Becoming an Age-Friendly Health System

_AHA Action Community: An Invitation to Join Us_

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

• Value of Age-Friendly Health Systems and 4Ms
• Overview of Action Community
• Recognition of Becoming an Age-Friendly Health System
• Implementation at Stanford Health Care
• How to Join the Action Community
• Q&A
Speakers

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

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

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

To submit a question, please type your question on the left-hand side of your presentation screen.
Age-Friendly Health Systems 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).
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

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

Complexity

Fast Facts: Adults Age 65 and Older

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

Disproportionate Harm

- Figure 1. COVID-19 death rates by age and race
  - Rates per 100,000

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
What is an Age-Friendly Health System?

- Represents core health issues for older adults
- Builds on strong evidence base
- Simplifies and reduces implementation and measurement burden on systems while increasing effect
- Components are synergistic and reinforce one another
Spread and Scale AFHS – Action Communities

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

www.aha.org/AgeFriendly
Join AHA Action Community 2020-2021

- Join and get your Age-Friendly Recognition. It’s FREE
- AHA AFHS Action Community is from September 2020 – April 2021
  - Starts Mid-September with 2 Kick off Calls
  - Starting October
    - Monthly all-team webinars
    - Scale-up leaders webinars
    - Listserv, sharing learnings
    - Monthly reports on testing and learnings
  - Celebration of joining the movement!

- Download AHA’s Invitation Guide
- Visit aha.org/agefriendly to learn more
- Email ahaactioncommunity@aha.org with any questions.
AHA Action Community Activities

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

Some of the 4Ms sometimes with some older adults

Reliable 4Ms implementation at the scale of the system

Monthly Webinars and Drop-In Coaching on Measurement and Changes

7 Months
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
Resources

www.ihi.org/AgeFriendly

The Business Case for Becoming an Age-Friendly Health System

Age-Friendly Health Systems Inpatient ROI Calculator Instructions

Age-Friendly Health Systems Outpatient ROI Calculator Instructions

Age-Friendly Health Guide to Using the 4Ms in Care of Older Adults

“What Matters” to Older Adults?
A Toolkit for Health Systems to Design Better Care with Older Adults
Age-Friendly Health System Recognition

An Age-Friendly Health System...

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

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

- **Scales** the work and **celebrates** recognition nationally
Putting the 4Ms into Practice: A “Recipe”

1. Understand your current state
2. Describe what it means to provide care consistent with the 4Ms
3. Design/adapt your workflow to deliver care consistent with the 4Ms
4. Provide care consistent with the 4Ms
5. Study your performance
6. Improve and sustain care consistent with the 4Ms
Customizing Putting the 4Ms into Practice: A “Recipe”
## 4Ms Description Worksheet: Hospital

<table>
<thead>
<tr>
<th>What Matters</th>
<th>Medication</th>
<th>Mentation</th>
<th>Mobility</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>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.</td>
<td>Prevent, identify, treat, and manage delirium across settings of care</td>
<td>Ensure that each older adult moves safely every day to maintain function and do What Matters.</td>
</tr>
</tbody>
</table>

### Engage / Screen / Assess
- List the question(s) you ask to know and align care with:
  - Check the medications you screen for regularly:
    - Benzodiazepines
    - Opioids
    - High-dose insulin
    - All prescription and over-the-counter sedatives and sleep medications
    - Muscle relaxants
    - Tricyclic antidepressants
    - Antipsychotics
    - Other:
  - Check the tool used to screen for delirium:
    - Minimum requirement: One box must be checked, if only "Other" is checked, will review.
  - Check the tool used to screen for mobility:
    - Minimum requirement: At least one of the first six boxes must be checked. If only "Other" is checked, will review.

- Minimum requirement: At least one of the first seven boxes must be checked.

### Act On
- Align the care plan with What Matters most:
  - Minimum requirement: First box must be checked.
- Deprescribe (includes both dose reduction and medication discontinuation):
  - Minimum requirement: At least one box must be checked.
- Delirium prevention and management protocol including, but not limited to:
  - Minimum requirement: First five boxes must be checked.
## 4Ms Description Worksheet: Ambulatory

<table>
<thead>
<tr>
<th>What Matters</th>
<th>Medication</th>
<th>Mentation</th>
<th>Mobility</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Prevent, identify, treat, and manage delirium across settings of care.</td>
<td>Ensure that each older adult moves safely every day to maintain function and do What Matters.</td>
</tr>
</tbody>
</table>

**Engage/Screen/Assess**

Please check the boxes to indicate items used in your care or fill in the blanks if you check “Other.”

