2022
AMERICAN HOSPITAL ASSOCIATION
LEADERSHIP SUMMIT
JULY 17-19, 2022 • SAN DIEGO, CA

Healthy Aging: Creating Age-Friendly Health Systems

July 19th 7:15-8:15am PST

Please note that the views expressed by the conference speakers do not necessarily reflect the views of the American Hospital Association.

Agenda

- Opening Remarks- The John A. Hartford Foundation
  - Rani Snyder
- How to Restore Public Trust & Confidence
- Overview of Age-Friendly Health System Movement
- Importance of Community Partnerships
- Care Across the Continuum Speakers
  - Dr. Kevin Biese
  - Brynn Bowman
- Q&A
- Close Out

Today’s Speakers

Marie Cleary-Fishman, MS, MBA

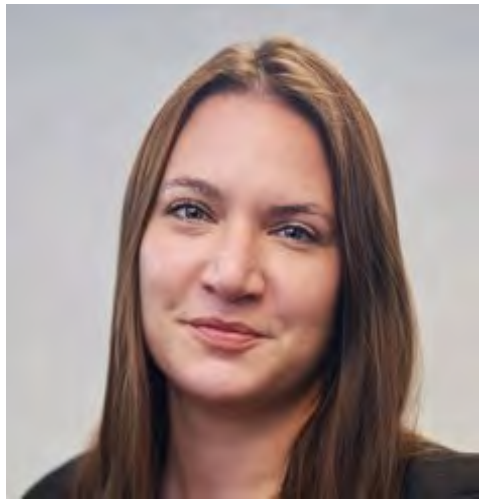
Vice President

Clinical Quality AHA

Kevin Biese, MD, MAT

Geriatric Emergency Department Collaborative Implementation PI,

Chair, Geriatric Emergency Department Accreditation



Brynn Bowman, MPA

Chief Executive Officer,
Center to Advance Palliative Care

The John A. Hartford Foundation

Healthy Aging: Creating Age-Friendly Health Systems

2022 American Hospital Association Leadership Summit

July 19, 2022

Rani Snyder, MPA

Vice President, Program

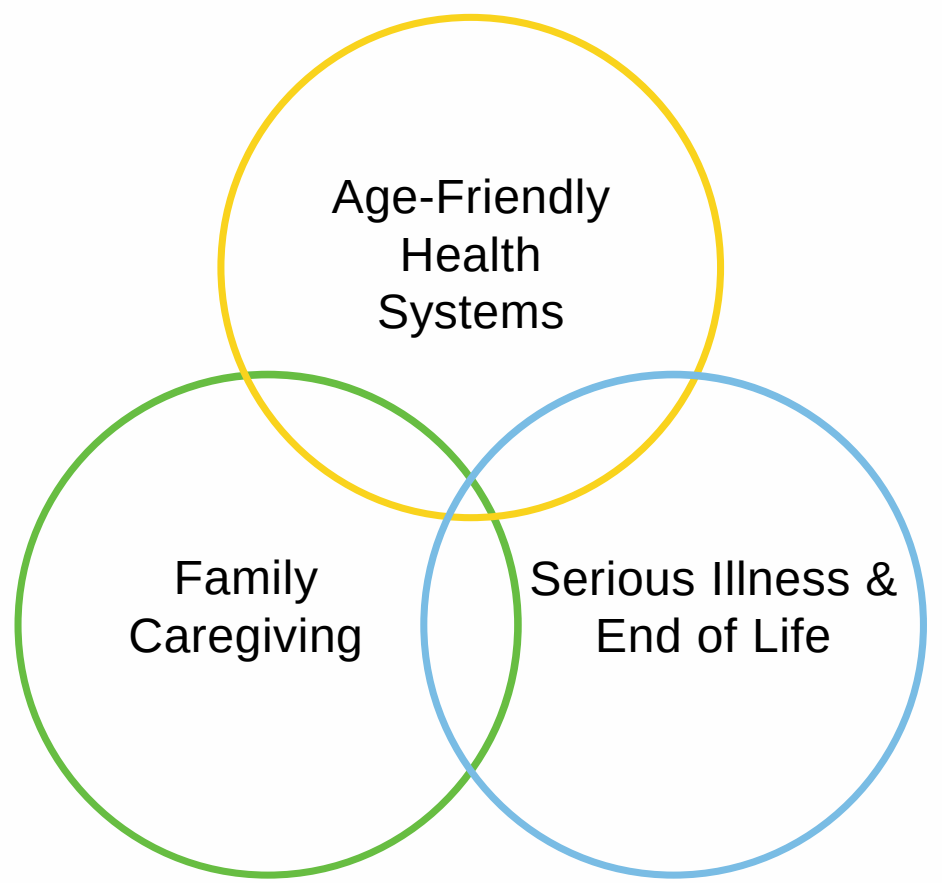
The John A. Hartford Foundation


The
John A. Hartford
Foundation
A private philanthropy based in New York City, established by family owners of the A&P grocery chain in 1929.
DEDICATED TO IMPROVING THE CARE OF OLDER ADULTS

Mission

DEDICATED TO IMPROVING THE CARE OF OLDER ADULTS

PRIORITY AREAS



The Need for an Age-Friendly Ecosystem

The John A. Hartford Foundation

A Multi-Sector Initiative to Accelerate Age-Friendly Impact

Age-friendly practitioners are doing transformational work in cities and communities, universities, health systems, the employment and public health sectors around the world.

We are working with partners to develop shared language that describes what it means to be age-friendly in all settings and provides a framework for cross-sector collaborative action and measurable impact.

Age-Friendly Ecosystem

Learn more at agefriendlyinstitute.org

Fulmer, et al. Moving Toward a Global Age-Friendly Ecosystem, *Journal of the American Geriatrics Society*, July 2020

Age-Friendly Clinical Programs with Resources for Your Health System

The John A. Hartford Foundation

Today you will hear about:

Age-Friendly Health Systems

ACEP Geriatric Emergency Department Accreditation

GEDC THE GERIATRIC EMERGENCY DEPARTMENT COLLABORATIVE
EDUCATE IMPLEMENT EVALUATE

Center to Advance Palliative Care
capc

Other Age-Friendly Programs:

AAHCM AMERICAN ACADEMY OF HOME CARE MEDICINE

HCCI HOME CENTERED CARE INSTITUTE

National Home-Based Primary Care Learning Network

Geriatric Surgery Verification
QUALITY IMPROVEMENT PROGRAM

Hospital AT Home USERS GROUP

The John A. Hartford Foundation

A special thank you to AHA for its dedication to the Age-Friendly Health Systems movement

American Hospital Association™
Advancing Health in America

Age-Friendly Health Systems

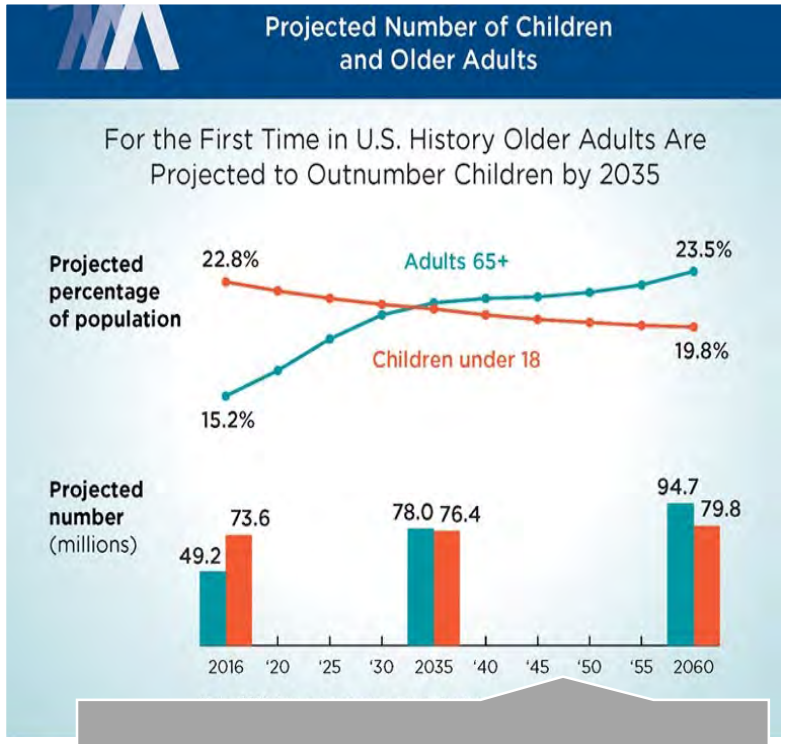
Join Us in the Age-Friendly Movement

The John A. Hartford Foundation

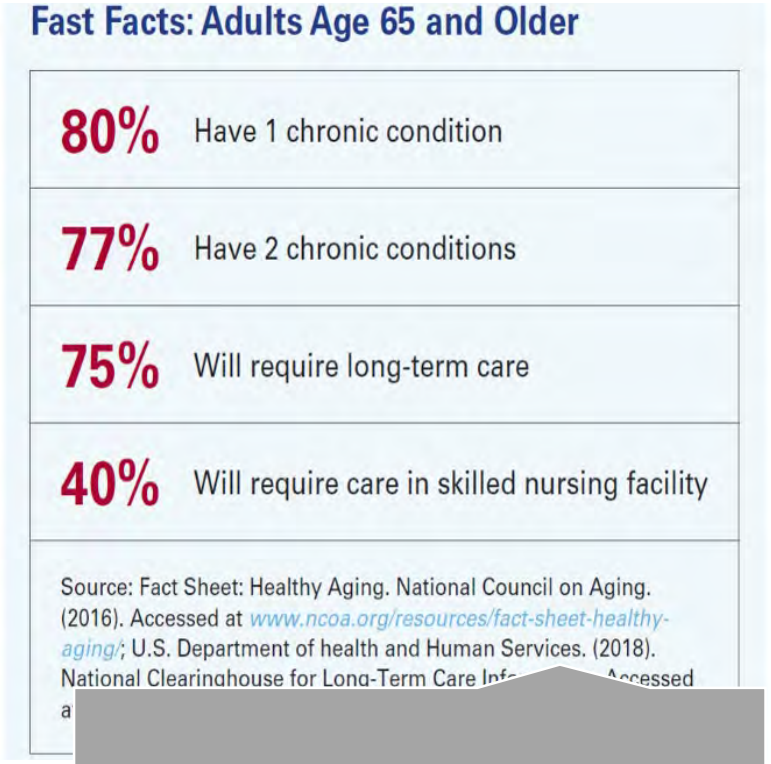
- **Visit** johnahartford.org for information on all programs noted
- **Subscribe** and receive regular updates on resources and tools you can use
- **Share** your ideas with us about how to improve care for older adults through age-friendly care


DEDICATED TO IMPROVING THE CARE OF OLDER ADULTS • 1929 •
The John A. Hartford Foundation
Thank You!
Rami.Snyder@johnahartford.org
WWW.JOHNAHARTFORD.ORG
DEDICATED TO IMPROVING THE CARE OF OLDER ADULTS

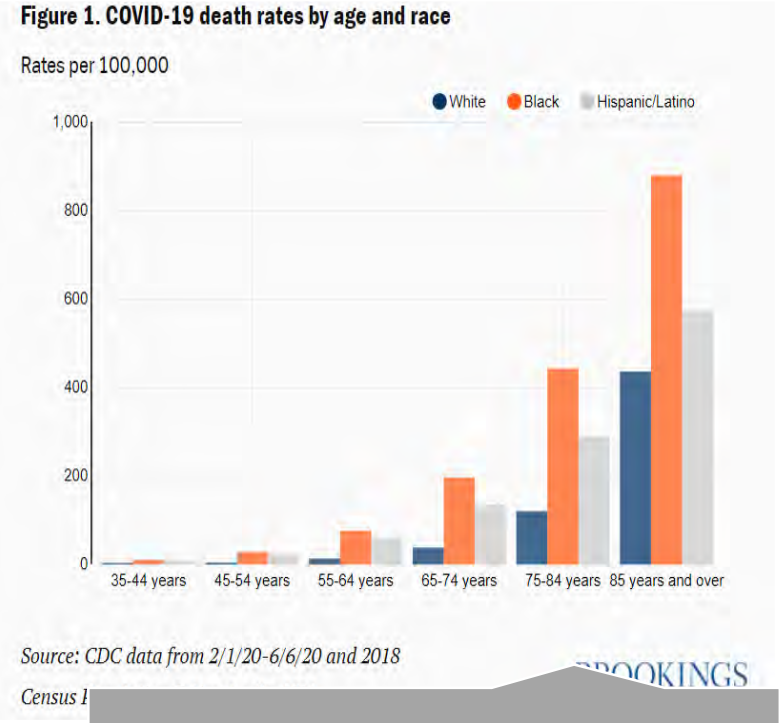
Why Age-Friendly Health Systems?



