



Hospital Elder Life Program Special Interest Group: HELP and Age-Friendly Hospitals

Gerontological Society of America (GSA) Annual
Scientific Meeting

*October 21, 2020
1-2pm ET*



Welcome and Agenda



- **Keynote Speaker – Donna Fick, RN, PhD, FAAN**

Elouise Ross Eberly Professor, Director of the Center of Geriatric Nursing Excellence, Pennsylvania State University

Age-Friendly hospital system and Two-Item Ultra Brief (UB-2) delirium screening tool

- **Speaker – Molly Anderson**

Manager, Geriatrics Programs, Maine Medical Center

Site 1 – HELP and Age-Friendly hospital initiative

- **Speaker – Miriam Beattie, DNP, GNP, ANP**

Elder Life Nurse Specialist, University of Utah Hospital

Site 2 – HELP and Age-Friendly hospital initiative

- **Panel Discussion** with HELP Sites with Age-Friendly Initiatives

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A MULTICOMPONENT INTERVENTION TO PREVENT DELIRIUM IN HOSPITALIZED OLDER PATIENTS

SHARON K. INOUE, M.D., M.P.H., SIDNEY T. BOGARDUS, JR., M.D., PETER A. CHARPENTIER, M.P.H.,
LINDA LEO-SUMMERS, M.P.H., DENISE ACAMPORA, M.P.H., THEODORE R. HOLFORD, PH.D., AND LEO M. COONEY, JR., M.D.

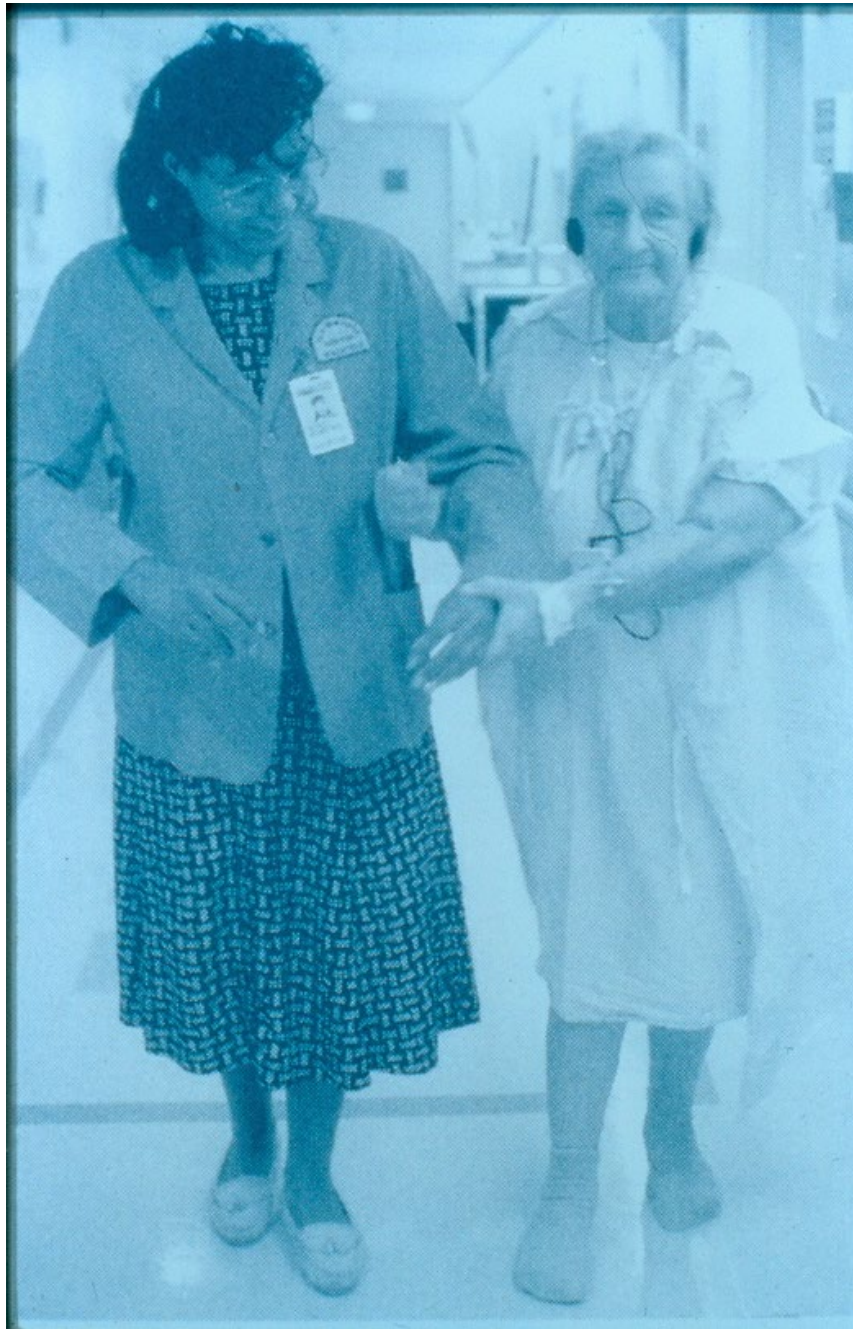
NONPHARMACOLOGIC DELIRIUM PREVENTION: HOSPITAL ELDER LIFE PROGRAM (HELP)

Multicomponent intervention strategy targeted at 6 delirium risk factors

<u>Risk Factor</u>	<u>Intervention</u>
Cognitive Impairment.....	Reality orientation Therapeutic activities protocol
Sleep Deprivation.....	Nonpharmacological sleep protocol Sleep enhancement protocol
Immobilization.....	Early mobilization protocol Minimizing immobilizing equipment
Vision Impairment.....	Vision aids Adaptive equipment
Hearing Impairment.....	Amplifying devices Adaptive equipment and techniques
Dehydration.....	Early recognition and volume repletion

Inouye SK. N Engl J Med 1999;340:669-76.

