Provide focused care by geriatric oncologist and geriatrician
  ➢ Determine patient wishes and goals
  ➢ Assess risks
  ➢ Intervene for modifiable risks
  ➢ Make recommendations for treatment/care based upon patient fitness and individualized goals
Center For Healthy Aging Services

- Resource Coordinators
- Transitional Care Nurses
- Dementia Specialists
- Geriatric Care Management
Outcomes - Quality Data for TCNs

TCN Identified:
• 92% Medication discrepancies
• 82% High risk for readmission/hospitalization
• 16% Moderate risk for readmission/hospitalization
• 91% Fall risk
• 35% of patients were hospitalized within 12 months prior to seeing TCN
• 43% of patients live alone

Link to Community Services
• 57% referred to certified homecare services
• 41% connected to provider
• 23% linked to caregiver services
• 71% required referral to social work/resource coordination
• 24% connected to dementia specialists
• 17% linked to behavioral health services
• 7.4% required referral to elderly protective services

Readmission rate: 3.7%
Hospitalization 12.6%
Benefits of Dementia Education

Training for caregivers of people with dementia improves:

• Caregiver confidence
• Ability to manage daily care challenges
• Supports caregivers in their role and relationship

Caregiver education and support has delayed Skilled Nursing Facility (SNF) placement by approx. 1.5 years

• N=198
• Annual CT SNF = $144,000/year
• 18 Months CT SNF = $216,000
• Possible healthcare cost savings = $42,768,000

Discussion/Q & A

Type in the chat!
2020 TVI Virtual Workshops

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

You are invited to explore The Value Initiative at: [www.aha.org/TheValueInitiative](http://www.aha.org/TheValueInitiative)
COVID-19 Resources

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

• Join the Friends of Age-Friendly Community

• Receive communications with tools and resources to accelerate the adoption of the 4Ms

• Opportunities to join quarterly webinars to connect with hundreds of organizations across the movement

For questions, email AFHS@ihi.org
Join AHA Action Community 2020-2021

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

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

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

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

- Email ahaactioncommunity@aha.org with any questions.
Evaluation Survey

• Share your feedback