Demography

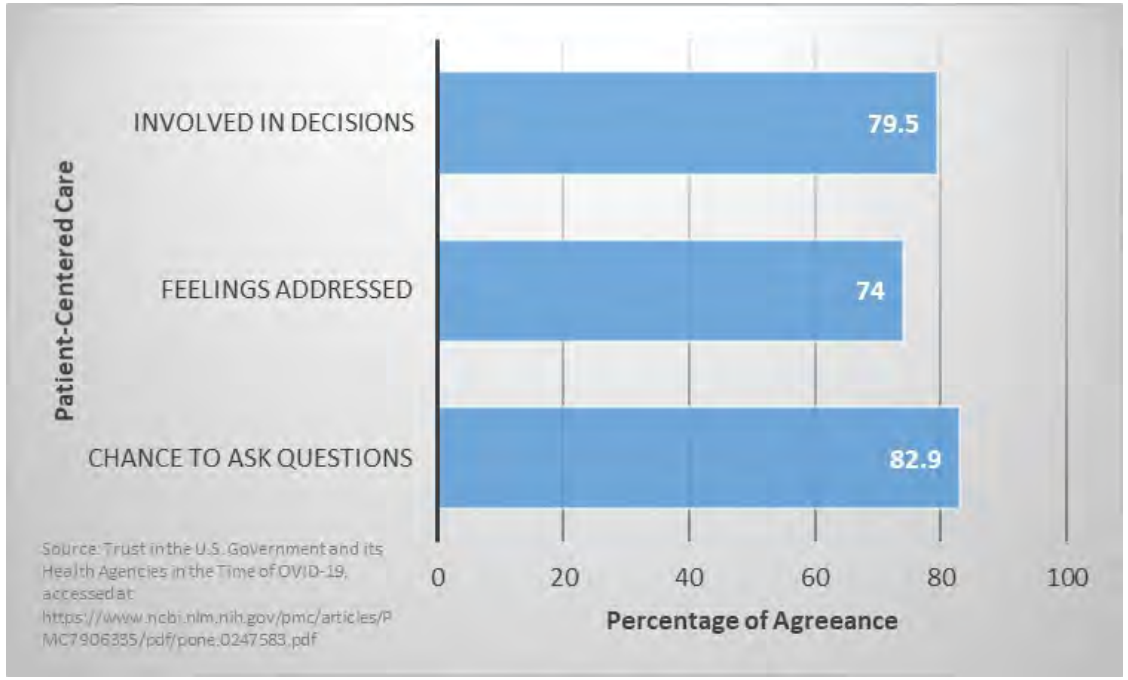


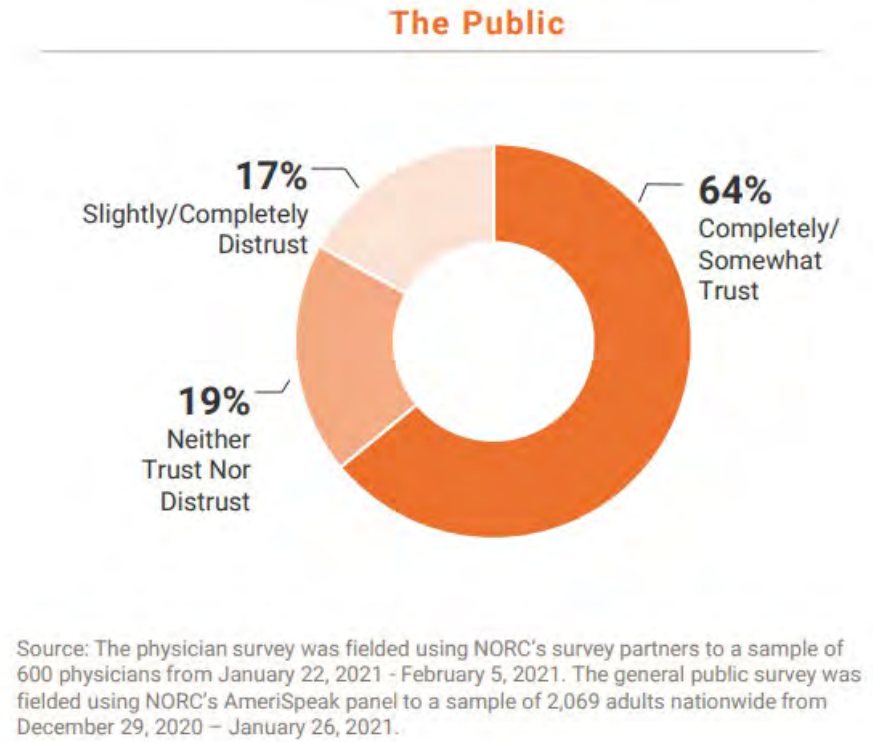
Complexity



Disproportionate Harm

Patient-Centered Care Directly Influences Levels of Public Trust in Healthcare Systems





Source: The physician survey was fielded using NORC's survey partners to a sample of 600 physicians from January 22, 2021 - February 5, 2021. The general public survey was fielded using NORC's AmeriSpeak panel to a sample of 2,069 adults nationwide from December 29, 2020 – January 26, 2021.

2022-2024 AHA/HRET Strategic Plan

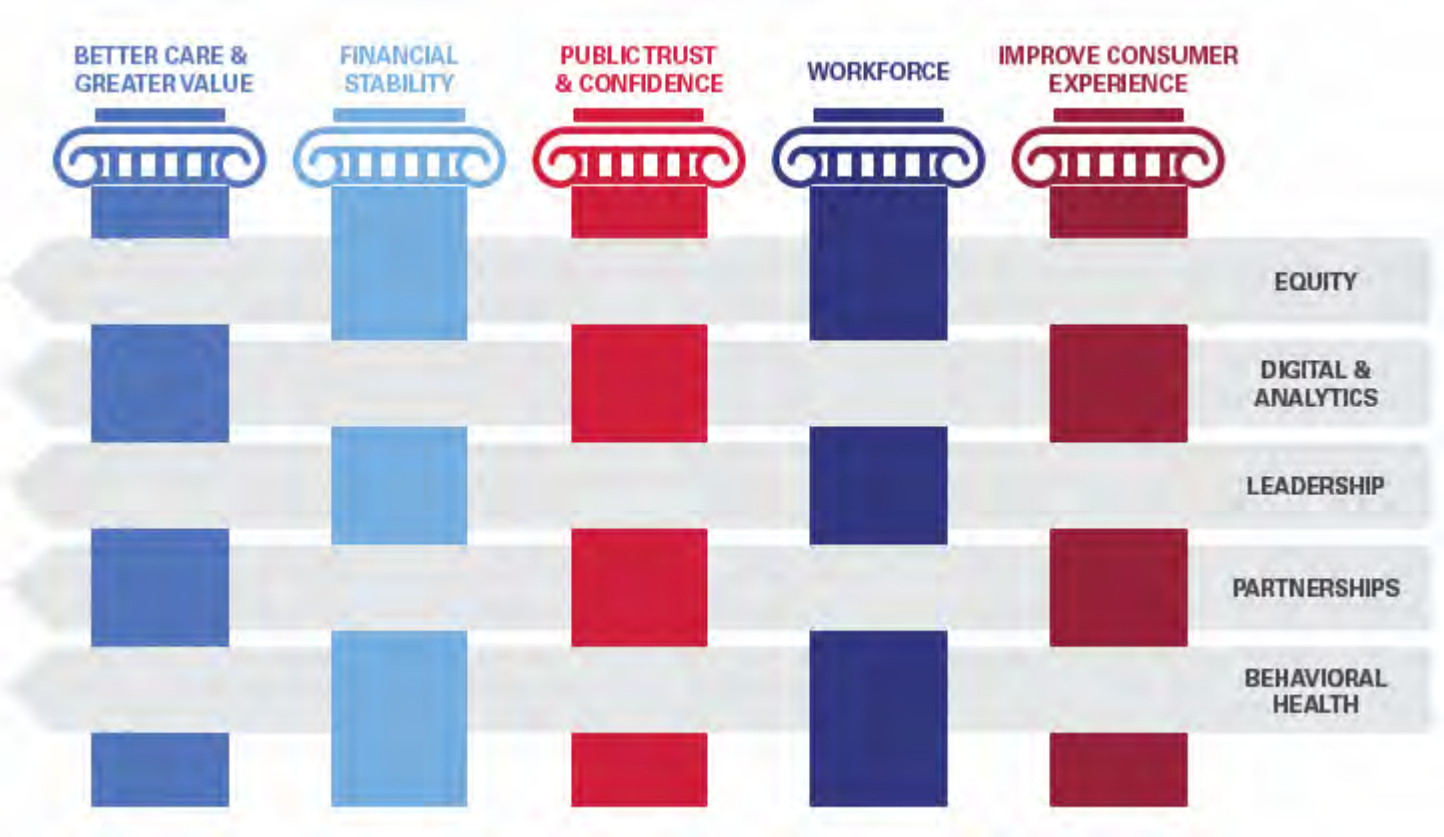
The strategies and priority issues of the AHA are focused on accomplishing the broader goals of:

- ► Provide Better Care and Greater Value
- ► Ensure the Financial Stability of Hospitals and Health Systems
- ► Enhance Public Trust and Confidence in Hospitals and Health Systems
- ► Address Workforce Challenges: Now, Near and Far
- ► Improve the Health Care Consumer Experience

The AHA is the trusted partner of hospitals and health systems and stands ready to work in collaboration to advance health in America. Visit www.aha.org for more.

AHA/HRET Strategic Plan

OUR PILLARS 7 GOALS (2022-2024)



OUR APPROACH

ADVOCACY/ REPRESENTATION	THOUGHT LEADERSHIP	KNOWLEDGE EXCHANGE	AGENT OF CHANGE
Advancing field priorities in Congress, with the Administration, in courts, in media, in public opinion and beyond.	Highlighting thoughts, data, insights and solutions that are new or do not yet have consensus.	Facilitating the exchange of information and best practices in a way participants can understand and apply it.	Supplying tools and information to empower people to enact change in organizations, systems and communities.

Our Partners

Terry Fulmer, PhD, RN
President, The John A. Hartford Foundation

Amy Berman, BSN, LHD
Senior Program Officer
The John A. Hartford Foundation

Kedar Mate, MD,
President and CEO, IHI

Leslie Pelton, MPA,
Vice President
IHI

KellyAnne Pepin, MPH
Project Director
IHI

Julie Trocchio, MS,
Senior Director
Community Benefit and Continuing Care, CHA

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

What is Our Goal?

Build a social movement so ***all care*** with older adults is ***age-friendly care***:

- Guided by an essential set of evidence-based practices (4Ms);
- Causes no harms; and
- Is consistent with What Matters to the older adult and their family.

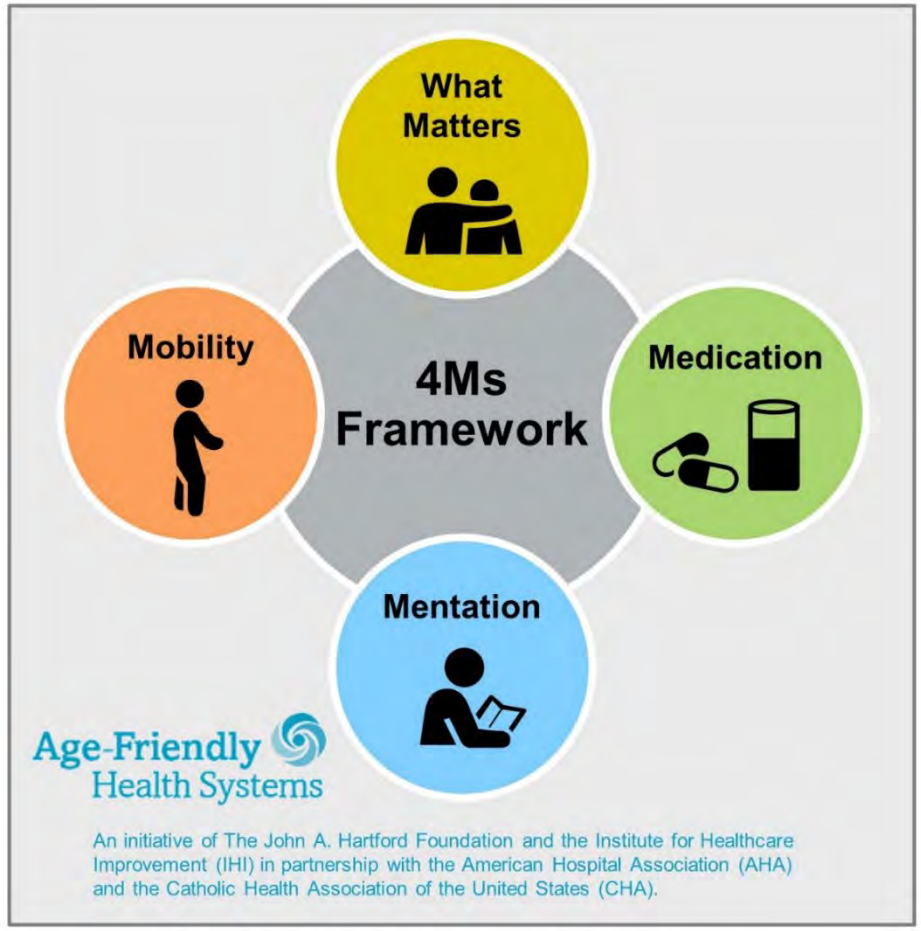
Specific Aims:

✓ By 12/31/20: Reach older adults in 1000 hospitals and practices recognized as Age-Friendly Health Systems

✓ By 6/30/23: Reach older adults in 2500 hospitals and practices, and 100 post acute communities recognized as Age-Friendly Health Systems

What is an Age-Friendly Health System?