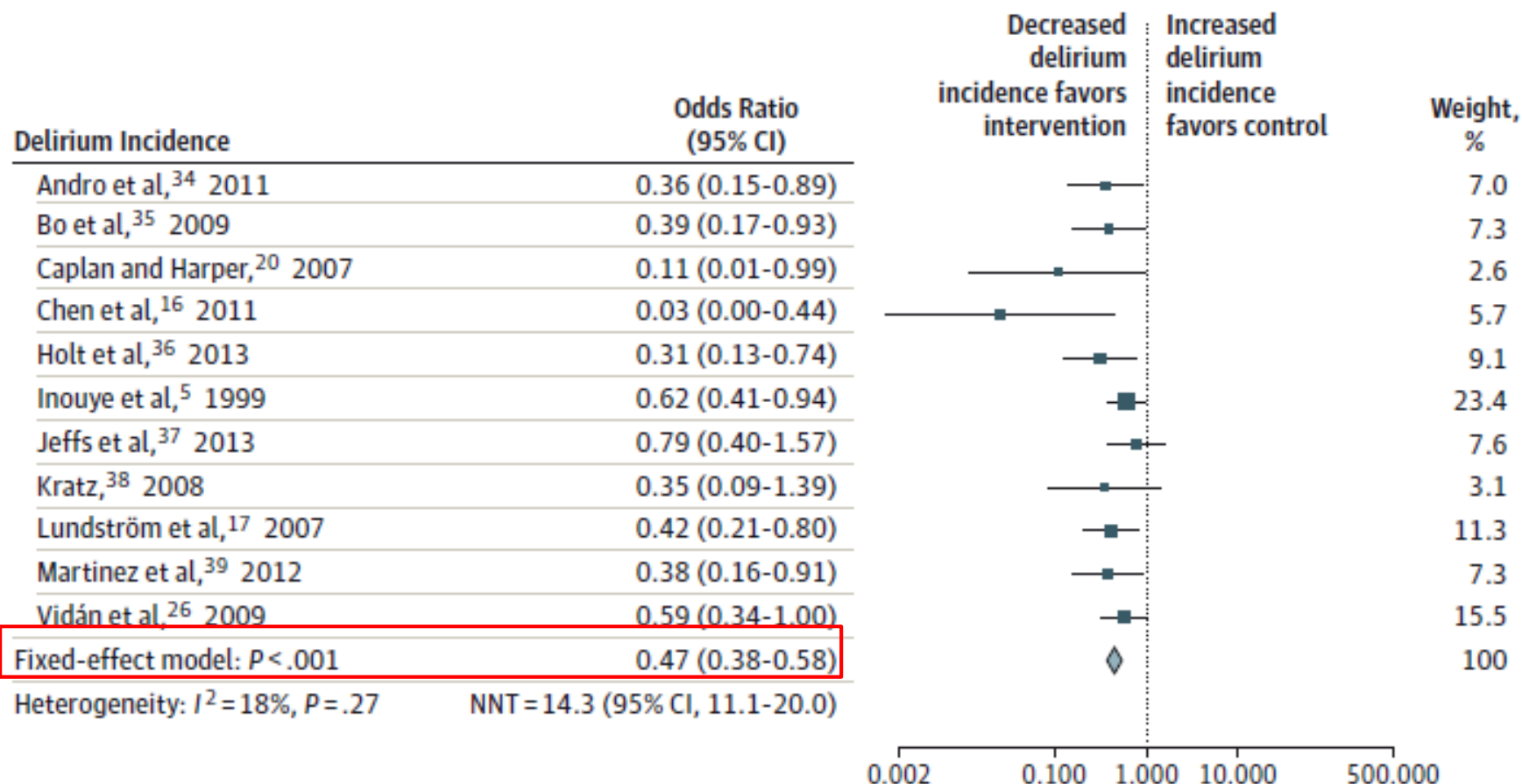






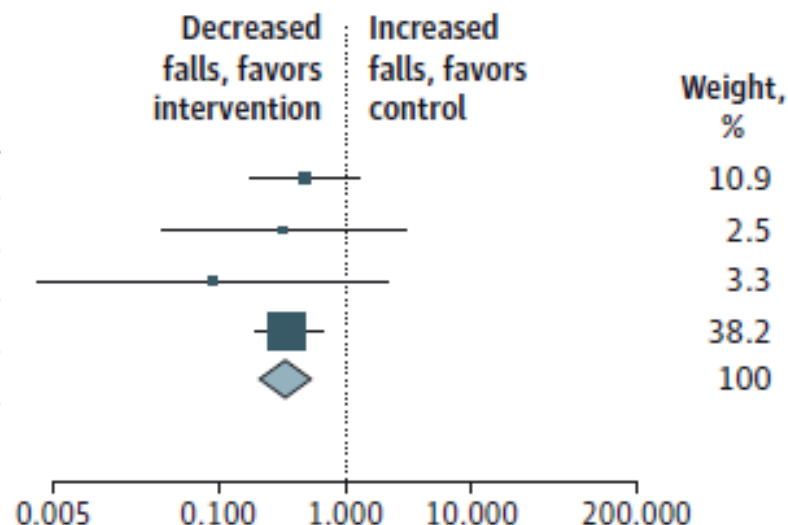


Results: Delirium Incidence (N=3,751)



Results: Falls and Other Outcomes (N=1,038)

Falls	Odds Ratio (95% CI)
Babine et al, ¹⁴ 2013	0.49 (0.19-1.27)
Caplan and Harper, ²⁰ 2007	0.33 (0.04-2.93)
Martinez et al, ³⁹ 2012	0.11 (0.01-2.05)
Stenvall et al, ¹⁸ 2007	0.38 (0.23-0.65)
Fixed-effect model: $P < .001$	0.38 (0.25-0.60)
Heterogeneity: $I^2 = 0\%$, $P = .78$	



- Prevention of cognitive and functional decline
- Decreased hospital length of stay
- Reduced nursing home placement
- Fewer readmissions within 90 days
- Decreased sitter use
- Cost savings of >\$1000 per hospitalization; \$10,000 in long-term nursing home costs



PennState
College of Nursing



How to Incorporate Age-Friendly 4Ms into Care: Delirium Screening & Best Practices

Donna Fick, PhD, GCNS-BC, FGSA, FAAN



Elouise Ross Eberly Professor
Penn State College of Nursing
Director, Center for Geriatric
Nursing Excellence

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**First, I
would like
to tell you
a story**

– Juanita



The 4Ms Framework – Every Older Adult

Age-Friendly care is the reliable implementation of a set of evidence-based geriatric best practice interventions across four core elements, known as the 4Ms, to all older adults in your system. **EVERY** older adult, **EVERY** encounter.

4Ms	
What <u>M</u> atters	Aligns care with the older adults' specific health outcome goals and care preferences, including, but not limited to end-of-life care
<u>M</u> edication	Deprescribe or avoid high-risk medications and if necessary, use age-friendly medications that do not interfere with What Matters to the older adult, mobility, or mentation
<u>M</u> entation	Prevent, identify, treat and manage dementia, depression and delirium
<u>M</u> obility	Ensure that older adults move safely every day in order to maintain function and do What Matters. SETTING DAILY MOBILITY/ACTIVITY GOALS WITH OLDER ADULTS.

Age-Friendly Health System Recognition



- Teams have electronically submitted a **completed 4Ms Description**, which operationally defines how the 4Ms will be practiced in their setting.
 - **Note:** some teams receive a notification they are a Participant, but that 1 or more updates to their Description are required to be aligned with the Guide to 4Ms.
- SEE THE LINK TO JOIN AT THE END OF THIS PRESENTATION & RESOURCES
<http://www.ihl.org/AgeFriendly>
- A teams' 4Ms Descriptions is approved for alignment with the Guide to 4Ms.
- Teams have shared at least 3 months counts of encounters with older adults that included all 4Ms.

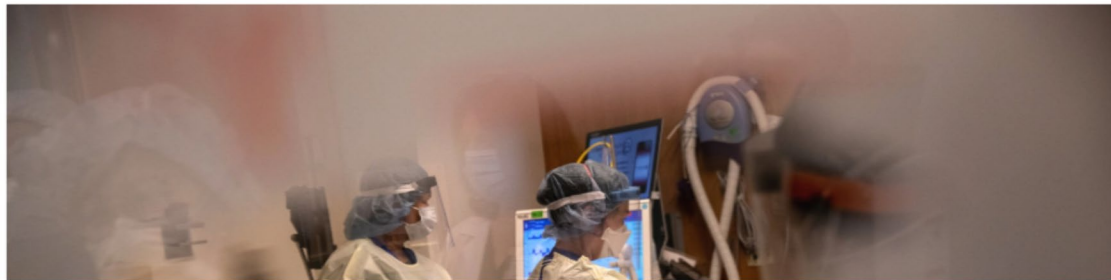
The Epidemic Within the Pandemic: Delirium

Delirium is leaving many older patients more vulnerable. They need caregivers, despite no-visitor rules.

By Sharon K. Inouye

Dr. Inouye is a geriatrician and founder of the Hospital Elder Life Program.

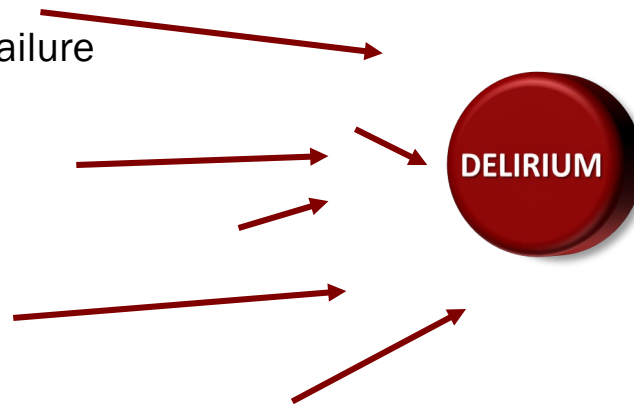
May 10, 2020, 11:00 a.m. ET



“THINK DELIRIUM”/Assess Delirium

ATYPICAL PRESENTATIONS in older adults & PWD and IDD

- Pneumonia
- MI/Congestive Heart failure
- **COVID-19**
- Infection/SEPSIS
- Depression
- Adverse Drug reaction
- Dehydration
- DELIRIUM MEASURES NIDUS



<https://deliriumnetwork.org/measurement/delirium-info-cards/>

4 Key Features of Delirium Measured by the **C**onfusion **A**ssessment **M**ethod (CAM)

POSITIVE =
Features 1 & 2,
and **either** 3 or 4

1) Acute onset and/or fluctuating course

2) Inattention

3) Disorganized thinking

4) Altered level of consciousness

Should be performed AFTER cognitive testing

[Inouye et al., 1990]

UB-CAM: Ultra-Brief CAM

- Derived from the 3D-CAM
- Start with UB-2—if negative, assessment is complete, no delirium
- If UB-2 “positive”, continue with 3D-CAM
 - Employ skip pattern—if any item is “positive”, CAM feature is positive, skip rest of feature items
- Simulation studies: Sensitivity 93%, Specificity 95%, Administration time: 1 min, 14 secs
- Example of “adaptive testing”
 - Developed an iOS App to facilitate use

Motyl et. al, J Am Geriatr Soc, 2020

- Nursing assistants do the UB-2 with over 90% sensitivity!
- ANY TOOL YOU USE TRAINING SESSIONS AND ANNUAL COMPETENCIES FOR STAFF ARE CRITICAL TO GET THE BEST RESULTS!

2-ITEM ULTRA-BRIEF (UB-2) DELIRIUM SCREEN Quick Guide ©

POSITION Try to sit at eye level
SENSORY Be sure sensory aides (glasses, hearing) are in place
WORDING Please read the script exactly as written

1: Please tell me the day of the week

The participant can check anywhere (e.g., white board, newspaper, etc.), but cannot ask anyone else in the room.

2: Please tell me the months of the year backward, say December as your first month

MISSED MONTH If participant finished reciting months but missed one or more, it is incorrect and no prompting is allowed.

STUCK Prompt only with: "what month comes before _____ (last month they said)?"

 Prompt up to two times; if after 2 prompts participant is frustrated, confused, or taking a long time, mark it incorrect and offer them an exit such as, "that's a tough one, you're doing well... let's try the next question."

