AGE-FRIENDLY HEALTH SYSTEMS

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

The goal of the initiative is to develop an Age-Friendly Health Systems framework and rapidly spread to 20 percent of U.S. hospitals and health systems by 2020.
Age-Friendly Health Systems

Four Core Organizations
- The John A. Hartford Foundation
- Institute for Healthcare Improvement (IHI)
- American Hospital Association (AHA)
- Catholic Health Association of the United States (CHA)

Five Age-Friendly Health Systems Pioneers
- Anne Arundel Medical Center (Headquarters: Annapolis, MD)
- Ascension (Headquarters: St. Louis, MO)
- Kaiser Permanente (Headquarters: Oakland, CA)
- Providence St. Joseph Health (Headquarters: Renton, WA)
- Trinity Health (Headquarters: Livonia, MI)
Age-Friendly Health Systems Action Community

New Hampshire
- Capital Region Health Care
- Elliot Health System
- Dartmouth Hitchcock Centers on Aging
- Parkland Medical Center
What is an Age-Friendly Health System?

An Age-Friendly Health System is one in which every older adult:

• Gets the best care possible;
• Experiences no health care-related harms; and
• Is satisfied with the health care he or she receives.

In an Age-Friendly Health System, value is optimized for all — patients, families, caregivers, health care providers, and the overall system.
IHI Action Learning Community

- 7-month Action Community started in September 2018
- Participating as Capital Region Health Care
- Monthly Interactive Webinars
- Ability to test age-friendly interventions
- Shared data on a set of standard age friendly measures

- CRHC’s team during this Action Learning Community phase is: Concord Regional VNA, CH Nursing, Care Management, CH Pharmacy, CH Population Health, CH Emergency Department
4M’s Framework of an Age-Friendly Health System

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

**Medication**
If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

**Mentation**
Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

**Mobility**
Ensure that older adults move safely every day in order to maintain function and do What Matters.
The goal is to have the “4 Ms” become the focus of decision making not an add on. For example, if some one has heart disease and lung disease, find out what activities the person wants to do (the What Matters).

Then you decide what care helps them accomplish these activities and which medications may be impeding these activities (stop them) and what medications for their heart or lung disease may help them achieve their activities better or easier. Start them.

Then determine whether cognitive impairment or mobility issues are impediments to achieving the activities that matter most. If so, consider what care such as home aides or PT can be added.

This is not something that occurs in one visit but becomes the focus for all encounters.
What is Capital Region Health Care?

Concord Regional VNA
Primary Service Area: 42 towns
FY17 Community Benefits: $4.3M
Total job impact: 400
Average Daily Census: 2,000

Primary Service Area: 28 towns in 30-40 min drive
FY17 Community Benefits: $54M
Total job impact: 6,500
Unique patients: 118,000
Hospital admissions: 20,000; ED visits: 68,000
Outpatient visits: over 500,000

10 Primary Care Practices in 13 locations | 7 Satellite Laboratory sites | 2 Imaging Centers | 3 Satellite Specialty Care Clinics
How does Palliative Care and Hospice Care fit with Age Friendly Health Systems

Improving the Care of Older Adults, Priority Areas Identified by John Hartford Foundation
What are we trying to achieve across all Populations?

An integrated model of exceptional service delivery, sustainable resource stewardship, a highly engaged and healthy care team, and partnerships to create community wellbeing.
Why? What we know about our Older Population

Aging:
✓ The 65+ population is projected to grow by 17% over the next five years. This growth will impact the demand for and type of healthcare services needed.
✓ More than 1 in 10 adults in the service area is a veteran and more than half are 65 or older.

Chronic Conditions:
✓ A high percentage of Medicare beneficiaries suffer from one or more chronic conditions.

Social Vulnerability:
✓ While social vulnerability exists in census tracts across the service area some of the highest levels of vulnerability primarily exist within the city of Concord:
  • Many of the Concord census tracts with higher % of individuals over 65, also have higher rates of poverty, transportation challenges, higher rates of disability and housing challenges

Behavioral Health & Substance Use:
✓ Impact of depression, social isolation, substance use
The Social Vulnerability Index (SVI) uses U.S. Census data to determine the social vulnerability of every census tract. The SVI ranks each census tract on 15 social factors, including poverty, lack of vehicle access, and crowded housing, and groups them into four related themes:

- Socioeconomic
- Housing Composition and Disability
- Minority Status and Language
- Housing and Transportation

Percentile ranking values range from 0 to 1, with higher values indicating greater vulnerability.