- Represents core health issues for older adults
- Builds on strong evidence base
- Simplifies and reduces implementation and measurement burden on systems while increasing effect
- Components are synergistic and reinforce one another



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

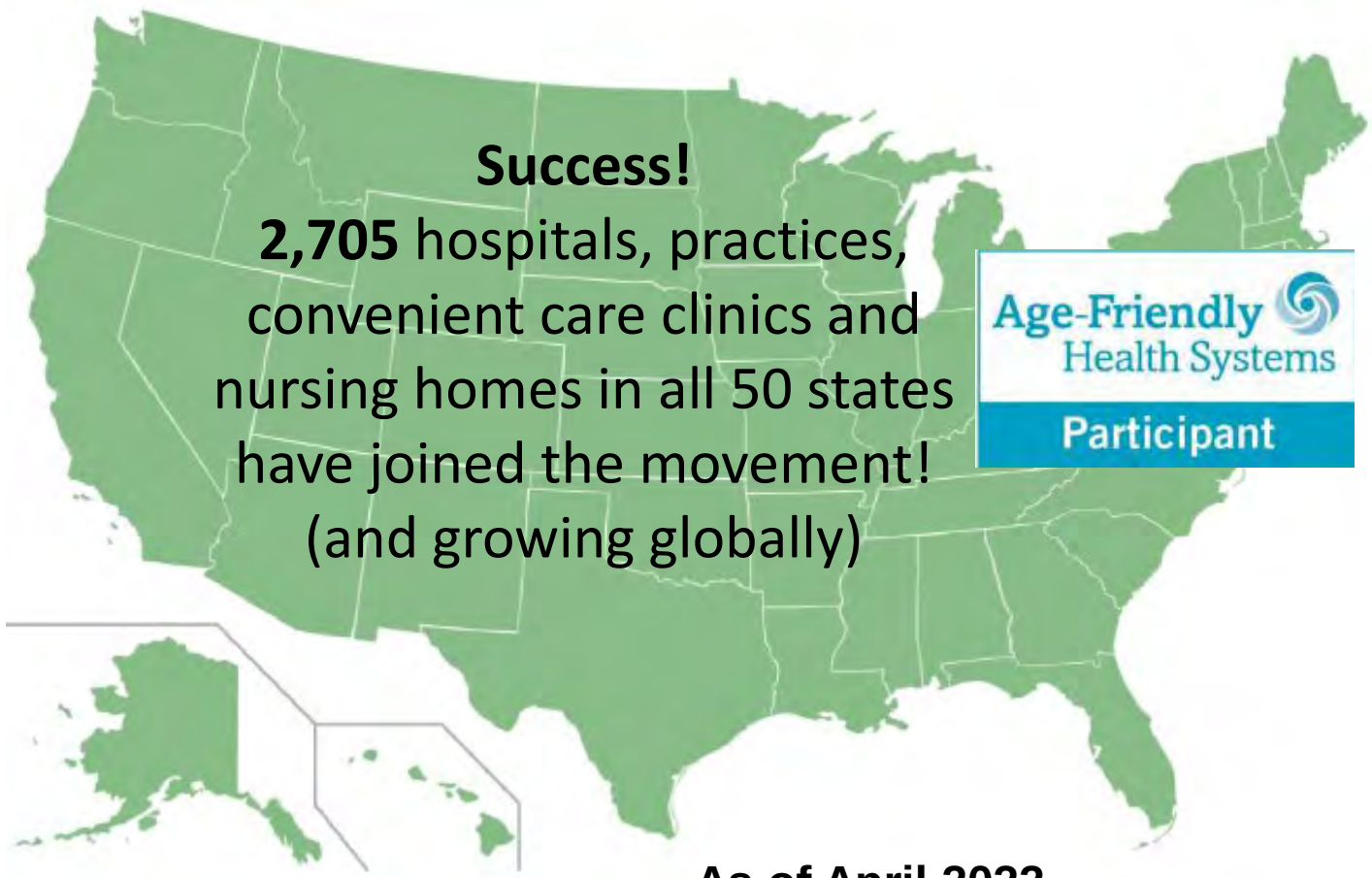
A Goal Met and a Growing Movement!

Goal #1 Achieved: **Spread to 1,000 sites by end of 2020**

Goal Achieved!

Goal #2 Achieved: **Spread to 2,600 sites by June 2023**

Goal Achieved!



As of April 2022

728

Age-Friendly Health Systems
Committed to Care Excellence for Older Adults

More than **1,400,000** older adults have been reached with 4Ms care

Age-Friendly Action Communities

In an Action Community, teams from across different organizations come together to accelerate their work of putting the 4Ms into practice. During the 7-month virtual learning community, your team will test the 4Ms Framework and share learnings.

- Multiple sites of care within an organization can join at the same time
- No cost to participate. The cost of participation includes the time teams must allocate to engage in 7 month Action Community activities
- The Action Community testing and learning is designed to occur as part of each person's existing activities and is, therefore, a re-purposing of time

Pioneers

Anne Arundel Medical Center

Ascension

Kaiser Permanente

Providence St. Joseph Health

Trinity Health

Age-Friendly Health Systems Pioneer

Age-Friendly Health Systems

Engage in the AHA Action Community

7 Months

Participate in monthly interactive webinars

- Monthly content calls focused on 4Ms
- Opportunity to share progress and learnings with other teams

In-person meeting

- One in-person or virtual meeting (TBD)

Test Age-Friendly interventions

- Test specific changes in your practice

Share data on a standard set of Age-Friendly measures

- Submit a 4Ms Care Description worksheet to IHI on a standard set of processes to identify opportunities for improvement

Join monthly topical coaching sessions

- Join other teams for measurement and testing support in monthly coaching sessions

Leadership track to support system-level scale up

- Leaders join quarterly C-suite/Board level calls to set-up local conditions for scale up (Hosted by IHI)

Age-Friendly Health System Action Community

Age-Friendly Health Systems

Age-Friendly Health System Recognition

An Age-Friendly Health System…

- **Defines** the 4Ms for its hospital and/or practice

- **Counts** the number of 65+ people whose care includes the 4Ms (reported by each site)

- **Scales** the work and **celebrates** recognition nationally

Age-Friendly Health Systems
Participant

Age-Friendly Health Systems
Committed to Care Excellence for Older Adults

Age-Friendly Health Systems

Improve Outcomes - Providence St. Joseph Health

- What Matters conversation guide, convened a patient advisory council, rolled out an outpatient mobility program
- Trained provider champions in 12 primary care clinics through a Geriatric Mini-Fellowship, formed in 2018.
  - 65 and older **twice as likely** to be screened for fall risk and cognitive impairment, were **4 times more likely** to receive fall-risk interventions, and **engaged** in more “what matters” conversations.
  - **3% reduction in high-risk medication** upon seeing a mini fellow, and **2%-7% decrease in hospitalizations** for patients seen at the mini fellow clinics.
  - https://oregon.providence.org/forms-and-information/p/providence-selected-for-national-initiative-to-create-new-models-of-care-for-seniors/

Improve Outcomes – Cedars-Sinai Medical Center

- Time to surgery for hip and other serious fractures—meaning the time from arrival in the emergency room until entering the operating room—has declined by **41%.**
- Length of stay in the hospital was cut **11%**, down to four-and-a-half days.
- Program saved **$330,000 in direct costs** its first year, when it served 153 patients.
- Expanding to cover about 300 patients a year.
- Annual savings of about **$1 million** are projected.

THE Value Initiative

Join AHA Action Community 2022-2023

- **Join and get your Age-Friendly Recognition. It's FREE**
- **AHA AFHS Action Community is from September 2022 – April 2023**
  - Starts Mid-September with 2 Kick off Calls
  - Starting October
    - Monthly all-team webinars
    - Quarterly Scale-up leaders webinars
    - Sharing testing and learnings on peer to peer calls
    - 1:1 coaching calls
  - Celebration of joining the movement!

- **Download AHA's Invitation Guide**
- **Visit aha.org/agefriendly to learn more**
- **Email ahaactioncommunity@aha.org with any questions or to set up a 1:1 coaching call.**

Enroll Today

Continuum of Care

Community Based Partnerships

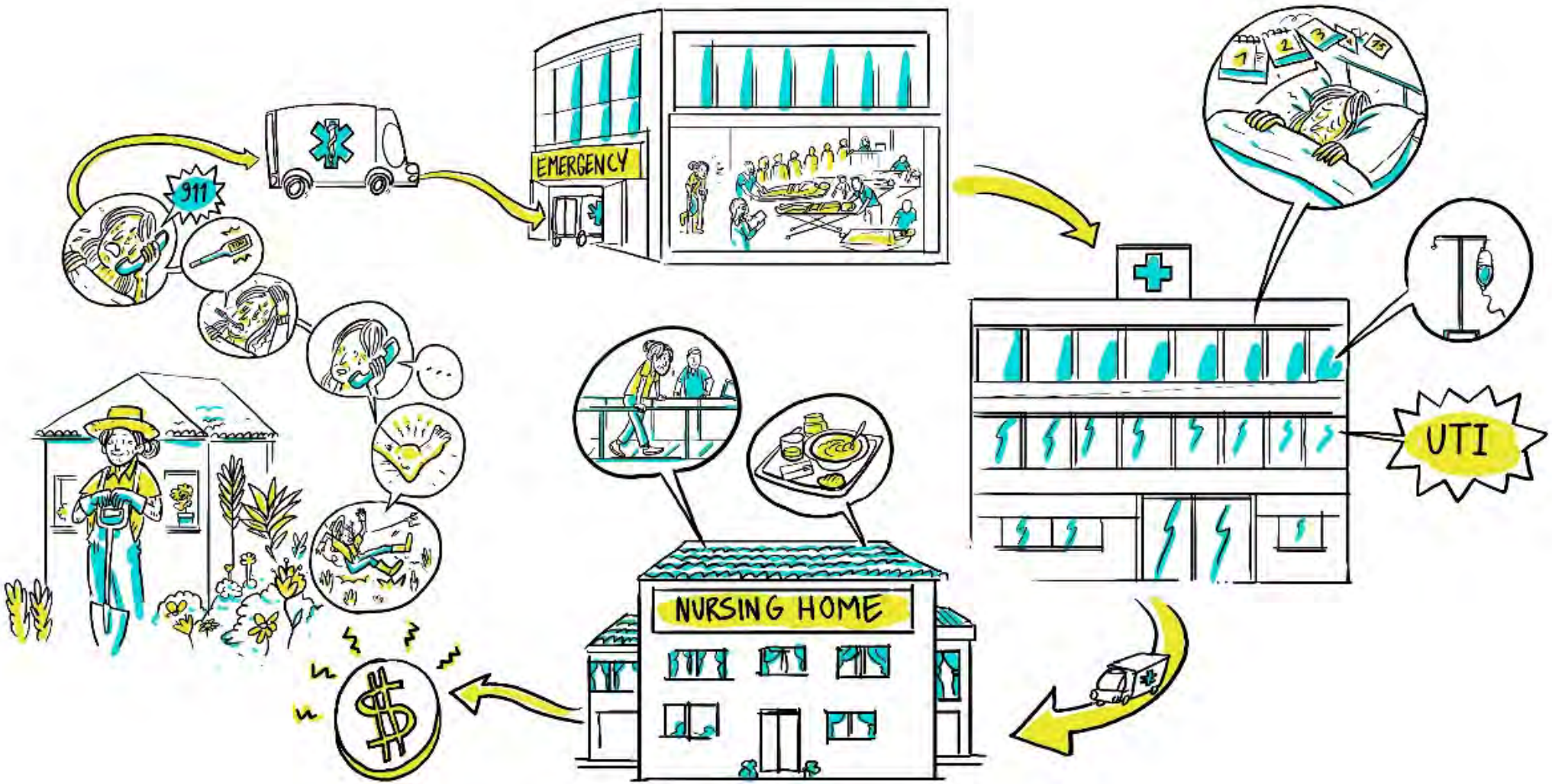
Geriatric EDs: Core capacity to treat an aging population

Kevin Biese
MD, MAT

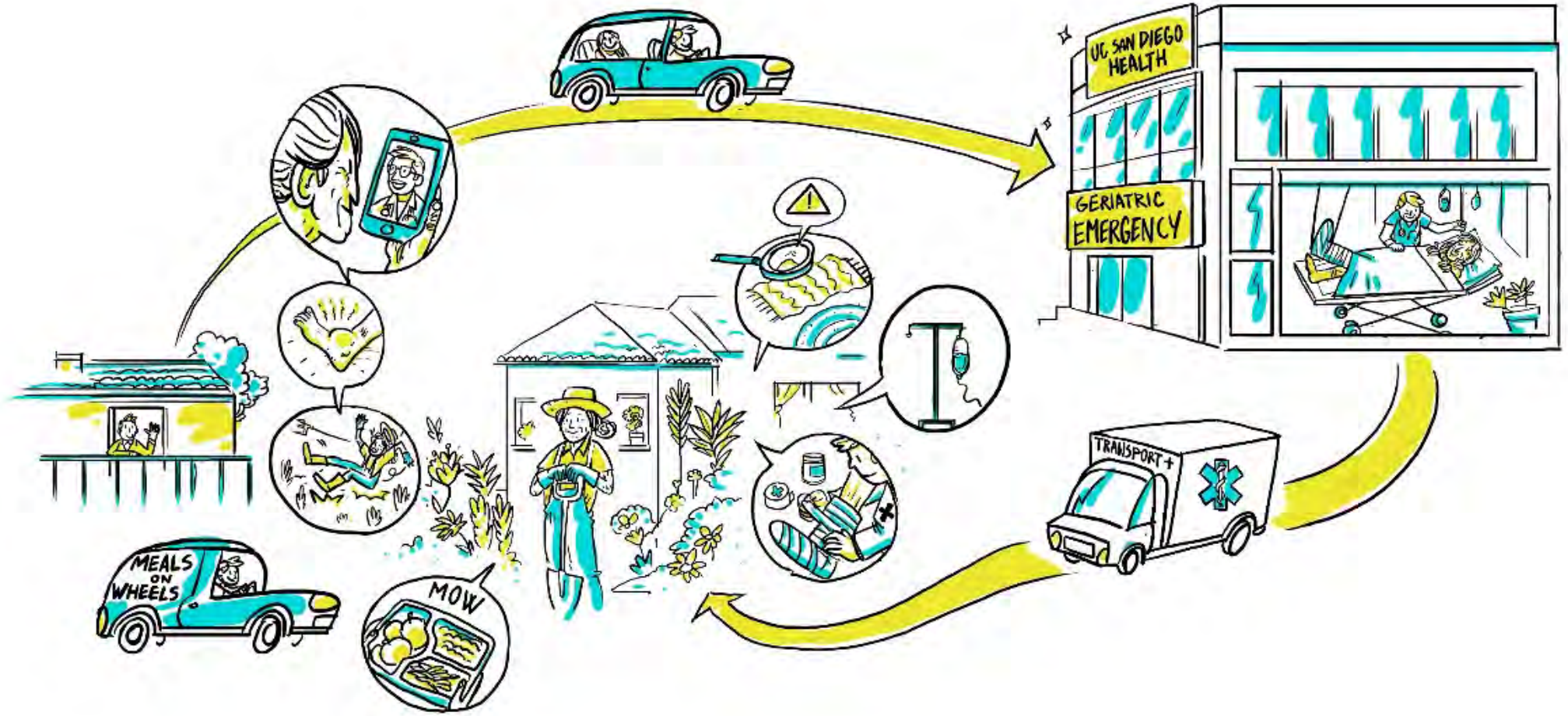
Geriatric Emergency Department Collaborative Implementation PI

