Creating Age-Friendly Health Systems

AHA Action Community: An Invitation to Join Us

Age-Friendly Health Systems is an initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI) in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA).
Agenda

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

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

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

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

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

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The John A. Hartford Foundation

Institute for Healthcare Improvement

Catholic Health Association of the United States

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The John A. Hartford Foundation

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

Dedicated to Improving the Care of Older Adults

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

Hospitals and health care systems are committed to 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.

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

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

Source: CDC data from 2/1/20-6/6/20 and 2018 Census Population Estimates for USA

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

<table>
<thead>
<tr>
<th>Cases in long-term care facilities</th>
<th>All other U.S. cases</th>
</tr>
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<tbody>
<tr>
<td>11%</td>
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<table>
<thead>
<tr>
<th>Deaths in long-term care facilities</th>
<th>All other U.S. deaths</th>
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<tbody>
<tr>
<td>35%</td>
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</table>
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?

**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.

For related work, this graphic may be used in its entirety without requesting permission. See graphic files and guidance at ih.org/agefriendly.
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

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

- **In-person meeting**
  - One in-person or virtual meeting (TBD)

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

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

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

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

**7 Months**
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

Learning & Action Period 1
Webinar 1 October 2020

Learning & Action Period 2
Webinar 2 November 2020

Learning & Action Period 3
Webinar 3 December 2020

Learning & Action Period 4
Webinar 4 January 2020

Learning & Action Period 5
Webinar 5 March 2021

Learning & Action Period 6
Celebratory Webinar April 2021

In-Person/Virtual Meeting 2021

Some of the 4Ms sometimes with some older adults
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 [www.aha.org/agefriendly](http://www.aha.org/agefriendly)
Level 1 & 2 Recognition

- Level 1 – Be recognized as an Age-Friendly participant
- Level 2 – Committed to Care Excellence
1. Definition of the how you are putting the 4Ms into practice

2. Count of 65+ people whose care includes the 4Ms
Hospitals, practices, retail clinics and post-acute communities have described how they are putting the 4Ms into practices (4Ms Description Survey).

www.ihi.org/AgeFriendly

www.aha.org/AgeFriendly

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

### Value Equation

![Value Equation Diagram](image)

<table>
<thead>
<tr>
<th>Basic Outcome Measures</th>
<th>Hospital Setting</th>
<th>Ambulatory/Primary Care Setting</th>
<th>Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-day readmission</td>
<td>X</td>
<td></td>
<td>Patient outcomes, cost</td>
</tr>
<tr>
<td>Emergency department utilization</td>
<td></td>
<td>X</td>
<td>Patient outcomes, cost</td>
</tr>
<tr>
<td>Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey</td>
<td>HCAHPS</td>
<td>CGCAHPS</td>
<td>Patient outcomes, Patient experience</td>
</tr>
<tr>
<td>Length of stay</td>
<td>X</td>
<td></td>
<td>Patient outcomes, cost</td>
</tr>
</tbody>
</table>

### Advanced Measures

<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 Webinar
  - August 19, 2020 (12:00 – 1:00 PM ET) - Register here
    - Featuring Stanford Health Care

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

- Email ahaactioncommunity@aha.org with any questions.
Putting the 4Ms into Practice: Geriatric Fracture Program

Cedars-Sinai Health System
Sonja Rosen, MD, FACP
Chief, Geriatric Medicine, CSHS
Medical Director, Geriatrics, Cedars-Sinai Medical Care Foundation
Professor of Medicine, UCLA David Geffen School of Medicine
Kathleen Breda NP, MSN, BBA, AGACNP-BC, ONP-C
Nurse Practitioner Lead, Geriatric Fracture Program, CSHS

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Background

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

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

<table>
<thead>
<tr>
<th>1/3 of community dwelling older persons fall every year</th>
<th>Complications from falls are the leading cause of death from injury in persons &gt; 65 years of age</th>
<th>Of these falls, 300,000 persons are hospitalized every year with hip fractures</th>
</tr>
</thead>
<tbody>
<tr>
<td>These patients are at higher risk for delirium, and subsequent functional decline and dementia</td>
<td>The 1-year mortality after sustaining a hip fracture is 14% - 58%, the first year after fracture is critical</td>
<td>Falls among older adults are costly: $50 billion annually for Medicare &amp; Medicaid in 2015</td>
</tr>
</tbody>
</table>
Prior State

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

• Genesis of the GFP program
  – How can a complex, pluralistic medical environment implement a geriatric fracture program?
  – How will the program impact time to surgery (TTS), Length of Stay (LOS) and readmissions?
Geriatric Fracture Program Tenets

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

- Committed Inter-professional team
- Defined goals, scope and communication
- Geriatric Training of MDs, Nurses and CPs
- Standard, geriatric-centric pre-operative assessments
- Standard, geriatric-centric in-patient interventions
- Daily project data collection and regular reporting