At-risk populations defined as "individuals with social risk factors for poor health outcomes such as low socioeconomic position, social isolation, residing in a disadvantaged neighborhood, identifying as a racial or an ethnic minority, having a non-normative gender or sexual orientation, and having limited health literacy."
Vulnerable Population – Older Residents
<table>
<thead>
<tr>
<th>Age Friendly Measure</th>
<th>Current State - CRHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>% 30-day readmissions, 65+</td>
<td>13.34%</td>
</tr>
<tr>
<td>Emergency Department visits, 65+</td>
<td>511 per month</td>
</tr>
<tr>
<td>% High Risk Delirium, 65+</td>
<td>50% (Medical/Surgery Unit Study 2018)</td>
</tr>
<tr>
<td>% Screened Positive Delirium, 65+</td>
<td>43% (Medical/Surgery Unit Study 2018)</td>
</tr>
<tr>
<td>% Screened Delirium</td>
<td>100% ICU only</td>
</tr>
<tr>
<td>% of Inpatient Admissions, 65+</td>
<td>50%</td>
</tr>
<tr>
<td>% Depression screening, Medicare</td>
<td>70% (Based on historical data, CHMG practices only)</td>
</tr>
</tbody>
</table>

* Reporting period: Jan-Oct 2018 unless noted otherwise
Capital Region Health Care – Our Approach

Initial Workgroups formed in Fall 2018:
• Inpatient
• Emergency Department
• Transitions in Care

Projects identified based on:
✓ Data
✓ Build on existing work to more deeply understand current state of 4Ms:
  • Connect with existing inpatient Delirium Initiative
  • Connect with pilot of pharmacist in Internal Medicine
  • Connect with strategic priorities (reducing falls, avoidable ED, patient experience, population health)
✓ Interest across all groups to know What Matters
Project 1: Inpatient 4Ms Current State Assessment

Approach:

 ✓ Data analysis
 ✓ Direct observation of 2 of the 4Ms in workflow in Emergency Department, Floor, Discharge
   • 2 M’s: Mentation, Mobility
   • Nursing, Physicians, PT, Support
   • Screening & assessment, documentation, decision support in medical record, team communication
 ✓ Completed end of February, final report is in process
 ✓ Continued expansion of Delirium Initiative
Mentation/Delirium Nursing Current State

Nursing
Delirium Prevention on all inpatients:

- **UP BY 10**
  - Lights on/shades up
  - Correct vision and hearing
  - Face washed/oral care given
  - OOB to chair

- **Visual Management System**
Mentation/Delirium Support Current State

Support:

Delirium Prevention Committee
Delirium Nurse Specialist
ABCD carts on each unit
Reverie Harp on each unit
Therapeutic Arts and Holistic Services
Project 2: Patient Experience, What Matters

Approach:

- Data analysis
- Direct observation of patient and team interaction related to “What Matters” across inpatient settings
  - Multidisciplinary Team Board Meeting on 10 units: Observed to evaluate for the presence of the 4M’s in the content of the individual reports on each patient.
- Patient Surveys:
  - IHI “collaboRATE” tool: Slightly modified to use with inpatients following visit from doctor on unit
  - Community-based (CRVNA, Center for Health Promotion): borrowed Anne Arundel Medical Center What Matters Survey. 6 questions about what matters to them when they are in the hospital
- Observation completed, Surveys still in process
82 patients age 65 and older

- Matters: Patient preference for dc plan or plan of care mentioned 25/82 times. DPOA or decision maker (1x). DNR status (1x).
- Mobility: PT/OT referral mentioned 30/82 times. Mention of mobility needs at discharge (2x).
- Medication: Medication discussed relative to inpatient treatment 25/82.
- Mentation: Alert or aware 14/82. Ability to make own decisions (1x). Delirium Protocol (1x).
15 respondents: 10 patients/3 Family Members/2 Both

- All 4 ICU patients indicated “Every Effort”
- Patients in general seemed grateful and hesitant to say anything negative.
- Patients answering on day of discharge indicated “No effort” or “Little Effort”
What Matters - Hospital Current State, Community Survey Results

45 responses, Ages 65-93

✓ When you are in the hospital, what is the most important thing you want to know?
  1. 58%: What will happen during my stay
  2. 20%: When am I going home
  3. 17%: What is the plan for the day