Chair, Geriatric Emergency Department Accreditation

GEDC

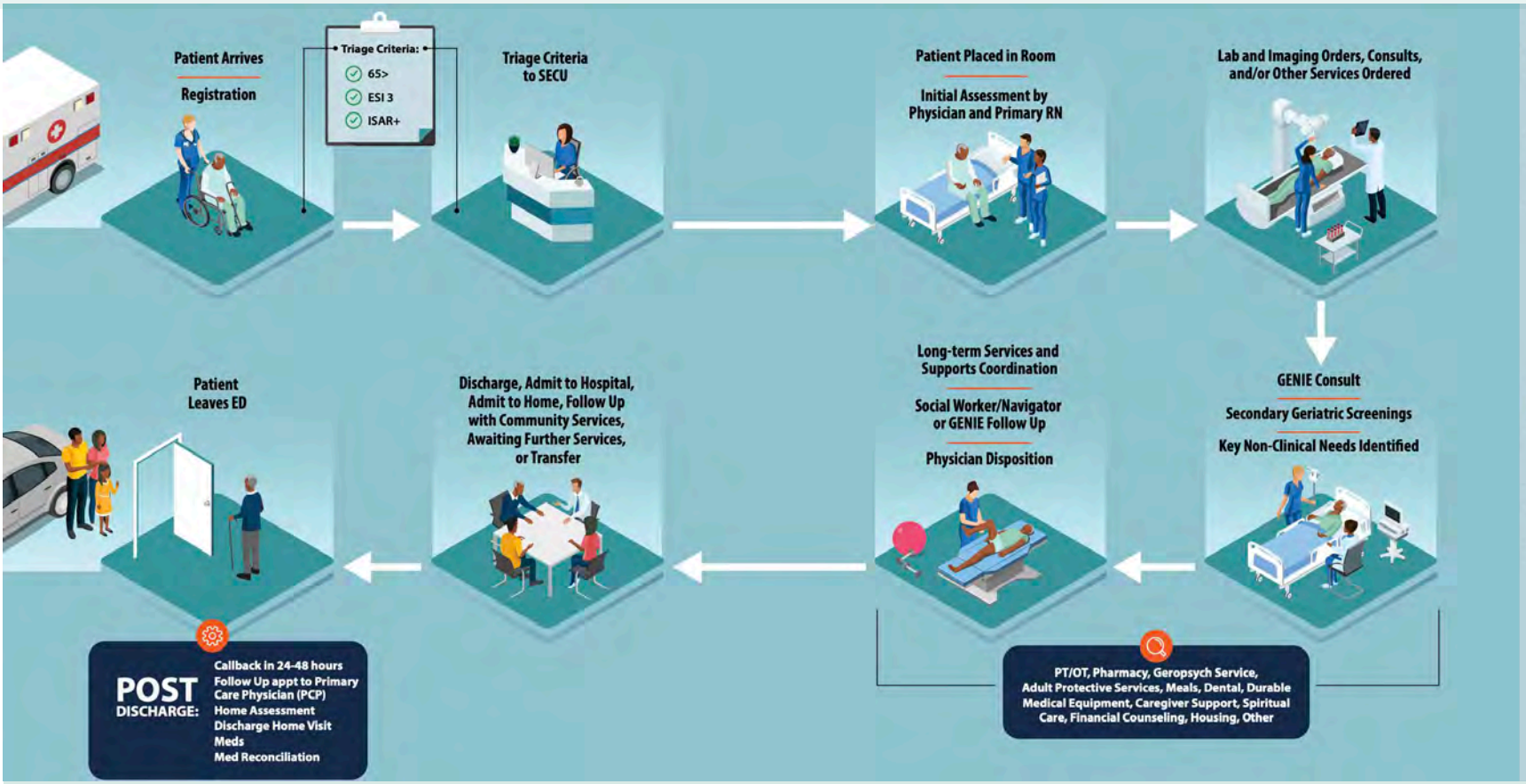


GEDC

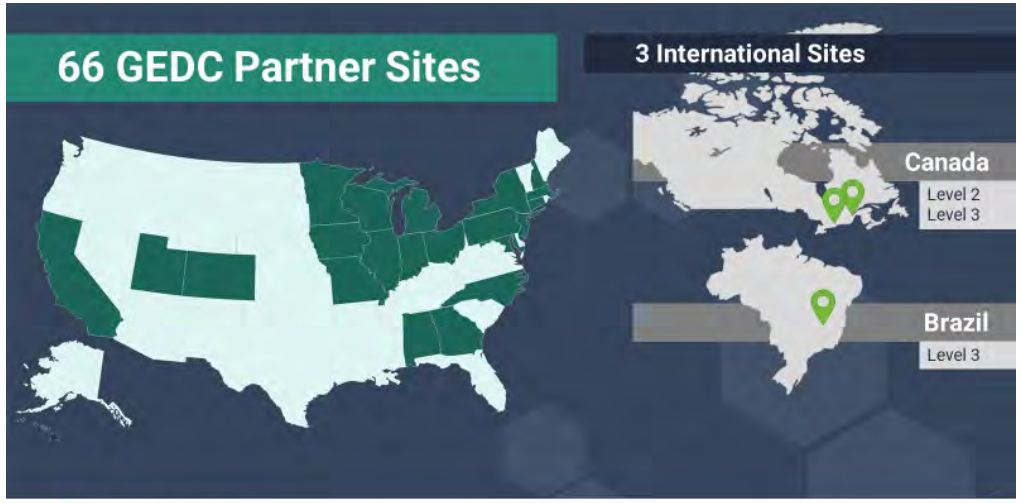


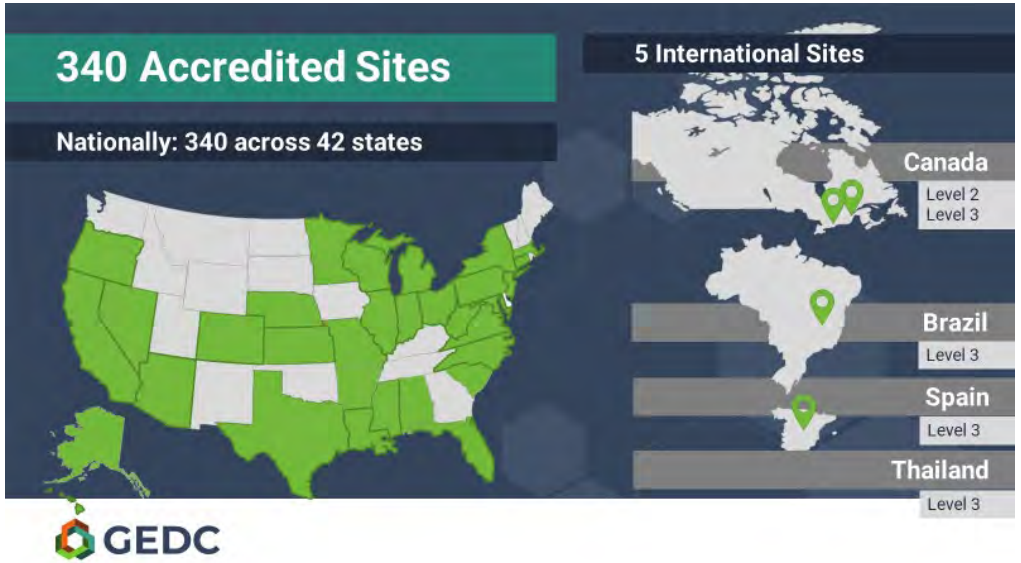
GEDC

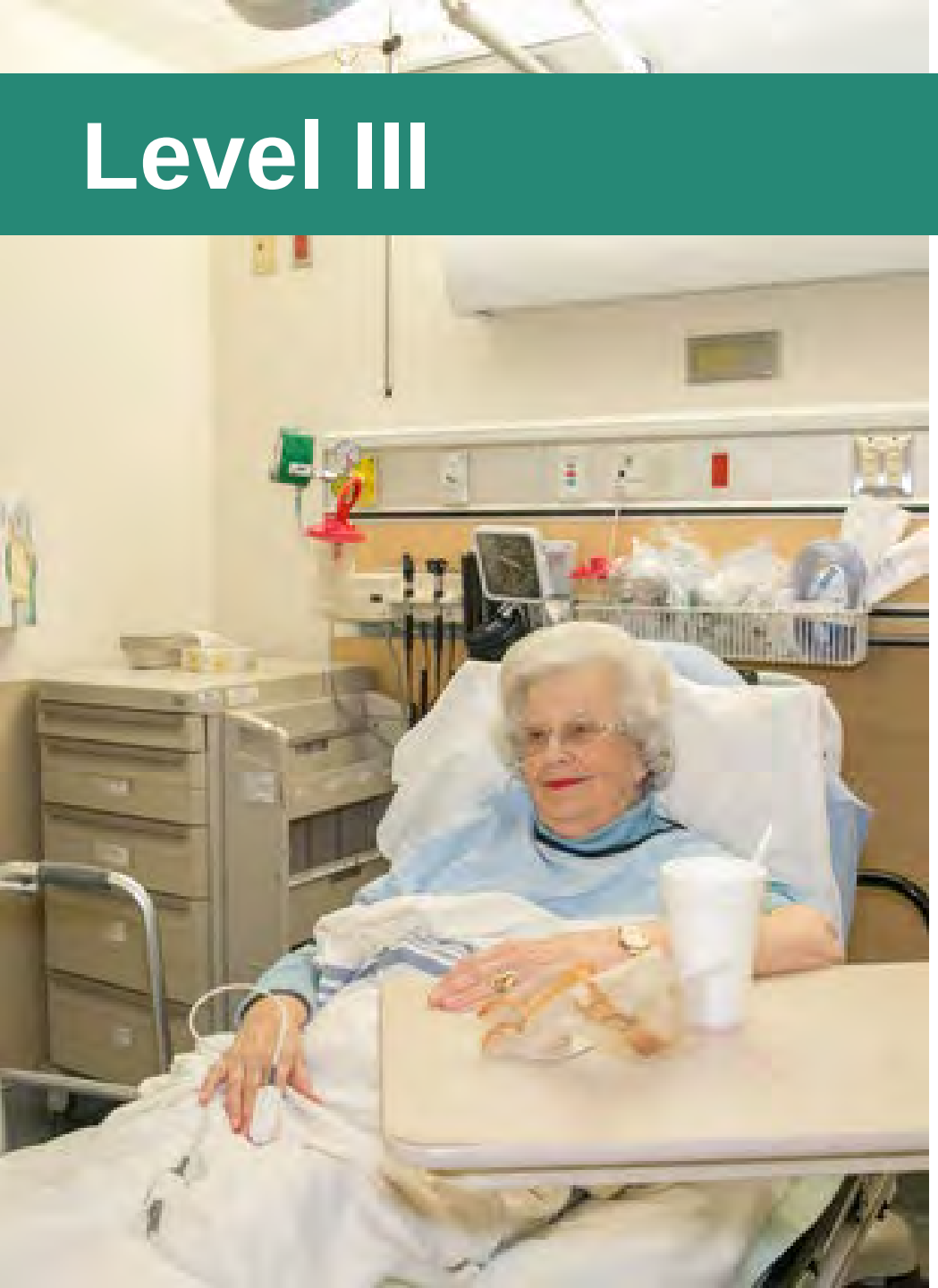
GEDs Provide Standardized and Integrated Care



GEDC







Level III

Good geriatric ED care

- At least one MD and one RN with evidence of geriatric focus (champions)
- Evidence of geriatric focused care initiative
- Mobility aids
- Food & drink 24/7

Level II

Advanced geriatric ED care

- Physician & nurse champions (medical/ nurse director) with focus on geriatric EM
- Geriatric-focused nurse case manager 56 hours/ week
- Geriatric assessment team: 2 of PT, OT, SW or Pharmacy available in ED
- Hospital executive-assigned supervision of and support for geriatric ED resources
- Geriatric EM education for MDs and RNs
- Demonstrable adherence to at least 10 (of 26) policies and protocols
- QI process for selected policies
- Tracking at least 3 of 11 outcome measures
- Physical supplies and food/drink

