Forward Momentum: It’s time for an Age-Friendly Health System

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Situation (1):

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.
Situation (2):

Counties Included in Data Set:
- Livingston
- Macomb
- Monroe
- Oakland
- Washtenaw
- Wayne

Source: SEMCOG 2040 Forecast
Situation (3):

- We have lots of evidence-based geriatric-care models of care that have proven very effective
Situation (3):

- 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
“The First Law of Improvement”

Every system is perfectly designed to achieve exactly the results it gets.

Dr. Paul Batalden

To get a different result, we must change the system
Model I: Bad Apples

The Problem

Frequency

Quality

Better

The Problem

Better
The Simple, Wrong Answer

Name, Shame & Blame

Somebody
The Cycle of Fear

- Micromanage
- Engender Fear
- Filter the Information
- Kill the Messenger
Model 2: Continuous Improvement
“All teach, All learn”
“…98,000 people die in hospitals each year as a result of medical errors that could have been prevented.”

Institute of Medicine, November 1999
Origins of the 100,000 Lives Campaign

• By 2004, as a country we had made little progress
• The science was available, our implementation was unreliable
• Variability in the quality of care was persistent & entrenched
• There were isolated islands of excellence in patient safety
• We believed that our sense of urgency was shared by leaders and providers everywhere in healthcare
100,000 Lives Campaign Objectives
(December 2004 – June 2006)

• Save 100,000 Lives
• Enroll more than 2,000 hospitals in the initiative
• Build a national infrastructure for change
• Raise the profile of the problem - and our proactive response
Six Changes That Save Lives

• Rapid Response Teams
• Evidence-Based Care for Acute Myocardial Infarction
• Medication Reconciliation to prevent Adverse Drug Events (ADEs)
• Apply Central Line Infection Bundle
• Prevent Surgical Site Infections
• Apply Ventilator-Associated Pneumonia Bundle
Over 3,100 Hospitals Enrolled
78% of all acute care beds
Hospitals cut errors, save over 120,000

The Boston Globe
June 14, 2006
When we talk of social change, we talk of movements, a word that suggests vast groups of people walking together, leaving behind one way and traveling toward another.

Rebecca Solnit
Roadmap for a movement

- Will for change
- Aim & Purpose
- Evidence-based interventions
- Technical method for change
- Social system for spread
Roadmap for a movement

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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

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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?
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 Four 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
Evidence-base

- **What Matters:**
  - Asking what matters and developing an integrated systems to address it lowers inpatient utilization (54% dec), ICU stays (80% dec), while increasing hospice use (47.2%) and pt satisfaction (AHRQ 2013)

- **Medications:**
  - 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)

- **Mentation:**
  - 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:**
  - 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
# 4Ms, high level interventions and implementation actions

<table>
<thead>
<tr>
<th>What Matters</th>
<th>High-level Interventions</th>
<th>Implementation Actions</th>
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<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>
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<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>
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<table>
<thead>
<tr>
<th>Mobility</th>
<th>Implement an individualized mobility plan</th>
<th>We will learn from one another and share generously.</th>
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<tbody>
<tr>
<td>3</td>
<td>Implement an individualized mobility plan</td>
<td></td>
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<tr>
<td>4</td>
<td>Create an environment that enables mobility</td>
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<table>
<thead>
<tr>
<th>Medications</th>
<th>Implement standard process for age-friendly medication reconciliation</th>
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<tbody>
<tr>
<td>5</td>
<td>Implement standard process for age-friendly medication reconciliation</td>
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<tr>
<td>6</td>
<td>De-prescribe and adjust doses to be age-friendly</td>
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<tr>
<th>Mentation</th>
<th>Ensure adequate nutrition &amp; hydration, sleep and comfort</th>
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<tr>
<td>7</td>
<td>Ensure adequate nutrition &amp; hydration, sleep and comfort</td>
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<tr>
<td>8</td>
<td>Engage and orient to maximize independence and dignity</td>
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<tr>
<td>9</td>
<td>Identify, treat, and manage dementia, delirium, and depression</td>
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Roadmap for a movement

- Will for change
- Aim & Purpose
- Evidence-based interventions
- Technical method for change
- Social system for spread
The Model for Improvement

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

Plan | Do
---|---
Study | Act
Roadmap for a movement

• Will for change
• Aim & Purpose
• Evidence-based interventions
• Technical method for change
• Social system for spread
Design to Achieve National Scale