WRONG TYPE OF ANSWER If the participant begins at November, starts forward, or begins spelling, assume they don't understand the question and re-read the instructions **once**. If the participant is incorrect again, mark it as incorrect but let them finish.

If incorrect on either question, use an additional screening tool to further assess, such as the CAM or 3D-CAM <https://www.hospitalelderlifeprogram.org/request-access/delirium-instruments/>

Inquiries to: Donna Fick dmf21@psu.edu.
 (Please cite Fick et al, Journal of Hospital Medicine, 2015)

93-96% Sensitivity to pick up delirium but lower specificity-so if they fail it you need to follow up another CAM-based tool like the UB-CAM

<https://deliriumnetwork.org/ub-cam/>

If they pass it document their strengths!

Free training video and cards here:

www.nursing.psu.edu/readi

Sensitivity & Specificity (Fick et al., 2018)

	2 Item Ultra-Brief Screener		2-Step Delirium Identification Protocol	
Clinician Type	Sensitivity	Specificity	Sensitivity	Specificity
Physicians (n=7)	80%	56%	80%	78%
Nurses (n=13)	100%	67%	100%	89%
CNA's (n=7)	100%	61%	N/A	N/A

UB-CAM
takes less
than a
minute
combines
UB-2 and
3D-CAM >
90%
sens/spec

**LINK to
UB-CAM**
<https://deliriumnetwork.org/the-ultra-brief-confusion-assessment-method-ub-cam/>

Ultra-Brief CAM [UB-CAM] UB-2/3D-CAM	
Instructions: Administer items in order specified. Direct questions of patients are <i>shown in italics</i> . • A positive sign for delirium is any incorrect, don't know, non-response, or non-sensical response. • CAM features 1-4 are indicated with F1, F2, F3, F4, respectively.	
Severe lethargy or severe altered level of consciousness	
1 Severe lethargy or severe altered level of consciousness (no or minimal response to voice/touch). If present, terminate assessment and ratings. Patient is considered DELIRIOUS. If not present, proceed to UB-2 Screener.	Check ☐
UB-2 Screener	
2 Ask both questions	Check if positive
<i>Please tell me the day of the week (F3)</i>	☐
<i>Please tell me months of the year backwards, say "December" as your first month (F2)</i>	☐
Checkpoint: - If neither sign is positive/checked, STOP: patient is NOT DELIRIOUS - If at least one sign is positive/checked, proceed to next section (3) and follow as directed	
3D-CAM Algorithm: Part 1 - Patient Assessment	
3 Assess Disorganized Thinking (Feature 3/F3). Stop, and go to Section 4, after the first positive sign (error) of Disorganized Thinking. Carry-forward errors from the UB2 Screener: Carry forward: Was the patient unable to correctly identify the day of the week? (F3, UB2) <i>Please tell me the year we are in right now (F3)</i> <i>Please tell me what type of place is this [hospital, rehab, home, etc.] (F3)</i>	Check if sign positive ☐ ☐ ☐
4 Assess Attention (Feature 2/F2). Stop, and go to Section 5, after the first positive sign (error) of Inattention. Carry-forward errors from the UB2 Screener: Carry forward: Was the patient unable to correctly name the months of the year backwards (UB2) <i>Please tell me the days of the week backwards, say "Saturday" as your first day(F2)</i> <i>Repeat these numbers in backwards order: "7-5-1" (F2)</i> <i>Repeat these numbers in backwards order: "8-2-4-3" (F2)</i>	Check if sign positive ☐ ☐ ☐ ☐
5 Assess Acute change or Fluctuation (Feature 1/F1). Stop, and go to Section 6, after the first positive sign of Acute Change is noted: <i>Over the past day have you felt confused? (F1)</i> <i>Over the past day did you think that you were not really in the hospital [or location of interview]? (F1)</i> <i>Over the past day did you see things that were not really there? (F1)</i>	Check if sign positive ☐ ☐ ☐

Research Brief

Pilot Study of a Two-Step Delirium Detection Protocol Administered By Certified Nursing Assistants, Physicians, and Registered Nurses

Donna M. Fick, PhD, RN, FAAN; Sharon K. Inouye, MD, MPH; Caroline McDermott, RN; Wenxiao Zhou, MSc; Long Ngo, PhD; Jackie Gallagher, MS; Jane McDowell, CRNP[†]; Janice Penrod, PhD, RN, FAAN; Jonathan Siuta, MD; Thomas Covalleski, MD; and Edward R. Marcantonio, MD, SM

CLINICAL INVESTIGATION

Comparative Accuracy and Efficiency of Four Delirium Screening Protocols

Claire M. Motyl, BA,^{*,} Long Ngo, PhD,^{†,‡} Wenxiao Zhou, MSc,[†] Yoojin Jung, PhD,[†] Douglas Leslie, PhD,[§] Marie Boltz, GNP-BC, PhD,[¶] Erica Husser, PhD,[¶] Sharon K. Inouye, MD, MPH, AGSF,^{‡§**} Donna Fick, RN, PhD,^{§†} and Edward R. Marcantonio, MD, MSc^{†,‡**}

JAMDA 20 (2019) 1391–1396



JAMDA

journal homepage: www.jamda.com



Original Study

Ultra-brief Screeners for Detecting Delirium Superimposed on Dementia

Erika Steensma BS,^a Wenxiao Zhou MSc,^b Long Ngo PhD^{b,c}, Jacqueline Gallagher MS^b, Sharon Inouye MD, MPH^{c,d,e}, Douglas Leslie PhD^f, Marie Boltz RN, PhD^g, Ann Kolanowski RN, PhD^h, Lorraine Mion RN, PhD^h, Edward R. Marcantonio MD, SM^{b,c,d,e,*}, Donna Fick RN, PhD^g

^a University of Michigan Medical School, Ann Arbor, MI

^b Division of General Medicine, Beth Israel Deaconess Medical Center, Boston, MA

^c Harvard Medical School, Boston, MA

^d Aging Brain Center, Institute for Aging Research, Hebrew SeniorLife, Boston, MA

^e Division of Gerontology, Beth Israel Deaconess Medical Center, Boston, MA

^f College of Medicine, Pennsylvania State University, Hershey, PA

^g College of Nursing, College of Medicine, Penn State University, University Park, PA

^h College of Nursing, Ohio State University, Columbus, OH



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www.journalofhospitalmedicine.com

ORIGINAL RESEARCH

Preliminary Development of an Ultrabrief Two-Item Bedside Test for Delirium

Donna M. Fick, PhD^{1,2*}, Sharon K. Inouye, MD, MPH^{2,3,4}, Jamey Guess, MS⁴, Long H. Ngo, PhD⁴, Richard N. Jones, ScD^{4,5}, Jane S. Saczynski, PhD^{6,7}, Edward R. Marcantonio, MD, SM^{2,4,8}

¹College of Nursing, College of Medicine, Department of Psychiatry, Penn State University, University Park, Pennsylvania; ²Aging Brain Center, Institute for Aging Research, Hebrew SeniorLife, Harvard Medical School, Boston, Massachusetts; ³Division of Gerontology, Department of Medicine, Beth Israel Deaconess Medical Center, Harvard Medical School, Boston, Massachusetts; ⁴Division of General Medicine and Primary Care, Department of Medicine, Beth Israel Deaconess Medical Center, Harvard Medical School, Boston, Massachusetts; ⁵Department of Psychiatry and Human Behavior, Warren Alpert Medical School, Brown University, Providence, Rhode Island; ⁶Departments of Medicine and Quantitative Health Sciences, University of Massachusetts Medical School, Worcester, Massachusetts.

DO THIS TO PREVENT DELIRIUM

PREVENTION IS MORE EFFECTIVE THAN TREATMENT

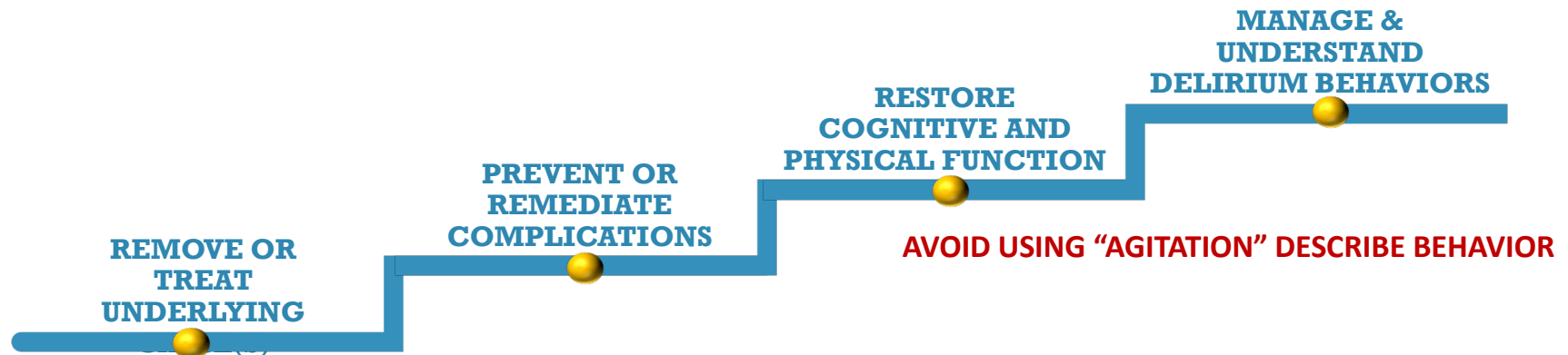
JAMA 2015 review 11/14 studies and 62% falls reduct.

