Creating Age-Friendly Health Systems

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Introductions

- Ann Hendrich, PhD, RN, FAAN Senior Vice President and Chief Quality/Safety and Nursing Officer, Ascension (Co-Chair, Creating Age-Friendly Health Systems)
- Mary Tinetti, MD, Gladys Phillips Crofoot Professor of Medicine (Geriatrics) and Professor, Institution for Social and Policy Studies; Section Chief, Geriatrics (Co-Chair, Creating Age-Friendly Health Systems)
- Marie Cleary-Fishman, BSN, MS, MBA, Vice President Clinical Quality at Health Research & Educational Trust (HRET), American Hospital Association
- Leslie Pelton, MPA, Director, Innovation, Institute for Healthcare Improvement
Workshop objectives

• Understand the 4M model of Age-Friendly Health Care
• Understand the challenges and barriers to implementing Age-Friendly care system-wide
• Develop a plan to test Age-Friendly interventions in your health system
• Understand the value proposition of becoming an Age-Friendly Health System
Improving the Health of Older Adults

$565,000,000

amount invested in aging and health since 1982

- Age-Friendly Health Systems
- Family Caregiving
- Serious Illness and End-of-Life

Photo by Julie Turkewitz
Roadmap for a movement

• Will for change
• Aim & Purpose
• Evidence-based interventions
• Technical method for change
• Social system for spread
Where we are today

Older adults:
- do not reliably receive necessary and evidence-based care;
- routinely receive unwanted care and treatment when we don’t know what matters to;
- are needlessly harmed by inappropriate medications;
- are vulnerable to falls when we don’t encourage mobility;
- experience avoidable delirium and cognitive decline.
Population of older adults is growing
Population Growth by Age Group 2010-2040

Source: SEMCOG 2040 Forecast

Counties Included in Data Set:
- Livingston
- Macomb
- Monroe
- Oakland
- Washtenaw
- Wayne
Where we are today

- We have lots of evidence-based geriatric-care models of care that have proven very effective

- Yet, most reach only a portion of those who could benefit
  - Difficult to disseminate and scale
  - Difficult to reproduce in settings with less resources
  - Most don’t translate across care settings

- 4m of 46m
The know-do gap

What we know

What we do

Yesterday

Today

Tomorrow
Case for change

- Make a sustainable business case for age-friendly care
- Reduce costs associated with poor quality care
  - Reduce harm that results in penalties and/or use of higher level of care settings, longer inpatient LOS, ED visits, readmissions to inpatient settings
  - Improve care transitions, discharge planning, and care coordination
  - Reduce risk of malpractice claims
  - Increase consistent use of underused, evidence-based services and practices
  - Reduce over-utilization of unwanted care
  - Optimize site of care (shift care to lower cost care settings)
- Increase utilization of cost-effective services
  - Increase staff productivity and decrease turnover
  - Increase bed capacity
  - Improve reputation as an AFHS to attract patients
- Enhance revenue and market share
Ascension’s Commitment

One Ascension culture: Basis for all strategic efforts

• This visual model represents the One Ascension culture and aspirations serving as an anchor to define our values, and an activator to inspire purposeful behavior of leaders, providers and associates.
Roadmap for a movement

Planning for Scale: A Guide for Designing Large-Scale Improvement Initiatives

- Will for change
- Aim & Purpose
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What is our aim?

The John A. Hartford Foundation and IHI have adopted the bold and important aim of establishing Age-Friendly Care in 20 percent of US hospitals and health systems by 2020.

