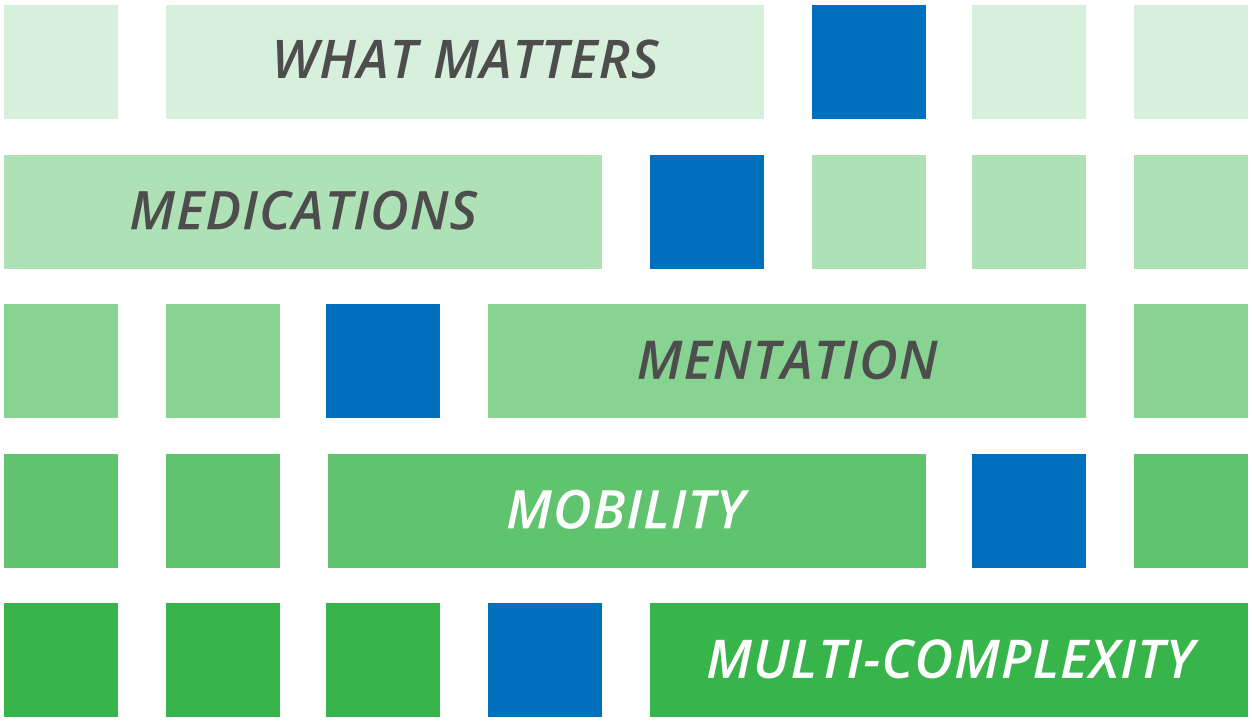
Hospital AT Home USERS GROUP

AN INTRODUCTION TO

AGE-FRIENDLY CARE IN HOSPITAL AT HOME



This brief guide was created through contributions from the Cincinnati VA, Saint Luke's Hospital of Kansas City, Kent Hospital in Rhode Island, the Complex Care Hub at the University of Calgary, Canada, and additional members of the Hospital at Home Users Group in collaboration with The John A. Hartford Foundation.

This guide is intended to be an introduction to age-friendly care concepts in Hospital at Home, not an exhaustive resource. For a deeper dive into the topics covered, we encourage you to review the Institute for Healthcare Improvement's "Age-Friendly Health Systems: Guide to Using the 4Ms in the Care of Older Adults in Hospitals and Ambulatory Care Practices."

WHAT IS AN AGE-FRIENDLY HEALTH SYSTEM?

Age-Friendly Health Systems (AFHS) 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. Age-Friendly Health Systems aim to follow an essential set of evidence-based practices, cause no harm, and align with What Matters to the older adult and their family caregivers. Becoming an Age-Friendly Health System entails reliably providing a set of four elements of high-quality care, known as the "4Ms," to all older adults in your system: What Matters, Medication, Mentation, and Mobility. Implementing the 4Ms involves both assessing the 4Ms for older adults and acting on assessment findings. In late 2024, there were nearly 5,000 designated sites of age-friendly care in the US, including more than 570 hospitals, 500 Geriatric Emergency Departments (GERI-EDs), and 700 nursing homes.

In FY 2025, a new Age-Friendly Hospital Measure will require hospitals that participate in Medicare's Hospital Inpatient Quality Reporting (IQR) Program to report on whether they have protocols in place to: 1) elicit patient health care goals, 2) responsibly manage medications, 3) implement frailty screening and intervention (including for cognition and mobility), 4) identify and address issues of social vulnerability (e.g., social isolation, caregiver stress, elder abuse) and 5) designate age-friendly leadership.