✓ What is the one thing your doctors and nurses should know about you?
  1. 33%: My medical history
  2. 30%: My plan of care
  3. 28%: What is important to me as a person
  4. 5%: What makes me feel comfortable at home
  5. 5%: What is important to me
What Matters - Hospital Current State, Community Survey Results

45 responses, Ages 65-93

On a scale of 1 (Not Important) to 5 (Very Important)

✓ The doctors and nurses know what is most important to me as a person: 100% answered ≥ 4
✓ The doctors and nurses know my medical history and plan of care: 100% answered ≥ 4
✓ The doctors and nurses know what makes me feel comfortable in the hospital and “at home” (like my favorite food, music, etc...): 69% answered ≥ 4
✓ The doctors and nurses know who is important to me (like spouse, son, daughter, friend...): 100% answered ≥ 4
✓ Develop a 4 M’s framework for how the clinical providers present information about each of their patients.
  • Foster an awareness of the 4 M’s philosophy and support future initiatives.

✓ Use the Collaborate Tool in the ambulatory setting to begin evaluation of practices and outpatient services relative to the 4 M’s.
  • The tool as adapted for inpatient was not as effective given the circumstances of team care. Patients see many providers and this created confusion.
# Hartford Healthcare Cares About Me...

**I like to be called:**

- Hunter

**My family, friends, pets names are:**

- Love, my grandchildren

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**What I do or used to do for work:**

- Fire Marshall

**What I do for fun and activity:**

- Ice-cream

**My favorite TV shows, music, books are:**

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**I brought with me:**

- Dentures: No / Yes
- Upper / Lower / Both
- Glasses: No / Yes
- Hearing Aides: No / Yes / Right / Left / Both

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_Hartford Healthcare Cares About Me..._
Project 3: What Matters to Patients Regarding Medication

Approach:

- Small scale test of change to determine the patient’s priority goals and identify medication related issues affecting these goals in 25 patients admitted to the CH.

- Internal Medicine pharmacist worked with Dr. Vanderlinde’s patients who are 65+ yo and hospitalized. Excluded if only an Emergency Room visit or Pharmacist is not able to meet with patient in the hospital.

- Objectives:
  - Create priority goals for older adults admitted to the hospital.
  - Identify medication related issues that may interfere with these goals.
  - Implement a customized medication care plan in these patients once discharged from the hospital.

- Started project January 2019, in process, only < 5 patients to date, applied learning to other patients not hospitalized.
Capital Region Palliative Care Team

- Joint program created 2015 between Concord Hospital and Concord Regional VNA
- Leadership: Executive Medical Director, Practice Administrator
- Palliative care team: Providers, social work, spiritual care, Nurse Navigation, administrative coordinator employed by the hospital
- 85-90 consults per month: 50% inpatient, 25% Skilled Nursing Facilities, 25% community (home, office, 3 embedded clinics, Payson Center)
- 95% goals of care completed (AD’s, POLST, DNR completed, in file)
CRVNA Hospice House Falls Prevention Quality Initiative

- What Matters:
  - Unwanted ICU care
  - Days in hospital
  - Adverse drug events

- Mobility:
  - Injurious falls
  - Pressure sores
  - Venous thromboembolism

- Mentation:
  - Delirium
Domains

- Evidenced Based Care
- Coordination of Care
- Building and Leveraging Community Partnerships
- Developing and Deploying the Workforce
- Aligning with Value Based Model
- Engaging Patients in their Care

Population Health System-level work aligns with the 4Ms

- COPD Clinical Care Pathway
- Age Friendly Health System
- Frail Elder Program
- Transitional Care Nurses
- Nurse Navigation
- ED Turnaround
- Smart Heart
- Regional Public Health Network
- Capital Area Wellness Coalition
- Community Health Educators
- Population Health Plan 2.0
- Center for Health Promotion Plan 2.0
- NH-Cares ACO NH Accountable Care Partners
- COPA Joint Bundle
- Capital Region Palliative Care & CRVNA Hospice
- Community Health Education and Wellness Programs
What’s Next?

- Will internally review decision to apply for 1st Level IHI Age-Friendly Health System recognition
- Will develop and implement small tests of change where there is a natural affinity for age-friendly work
For those interested in learning more or participating in an IHI Age Friendly Health System Learning Collaborative contact AFHS@IHI.org or www.ihi.org