An Age-Friendly Health system is one where every older adult:

• Gets the best care possible;
• Experiences no healthcare-related harms; and
• Is satisfied with the health care they receive.
Roadmap for a movement

- Will for change
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Planning for Scale: A Guide for Designing Large-Scale Improvement Initiatives
Deriving the evidence-based interventions

- Reviewed 17 evidence-based models and programs serving older adults:
  - What population is served?
  - What outcomes were achieved?
  - What are the core features of the model?
July – August 2016

- 90 discrete core features identified by model experts in pre-work
- Redundant/similar concepts removed and 13 core features synthesized by IHI team
- Expert Meeting led to the selection of the “vital few”: the 4Ms
The 4 M’s

- **What Matters**: Knowing and acting on each patient’s specific health goals and care preferences
- **Medication**: Optimizing medication use to reduce harm and burden, focused on medications affecting mobility, mentation, and what matters
- **Mentation**: Identifying and managing depression, dementia and delirium across care settings
- **Mobility**: Maintaining mobility and function and preventing complications of immobility
Why the 4 Ms?

• Provides feasible framework for implementation and measurement
• Represents core health issues for older adults
• Builds on strong evidence base
• Synergistic relationships → simplify & reduce burden of implementation while increasing effect
Evidence-base

• What Matters:
  – Older adults vary in their health goals & care preferences (Fried,
  – Asking & addressing what matters lowers inpatient utilization (54%), ICU stays (80%), while increasing hospice use (47%) and pt satisfaction (AHRQ 2013)

• Medications:
  – Multiple medications increases adverse events & burden
  – Older adults receive many medications that are potentially harmful & of little benefit (Hill-Taylor)
  – 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)
Evidence-base

• Mentation:
  – Dementia, delirium, and depression often unrecognized & untreated; associated with increased morbidity, mortality, and costs
  – Delirium preventable (Inouye)
  – 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:
  – Cost-effective interventions for mobility & fall prevention (Stubbs)
  – 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)

References at end of slides
Reciprocal / synergistic relationships among the 4Ms

MATTERS MOST

Mentation  ↔  Mobility (function)

Medications
(Same medications adversely affect)
# 4Ms, high level interventions and implementation actions

<table>
<thead>
<tr>
<th>What Matters</th>
<th>High-level Interventions</th>
<th>Implementation Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Know what matters: health outcome goals and care preferences for current and future care, including end of life</td>
<td>Developed with the health systems teams.</td>
</tr>
<tr>
<td>2</td>
<td>Act on what matters for current and future care, including end of life</td>
<td>Teams can select from our ideas or identify their own ideas for reliable implementation.</td>
</tr>
<tr>
<td>Mobility</td>
<td>3 Implement an individualized mobility plan</td>
<td>We will learn from one another and share generously.</td>
</tr>
<tr>
<td>4 Create an environment that enables mobility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medications</td>
<td>5 Implement standard process for age-friendly medication reconciliation</td>
<td></td>
</tr>
<tr>
<td>6 De-prescribe and adjust doses to be age-friendly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mentation</td>
<td>7 Ensure adequate nutrition &amp; hydration, sleep and comfort</td>
<td></td>
</tr>
<tr>
<td>8 Engage and orient to maximize independence and dignity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Identify, treat, and manage dementia, delirium, and depression</td>
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</tbody>
</table>
Roadmap for a movement

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Planning for Scale: A Guide for Designing Large-Scale Improvement Initiatives
Model for improvement

1. What are we trying to accomplish?
2. How will we know that the change is an improvement?
3. What changes can we make that will result in improvement?

Plan → Do → Study → Act → Plan → Do → Study → Act → ...
Roadmap for a movement

• Will for change
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Design to Achieve National Scale

Stage 0:
Activity: Literature review & Expert meeting
Output: Age Friendly Prototype

Stage 1:
Activity: Testing the Prototype for refinement (3/17 – 2/18)
Output: Age Friendly Model & Scale-up Guidance

Stage 1:
Activity: Prototype testing with five systems & scaling within those five
Output: Age Friendly Model & Scale-up Guidance

Stage 2 Scale-Up
Activity: Campaign spreads to 1000+ care sites
Output: 1000+ Age Friendly Health Systems with evidence of improved outcomes for older adults

Scaling up the Prototype in the five prototyping systems (1/18 – 12/18)
Where are we now? By the numbers…