WHY INTEGRATE THE 4MS INTO HOSPITAL AT HOME CARE?

The home environment — where patients navigate their usual, familiar space, have access to their own devices and possessions, and are in close contact with their companions and caregivers — is uniquely conducive to implementing the 4Ms. Integrating the 4Ms of age-friendly care into Hospital at Home (HaH) care not only ensures that the care is patient-centered, but that it is likely to foster better health outcomes and enhance the quality of care for older adults. The AFHS initiative has developed a list of actions to perform to implement the 4Ms in acute hospital care as well as a detailed guide to implementing the 4Ms in hospitals and ambulatory care settings, measuring the impact of 4Ms care, continuously improving the quality of care, and sustaining care. Currently, there is no established playbook for Hospital at Home programs.

While the HaH model inherently addresses key principles of age-friendly care, there is an opportunity to proactively incorporate more of these ideas in practice — and a number of HaH programs are developing innovative approaches. In April 2024, Hospital at Home Users Group members from four different health systems (the

Cincinnati VA, Saint Luke's Hospital of Kansas City, Kent Hospital in Rhode Island, and the Complex Care Hub at the University of Calgary, Canada) gathered to discuss how they incorporate age-friendly principles and the 4Ms into the care that they provide in Hospital at Home.

- Watch this webinar to learn more about the basics of age-friendly health care and the 4Ms framework, the preliminary research about the 4Ms in HaH, and how programs are adapting and implementing the 4Ms model in practice.
- As you read on, review a preliminary list of suggestions for how to start addressing each of the Ms in your HaH practice.
- To learn more about age-friendly care, and access comprehensive guides and resources for implementing the 4Ms, visit www.ihi.org/agefriendly.

THE 4MS IN PRACTICE

WHAT MATTERS

Prioritizing What Matters ensures that care plans are personalized, taking into account individual preferences and goals. This starts with honoring the choice of the patient of whether to receive care in their home versus in the hospital; later, it may be deciding to remain at home rather than return to the bricks-and-mortar hospital if their clinical status changes.

- Find out what matters most to patients during their Hospital at Home stay - maybe they get their best sleep in the morning, and prefer not to be awoken for early visits, if possible. Maybe it is to have their pet by their side, and the team can adjust protocol to accommodate visits with a pet in the room. Document and share this information.
- Be diligent with asking about and documenting goals of care, code status, and advance directives. Share important findings across the care team in hand-offs and sign-outs.
- Conduct and review patient and caregiver satisfaction surveys. Use feedback to inform rapid cycle changes to your practices, policies, and procedures.

MEDICATIONS

Addressing Medications involves a thorough review to minimize polypharmacy and adverse drug interactions, and is crucial in a home setting where medication management may be challenging.

- Some programs find that having a dedicated pharmacist is essential to ensure safe, timely, and appropriate treatment.

- Having a clinician review medications in the home means they can perform a truly comprehensive and accurate survey of a patient's current and old medications and observe how they organize their meds (pillboxes, blister packs, etc.).
- Enact best practices for medication safety. At minimum, implement directly-observed medication administration. Some programs, such as St. Luke's, use key- or password-accessible lockboxes and are starting to implement barcode scanning.
- Deprescribe when appropriate. At Saint Luke's, they have focused on deprescribing or tapering benzodiazepines, opioids, sleep aids, and NSAIDs. Inform PCPs or other outpatient providers when medications are discontinued or tapered.
- Perform the discharge medicine reconciliation with the patient, using their own pill bottles. Show them what is being changed, added, or discontinued. Physically remove or discard medications that are no longer prescribed upon discharge.

MENTATION

***Mentation** focuses on early detection and management of cognitive impairment or delirium. Hospital care in the home has been shown to result in reduced rates of delirium in older adults after discharge. Familiar surroundings, fewer overnight interruptions, and improved sleep all likely contribute to improved mentation.*

- Screen and monitor for delirium at least daily (for example, using the Ultra-Brief Confusion Assessment Method) and implement delirium prevention. Orient frequently to time, place, and situation.
- Optimize non-pharmacological sleep and adhere, where possible, to patient preferences around sleep hours. Avoid long or complex care visits late at night or very early in the morning, as clinically appropriate. Minimize overnight interruptions, and obtain lab samples during normal waking hours.
- Detect and treat or mitigate modifiable causes of altered mental status including lack of sleep, infection, adverse medication effects, substance use, constipation, dehydration, electrolyte imbalances, pain, sensory impairments, and depression.
- Ensure patients are using their adaptive equipment such as glasses, hearing aids, and dentures.
- Incorporate psychiatry consults via telehealth into your clinical structure, as Saint Luke's Hospital has done.
- Consider screening for depression and cognitive impairment when clinically appropriate, and initiate any needed treatments, make necessary referrals, and share appropriate resources.