- Benzodiazepines
- Opioids
- Highly-anticholinergic medications (e.g., diphenhydramine)
- All prescription and over-the-counter sedatives and sleep medications
- Muscle relaxants
- Tricyclic antidepressants
- Antipsychotics
- Other: ________

Minimum requirement: At least one of the three boxes must be checked. If any “Other” is checked, we review.

One or more What Matters questions must be listed. Questions cannot focus only on end-of-life forms.

**Frequency**

- □ Daily
- □ Other: ________
- □ Other: ________

Minimum frequency is once per stay.

**Documentation**

- □ EHR
- □ Other: ________

One box must be checked; preferred option is EHR. If “Other,” will review to ensure documentation method is accessible to other care team members for use during the hospital stay.

One box must be checked; preferred option is EHR. If “Other,” will review to ensure documentation method can capture assessment to trigger appropriate action.

**Act On**

- □ Align the care plan with What Matters most
- □ Other: ________
- □ Other: ________

Minimum requirement: First box must be checked. Minimum requirement: At least one box must be checked.

Delirium prevention and management protocol including, but not limited to:
- Ensure sufficient oral hydration
- Orient older adult to time, place, and situation on every nursing shift
- Ensure older adult has their personal adaptive equipment (e.g., glasses, hearing aids, dentures, walkers)
- Prevent sleep interruptions; use non-

Guidelines: Ambulate 3 times a day:
- Out of bed or leave room for meals
- PT intervention (balance, gait, strength, gate training, exercise program)
- Avoid restraints
- Remove catheters and other tethering devices
- Avoid high-risk medications

**Knowledge Check**

- TUG
- Get Up and Go
1. Definition of the how you are putting the 4Ms into practice

2. Count of 65+ people whose care includes the 4Ms
Sites Recognized by the Movement

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

805

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

179*

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 July, 2020.

www.ihi.org/AgeFriendly

www.aha.org/AgeFriendly
Connecting Age-Friendly Measures with Value

### Figure 3: Age-Friendly Measures Contribute to Value

<table>
<thead>
<tr>
<th>Age-Friendly Measures</th>
<th>Hospital Setting</th>
<th>Ambulatory/Primary Care Setting</th>
<th>The Value Equation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Outcome Measures</td>
<td></td>
<td></td>
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<tr>
<td>30-day readmission</td>
<td></td>
<td></td>
<td>Patient outcomes,</td>
</tr>
<tr>
<td>ED utilization</td>
<td></td>
<td></td>
<td>cost</td>
</tr>
<tr>
<td>Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey</td>
<td>HCAHPS</td>
<td>CGCAHPS</td>
<td>Patient experience, patient outcomes</td>
</tr>
<tr>
<td>Length of stay</td>
<td></td>
<td></td>
<td>Patient outcomes, cost</td>
</tr>
<tr>
<td>Advanced Measures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delirium</td>
<td></td>
<td></td>
<td>Patient outcomes, cost</td>
</tr>
<tr>
<td>CollaborATE (or similar tool to measure goal-concordant care)</td>
<td></td>
<td></td>
<td>Patient outcomes, patient experience</td>
</tr>
</tbody>
</table>

Value Initiative

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

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

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Stanford Health Care High Value Care Model

Integrated model of patient-centered and system-level performance

Diagnostic & Therapeutic Efficiency
Clinical Redesign/ Evidence-based Medical & Surgical Pathways
Discharge Transitions
Optimizing Patient Care Settings
Preventative Medicine
Clinical Pathways, Care Redesign, and Coordination

Pre-admission
- ED
- PCP/Specialty Clinic

Index
- Acute Care Hospital
- Ambulatory Surgery
- Outpatient Clinic

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

Episode of Care

- ED
- PCP/Specialty Clinic
- Acute Care Hospital
- Ambulatory Surgery
- Outpatient Clinic
- Home
- Skilled Nursing Facility
- Home Health
- PCP/Specialty Clinic

Analyze Cost and Quality Metrics
Analyse Current State
Identify Core team: Outpatient, Inpatient, Post- Acute care
Develop Clinical Pathway
Optimize EMR
Develop Sustainability Infrastructure
Monitor Outcomes
Clinical Pathway and Care Redesign Development