Continuous review, assessment and intervention
Cedars-Sinai Geriatric Fracture Program Goals

Goal #1
Reduce time to surgery ≤24 hours

Goal #2
Reduce average length of stay ≤5 days

Goal #3
Reduce post-operative delirium

Goal #4
Improve follow-up osteoporosis care

Goal #5
Reduce readmissions
**Key Elements of GFP**

1. Timely Assessment and Evaluation
2. Minimization of Unnecessary Testing
3. Coordination Among the Care Team
4. Post-Discharge Geriatric Assessment
Multi-professional Team

- Emergency Medicine
- Anesthesia
- Geriatrician
- Geriatric NP
- Pharmacy
- Orthopaedic Trauma Surgeon
- Hospitalist
- Therapy
- RN

Age-Friendly Health Systems
GFP Daily Activities

GFP Huddle

Data collection and analysis

Geri-centric Pain protocol

Post-discharge Geriatric Assessment and calls

Delirium Assessment Prevention/Mitigation

Osteoporosis and Falls Patient Education

Geri-centric Epic templates, order sets
Typical Cedars-Sinai Geriatric Fracture Patient

• Female (70%) / Male (30%)
• Operative Cases (75%)
• Hip Fracture Cases (60%)
• Often frail
• Majority of patients discharge to SNF, followed by ARU and Home Care
## Step 5: Studying Your Performance – First year results

<table>
<thead>
<tr>
<th></th>
<th>Pre-GFP FY 18</th>
<th>Non-GFP FY 19</th>
<th>GFP FY 19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average Age (Years)</strong></td>
<td>82</td>
<td>82</td>
<td>81</td>
</tr>
<tr>
<td><strong>Operative + Non-Operative Fractures</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>612</td>
<td>407</td>
<td>153</td>
</tr>
<tr>
<td>Hip</td>
<td>343 (56%)</td>
<td>214 (53%)</td>
<td>71 (46%)</td>
</tr>
<tr>
<td>All Other Non-Hip Fractures</td>
<td>269 (44%)</td>
<td>193 (47%)</td>
<td>82 (54%)</td>
</tr>
</tbody>
</table>
Step 5: Studying Your Performance – First year results

<table>
<thead>
<tr>
<th>Average Time to Surgery (TTS) for Operative Fractures (Hours)</th>
<th>Pre-GFP FY 18</th>
<th>Non-GFP FY 19</th>
<th>GFP FY 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Fractures</td>
<td>36*</td>
<td>24.3</td>
<td>21.1</td>
</tr>
<tr>
<td>Hip</td>
<td>33*</td>
<td>22.7</td>
<td>20.7</td>
</tr>
</tbody>
</table>
Step 5: Studying Your Performance – First year results

<table>
<thead>
<tr>
<th>Average Length of Stay (ALOS) (Days)</th>
<th>Pre-GFP FY 18</th>
<th>Non-GFP FY 19</th>
<th>GFP FY 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Fractures</td>
<td>5</td>
<td>5.7</td>
<td>4.5</td>
</tr>
<tr>
<td>Hip</td>
<td>5.2</td>
<td>5.8</td>
<td>4.5</td>
</tr>
<tr>
<td>All Other Non-Hip Fractures</td>
<td>4.7</td>
<td>5.5</td>
<td>4.3</td>
</tr>
<tr>
<td>Vizient LOS Index</td>
<td>0.93</td>
<td>1.03</td>
<td>0.76</td>
</tr>
</tbody>
</table>
# Financial Impact

### Step 5: Studying Your Performance – First year results

#### Pre-GFP compared to GFP

<table>
<thead>
<tr>
<th>Pre-GFP FY18 average direct cost</th>
<th>GFP FY19 average direct cost</th>
<th>Δ costs</th>
<th># of FY19 GFP patients</th>
<th>1 year of ‘Savings’ with GFP</th>
</tr>
</thead>
<tbody>
<tr>
<td>$17,048</td>
<td>$14,884</td>
<td>$2,164</td>
<td>153</td>
<td>$330,000 less spent in direct costs</td>
</tr>
</tbody>
</table>