MOBILITY

***Mobility** centers around interventions that maintain or improve functional status, thereby reducing the risk of deconditioning. Hospital at home patients are in familiar surroundings, with well-charted paths for maneuvering around the home or walking around a backyard.*

- Consider working with inpatient Physical Therapy (PT) departments, like Kent Hospital in Rhode Island, to identify new admissions at greatest risk of deconditioning in the hospital and prioritize evaluating them for HaH care.
- With PT department buy-in and integration with the HaH team, consider expedited PT evaluations for select patients prior to the transfer in order to better prepare for the transition home, or same- or next-day evaluations in the home after transfer. Provide all appropriate ancillary assessments and therapies in the home, including PT, OT, and speech. Kent Hospital partners closely with PT to do expedited assessments as well as ongoing sessions in the home.
- Aim to promote early, frequent, and safe functional mobility.
- Minimize fall risk through screening, evaluation, and the provision of needed equipment and therapies.
- Ensure all recommended DME is made available in the home either before or upon transfer to the home.
- Reduce tethering and mobility restrictions as much as possible. For patients receiving 24-hr infusions, explore IV pumps that can be carried in a pack or pouch, rather than those that must hang from an IV pole. For patients with a urinary catheter, consider one connected to a leg bag vs. a large bag meant to hang on a hospital bed.
- Refer to home safety checklists to identify adjustments necessary for safe mobility (e.g., replacing non-functioning light bulbs or removing slippery rugs, clutter, or objects impeding pathways).
- Some HaH services, including Kent Hospital, use remote patient monitoring to detect falls, monitor activity levels, and obtain step counts. These data may contribute to understanding whether patients are maintaining their function or provide information towards risk-stratifying for DVT prophylaxis.

MULTI-COMPLEXITY

While the Age Friendly Health Systems framework includes the 4Ms above, some hospitals and other setting have identified additional Ms (e.g., meals or elder mistreatment). In the case of hospital at home, sites have noted a 5th M: Multi-complexity. Many older patients have multiple chronic conditions and complex health needs. Some HaH programs have started to address the 5th M for vulnerable older adults through comprehensive geriatric assessments for their older patients, involvement of case management for safer transitions of care, and involvement of social work for appropriate community referrals.

- Some teams, like Saint Luke's Hospital, include geriatricians on their clinical HaH teams, either as embedded consultants or primary attendings; others are able to place geriatric consults for specialist input.
- Screen for caregiver burden, for example using tools such as the Zarit Burden Interview or Caregiver Strain Index. Take action when appropriate, whether by providing an HHA for a caregiver who needs respite and/or making appropriate community-based referrals.
- Ensure safe transitions of care, from follow up appointment scheduling to a plan for transportation. The Complex Care Hub in Calgary has nurse navigators that act as transition services nurses and perform intensive case management; they perform medication management, provide education and self-management support, link patients to providers, and ensure patients are connected to their family doctors.

Community Paramedic Lou Labrash, right, stops by the home of Complex Care Hub patient Olive Willey to check her vital signs. https://www.albertahealthservices.ca/about/Page13602.aspx

EARN RECOGNITION + JOIN THE MOVEMENT

IHI recognizes clinical care settings that are working toward reliable practice of evidence-based interventions for all older adults in their care known as the 4Ms (4Ms: What Matters, Medications, Mentation, Mobility). As of late 2024, nearly 5,000 health care organizations have earned either level 1 (Participant) or level 2 (Committed to Care Excellence) recognition in the Age-Friendly Health Systems movement.

- **Level 1** (Participant) teams have successfully developed plans to implement the 4Ms.
- **Level 2** (Committed to Care Excellence) teams have three months of data of older adults who received 4Ms care.

Hospital at home care sites can be recognized using the hospital recognition care description.

Action Communities enable teams to accelerate reliable practice of the 4Ms in an active community of learners and testers. This 7-month journey to Recognition provides a structure for learning with and from other health systems and expert faculty. Over the course of the Action Community, teams participate in webinars and develop their plan for practicing the 4Ms. The next IHI Action Community begins March 2025.

The new Online Course with Coaching includes virtual coaching calls and asynchronous learning. It is designed for individuals who may not have colleagues who are actively working on age-friendly care, with advice for championing age-friendly care in your organization, building the business case, and developing leadership buy-in. The course, held March–June 2025, will offer continuing education credits for physicians, nurses, pharmacists, and social workers.