1. Initial Design, Scoping, Target Cohort Identification
2. Detailed Data Analysis
3. Review of literature and evidence-based best practices
4. Pathway Development with Multidisciplinary Team with providers and patients
5. EPIC Optimization and Order Set Creation
6. Automated Data Dashboard
7. Initial Implementation
8. Patient Education Materials
9. Iteration/ Sustainability Plan
**High Value Care Improvement Scoping and Implementation**

**Governance Team**

**Scoping Phase**
- **Strategy**: Enterprise wide impact/feasibility analysis using national data platforms
- **Clinical data analytics**: Identify clinical improvement opportunities in each clinical area

**Clinical/Business Leaders**

**Implementation Phase**
- **EMR and Reports**: Evaluate necessary IT support in EMR enhancement and CBA reporting
- **Implementation**: Develop and implement pathways with clinical and business partners

- **Pathway A Clinical Team**
- **Pathway B Clinical Team**
- **Pathway C Clinical Team**
- **Non-Pathway D Clinical Team**
- **Non-Pathway E Clinical Team**
NSQIP Risk-Adjusted Complication Rates for SHC

Need Improvement  Expected  Exemplary

<table>
<thead>
<tr>
<th>Year</th>
<th>Need Improvement</th>
<th>Expected</th>
<th>Exemplary</th>
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<tbody>
<tr>
<td>2012</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2013</td>
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<td>2015</td>
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<td>2016</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2017</td>
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Objectives

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

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

**October 2016**

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

**Geriatric Specific Order sets**

**May 2017**

1. **Admission order sets:**
   Trauma admission order sets reviewed and updated for senior-friendly pharma and non-pharma interventions

2. **Elderly Rib Fracture pain Mx protocol**
   - Standardized pain evaluation and management protocols created by Pain service, Geriatrics and Trauma.

**Acute Care for Elders Unit (Trauma)**

**October 2017**

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

1. **Nursing-driven screening** at admission and daily report-out for geriatric syndromes based on ‘SPICES’ format.
2. **Geriatric APP driven** guidance to IDT regarding geriatric syndromes as barriers to discharge during daily IDT rounds.

Continuous Process Improvement
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**November 2016**

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**May 2017**

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- 2. Elderly Rib Fracture pain Mx protocol
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- 2. Geriatric APP driven guidance to IDT regarding geriatric syndromes as barriers to discharge during daily IDT rounds.

Geriatric Trauma High-Value Care Pathway

**November 2018**

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

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

AFHS SMART GOAL: To improve the consistent delivery of “4M care bundle” from 60% to 80% in the geriatric trauma population from Nov 2018 to Nov 2019.
Multidisciplinary Workshop
• Brainstorming session with multidisciplinary team in May 2018
Integrating Age-Friendly Care

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

**Recovery Milestones**

- **PHASE A: ED**
- **PHASE B: Initial 24h of Admission**
- **PHASE C: Recovery**
- **PHASE D: Discharge Milestones**
- **PHASE E: Post Discharge F/U**

**Safety**
- Pain Control
- Early Nutrition
- Discharge Planning
- Medication Management
- Early mobility
- Pulmonary Hygiene
Geriatric Trauma Non-Surgical Clinical Pathway

### Categories

<table>
<thead>
<tr>
<th>Provider</th>
<th>Geriatric Trauma Non-Surgical Clinical Pathway</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
<tr>
<td>Medication</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>Activity</td>
<td>Rehab</td>
</tr>
<tr>
<td>Discharge planning</td>
<td>Casemanager</td>
</tr>
<tr>
<td>Psycho-Social</td>
<td>Social Worker</td>
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</tbody>
</table>

### Categories

<table>
<thead>
<tr>
<th>Provider</th>
<th>Pharmacist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider</td>
<td>Diagnostics</td>
</tr>
<tr>
<td>Provider</td>
<td>Laboratory</td>
</tr>
<tr>
<td>Provider</td>
<td>Consults</td>
</tr>
<tr>
<td>Provider</td>
<td>Pain Management</td>
</tr>
</tbody>
</table>

### Roles

- **Pharmacist**: Medication
- **Laboratory**: Diagnostics
- **Consults**: Consultations
- **Pain Management**: Pain Management

### Goals of Care (60Q)

1. Early mobilization and discharge to home
2. Identify and document DPOC and/ or surrogate decision maker
3. Provide list of DPOC that family can visit prior to discharge
4. Identify and document DPOC and/or surrogate decision maker