Table 4. Multicomponent Nonpharmacologic Approaches to Delirium Prevention Esther Oh et al., 2017 JAMA

Approach	Description
Orientation and therapeutic activities	Provide lighting, signs, calendars, clocks Reorient the patient to time, place, person, your role Introduce cognitively stimulating activities (eg, reminiscing) Facilitate regular visits from family, friends
Fluid repletion	Encourage patients to drink; consider parenteral fluids if necessary Seek advice regarding fluid balance in patients with comorbidities (heart failure, renal disease)
Early mobilization	Encourage early postoperative mobilization, regular ambulation Keep walking aids (canes, walkers) nearby at all times Encourage all patients to engage in active, range-of-motion exercises
Feeding assistance	Follow general nutrition guidelines and seek advice from dietician as needed Ensure proper fit of dentures
Vision and hearing	Resolve reversible cause of the impairment Ensure working hearing and visual aids are available and used by patients who need them
Sleep enhancement	Avoid medical or nursing procedures during sleep if possible Schedule medications to avoid disturbing sleep Reduce noise at night
Infection prevention	Look for and treat infections Avoid unnecessary catheterization Implement infection-control procedures
Pain management	Assess for pain, especially in patients with communication difficulties Begin and monitor pain management in patients with known or suspected pain
Hypoxia protocol	Assess for hypoxia and oxygen saturation
Psychoactive medication protocol	Review medication list for both types and number of medications

We MUST use best practices for PWD & Delirium

(anti-psychotic use has increased in COVID-19)



All behavior has meaning, do NOT treat with drugs, use non-pharmacological person-centered approach **ALIGN WITH GOALS OF CARE AND 4Ms MODEL**. Delirium is common in persons with dementia (see try this DSD Fick & Mion, 2018)

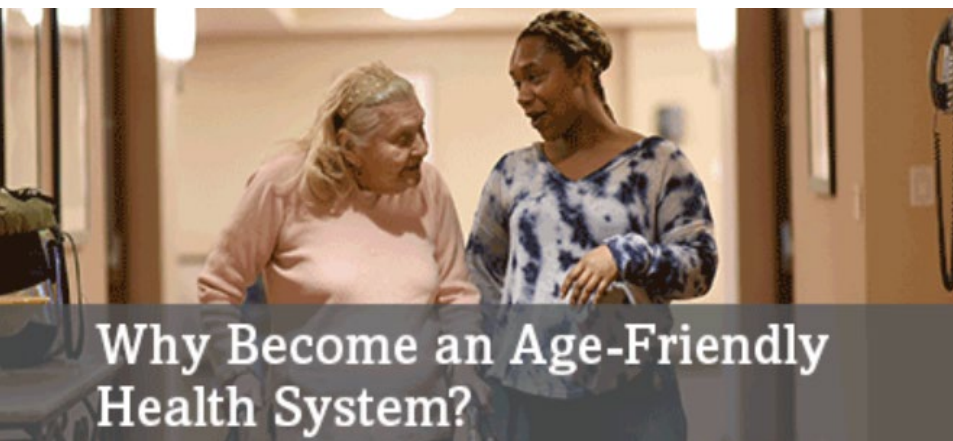
KNOW YOUR RIGHTS IN THE HOSPITAL

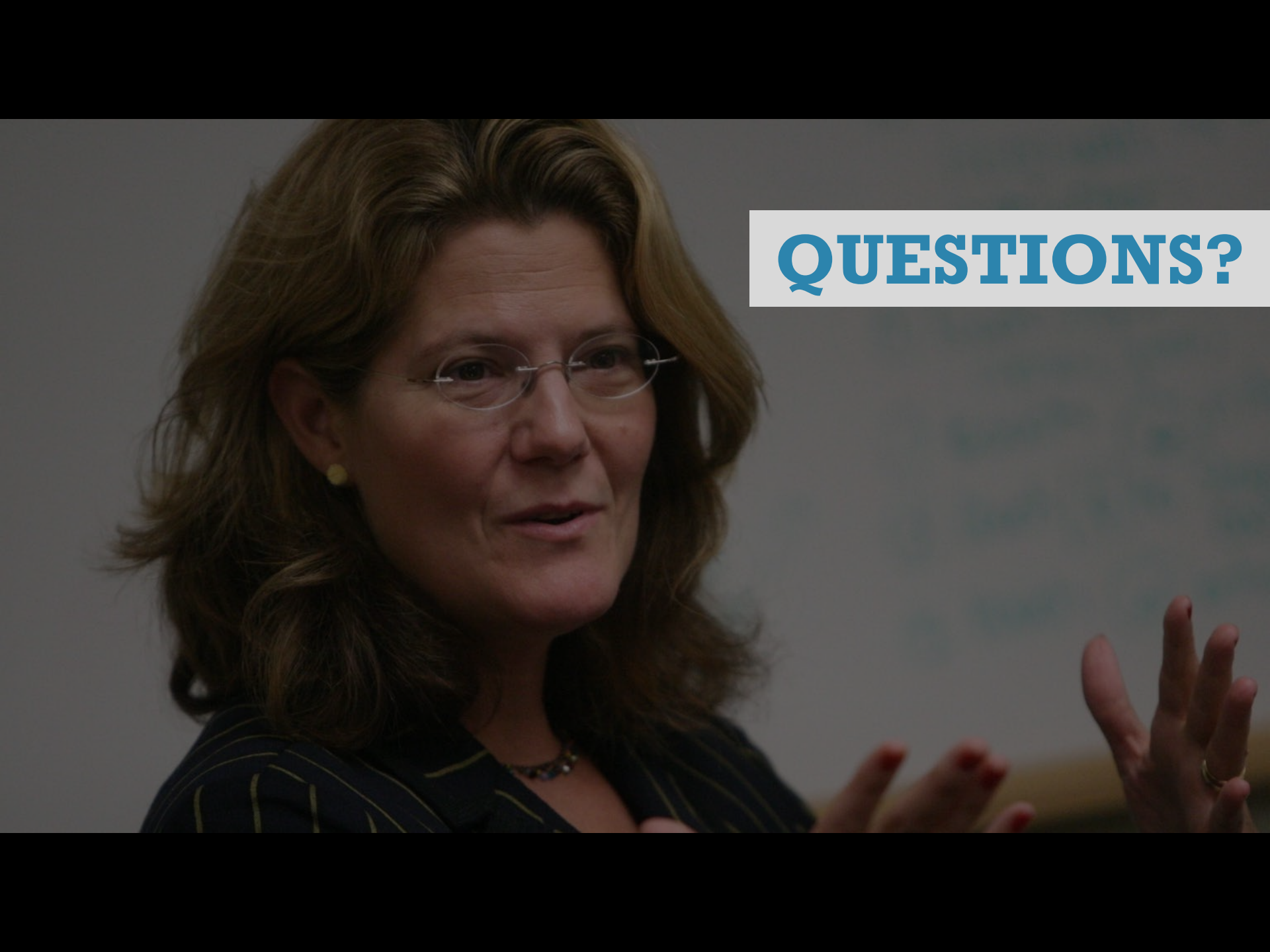
Persons with disabilities **CAN** have a support person at the bedside during COVID-19

- The supporter is essential and a “reasonable accommodation” to help communicate, make decisions, feel safe, understand choices, help with personal care, safety and ADLs
- Be ready to tell the health system **WHY YOU/THEY NEED A SUPPORT PERSON** at the bedside — they are NOT visitors
- This is **YOUR RIGHT under the Americans With Disabilities Act (ADA) and Section 504** of the Rehabilitation Act must provide equal access
- Have a plan for how your supporter will be safe while in the hospital (masks, handwashing, testing if needed)
- LINK to Office of Civil Rights <https://bit.ly/35rYG2v>

Join the Age-Friendly Movement & an Action Community-2 Levels of Recognition from IHI

www.ihi.org/AgeFriendly



A woman with shoulder-length, wavy brown hair and glasses is shown from the chest up. She is wearing a dark blue shirt with thin yellow vertical stripes and a small yellow earring. Her hands are raised in a gesturing motion, with fingers spread. The background is a plain, light-colored wall.

QUESTIONS?

