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Background

Duke Health has seen an increase in the number of older adults hospitalized over time. Several efforts to improve the care delivered to older adults have been initiated, which align with the Age-Friendly Health System movement. However, gaps in complex geriatric care delivery still exist. In addition, the Geriatric Coordinating Council strategic plan identified a need for a unified approach to addressing the multiple geriatric syndromes. Our aim is to implement an Age-Friendly Health System initiative at Duke Regional Hospital that is sustainable and scalable for future implementation hospital- and system-wide to improve the interprofessional care of hospitalized older adults. We'll do this by forming steering committee and workgroups representing each of the 4Ms (What Matters, Medication, Mentation, Mobility) to lead practice change, starting in one unit and moving across clinical units. We will be recognized as Committed to Care Excellence by the Institute for Healthcare Improvement (IHI).

Approach

To meet our stated aim, we outlined the following goals:

1. Bring together a team of interprofessional leaders to form an Age-Friendly Health System program initiative at Duke Regional Hospital.
2. Identify a champion unit and champion unit nurse to initiate the 4Ms practices.
3. Create an older adult-specific medication review and management process to reduce the number of high-risk medications prescribed throughout the hospitalization and at discharge.

Outcomes

Despite challenges related to COVID-19, a team of 22 stakeholders, representing eight professions (medicine, nursing, case management/social work, physical therapy, occupational therapy, speech therapy, chaplaincy and pharmacy) met regularly to discuss goals, barriers and facilitators to successful Age-Friendly Health System implementation. After losing the first patient care unit to competing priorities, the team engaged a pilot unit, charge nurse and bedside nursing assistant in March 2021. The unit was chosen for its adoption of other geriatric-friendly initiatives and pilots. To date, we have enrolled six patients in the program.

Four workgroups, each with a project leader, were formed to represent each 4M, and each created goals and outlined workflows. The workflows of the Mobility and Mentation workgroups are based on the mobility and delirium redesign projects that predate our project. System-wide, nursing staff already assesses for mobility and delirium at every hospital shift. The Age-Friendly team is working to ensure that the previously created design workflows are followed appropriately. Matters Most and Medications workflows required additional early stage planning and, hence, took longer to get to pilot launch phase. The

Medications team elected to focus on creating system-level automatic prescribing alerts (still in progress) and on an occupational-therapy-led medication management education project. OT templates were changed to include questions regarding medication management, and an algorithm determined which patients would benefit from further medication administration education and interventions.

Lessons Learned

The process towards recognition as Committed to Care Excellence requires significant culture change, which requires buy-in at all levels and adequate representation of all stakeholders in the decision-making process. In the first year of our project development, we did several things well that will be critical for success. These include the engagement of a committed group of interprofessionals to sit on the steering committee and participate in M-related workgroups; the establishment of a solid leadership team of four M workgroup thought leaders who set group expectations and meeting agendas, and addressed implementation barriers; and participation in a community of practice offered by the IHI for Age-Friendly Healthcare teams around the country. While the pandemic delayed our ability to engage a pilot unit and begin enrolling patients, the rapid acceptance of virtual meetings allowed us to convene diverse stakeholders on a regular basis. We also met several unexpected barriers that delayed pilot initiation.

Overall, our key lessons are:

Engage senior leadership often throughout the process, not just at the project's beginning. Key leadership stakeholders gave early support for the program but competing interests shifted priorities. Missed opportunities for communication led to an increased amount of time re-engaging senior leaders and educating them on our efforts.

Early front-line nursing staff participation is critical. While we had excellent nursing representation on the steering committee, no bedside nurses were on the pilot unit because COVID-related priorities made it difficult to engage a nurse manager. After the original patient care pilot unit could no longer commit, a second unit was chosen, but it took time to get the bedside nurses informed and well engaged.

Elicit stakeholders' preferred communication methods. Some groups preferred us to attend their regular meetings, others wanted to be part of the steering committee, and still others preferred email or other digital asynchronous communication.

Solicit input from the Patient and Family Advisory Panel (PFAC) early and often. Our PFACs are engaged and committed community members who are willing to steer the project in a more meaningful direction. However, they are also very busy with several other projects. Necessary information from early education and specific asks are important for person-centered care.

Next Steps

Since we have not yet reached Committed to Care Excellence status, we will continue our small tests of change in each 4M on our chosen pilot unit. We are currently still in the 1 patient, 1 nurse phase and will scale up following the current Plan-Do-Study-Act cycle. We've identified outcome measures and we are developing ways to measure staff and patient/family satisfaction. In terms of medication management, the workgroup's next steps are to create a pharmacy protocol to reduce medication administration between the hours of 11 p.m. and 6 a.m. and to initiate an automatic alert for high-risk medications for older adults.

The four-person leadership team will remain the same but the main coordination will shift from the current AHA Next Generation Leaders Fellow to the next one, who is also the medical director of geriatrics at Duke Regional Hospital. Her additional roles in the hospital make her well-suited to continue to build the program. A communication plan has been developed and will be launched, including creation of patient-facing materials and staff education signs. We are also working to disseminate education on Age-Friendly care to other groups, including environmental services and dietary. We are also applying to be considered a system redesign project to access additional funding and informational technology support. We expect to be recognized by the IHI as Committed to Care Excellence by December 2021.