### Medications

- Medication name
- Dosage
- Route

### Activity

- Activity order: if appropriate (clarify instructions)
- Early mobilization
- Head of Bed: 30 degrees
- Externally walker
- Furnish patient with appropriate COT consult for sleep hygiene

### Discharge planning

- Discharge planning
- Home Health
- SNF needs

### Pain Management

- Pain Management
- Basic pain control
- Neuropathic pain

### Consults

- Consults
- PT/OT consult
- Social Work (Cas) consult

### Laboratory

- Laboratory
- Basic lab work
- Level of care

### Diagnostics

- Diagnostics
- CT/MRI scan
- Chest X-ray
- Laboratory tests

### Pain Management

- Pain Management
- Pain management
- Basic pain control
- Neuropathic pain

### Consults

- Consults
- PT/OT consult
- Social Work (Cas) consult

### Laboratory

- Laboratory
- Basic lab work
- Level of care
## AFHS 4M Care Definition – SHC Geriatric Trauma

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

HIGH VALUE CARE

GERIATRIC TRAUMA (NON-SURGICAL) CARE PATH

OVERVIEW

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

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

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

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

Geriatric Trauma Non-Surgical Pathway
### Standardized EPIC Documentation

#### Pain Assessment
- **Pain Scale Type**
- **Pain Scale Instruction**
- **Pain Level - 1st Site**
- **Pain Goal**
- **Anxiety Level**
- **Does Patient have Chronic Pain**

#### Pulmonary
- **Pulmonary (WDL)**
- **Incentive Spirometer (ml)**
- **Deep Breathing**
- **Flutter Valve**

#### Mobility/Activity
- **Mobility/Activity**
- **Bed Position**
- **Patient Position**
- **# of Siderails Up**
- **Therapy Bed Surface**
- **Pressure Redistribution/Off-loading Devices**
- **Bedside Mobility Level (BMA)**
  - **Activity**
  - **Activity Assistance**
  - **Activity Aid/Device**
  - **ADL Assistance**
  - **Safety Precautions**

#### Sleep Pattern
- **Sleep Pattern**
- **Hours of Sleep**
**Geriatric Trauma (Non-Surgical) Care Path**

**Frequently Asked Questions**

**Does the Pathway apply to all patients?**
- The following cases will be excluded from the care path: All major surgical procedures.
- Following cases will be flagged as “Off the target LOS”: Insertion of pacemaker & defibrillator, Cardiac assist device- IABP, ECMO, VAD, patients on hemodialysis or CRRT, prolonged vent>24 hrs.

**Where to find the Geriatric Trauma Non-Surgical Care Pathway?**
- The Care Path link is available here: [Geriatric Trauma Non-Surgical Pathway](#).
- The link is also available for reference in Epic (see screenshots below) and in order sets.

**Which order set to use?**
- The following order sets are updated and are available to use in Epic:
  - IP SUR General Admit
  - IP GEN/ICU Rib Fracture
Geriatric Trauma Non-Surgical Outcomes

Volume and Average LOS

Average # of Hours to First Mobility

Average # of Hours to First Goals of Care Note

Average Pain Score, Last 24 Hours

Unplanned Care

CAM/Delirium

Last Refreshed: 6/30/20 2:58:13 PM GMT-07:00
Value Improvement

\[ \text{Value} = \text{Team Engagement} \times \frac{\text{Quality} + \text{Service}}{\text{Cost}} \]
# Outcomes and Process Metrics (Improving Value)