- 5 systems actively testing across 26 sites (primary care, PACE, outpt hospice, SNF, inpatient acute, rehab, CCRC, senior ED) in 8 states
- 17 Advisory Group members (chaired by Mary Tinetti & Ann Hendrich)
- 9 expert geriatric faculty – the leaders of the field
- 60+ active tests executing now of age-friendly
- 214 members of AFHS list-servs (US and abroad)
- “Thousands” of lives improved…our most recent estimate was over 3500 in early testing
Your turn, Your health system

• Case for being an Age-Friendly Healthy System
  – Review the case for becoming an Age-Friendly Health System (handout)
  – Note the steps needed to complete the case for your health system

• Progress on journey towards being Age-Friendly
  – Review the journey to becoming Age-Friendly (handout)
  – Note on the handout where your health system is on this journey
  – Enter your progress on-line using the computer on the podium
  – Identify your next steps to progressing along the journey and what you will do by next Tuesday (handout)

• We will reconvene in 20 minutes for reflection and question and answer
What can we do by next Tuesday?
Break: Which of the 4Ms will you enjoy?

Want to play a brain game?
Say the color you see not the word that is written as fast as you can. Ready... go!

BLUE
GREEN
BROWN
RED
GREY
WHITE
BLACK
PINK
YELLOW
TAN
PURPLE
ORANGE

TEST YOUR BRAIN
natgeotv.com.au/brain
The 4 M’s

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Practical ideas for increasing hydration

73% increase
Knowing and acting on What Matters

MY STORY: Chet Gebarowski

Reduced falls by 18%
What Matters

Your Conversation Starter Kit

When it comes to end-of-life care, talking matters.

The end of life for many Americans is riddled with gaps and contradictions. According to the Centers for Disease Control and Prevention, 70 percent of Americans want to die at home, yet the same percentage die in institutional settings. Advance directives are starting to catch on, but a study by the Agency for Healthcare Research and Quality finds that only 12 percent of patients with an advance directive have discussed it with their health care providers.

Ready initiative, IHI is working with 10 pioneer organizations to test changes that will help organizations move toward this ambitious goal. While the conversation-ready principles are still evolving, there is early convergence on some key elements.

First, organizations need to elicit and capture information about what matters to patients and their families about end-of-life wishes. This information
Reduce Length of Stay; Go home not rehab
Your turn, Your health system

• Starting a testing plan for your health system
  – Identify a 3 – 5 tests of change you could run that would impact the 4Ms (handout)
  – Map out the step you need to take by next Tuesday to start two of the tests (handout)

• We will reconvene in 30 minutes for reflection and question and answer
What can we do by next Tuesday?
Offering of our lessons learned

• Work from both ends
  – Identify how becoming an Age-Friendly Health System aligns with your health system’s strategic plan
  – Find a nurse, a physician who wants to try out an Age-Friendly intervention
• Capture the stories
  – Our work is about people and stories move people
• Capture the evidence
  – Count the people your intervention reaches and its improvements
• Find out where and who and what is your health system doing improve health of adults. Join your Age-Friendly testing with it rather than competing.
• Learn about your health system’s strategic priorities; Which ones are aligned with Age-Friendly care?
• Have authentic conversations with staff and providers. What is their experience working with older adults? What has moved them? What is important to your colleagues? Find ways for Age-Friendly testing to advance what is important to your colleagues
• Try small tests of change
• Complete the baseline system
• Identify other successes your health system has had putting reliable care into place and learn how it got started
A call to action

• Who among you will go back and have a discussion with a senior leader about a good idea you can organize around even in this fiscal year?
Please join us

By 2020, we will reach older adults cared for in 20% of US health care facilities.

If we learn and share with each other.

Please be in touch with the IHI team:

Leslie Pelton: lpelton@ihi.org
Creating Age-Friendly Health Systems

ML15: 10,000 People Turn 65 Every Day: Is Your Health System Age-Friendly?
How can you improve your health system’s the business case for becoming an Age-Friendly Health System?