Participant Survey

<https://is.gd/AFCPAdemographics>

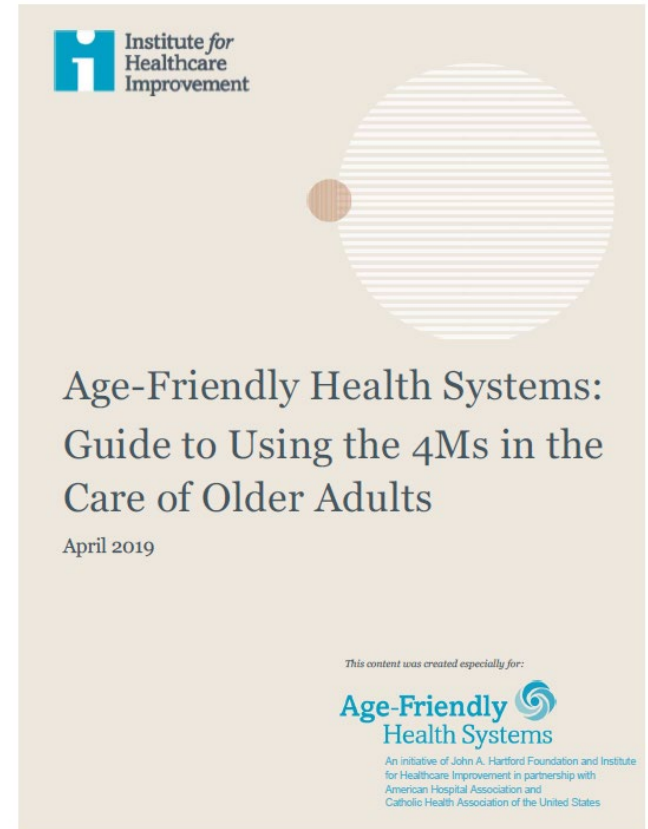
 Scan the QR Code

The survey link has been converted into a QR code, which can now be scanned by a device that has an app capable of reading QR codes. Once the QR code below is scanned, it should take the respondent directly to the survey in a web browser.



Guide to Using the 4Ms

- Posted on www.ihl.org/agefriendly
- Learn how to get started with key actions to incorporate the 4Ms into your plan of care, including:



Hyper Links for Resources

Paper – Cognitive Vital Sign of Delirium free access & tips

<https://bit.ly/3i7mTyk>

Office of Civil Rights Caregivers Essential at Bedside

<https://bit.ly/35rYG2v>

LINK to UB-CAM blog

<https://deliriumnetwork.org/the-ultra-brief-confusion-assessment-method-ub-cam/>

References and Resources

- <https://www.chausa.org/publications/health-progress/article/january-february-2020/age-friendly---providing-delirium-prevention-in-age-friendly-care>
- Eric Liotta and colleagues-confusion and neurologic manifestations of COVID-19
<https://onlinelibrary.wiley.com/doi/full/10.1002/acn3.51210>

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- Board member American Geriatrics Society
- Faculty expert IHI
- Editor, Journal of Gerontological Nursing



The Hospital Elder Life Program and Age-Friendly Health Systems

Implementing and Sustaining the 4Ms Framework

October 21, 2020

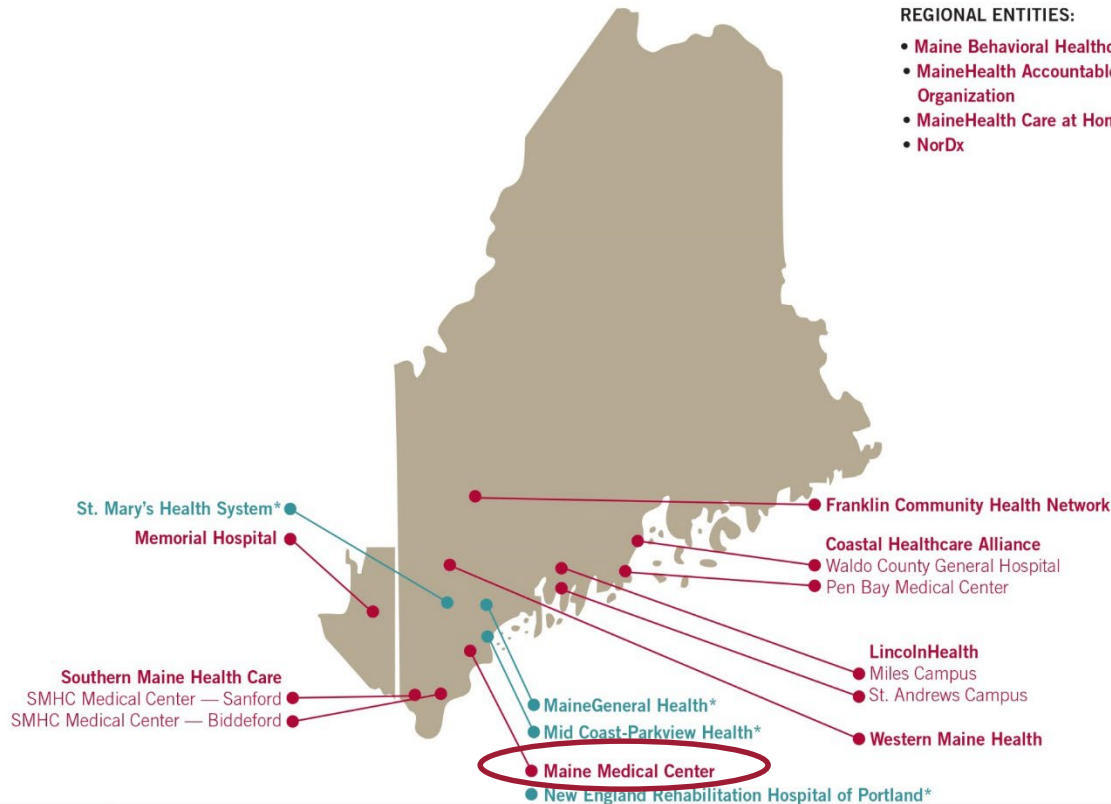


Molly Anderson, Manager, Geriatrics Programs,
Maine Medical Center



REGIONAL ENTITIES:

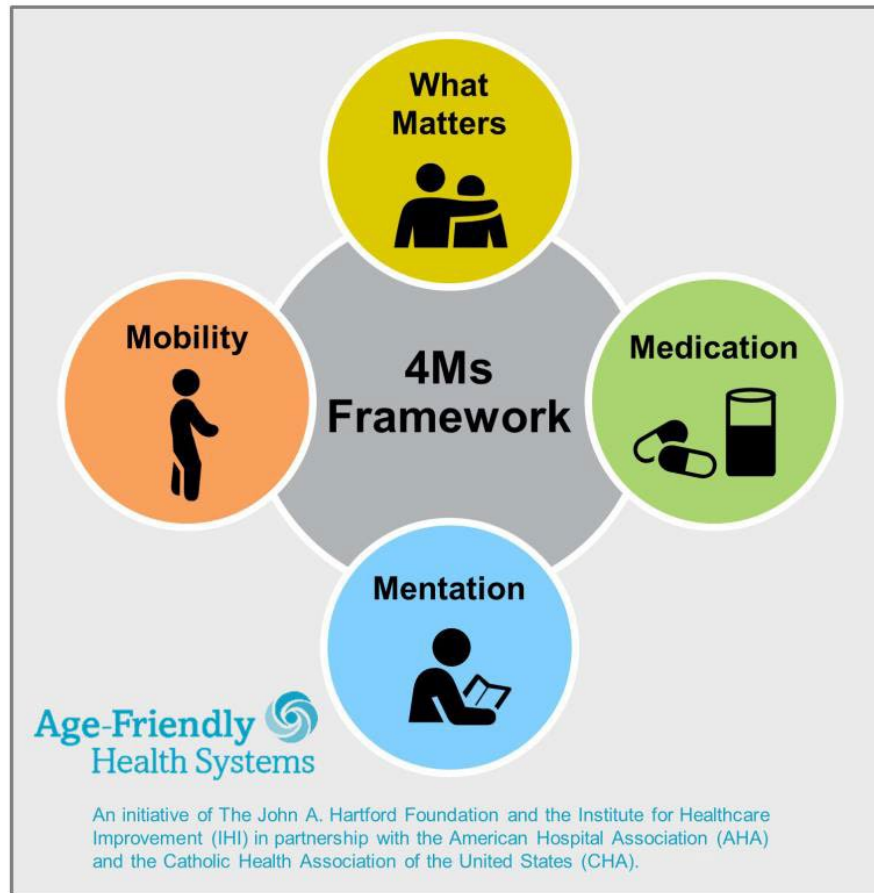
- Maine Behavioral Healthcare
- MaineHealth Accountable Care Organization
- MaineHealth Care at Home
- NorDx



Hospital Elder Life Program at Maine Medical Center

- HELP was started in 2002 and is longest running site in Maine.
- Center of Excellence since 2010.
- HELP team consists of Medical Director, two part-time Elder Life Nurse Specialists and full time Elder Life Specialist.
- Typically have around 40 active volunteers covering three shifts per day/7 days per week.
- Enrolled a total of 2434 patients in 2019, which is an average of 203 patients per month.

AFHS 4Ms framework



For related work, this graphic may be used in its entirety without requesting permission.
Graphic files and guidance at ihi.org/AgeFriendly

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.