<table>
<thead>
<tr>
<th></th>
<th>FY17 (Pre-Implementation)</th>
<th>FY18 (Implementation)</th>
<th>FY19 (Post-Implementation)</th>
<th>FY20 (-Jan20) (Sustainability)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4M Care Process Implementation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>193</td>
<td>214</td>
<td>249</td>
<td>101</td>
</tr>
<tr>
<td>What Matters: Time to first ACP/GOC note and % completed</td>
<td>50hrs</td>
<td>38hrs (60%)</td>
<td>32hrs (70%)</td>
<td>(70%)</td>
</tr>
<tr>
<td>Mobility: Average time to first mobility</td>
<td>48hrs</td>
<td>23hrs (99%)</td>
<td>(99%)</td>
<td></td>
</tr>
<tr>
<td>Medications: Admission Med Review</td>
<td>60%</td>
<td>(70%)</td>
<td>(70%)</td>
<td></td>
</tr>
<tr>
<td>Mentation: Nursing CAM Assessments</td>
<td>90%</td>
<td>(99%)</td>
<td>(99%)</td>
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</tr>
<tr>
<td><strong>Utilization/Cost</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LOS (Non-Surgical) (days)</td>
<td>4.55</td>
<td>4.13</td>
<td>4.1</td>
<td>4.33</td>
</tr>
<tr>
<td>LOS (CAM+ vs CAM-) (days)</td>
<td>6.7 vs 3.6</td>
<td>5.7 vs 3.4</td>
<td>6.1 vs 3.5</td>
<td>6.2 vs 3.8</td>
</tr>
<tr>
<td>Direct cost/patient</td>
<td>BL</td>
<td>(-$3,100)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-day Readmission Rate (%)</td>
<td>6</td>
<td>1</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>30-day Return to ED (%)</td>
<td>5</td>
<td>4</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td><strong>Quality/Safety</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortality (%)</td>
<td>5.8</td>
<td>4.8</td>
<td>2.5</td>
<td>3</td>
</tr>
<tr>
<td>Delirium Incidence (%) (CAM + DRG)</td>
<td>32%</td>
<td>34%</td>
<td>24%</td>
<td>22%</td>
</tr>
<tr>
<td><strong>Patient Experience</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What number would you use to rate this hospital? (Top Box)</td>
<td>58.7%</td>
<td>63.5%</td>
<td>67.3%</td>
<td></td>
</tr>
<tr>
<td>Would you recommend this hospital to your friends and family?</td>
<td>69.6%</td>
<td>63.5%</td>
<td>66.7%</td>
<td></td>
</tr>
</tbody>
</table>
Care:
A very elderly lady with dementia being admitted for fall-related injuries. She was seen in the ED within 24 hours by rehab and the geriatrics team. We walked her around the ED and met with son to discuss GOC/ACP priorities. She was downgraded from ICU to the regular floor (ACE unit). Her pain was controlled early, she was taking PO and moving bowels, so was able to go home Day 3, avoiding delirium and disability from a protracted ICU and hospital stay.

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

Stanford Geriatric Trauma Program recognized nationally
November 2019
Value of the AFHS Initiative

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

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

...AND culture change, value improvement, advancing health equity!
On behalf of the – Stanford Geriatric Trauma Team

Trauma
Kristan Staudenmayer, MD
Lisa Knowlton, MD

Geriatric Medicine
Marina Martin, MD
Matthew Mesias, MD
Astrid Block, CNS
Nannette Storr-Street, CNS

High Value Team
Amy Lu, MD
Purnima Krishna, RN

Nursing
Ann Mitchell, CNS

Rehab
Alyssa Brown, OT

Aging Adult Services (Senior Care Transitions program)
Case Management and Social Work
Pharmacy
Janjiri Desai

Patient-Family Advisory Council
Alka

Thanks to the IHI-
John A. Hartford
AFHS community

Contacts:
Amy Lu: aclu@Stanford.edu
Ankur Bharija:
ankurb@stanford.edu
Discussion/Q & A

Type in the chat!
New Resources!

**Issue Brief: Creating Value with Age-Friendly Health Systems**

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

**The Aging Population**

The U.S. has 49 million individuals age 65 and older, and that number will grow to 90 million by 2060. This large increase will significantly affect how we deliver care for older adults and our country’s overall health care costs in the future.

Older adults have additional health risks that require customized care that starts early. Older adults also have higher rates of hospital readmission compared to any other age group.

Older adults also face medical and social challenges that may impact their well-being as they age, such as advanced disease, lack of care coordination across care settings, social isolation, and loneliness. For example, social isolation is associated with long-term diseases, such as chronic lung disease, arthritis, impaired mobility, depression, and increased rates of mortality. Loneliness increases the risk of dementia and cognitive decline.

**Fast Facts: Adults Age 65 and Older**

- 80% have 1 chronic condition
- 77% have 2 chronic conditions
- 75% will receive long-term care
- 40% will require care in a skilled nursing facility

**Disparities among Older Adults**

The unique needs of older adults can be triggered by the disparities they face related to access and the communities where they live. Lack of community capacity can impede access to affordable care, while social isolation can prevent them from seeking support networks. Additionally, severity rates of older adults are higher among Black and Hispanic communities. Racial and minority groups also have a higher risk of acquiring infectious diseases, such as COVID-19, and being hospitalized due to it.

**Case Study: Kent Hospital**

**Case Study: Rush University Medical Center**

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

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

• Share your feedback