Stage 0: Developing the Prototype

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

Testing the Prototype for refinement (3/17 – 2/18)

Stage 1: Testing the Prototype

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
A 95 year old woman
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<tr>
<th>M</th>
<th>Prevent</th>
<th>Assess</th>
<th>Treat</th>
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<tbody>
<tr>
<td><strong>What Matters</strong></td>
<td>Document health care agent</td>
<td>Ask What Matters questions and document responses; Ask for presence of health care agent</td>
<td>Apply What Matters in treatment</td>
</tr>
<tr>
<td><strong>Medication</strong></td>
<td>Remove in-hospital meds from discharge med list; Send updated med list to primary care physician; change order sets</td>
<td>Screen for high-risk meds</td>
<td>De-prescribe or dose adjust high-risk meds (especially opiates, insulin, sleepers)</td>
</tr>
<tr>
<td><strong>Mentation</strong></td>
<td>De-prescribe meds known to cause delirium; Ensure sufficient hydration; Support sufficient sleep</td>
<td>Screen for delirium (e.g., 2 questions)</td>
<td>Identify and reverse causes of delirium (non-pharmacologic); plus Prevention</td>
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<td><strong>Mobility</strong></td>
<td>Mobilize patients (if ambulatory; if not ambulatory)</td>
<td>Conduct mobility test (e.g., TUG)</td>
<td>Create mobility plan; plus Prevention</td>
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A sample of tests being run by our health system teams

1. Glacier Hills: Moving to single document, work flow, documentation of What Matters conversation
2. Glacier Hills: Education of providers about asking What Matters questions using Being Mortal film
5. St. Alphonsus: Asking What Matters questions in Assessment Bundle
6. St. Alphonsus: Moving advance care planning documents/advanced directives to the next level/site of care or provider at discharge
7. St. Mary Mercy: Integrate What Matters questions into geriatrics assessment
9. KP: Knowing older adults through “My Care My Life” binder
10. Ascension: Assessing caregiver burden with caregivers and patients
11. Ascension: Information on website about services and to enable self-referral
12. Ascension: Streamlined patient access Referral and intact process
13. St. Alphonsus: Bring home med containers to AWV for better med rec
14. St. Alphonsus: Checking home meds with provider profile in EMR with every admit
15. St. Alphonsus: Obtaining med list from pharmacy to review for deprescribing
17. St. Mary Mercy: Medication review for pill burden and sending deprescribing recommendations to pharmacy
18. Providence: PharmD reviews med list for high risk meds and recommends de-prescribing to PCP
19. PACE: Pharmacovigilance review with ER/hospital utilization review
20. Anne Arundel: Established an Age-Friendly prescribing “culture”; Looking for opportunities to scale-up to other units
21. KP: Patients encouraged to bring personal items to hospital to create a “Just like home” environment
22. KP: Coaching for staff to develop personal relationship with pts
23. KP: Educate providers re medication issues for deprescribing and treatment of delirium
24. KP: Self-care plan for high-risk patients, case manager creates plan to include hydration and nutrition
25. Glacier Hills: Screening (bCAM), standard intervention for delirium
26. St. Alphonsus: Assessment with mini-cog and PHQ2
27. St. Mary Mercy: Communication re 3D delirium assessment
28. St. Mary Mercy: Assessment with family member involvement
29. Anne Arundel: Hydration- geriatric cups
30. Glacier Hills: Assessment tool with what matters most about mobility
31. Glacier Hills: Workflow, PT referral to wellness center, education
32. St. Alphonsus: Timed Get Up and Go assessment
33. St. Mary Mercy: Matter of balance, check your risk for falling (CDC) plus meds
34. St. Mary Mercy: Story book, shorts, What Matters document, thank you letters, MOVE (mobility optimizes virtually everything)
35. Providence: STEADI results at annual wellness visit, patient who has fallen or with specific STEADI score has follow up visit with RN to address risk factors
36. Providence: Measure mobility with STEADI scores at AWV year-over-year
37. Providence: Patient who has fallen or with specific STEADI score participate in a shared medical appointment; PharmD reviews med list for high risk meds and recommends deprescribing to PCP
38. KP: Patient-initiated patient mobilization, MD’s provide 1-page prompt with exercises (includes exercises for patients in bed and wheelchair)
39. Anne Arundel: Mobility/quality tech
40. Anne Arundel: 6-clicks, refer to PT
Practical ideas for changing the system of production

Hydration

73% increase
Reduced falls by 18%
Mobility: Empowering older adults

Reduce Length of Stay;
Go home not rehab
## FY 18 Priority Strategic Aims – These are the priorities!