Level I

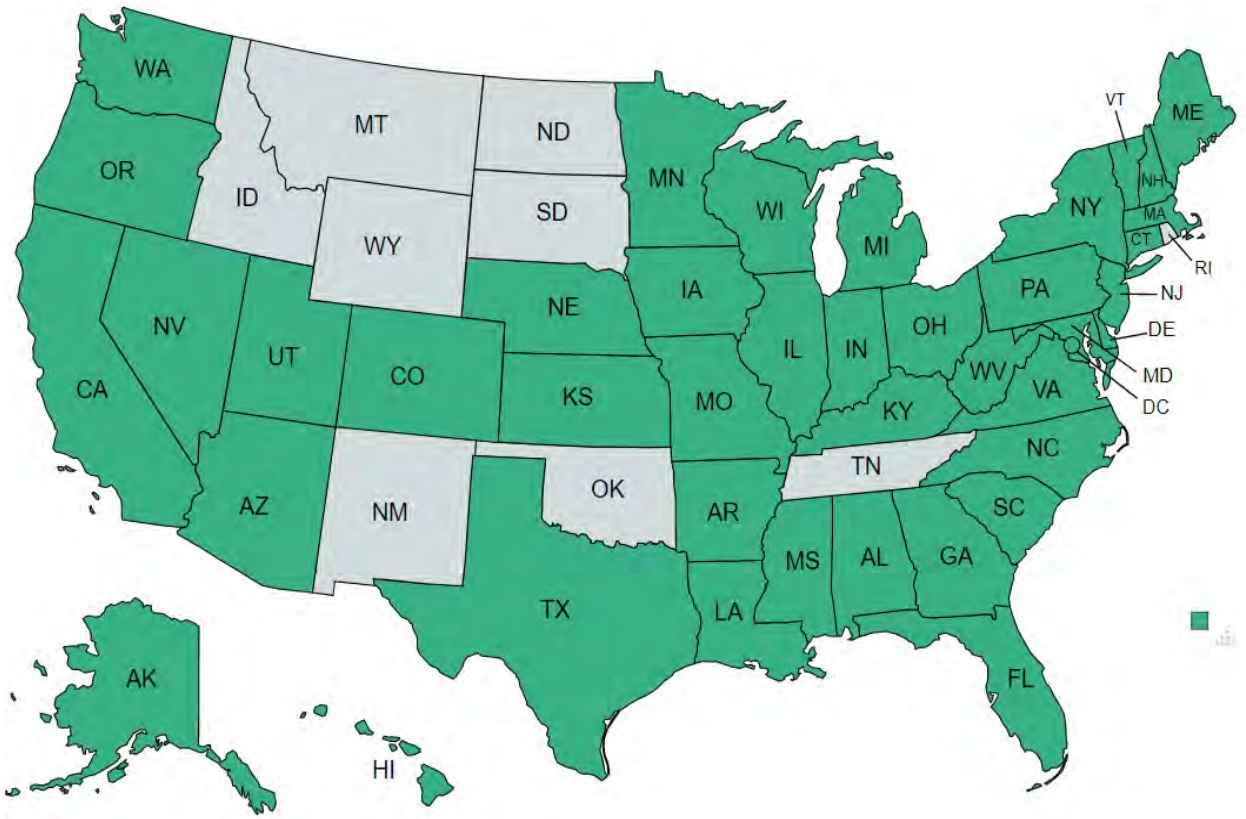
Center of excellence in geriatric ED care

- Physician & nurse champions (medical/nurse director) with focus on geriatric
  EM + patient advisor
- Geriatric-focused nurse case manager 56 hours/ week
- Geriatric assessment team: 4 of PT, OT, SW or Pharmacy available in ED
- Hospital executive-assigned supervision of and support for geriatric ED resources
- Geriatric EM education for MDs and RNs
- Demonstrable adherence to at least 20 (of 27) policies and protocols
- QI process for selected policies
- Tracking at least 5 of 11 outcome measures
- More physical supplies, space modifications and food/drink

Geriatric EDs: Spread

GEDC THE GERIATRIC EMERGENCY DEPARTMENT COLLABORATIVE
EDUCATE IMPLEMENT EVALUATE

Level 1	22
Level 2	38
Level 3	280
	340



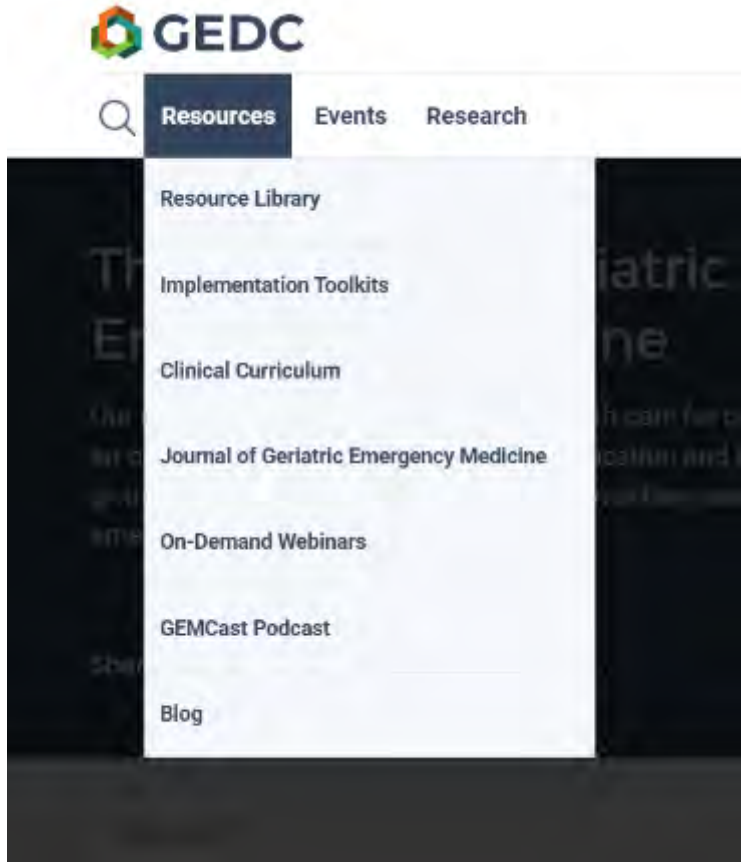
- 340 total GEDA sites
- 42 states represented
- >10% of all older adult ED visits occur at an accredited GED facility

GEDC

GEDCollaborative.com

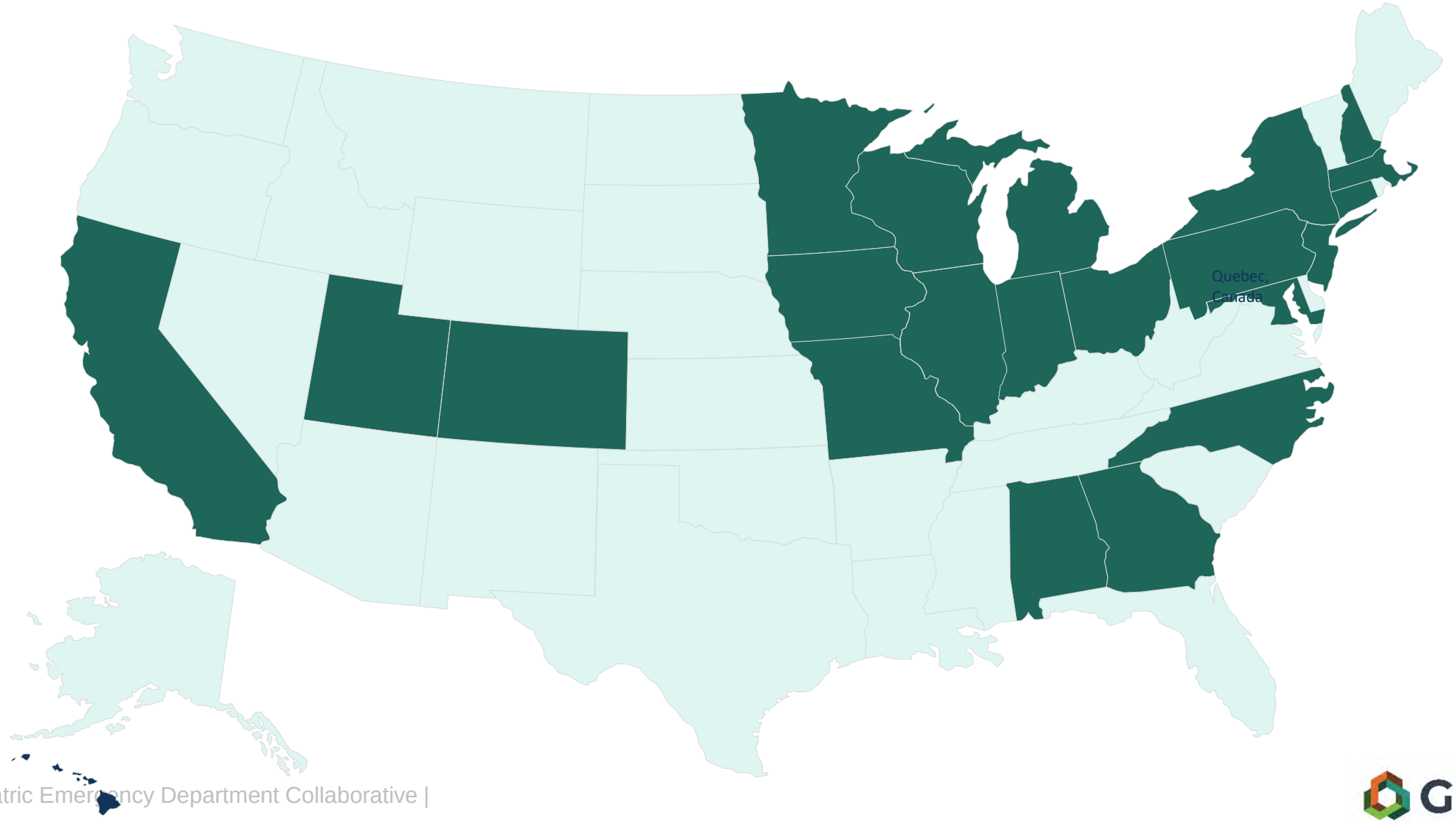
Resources

- Implementation Toolkits
- Clinical Curriculum
- Journal of Geriatric Emergency Medicine*
- On-Demand Webinars
- Blog
- Webinars
- Office Hours
- Tailored, unsearchable resource pages for partners
- Tailored Team Training
- Skills Fair
- Geri-EM
- GEMCAST Podcast



GEDC

66 GEDC Partner Sites



GEDC

Spread of GEDs…

… by system:

Advocate Aurora
- 14 EDs

Cleveland Clinic Health
- 10 EDs

Kettering Health
- 12 EDs

Northwell Health
- 18 EDs

Premier Health
- 7 EDs

Prime Health
- 16 EDs

VA
- 14 EDs (+ >30 sites under development)

Overall
- 32 Health systems have >1 GED

… by regional authority:

San Diego County, CA
- 20/20 EDs committed to becoming GEDs

Bay Area, CA
- 3 diverse EDs focused on dementia care

New York State
- 50% age-friendly health systems by 2023

University of California Health
- 5/5 EDs accredited/pursuing accreditation

GEDC

GEDC Health Care System Roundtable Members

Connection

Exchange among Health Care Systems leading the country in Geriatric Emergency Care

Collaboration

Identify ways each of your teams can support the others in their Quality Improvement Initiatives

Dissemination

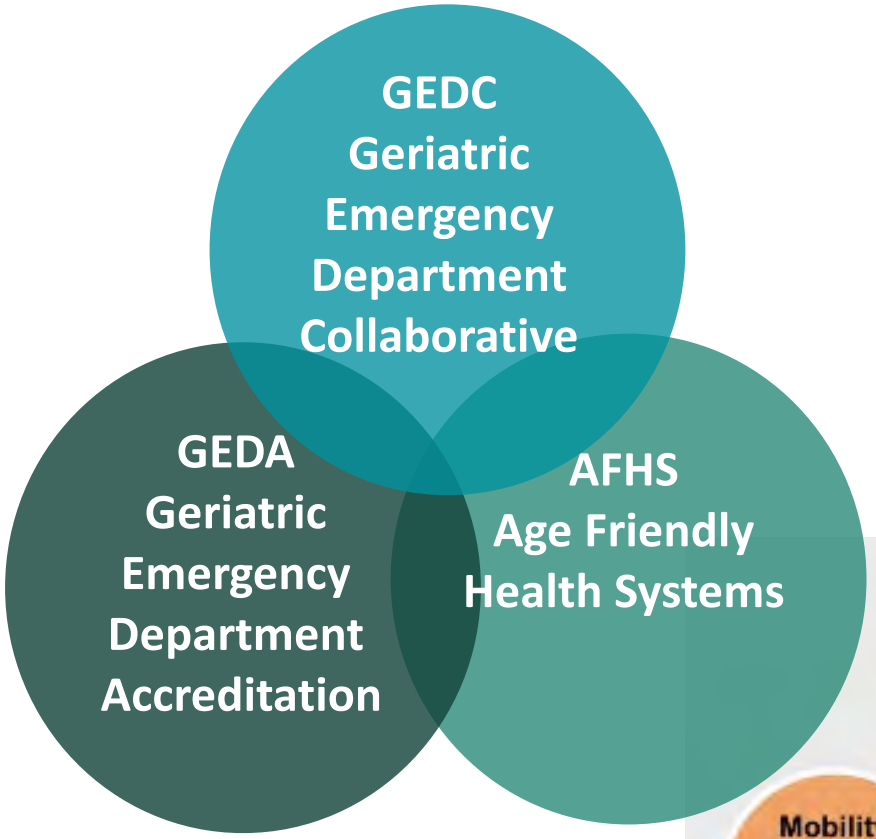
Explore opportunities to share Roundtable insights with other health systems interested in GEDs