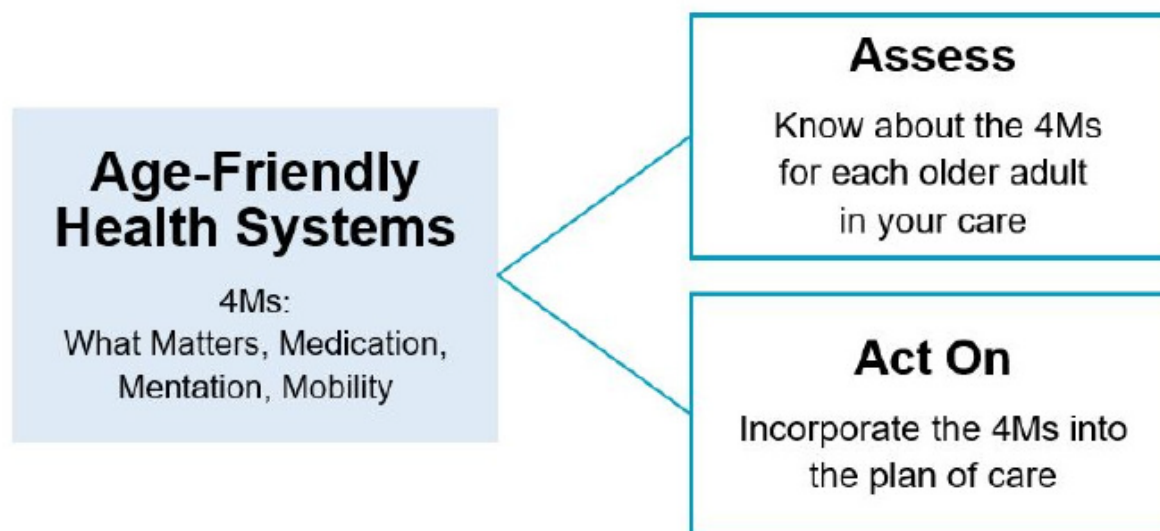
Mobility

Ensure that older adults move safely every day in order to maintain function and do What Matters.

Age-Friendly Health Systems

There are two key drivers of age-friendly care: knowing about the 4Ms for each older adult in your care (“assess”), and incorporating the 4Ms into the plan of care accordingly (“act on”) (see Figure 2). Both are supported by documentation and communication across settings and disciplines.

Figure 2. Two Key Drivers of Age-Friendly Health Systems



Assess - What were we doing?

Hospital Elder Life Program

Mentation

- Delirium - CAM
- Dementia – Mini Cog

Medication

- All pts assessed for Beers List, Anticholinergic & Sedative Medications

Mobility

- BMAT & Fall Screen completed by nursing
- Active ROM and walking with volunteers

What Matters

- Code Status, Adv Directives, POLST
- HELP Tx plan developed by staff, carried out by volunteers

*Needed a mechanism to explicitly ask and document What Matters with the information accessible to all care team members.

Assess - Where the 4Ms live in the EHR

Length of Stay	Bed	Isolation	CAM Score	Problem	BMAT Mobility Level	Fall History	Fall Risk Level	Beers Medications (2012)	Sedative Medications (Targeted)	Antici Score	Anticholinergic Priority 1	Anticholinergic Priority 2	Anticholinergic Priority 3
0h	SU...	—	Negative	Lumbar disc herniation	Level 3	No falls in last year	Moderate Fall Risk	diazepam tablet 2 mg	—	0	—	—	—
23h	327	—	Negative	Hematoma	Level 4	No falls in last year	Low Fall Risk	doxazosin tablet 2 mg	—	0	—	—	—
1d	215B	—	Negative	Violent behavior (Principal Hospital Problem)	Level 4	—	Moderate Fall Risk	prazosin capsule 1 mg	—	1	PARoxetine tablet 30 mg	—	—
1d 1h	555	Pr...	Negative	Acute respiratory failure with hypoxia (CMS-HCC) (Principal Hospital Problem)	Level 3	No falls in last year	Moderate Fall Risk	—	—	0	—	—	—
1d 7h	710A	—	Negative	Palpitations (Principal Hospital Problem)	Level 4	In Last 3 months	Moderate Fall Risk	—	—	0	—	—	—
1d 13h	721A	—	Negative	CAD (coronary artery disease) (Principal Hospital Problem)	Level 4	In Last 3 months	Low Fall Risk	amitriptyline tablet 75 mg - **Pt Own Med, Gluten Free**	—	3	—	—	amitriptyline tablet 75 mg - **Pt Own Med, Gluten Free**
1d 15h	1060	—	Negative	Fall, initial encounter (Principal Hospital Problem)	Level 2	In Last 3 months	High Fall Risk	—	—	1	Mirtazapine (REMERON) tablet 7.5 mg	—	—
1d 15h	726B	DRO	Negative	Ventricular tachyarrhythmia (CMS-HCC) (Principal Hospital Problem)	Level 3	—	Moderate Fall Risk	amiodarone tablet 400 mg	—	0	—	—	—
1d 16h	260	DRO	Negative	Acute on chronic diastolic heart failure (CMS-HCC) (Principal Hospital Problem)	Level 4	No falls in last year	Moderate Fall Risk	nitrofurantoin monohydrate macro capsule 100 mg	—	0	—	—	—
1d 16h	704B	—	Negative	A-fib (CMS-HCC) (Principal Hospital Problem)	Level 4	No falls in last year	Low Fall Risk	cyclobenzaprine tablet 5 mg sotalol partial tablet 40 mg	—	2	—	cyclobenzaprine tablet 5 mg	—
1d 16h	K04	—	Negative	Closed fracture of multiple ribs of right side, initial encounter (Principal Hospital Problem)	Level 3	In Last 3 months	Moderate Fall Risk	—	haloperidol Intravenous/Intramuscular 0.5 mg	1	haloperidol Intravenous/Intramuscular 0.5 mg	—	—
1d 17h	114B	—	Negative	Pleural effusion on left (Principal Hospital Problem)	Level 3	In Last 3 months (lost balance in	High Fall Risk	—	LORazepam tablet 0.5 mg haloperidol Intravenous/Intramuscular 0.5 mg	1	haloperidol Intravenous/Intramuscular 0.5 mg	—	—

Assess - EPIC report for HELP Team

EpicCare Inpatient

Geriatric Outcomes for Patients Discharged From 12/01/2018 To 12/31/2018 23:59:59

MaineHealth

Hospital Elder Life Program

Number of Patients Referred	317	
Number of Patients Enrolled	188	
Number of Patients Ineligible	99	
patient/family refuses	5	
behavioral status	0	
medical status	7	
discharge anticipated within 24 hours	10	
delirium present	27	
hospitalized longer than 48 hours	36	
other	3	
Number of Patients with Delirium on Admit	0	
Number of Patients with Delirium after Admit	8	
Average Number of Risk Factors for Delirium	3.5	
Number of Patients with Foley > 3 Days	8	
Number of Patients with Falls in Hospital	0	
Number of Patients with Falls and Delirium	0	
	Avg.	(Min. - Max.)
Number of Patients with Falls Screening	188	
Number of Patients with BMAT Screening	188	
Number of Patients with Dementia Screening	183	
Number of Patients with PHQ-2 Screening	0	
Hospital Length of Stay	6.6	(2 - 47)
Patients Discharged - HOME	50	
Patients Discharged - HOME HEALTH	59	
IP READMIT RATE 30 days	13.5%	
ED READMIT RATE 30 days	8.4%	

HELP Enrollment By Unit

MMC AVU	2
MMC BEAN 2	1
MMC EMERGENCY DEPARTMENT	2
MMC GPV1	9
MMC GPV2	7
MMC GPV3	1
MMC MBC	5
MMC P2C	8
MMC P3CD	30
MMC PSSU	3
MMC R1	4
MMC R2	23
MMC R3	14
MMC R4	12
MMC R5	10
MMC R6	7
MMC R6 IMC	1
MMC R7	32
MMC R9W	14
MMC SCU4	1

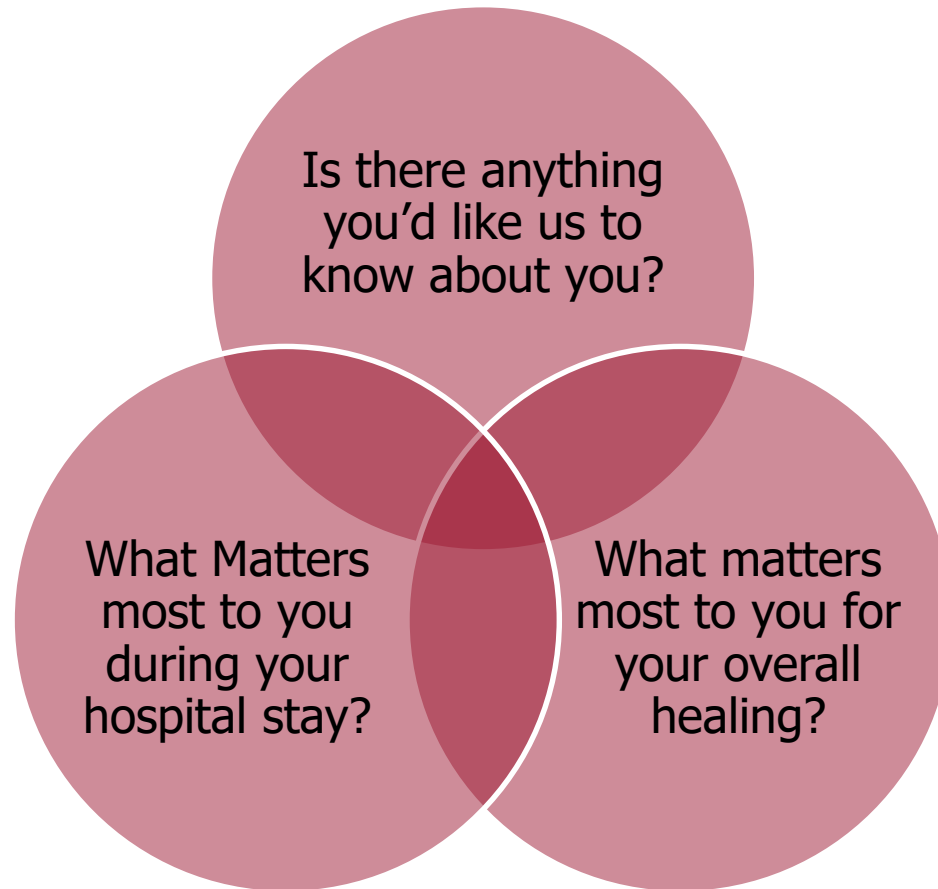
HELP Patients with Advanced Directives By Unit