**FY18 APPROVED System Level Performance Measures / Metrics**

<table>
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<tr>
<th>Goal Area/Weight</th>
<th>Measures</th>
<th>Level*</th>
<th>Threshold</th>
<th>Target</th>
<th>Maximum</th>
<th>Comments</th>
</tr>
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</table>
| 1. Community Health & Well Being (CHWB) / 20% | 75% of the 20% weight (i.e., 15%):  
- Clinical Services: Tobacco and BMI Screening and Referral Improvement (2 points available)  
- Clinical Transformation Portfolio (8 points available)  
25% of the 20% weight (i.e., 5%):  
- Growth | System Level | 4+ points | 7+ points | 9+ points | Clinical Services: Each ministry has an individual baseline and individual targets. Points earned based on improvement. Clinical Transformation Portfolio: Five policy, system and environmental change strategy initiatives | |
| 2. Clinical Care / 20% | • Reduction of unplanned 30 day readmissions to acute inpatient Trinity Health facilities (50% of the 20% weight)  
• Reduction of Hospital Acquired Infections (50% of the 20% weight) | System Level | at Target or better | at Target or better | Target or better | ministries at threshold or better |
| 3. Patient Experience / 20% | Willingness to Recommend:  
- Acute Care (34% of 20% weight)  
- Emergency Care (33% of 20% weight)  
- Owned physician practice groups CG-CAHPS (33% of 20% weight) | System Level | 30% of ministries at Threshold or better | 40% of ministries at Threshold or better | 50% of ministries at Threshold or better | For reference, FY17 = 30/40/50 % of ministries at threshold or better |
| 4. Colleague Engagement / 20% | • Colleague Engagement Score | System Level | 4.06 | 4.08 | 4.09 | For reference, FY17 = system level score of 4.03/4.05/4.09 |
| 5. Financial Stewardship / 20% | • Operating Margin (OM) (50% of the 20% weight)  
• Cost Per Case Mix-Adjusted Equivalent Discharge (CMAED) (50% of the 20% weight)** | System Level | 1.5% | 2.1% | 2.6% | **Reflects our overall cost position and actions to improve this cost position to move on glide path to be profitable under Medicare. This Cost per CMAED is based on Regional Health Ministries (RHMs) only. For National Health Ministries and Mission Health Ministries, cost per unit metrics will be:  
- Trinity Health Senior Communities (THSC): Cost per Day  
- Trinity Health at Home (THAH): Cost per Admission  
- Trinity Health PACE: Cost per Member per Month  
- Pittsburgh Mercy Health Services: Cost per Outpatient Unit  
- All other Mission Health Ministries: No cost metric; Operating Margin used as the sole measure of financial stewardship | |

*For RHM executives, weight on objectives is split between an RHM (70%) and System (30%) Components
The business case

Make a sustainable business case for age-friendly care

Reduce costs associated with poor quality care
Reduce harm that results in use of higher level of care settings, longer inpatient LOS, ED visits, readmissions to inpatient settings
Reduce risk of malpractice claims
Improve care transitions, discharge planning, and care coordination
Increase utilization of cost-effective services
Increase consistent use of underused, evidence-based services and practices
Reduce over-utilization of unnecessary care
Optimize site of care (shift care to lower cost care settings)

Enhance revenue and market share
Increase staff productivity and decrease turnover
Increase bed capacity
Improve reputation as an AFHS to attract patients
The risk…and the opportunity

• Motion…

“Every person in your company is a vector. Your progress is determined by the sum of all vectors.”—Elon Musk

• Or we could get what Elon Musk described as “the sum of all vectors”—what you call FORWARD motion
• Build a shared understanding of the problem
• Set “winnable milestones”
• Design approaches that will work at massive scale
• Drive (rather than assume) demand
• Embrace course corrections
What can we do by next Tuesday?
What can we do by next Tuesday?

This is our moment. It is time for an Age-Friendly system of care that touches every single older adult in this country.

• Talk to your local hospital CEO or Board chairperson about what it would take to become Age-Friendly
• Ask them to commit to one action—to one “M”—to becoming more Age-Friendly starting next month
• Tell them you will support them to realize it
• And…tell us about it so we can learn with you
Hope is not a plan
But, there is no plan without hope
Thank you

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Citations

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