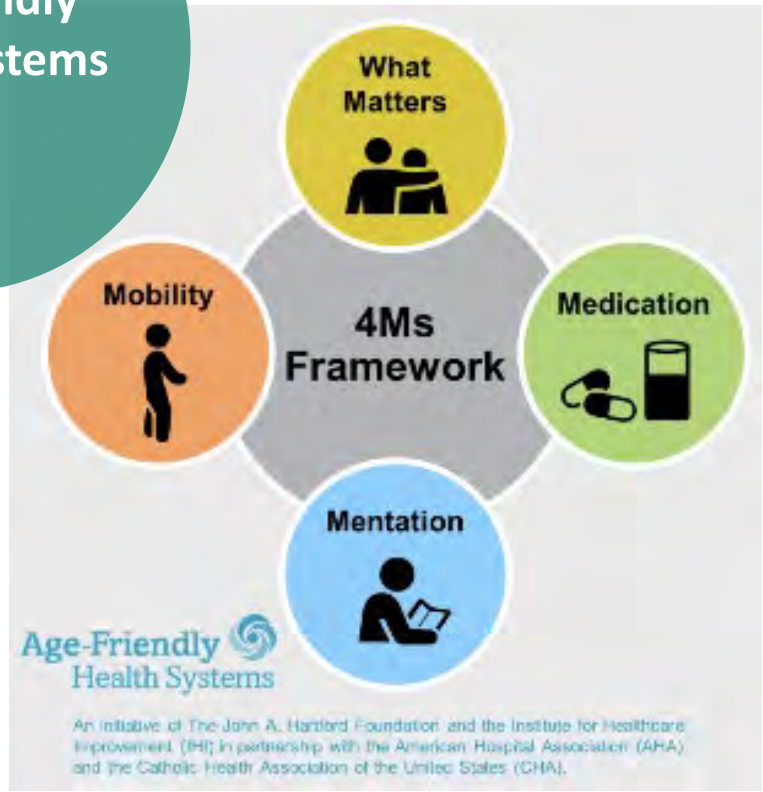
Direction

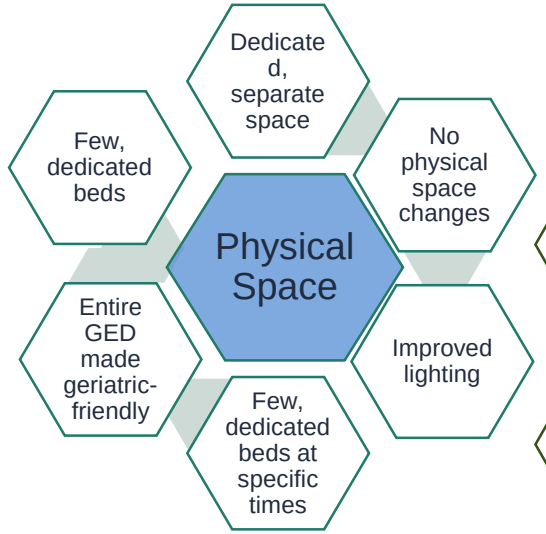
Identify major trends and topics to help lead change across health systems

GEDC

Geri ED Alignment





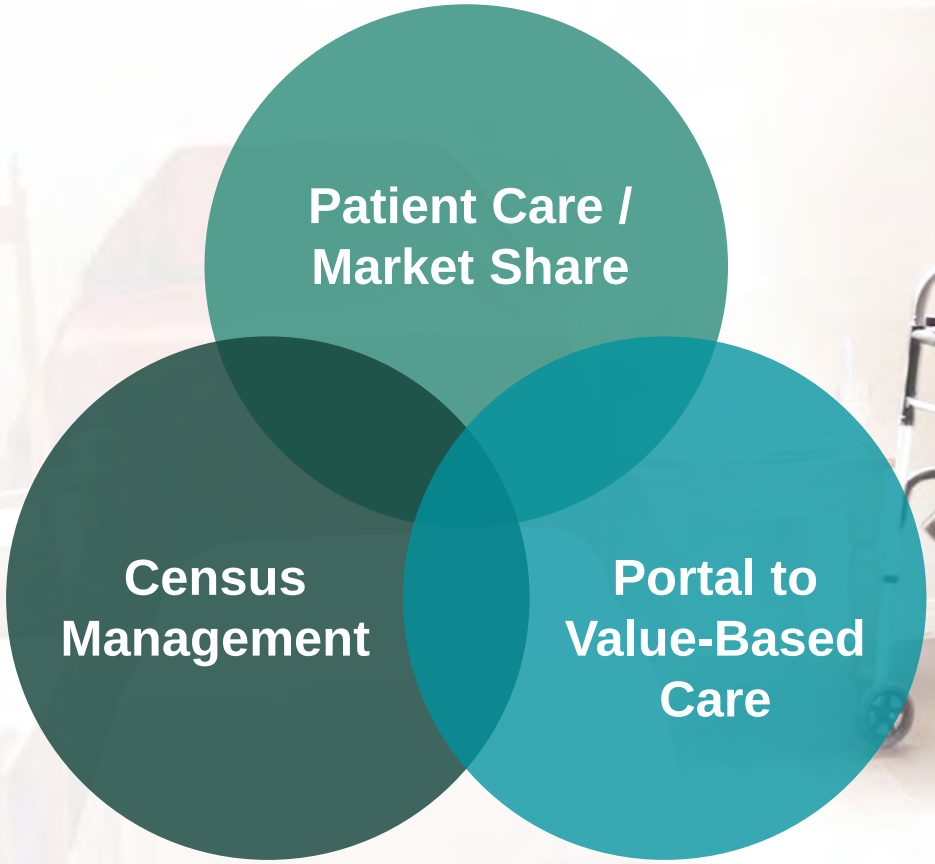


GEDC

A growing body of literature supports Geriatric EDs as a solution

GEDC

Healthcare System GED ROI



GEDC

What can a Geriatric Emergency Department do for my hospital?

Decrease readmissions

Recent update from SE US site:
13 Estimated Readmissions Prevented over first 3 months

Decrease ED revisits in high-risk pops

Midwest GED site: 9% decrease in ED revisits
JAGS article: PT in the ED associated with reduced 30 & 60 day revisits

Increase market share

Actual case: Urban safety net hospital seeking more Medicare patients

Better census management

CFO of academic system in NE: "I am tired of seeing the air-ambulance fly over us because we are on diversion. This can help us put our beds to better use."

Increase staff & patient satisfaction

Result seen at multiple health systems across all levels of accreditation

Reduce readmission penalties in senior patients

Geriatric Emergency Department		References
Goal	Provide senior-focused emergency care to prevent avoidable hospitalizations; improve patient outcomes and satisfaction; ***reduce iatrogenic complications, readmissions and penalties.***	• Koehler, et al., 2009 • Hwang, et al., 2018 • Caplan, et al., 2014
Target Population	Seniors experiencing a medical emergency	
Outcomes/ Source of Hospital ROI	Potentially reduce penalties for readmissions & preventable errors; increase patient satisfaction scores	
Source of Societal ROI	Potentially reduce ED crowding and time on divert status; improve patient outcomes and reduce iatrogenic complications / functional decline	

GEDC

Improve your bottom line

Geriatric Emergency Department		Resources
Goal	Provide senior-focused emergency care to prevent avoidable hospitalizations; improve patient outcomes; ***reduce low or negative margin Medicare patients; and, backfill beds with high-margin admissions***	• Aldeen, et al., 2014 • Wallis, et al., 2018 • Conroy, et al., 2014 • Keyes, et al, 2014 • Wright, et al., 2014 • Hwang, et al, 2018
Target Population	Seniors experiencing a medical emergency	
Outcomes/ Source of Hospital ROI	Potentially reduce penalties for readmissions & preventable errors; increase patient satisfaction scores	
Source of Societal ROI	Reduce seniors' need for ED and hospital care; improve patient outcomes and reduce iatrogenic complications / functional decline; provide a more senior-friendly care experience	

GEDC

Increase market share

Geriatric Emergency Department		Resources
Goal	Provide senior-focused emergency care to prevent avoidable hospitalizations; improve patient outcomes; ***backfill beds with high-margin admissions; and, attract new consumers to our system***	• Aldeen, et al., 2014 • Keyes, et al, 2014 • Hwang, et al, 2018 • Mion, et. al, 2003 • Cossette, et al., 2015 • Guttman, et al., 2004
Target Population	All seniors	
Outcomes/ Source of Hospital ROI	Increase patient satisfaction scores and clinical outcomes; build reputation in the community	
Source of Societal ROI	Improve patient outcomes and reduce iatrogenic complications / functional decline	

GEDC

Reduce crowding

Geriatric Emergency Department		Resources
Goal	Provide senior-focused emergency care to prevent avoidable hospitalizations; improve patient outcomes and satisfaction; and potentially ***reduce ED revisits among high-risk groups*** (e.g., falls, dementia)	• Jacob-sohn, et al., 2019 • Lesser, et al., 2018
Target Population	Seniors experiencing a medical emergency	
Outcomes / Source of Hospital ROI	Potentially reduce penalties for readmissions & preventable errors; increase patient satisfaction scores	
Source of Societal ROI	Potentially reduce ED crowding and time on divert status; improve patient outcomes and reduce iatrogenic complications / functional decline	

GEDC

March 1, 2021

Association of a Geriatric Emergency Department Innovation Program With Cost Outcomes Among Medicare Beneficiaries

Ula Hwang, MD, MPH[1,2]; Scott M. Dresden, MD, MS[3]; Carmen Vargas-Torres, MA[4]; et al

» Author Affiliations | Article Information

JAMA Netw Open. 2021;4(3):e2037334. doi:10.1001/jamanetworkopen.2020.37334

Editorial Comment

Key Points

Question Is there an association between geriatric emergency department (ED) programs and total costs of care for Medicare?

Findings In this cross-sectional study of 24 839 Medicare fee-for-service beneficiaries at 2 EDs, there was a significant association with reduced total costs of care after being seen by either a transitional care nurse and/or social worker trained to deliver geriatric emergency care. Per beneficiary, these savings were as much as $2905 after 30 days and $3202 after 60 days of the index ED visit.

Meaning These findings suggest that geriatric emergency department care programs may be associated with savings value to hospitals and payers.

Abstract

Importance There has been a significant increase in the implementation and dissemination of geriatric emergency department (GED) programs. Understanding the costs associated with patient care would yield insight into the direct financial value for patients, hospitals, health systems, and payers.

Objective To evaluate the association of GED programs with Medicare costs per beneficiary.

Invited Commentary | Health Policy

May 20, 2022

Emergency Department Care Transition Programs- Value-Based Care Interventions That Need System Level Support

Kevin Biese, MD, MAT[1,2]; Timothy A. Lash, MBA[2,3]; Maura Kennedy, MD, MPH[4]

» Author Affiliations | Article Information

JAMA Netw Open. 2022;5(5):e2213160. doi:10.1001/jamanetworkopen.2022.13160

Related Articles

Fruhan and Bills[1] report that their quality improvement callback program for patients presenting to the emergency department (ED) was associated with a decrease in 3-day and 7-day ED revisits compared with control patients who did not receive this intervention. Patients enrolled in the callback program received an automated telephone call 2 days after discharge that asked if they had questions about their discharge instructions and whether they wanted a follow-up telephone call from a clinician. Patients who requested a follow-up telephone call were called by a physician assistant or nurse practitioner. Over 10 weeks, 8110 patients were enrolled in the study, of whom 2958 (36.5%) were enrolled in the callback program. Importantly, the language spoken by the

Invited Commentary | Emergency Medicine

March 1, 2021

Geriatric Emergency Care Reduces Health Care Costs—What Are the Next Steps?

Maura Kennedy, MD, MPH[1,2]; Kei Ouchi, MD, MPH[2,3]; Kevin Biese, MD, MAT[4,5]

» Author Affiliations | Article Information

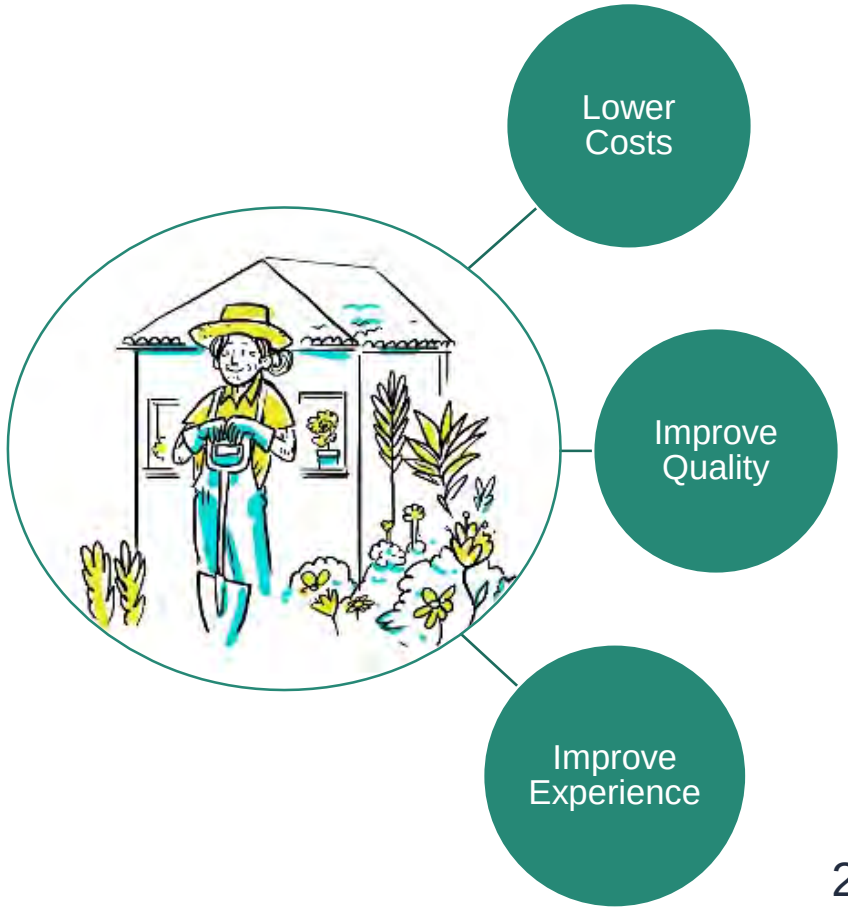
JAMA Netw Open. 2021;4(3):e210147. doi:10.1001/jamanetworkopen.2021.0147

Related Articles

Although older adults frequently receive care in emergency departments (EDs), conventional EDs may not adequately address the unique needs of geriatric patients, such as managing geriatric syndromes, addressing multimorbidity, and optimizing care transitions.[1] In direct response to the unique medical needs of older patients, the first self-identified geriatric ED (GED) in the United States was established more than a decade ago, after which there has been a rapid increase in the number of GEDs.[1] In 2018, the American College of Emergency Physicians launched a voluntary accreditation program, classifying GEDs as level 1 (gold), level 2 (silver), or level 3 (bronze) based on staffing, care processes, physical environment, and specialized equipment.[2] Despite rapid growth in the number of GEDs in the United States, there is limited research on the impact of GEDs and specialized geriatric emergency care models.