#### Potential savings with GFP expansion

<table>
<thead>
<tr>
<th># of non-GFP patients FY19</th>
<th>Avg direct cost delta: GFP vs non-GFP</th>
<th>Potential savings over one year</th>
</tr>
</thead>
<tbody>
<tr>
<td>407</td>
<td>$1,940</td>
<td>$790,000 less spent in direct costs</td>
</tr>
<tr>
<td>Outcome</td>
<td>Before:after</td>
<td></td>
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<tr>
<td>---------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>Exceeded Goal of ≤ 24 hours to surgery</td>
<td>A 45% improvement in Time to Surgery</td>
<td></td>
</tr>
<tr>
<td>Exceeded Goal of Length of Stay ≤ 5 days</td>
<td>A 38% improvement in reduced Length of Stay</td>
<td></td>
</tr>
<tr>
<td>Increased delirium assessment, prevention and mitigation by staff nurses</td>
<td>Delirium assessment performed every shift</td>
<td></td>
</tr>
<tr>
<td>Reduced average direct costs by $330,000</td>
<td>$1,000,000 in potential average direct cost savings with expansion</td>
<td></td>
</tr>
<tr>
<td>Decreased 30-day admissions</td>
<td>Better or equal to non-GFP readmissions</td>
<td></td>
</tr>
<tr>
<td>Bone health follow-up</td>
<td>20% of our patients seen for bone health &amp; fall prevention assessment by the Division of Geriatrics post discharge</td>
<td></td>
</tr>
</tbody>
</table>
Steps 3 – 5: Designing, Testing, and Studying Your Performance

• Challenges
  – All hospitalists following agreed upon pre-operative assessments for cardiac/pulmonary issues
  – Ensuring education of new hospitalists and nurses
  – Preventing drift in practice
  – Ensuring follow-up for ambulatory Geriatrics bone health & fall prevention
Step 5: Studying Your Performance - Patient Impact Story

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

-Albert Einstein

QuotesEverlasting.com
Step 5: Studying Your Performance - Staff Impact Story
Impact

The Geriatric Fracture Program optimizes the care of inpatient geriatric fracture patients to minimize potential complications and help them return to their homes and meaningful lives.
Incorporating the 4Ms during Covid-19 Pandemic

I. Cedars-Sinai Ambulatory Clinical Geriatrics Program
II. Multidisciplinary Total Care Management Program for Medicare Advantage
III. LEAP Exercise Program to Combat Social Isolation
Cedars-Sinai Ambulatory Clinical Geriatrics Program, Pre-Covid

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

Sonja Rosen MD, FACP

Elizabeth Whiteman, MD

Allison Mays, MD, MAS

Hiroshi Gotanda, MD, PhD

Cedars-Sinai Geriatrics offers primary care for patients over 75 years of age, as well as consultations for those with geriatric syndromes, such as bone health, dementia, functional decline and fall prevention.
March 19 – Safer at Home implemented in LA County

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

- **What Matters**: Know and align care with each older adult’s specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.
- **Medication**: If medication is necessary, use age-friendly medications that do not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.
- **Mentation**: Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.
- **Mobility**: Ensure that older adults move safely every day in order to maintain function and do What Matters.
Institutional support

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

- All patients and/or caregivers have the ability to talk on the phone – (what matters most)
- Physicians and pharmacists review medications on phone (medications)
- Informed decision making for necessity of in person visits or ED/hospital admission (what matters most)
- Access - patients (and physicians) are available (mobility)
- Ability to conference call (what matters most, medications, mentation)
- Patients love to feel connected; appreciative; report feeling more access to their physicians on patient satisfaction surveys
Additional benefits of video visits

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

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

- Enabled continuity of care and management of both acute and chronic medical conditions, thereby preventing avoidable admissions and directing access of care for higher level of care when appropriate
- Maintained patient satisfaction
- Ability for physicians and staff work from home during Covid pandemic
- Increased productivity to 130% of Pre-Covid productivity
Next steps

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

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

- Already a virtual program incorporating 4Ms
- Falls risk, high risk medication screening; AD discussed in outreach calls, identification of patient goals
AARP Foundation Grant: Leveraging Exercise to Age in Place (LEAP)

• AARP Foundation Strategic Objectives:
  1. Increase ability of individuals served to age-in-place
  2. Demonstrate sustained improvement in social connectedness as measured by the Duke Social Support Index

• Three year grant $750,000, Dr. Allison Mays, MD, MAS is Principal Investigator
• ~450 patients enrolled in first year
• 7 parallel evidence-based programs (Tai Chi, OA, Enhanced Fitness & Chronic disease management)
• 2 non-profit community partners (JFS & PICF)
• Program coordinator (“health coach”)
• Measuring DSSI and UCLA 30-item loneliness scale
• Measuring utilization for MA subset
First Virtual LEAP Class: Arthritis Exercise
LEAP transitions to Virtual LEAP

- AARP Foundation granted a no-cost extension; goal to enroll up to 150 new participants over the next year
- Online platform to Zoom with both community partners
- First Arthritis exercise class with 22 participants!
  - 1 participant Zoomed in from Michigan (3 hour time difference).
  - Class instructor uses a specialized webcam that rotates using a handheld remote control. She instructs participants to adjust their screens so that she can monitor and ensure their safety.
Appendix
Describe Care Consistent with the 4Ms - **Assess**

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

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