1. Reduce costs associated with poor quality care
   - Reduce harm that results in penalties and/or use of higher level of care settings, longer inpatient LOS, ED visits, readmissions to inpatient settings
   - Improve care transitions, discharge planning, and care coordination
   - Reduce risk of malpractice claims
   - Increase consistent use of underused, evidence-based services and practices
   - Reduce over-utilization of unwanted care
   - Optimize site of care (shift care to lower cost care settings)
   - Increase staff productivity and decrease turnover
   - Increase bed capacity
   - Improve reputation as an AFHS to attract patients

2. Increase utilization of cost-effective services

3. Enhance revenue and market share

The John A. Hartford Foundation
Dedicated to Improving the Care of Older Adults
## Change package v8.0 – All settings of care

<table>
<thead>
<tr>
<th>Treat older adults in accordance with their preferences (Matters)</th>
<th>Understands the importance but we do not yet address it with our older adult patients</th>
<th>Addresses with some older adult patients, in some care settings</th>
<th>Addresses with most older adult patients, in most care settings</th>
<th>Addresses with all older adult patients, in all care settings</th>
</tr>
</thead>
</table>
| • Know the preferences of older adults  
• Act on the preferences of older adults |  |  |  |  |

<table>
<thead>
<tr>
<th>Use medications that facilitate mentation and mobility (Medication)</th>
<th></th>
<th></th>
<th></th>
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</thead>
</table>
| • If medications are necessary, select medications that do not harm  
• If you identify use of medications that harm mentation and mobility, deprescribe them |  |  |  |  |

<table>
<thead>
<tr>
<th>Treat depression and dementia (in Ambulatory settings) (Mentation)</th>
<th></th>
<th></th>
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</thead>
</table>
| • Know if an older adult is depressed  
• Treat depression  
• Know if an older adult has dementia  
• Keep older adults with dementia safe |  |  |  |  |

<table>
<thead>
<tr>
<th>Treat underlying causes of delirium (in Ambulatory and Inpatient settings) (Mentation)</th>
<th></th>
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</thead>
</table>
| • Know if an older adult is delirious  
• Treat underlying causes of older adults’ delirium |  |  |  |  |

<table>
<thead>
<tr>
<th>Make sure older adults move every day (Mobility)</th>
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</table>
| • Set a daily mobility goal  
• Achieve mobility goal |  |  |  |  |
What can you do by next Tuesday to progress your health system on its journey to becoming Age-Friendly?

<table>
<thead>
<tr>
<th>Aim statement (Measurable, 90 day goal of your team)</th>
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<tr>
<th>Is your team confident you can achieve the 90 day aim?</th>
<th>Yes</th>
<th>Maybe</th>
<th>No</th>
</tr>
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<tr>
<th>How does your team feel about its ability to overcome barriers?</th>
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<tr>
<th>What are three significant tasks you will complete over the past month? Please describe how they advanced progress towards your 90 day aim.</th>
<th>1.</th>
<th>2.</th>
<th>3.</th>
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<tr>
<th>PDSA you will run on Tuesday to try (A PDSA is when you try out a change idea with one patient or one provider, etc.).</th>
<th>PDSA: Prediction</th>
<th>PDSA: What did you do? How did it go?</th>
<th>PDSA: What did you learn? How does it compare to your prediction?</th>
<th>PDSA: Next Actions or PDSA</th>
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1.

2.
More on Creating Age-Friendly Health Systems and the Model for Improvement

- **Age-Friendly Health Systems at IHI.org**
- Join *Friends of Age-Friendly Health Systems* quarterly calls
- The **How to Improve section** on IHI.org describes the Model for Improvement and PDSA cycles.
- **QI 102: The Model for Improvement** is a 90-minute IHI Open School free online course that takes learners through the basic principles of quality improvement.
- A series of "whiteboard" videos feature key improvement methods.