The most robust evidence supporting the GED model of care comes from the Geriatric Emergency Department Innovation in Care Through Workforce, Informatics, and Structural Enhancement (GEDI WISE) program. This multicenter care innovation program was supported by a Centers for Medicare & Medicaid Services (CMS) Health Care Innovations Award. It includes transitional care nurses (TCNs) and social workers (SWs) who staff the GEDI WISE level 1 GEDs and conduct geriatric assessments (including evaluations for delirium, fall risk, and functional decline), engage in

GEDs and VBC share similar goals



Up to 16.5% reduced risk of hospital admission[5] and 17.3% of readmission[6]

$3,202 savings per Medicare beneficiary after 60 days[7]

Decreased odds of 30 and 60 day fall-related ED revisit with PT services[8]

87.3% satisfaction with the clarity of discharge information and perceived wellbeing[9]

21 studies showcasing improved experience across a variety of interventions[10]

Collaborating Partnerships

GEDC

Geriatric EDs: THE FRONT PORCH

GEDC
THE GERIATRIC EMERGENCY DEPARTMENT COLLABORATIVE
EDUCATE IMPLEMENT EVALUATE

NY State Master Plan for Aging

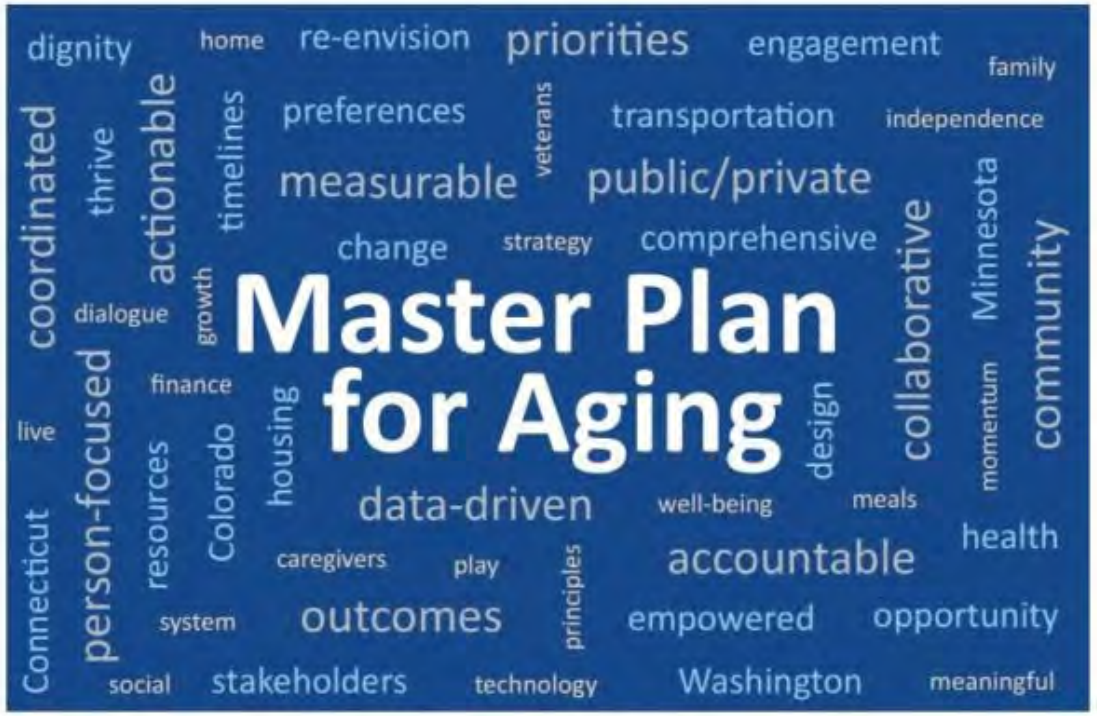
CA State Master Plan for Aging

Patients

NEW YORK STATE

Office for the Aging

- Meals on Wheels
- Area Agency on Aging
- At Home Healthcare



Together We ENGAGE
Master Plan for Aging

- Family Caregiver Alliance
- Transportation and Personal Care Services
- Case Management

Community Resources

EDs take care of those with no other place to go…

An opportunity to enhance Diversity, Equity and Inclusion

GEDC THE GERIATRIC EMERGENCY DEPARTMENT COLLABORATIVE
EDUCATE IMPLEMENT EVALUATE

Generously supported by

The John A. Hartford Foundation

westhealth™ institute

GEDC

Palliative Care:
Improving Quality by Addressing What Matters to Patients and Families

Brynn Bowman, MPA
Chief Executive Officer, Center to Advance Palliative Care

Center to Advance Palliative Care™

capc

Our Mission

The **Center to Advance Palliative Care (CAPC)** is a national organization dedicated to increasing the availability of quality health care for people living with a serious illness.

What is Palliative Care?

An interdisciplinary team-based specialty that:

→ Provides an added layer of support for relief of pain, symptoms, and stresses of serious illness

→ Focuses on patient and family quality of life at the same time as curative or life-prolonging treatment:

→Curable illness

→Chronic illness

→Progressive/terminal illness

capc Center to Advance Palliative Care™

What does palliative care mean in the life of a patient and family?

Meet Mrs. Smith

Louise Smith is an 82-year-old female and is considering her second knee replacement. She had her previous total knee replacement (TKR) 12 years earlier with excellent results.

You are asked to evaluate her for medical optimization in preparation for her surgery.

Meet Mrs. Smith

Mrs. Smith is coping with:

- Chronic renal insufficiency and diabetes
- Mild cognitive impairment
- Urinary incontinence
- Caregiver for her spouse, who is frail, resulting in not being able to spend time with friends
- Unable to go for walks due to knee pain
- Depression
- 2 adult children who live out of town
- 7 prescribed medications

What is at stake for Mrs. Smith?

- **What Matters**: Mrs. Smith and her husband live independently, and want to stay that way

- **Medication and Mentation**: Mrs. Smith is at risk for delirium from surgery and hospitalization

- **Mobility**: Mrs. Smith is no longer able to take walks and care for her husband due to knee pain

capc Center to Advance Palliative Care™

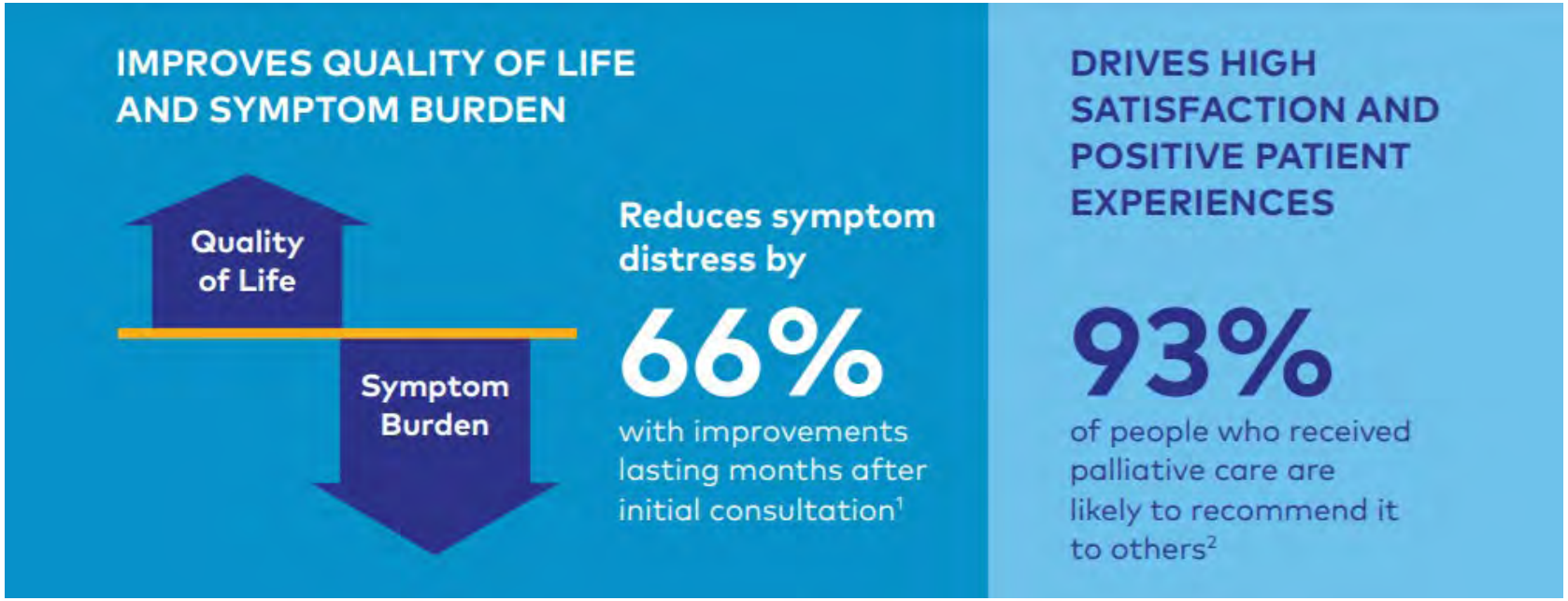
How does palliative care help?

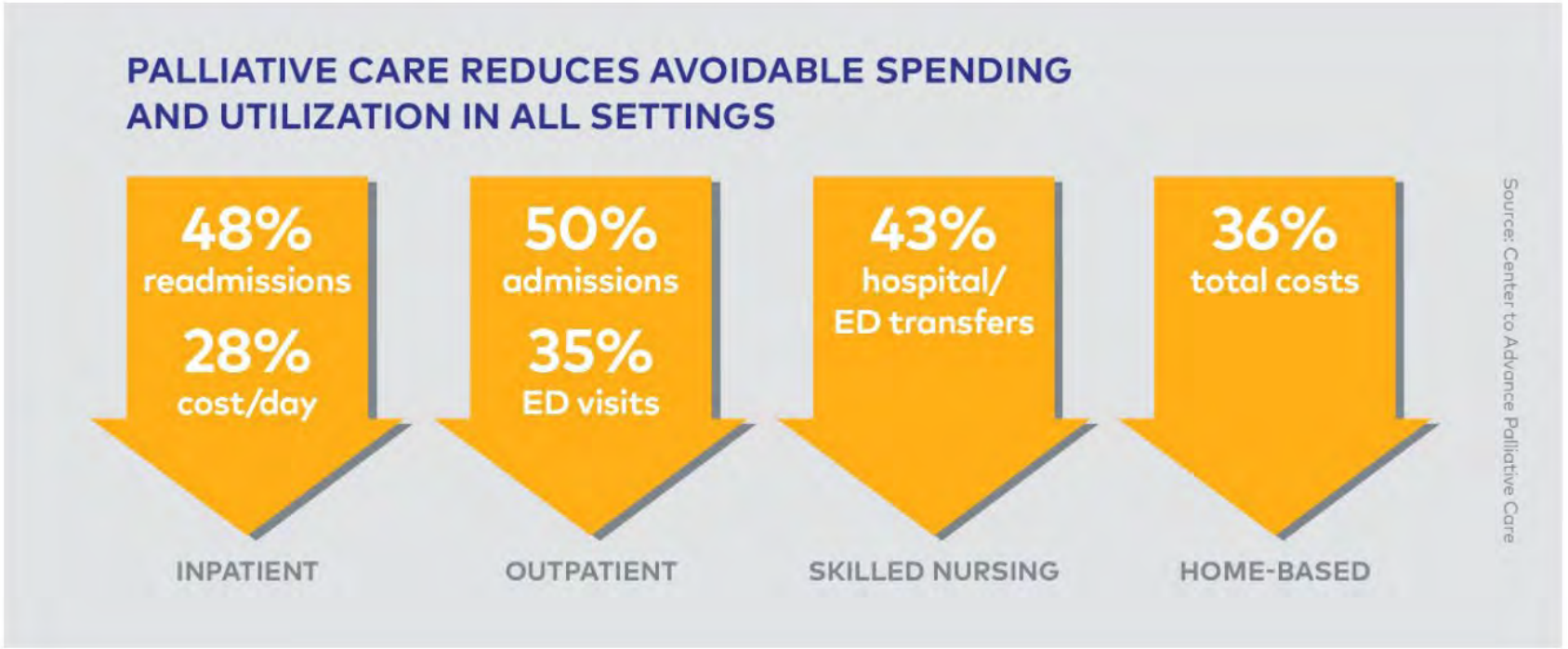
- Discuss the risks and benefits of surgery *in the context of what matters to Mrs. Smith*
- Given high risk of nursing home placement after surgery, decide *with Mrs. Smith* to try alternative ways to address pain prior to surgery
- Connect with physical therapy, arrange home safety evaluation, and order a lift chair
- Optimize pain regimen and reduce polypharmacy
- Connect Mrs. Smith with Meals on Wheels
- Identify a friendly visitor program in Mrs. Smith's community so that she can spend time with friends
- Communicate with Mrs. Smith's children about her and her husband's caregiving needs