MMC AVU	1
MMC BEAN 2	1
MMC EMERGENCY DEPARTMENT	1
MMC GPV1	3
MMC GPV2	3
MMC GPV3	1
MMC MBC	4
MMC P2C	2
MMC P3CD	16
MMC PSSU	1
MMC R1	1
MMC R2	7
MMC R3	3
MMC R4	4
MMC R5	2
MMC R6	4
MMC R7	10
MMC R9W	4
MMC SCU4	1

HELP Patients Medications

	Avg.	Num Meds	Num Pts	Den Pts	(Min. - Max.)
Total Meds	18.99	3,161	188	188	(4.00 - 52.00)
Beers Meds	0.34	64	48	188	(0.00 - 3.00)
Anticholinergic Meds	0.62	115	77	188	(0.00 - 7.00)
Sedative Meds	0.20	37	31	188	(0.00 - 2.00)

Act On - What Matters Smart Phrase in EPIC



Act On - What Matters Smart Phrase in EPIC

Consult Orders:

[Inpatient consult to HELP \(hospital elder life program\) \[147148375\] ordered by Carter, Emily L, MD at 02/06/19 1352](#)

Hospital Elder Life Program (for delirium prevention)

Patient enrolled in ACE/HELP for prevention of delirium and functional decline during hospitalization.

Recommendations

Medications: Discontinue PRNs not in use; ~~Avoid~~ sedating medications (02/06/19 1353)

General: Encourage use of Sleep Enhancement Guidelines; ~~Encourage~~ out of bed for meals; ~~Encourage~~ ambulation three times each day (02/06/19 1353)

Mr. *Example* feels **walking out of the hospital healthy** is most important to him during this hospital stay.

Mr. *Example* feels **that his and his wife's health** is most important for his overall healing.

Risk factors for delirium include

Risk Factors for delirium: Sleep Deficit (02/06/19 1353)

Cognition

Digit Span 3-6-9-2-5: Correct (02/06/19 1353)

Clock Drawing: Correct (02/06/19 1353)

Orientation (_/10): 10 (02/06/19 1353)

Attention: Intact to days of week backward (02/06/19 1353)

Registration (_/3): 3 (02/06/19 1353)

Recall (_/3): 2 (02/06/19 1353)

Prompted Recall: 1; Obtained with forced choice (02/06/19 1353)

Cognition Summary: No cognitive concerns (02/06/19 1353)

CAM (Confusion Assessment Method)

CAM Score Evaluation: Negative (02/06/19 1353)

Patient Caregiver Education

Current Barriers to Learning: fatigue/endurance (02/06/19 1353)

Plan to Address Barrier: Instructions verbalized and confirmed by ~~patient~~; ~~Instructions~~ given in writing to patient (02/06/19 1353)

See Geriatric Evaluation Flow sheet for full details. Please call with questions.

Christin Scott BSN, RN
Hospital Elder Life Nurse Specialist
Pager: 741-8141

Smart
Phrase

Act On - Implementing What Matters using the PDSA cycle



AIP Strategy: Patient Centered Care Value: Excellence

KPI Champion(s): Amber/Molly

Goal: What Matters

Department: Geriatrics - IP Current Month: April 2019

Start Date: 1.21.2019 End Date: _____

Quality Goal

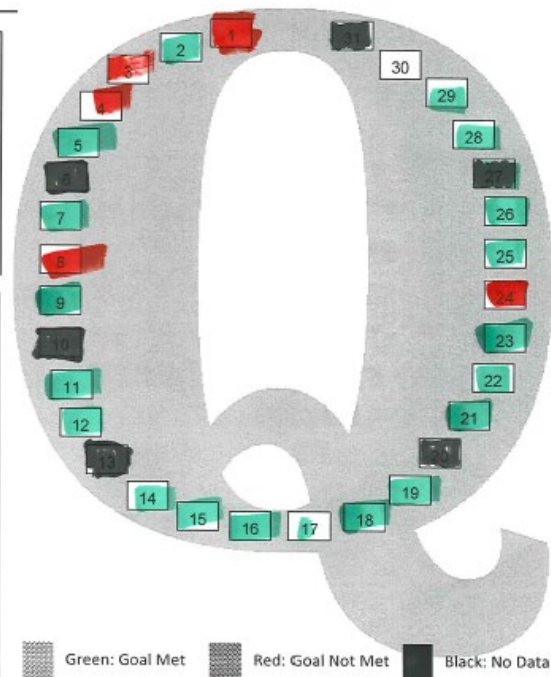
100% of the time, "What Matters" will be documented in the HELP consult note.

Improvement Plans

Date: _____ Changes made to sustain this goal:

February - started training learners to include

March - IP Consult service started to include

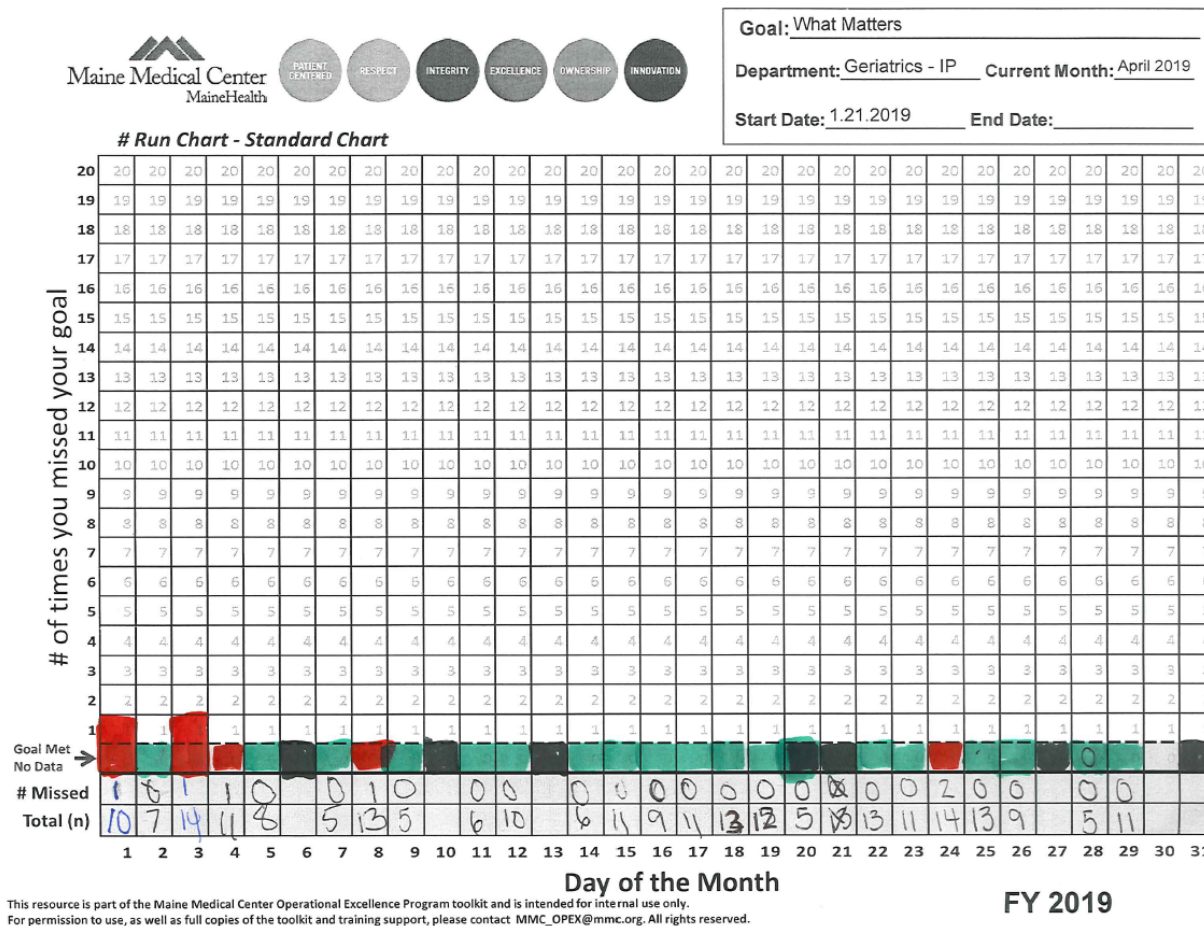


Green: Goal Met Red: Goal Not Met Black: No Data

FY 2019

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Act On – Implementing What Matters using the PDSA cycle



Joining the Age Friendly Health System(AFHS)Initiative

*Miriam Beattie, DNP, GNP, ANP
Elder Life Nurse Specialist, University of Utah Hospital*



October 21st, 2020

THE EXPERIENCE OF ONE HOSPITAL

- April 2019: AFHS Initiative rolled out at our Center on Aging Research Retreat
- Superb keynote speakers
- Essential departmental representatives and stakeholders included



HELP is the **quintessential**
Age-Friendly program
that addresses all 4Ms



MARY TINETTI, MD

The what, why and a bit of how of the 4 M's



[PIONEERS] Simple changes
BIG results

AFHS aim

- Age friendly Health

WHY?

- Aging population
- More diagnoses with age

4Ms

- 1 Matters Most
- 2 Medications
- 3 Mentation
- 4 Mobility

WHY the Ms?

- Unifying focus
- Simplified Framework
- Same Page

LINK CARE to
GOALS & PREFERENCES

- ASK**
- Get to Know Patient
 - Let Knowledge inform care

WHAT MATTERS MOST

WHY DOES "What matters most" MATTER MOST?

ADULTS

- Varies
- Feel more engaged
- Avoid unneeded care

HEALTH SYSTEMS

- Unifies Teams

IMPLEMENTATION

Where are Ms in practice?

Who are the champs?



What can you stop?

HOW?

- Reviewed 17 models
- Found Patterns

[WHAT MATTERS]

- Varies with age
- Increased Satisfaction

[MEDICATIONS]

- Adverse Drug Events
- Low benefit
- Increased costs

[MOBILITY]

- Fall related injuries are expensive

[MENTATION]

- Dementia
- Delirium
- Depression

RECIPROCAL & SYNERGISTIC RELATIONSHIP

WHY AFHS?

- Sustainable Business
- cost effective solutions

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KEVIN BIESE, MD

Creating a Geriatric Appropriate ED:
Making Change Stick



TODAY WE'RE
TALKING ABOUT
**CHANGING
SYSTEMS**

People are
living longer...
This is **NOT** a bad
thing...
but how do we
IMPROVE?



But we can
DISRUPT
elsewhere too

Disrupt
Destructive
Practices



We can
start in the
**GERIATRIC
ED**

[STORY]

Mrs. Smith

- Falls in garden
- Can't get immediate care
- Gets infection
- Now an emergency case
- Cascade of calamities

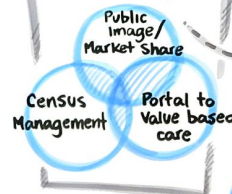


WE CAN
DISRUPT
THIS MODEL
TODAY



• Stuck in
system
• Delirium in
hospital

HEALTH CARE SYSTEM **GED ROI**



**ACCREDITATION =
VALIDATION**

[SCALE & SUSTAIN]

- change oriented education
- Clear Goals
- Recognize achievement
- Measure
- Value to key stakeholders



STRUCTURE



**CONNECTION
WITH
COMMUNITY**



EDUCATION



PROCESS

[SYSTEM]

- Activate
- Intervene
- Sustain

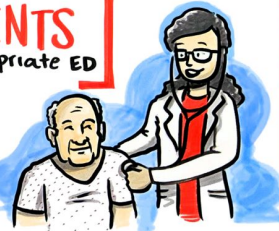
60
PERCENT of older adults
come through
the ED

Decisions made in
ED lead to
**EXPENSIVE
DECISIONS**
later...



[4 COMPONENTS of Geriatric-Appropriate ED]

**CHANGE the
TRAJECTORY
from the ED**



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MENTATION

[ANNUAL WELLNESS VISIT]

- Way to do the 4Ms

MENTATION

- Mini cog in template

WHAT MATTERS

- Personal Plan
- Review care Plan
- Patient wishes

MEDICATIONS

- Reconciliation

MOBILITY

- ADLS
- IADLS
- HRA

ROOM for OPPORTUNITY!

- More wellness visits could be had

[DATA SOURCES]

- micro cog
- Scanned documents

Follow up with patients who need AWV

Population Health Tool



HELP Volunteers

- Keep patients cognitively engaged
- companionship
- Soothing

[DELIRIUM PREVENTION]

In Patient
Hospital Elder Life Program
H.E.L.P.

[IMPACT]

- Delirium reduced
- length of stay
- Discharge Disposition



MEDICATION

CENTER ON AGING

NEW Collaborative between OT + PHARMACY



Medication management

Already have Data
What does it tell us?

Patients will need to manage medication

NEW Screening method

[MEDI-COG]

Mini Cog
- 3 word registration
- clock
- Recall

Medication Transfer Screening

Score 8/10 Passes

Medi-cog
Informs team of patient capability

2 elements = clear results

[PHARMACY]



Better able to prescribe

Help patients in weak areas

[IMPLEMENTATION]

- Pass or fail visible to multiple teams
- Pharmacy
- Interdisciplinary Team
- Occupational Therapy

[SOLUTIONS]

COLLABORATE!

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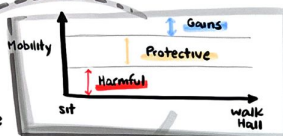


MOBILITY



BED REST IS TOXIC

- Causes serious problems
- May limit home self-care



[OUR REALITY]

- Growing in patients, not team
- Mobility took lower priority
- Not addressing overall problem

[MOBILITY & PHYSICAL THERAPY]

Wide range of patient needs

Metrics

- FIM levels
- AMPAC (often lost in translation)

AMPAC

- 6 clicks
- More readily understood

Able to track Patient Progress

Raw score =

- Easy data review
- Simple tool

HUMBLE BUT DOABLE

- MICU mobility Goals
- Simplified board
- Goal focused

IMPROVED

- Not updated often
- lost in clutter

[EXAMPLES]

- Mobility boards proved difficult

OUTCOMES

- Decrease length of ICU stay
- More data points

WHAT MATTERS MOST



WHY IS CHANGE NEEDED?

- Asking wrong questions
- Asking wrong people
- Family conflict
- Wait too long

WHY NOT EARLIER CONVERSATIONS?

- clinicians not formally trained on conversation
- Uncomfortable
- Too much time

ASK:

Where are you going?

Before giving directions

TREATMENTS are not the destination

LIFESTYLE IS.

EFFECTIVE ADVANTAGE CARE PLANNING

A specific way to ultimately honor choices

- Identify High-Risk patients
- Prepare Patient or surrogate
 - Podcasts
 - Videos
- Values, Goals & Preferences
- Make shared decisions about LST Plans
 - courses
 - education
- Honor VA choices
- Document LST orders

How can all departments help?

PROCESS MAP

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THE AGE-FRIENDLY WORK CONTINUES

- Virtual volunteer visits
- ELS & ELNS make face to face visits
- Presentations to nursing and medicine
- Pharmacy recs
- Business case for excellence in care



THANK YOU SO MUCH!



Panel Discussion: HELP sites with Age-Friendly initiatives



- How has the HELP program influenced or enhanced the Age-Friendly initiative? Have they been complementary?
- Panel participants:
 - **Morristown Medical Center**
 - **Hackensack University Medical Center**
 - **Advocate Aurora Health Care**
 - **Hurley Medical Center**
 - **MaineGeneral Health**
 - **Abington Hospital - Jefferson Health System**

Thank You and Closing



- Questions as time permits
- Recording to be posting on <https://help.agscocare.org/>
- Email Contact: ElderLife@hsl.Harvard.edu
- **Thank you!**

Participant Survey:

After watching this presentation, please consider filling out this anonymous survey for the Age-Friendly PA GWEP grant: <https://redcap.ctsi.psu.edu/surveys/index.php?s=HRLKFX9MA>

Resources:

Guide to using the 4Ms - Learn how to get started with key actions to incorporate the 4Ms into your plan of care: www.ihl.org/agefriendly

Paper – Cognitive Vital Sign of Delirium free access & tips: <https://bit.ly/3i7mTyk>

Office of Civil Rights Caregivers Essential at Bedside: <https://bit.ly/35rYG2v>

UB-CAM blog: <https://deliriumnetwork.org/the-ultra-brief-confusion-assessment-method-ub-cam/>

Age Friendly - Providing Delirium Prevention in Age-Friendly Care:
<https://www.chausa.org/publications/health-progress/article/january-february-2020/age-friendly---providing-delirium-prevention-in-age-friendly-care>

Eric Liotta and colleagues-confusion and neurologic manifestations of COVID-19:
<https://onlinelibrary.wiley.com/doi/full/10.1002/acn3.51210>

AGS CoCare: HELP Delirium Prevention Toolkit Amidst COVID-19:
https://help.agscocare.org/productAbstract/Delirium_Prevention_Toolkit_Amidst_COVID-19/H00107

UB-2 training video here <http://www.nursing.psu.edu/readi>