The Palliative Care Approach

capc Center to Advance Palliative Care™

Palliative Care Impact





https://www.capc.org/documents/download/245/

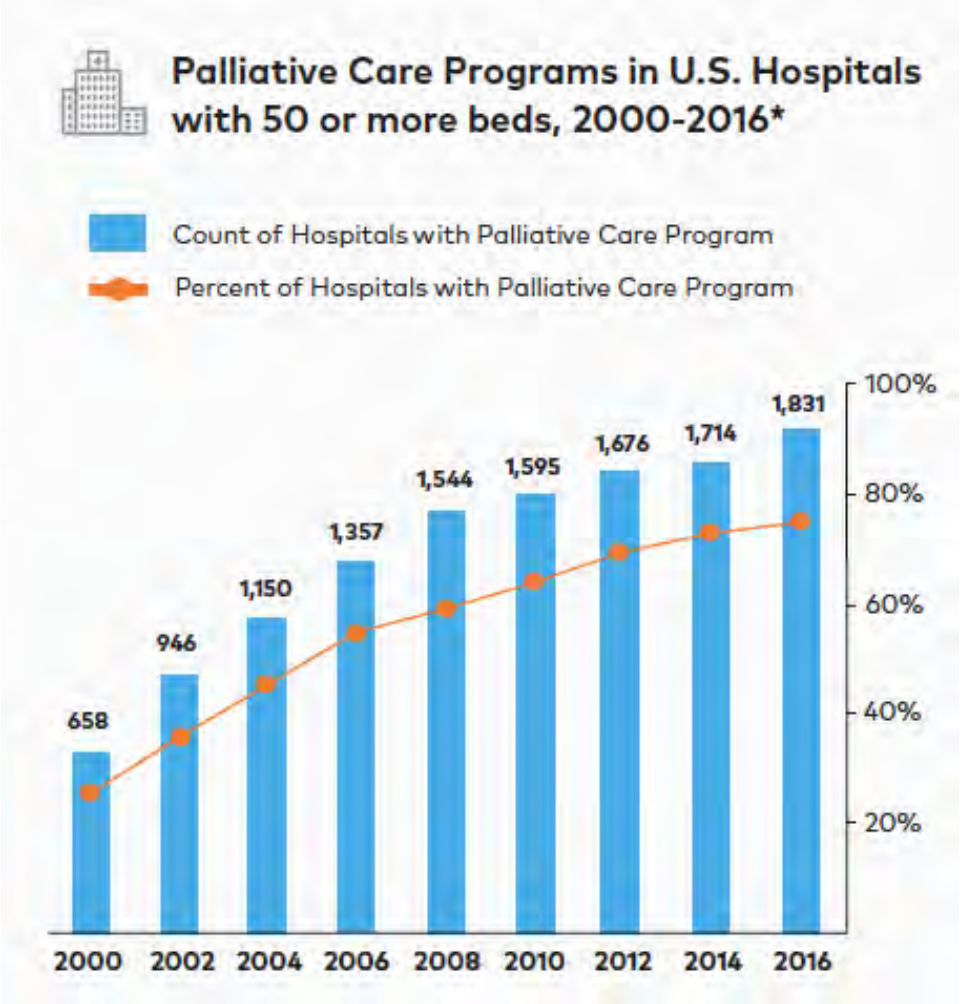
Where is palliative care delivered?

U.S. Hospital Palliative Care Growth

►In 2016, >1,800 hospital programs (78% of US hospitals) were serving over **10MM** patients each year.

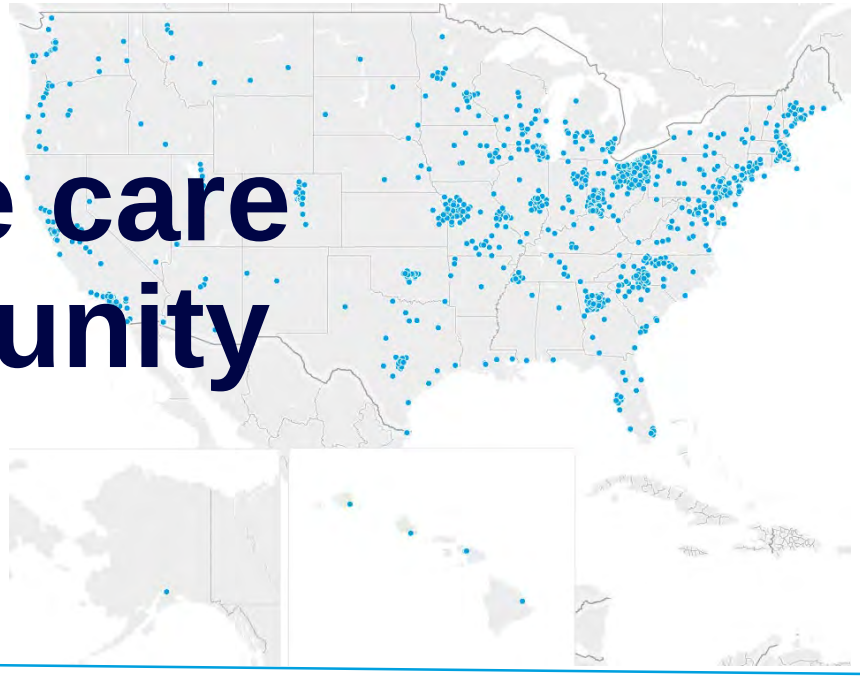
►Palliative care prevalence and # of patients served has more than **tripled** since 2000.

►**100%** of the U.S. News 2015 – 2016 Honor Roll Hospitals and Children's Hospitals Have a Palliative Care Team.

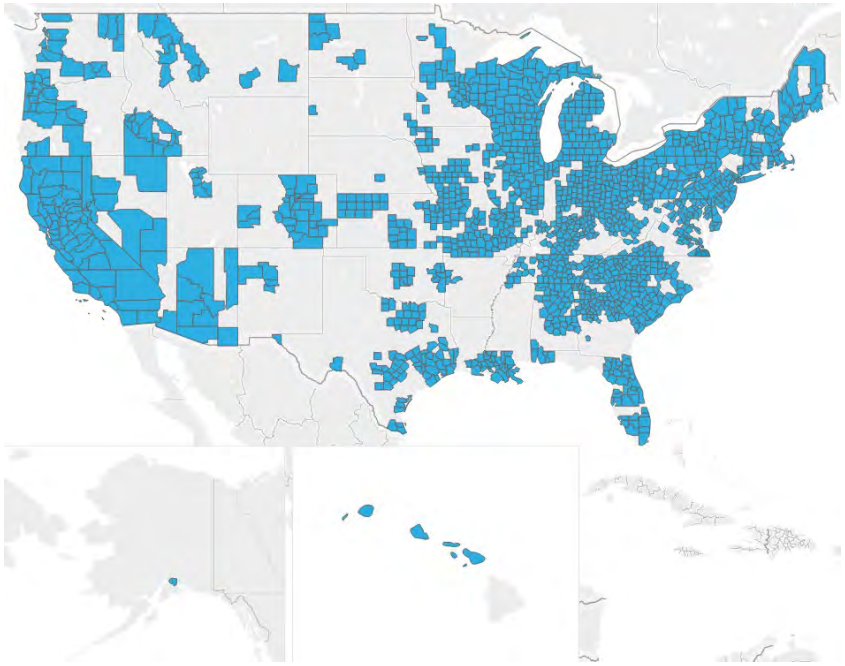


capc Center to Advance Palliative Care™

Palliative care in community settings



Nearly 3,000 office practices and long-term care facilities served by palliative care



At least 50% of US counties are served by a home-based palliative care program

capc Center to Advance Palliative Care™

Racial disparities in the context of serious illness

→ Poorer quality pain management (Less assessment and less treatment)

→ Poorer quality clinician-patient communication (Verbal and non-verbal differences noted)

→ Lower likelihood of advance care planning discussion and documents

→ Measurable differences in caregiver experiences and caregiver availability

capc Center to Advance Palliative Care™

Driving Toward Equity

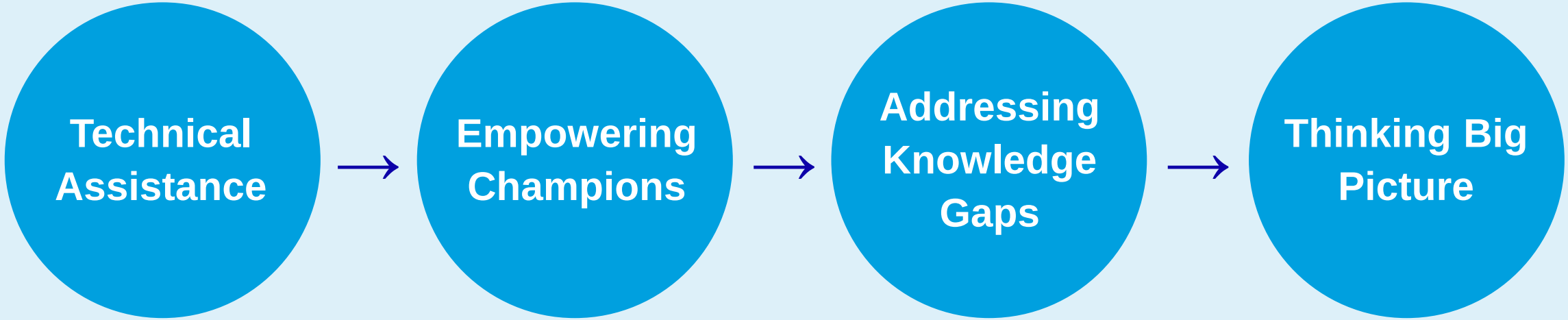
CAPC is currently gathering best practices to address disparities in the care of Black patients with serious illness and their families.

The Vision:
Best Possible Quality of Life for All Older Adults with Serious Illness

- Inpatient palliative care during crisis
- Community-based palliative care to meet patient needs over time
- Integration of health care and community services to address gaps for patients and families

capc Center to Advance Palliative Care™

CAPC Can Help



Replicable best practices synthesized into tools and implementation support

Equipping palcare leadership with tools, coaching, and awareness to drive growth initiatives

Practical, clinical education on communication, symptom management, and person-centered care

Strategic support to align and integrate palliative care with other initiatives to improve care for older adults

capc Center to Advance Palliative Care™

Center to Advance Palliative Care™

capc

55 West 125th Street
13th Floor
New York, NY 10027
347-802-6231
capc.org

Q&A

Please note that the views expressed by the conference speakers do not necessarily reflect the views of the American Hospital Association.

Thank You!

- AHA Age Friendly team

Appendix: Extra Slides

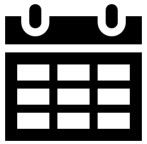
Measuring impact (samples)

Primary:

- Number of GED visits that result in an admission

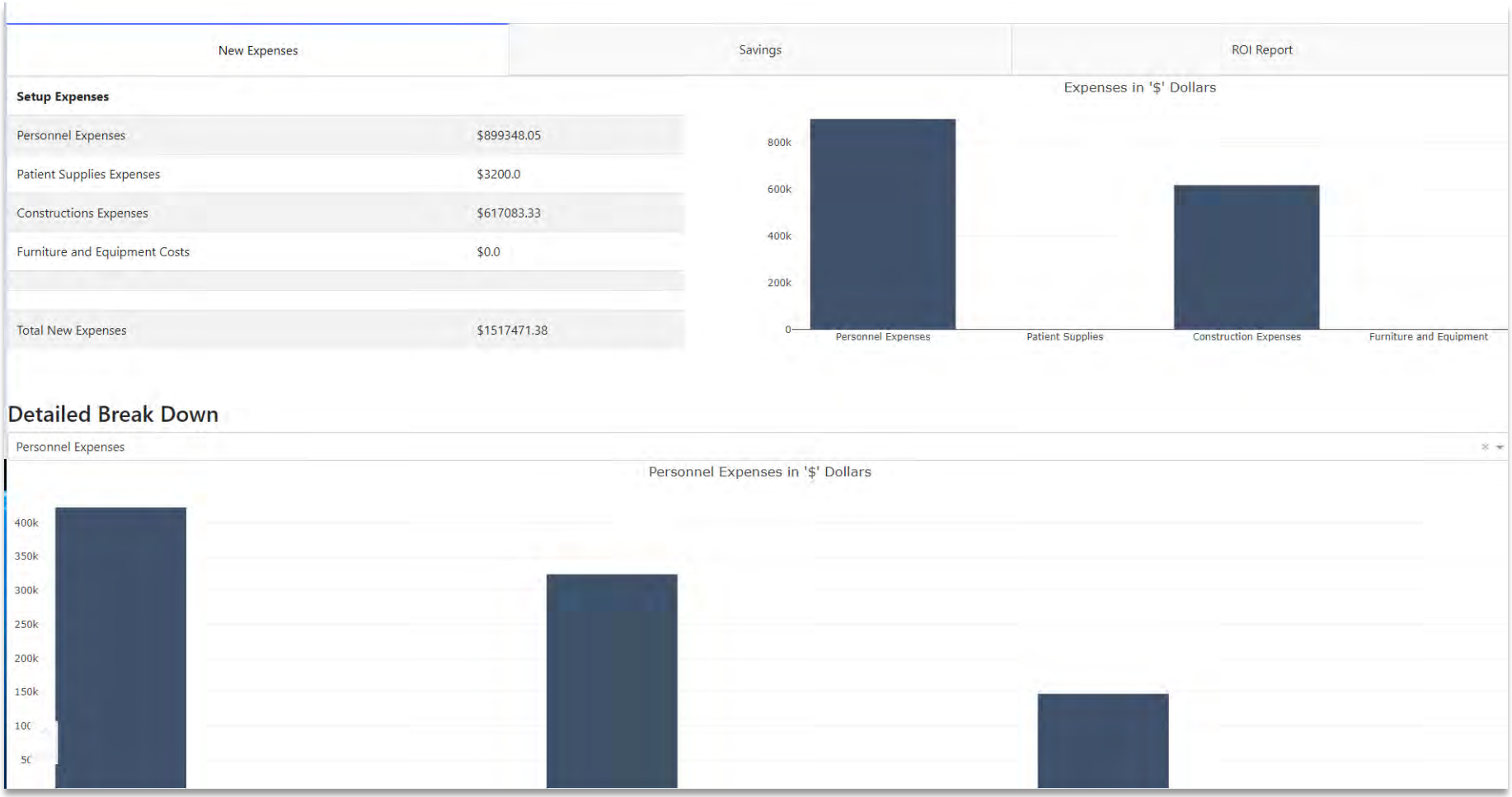
Secondary:

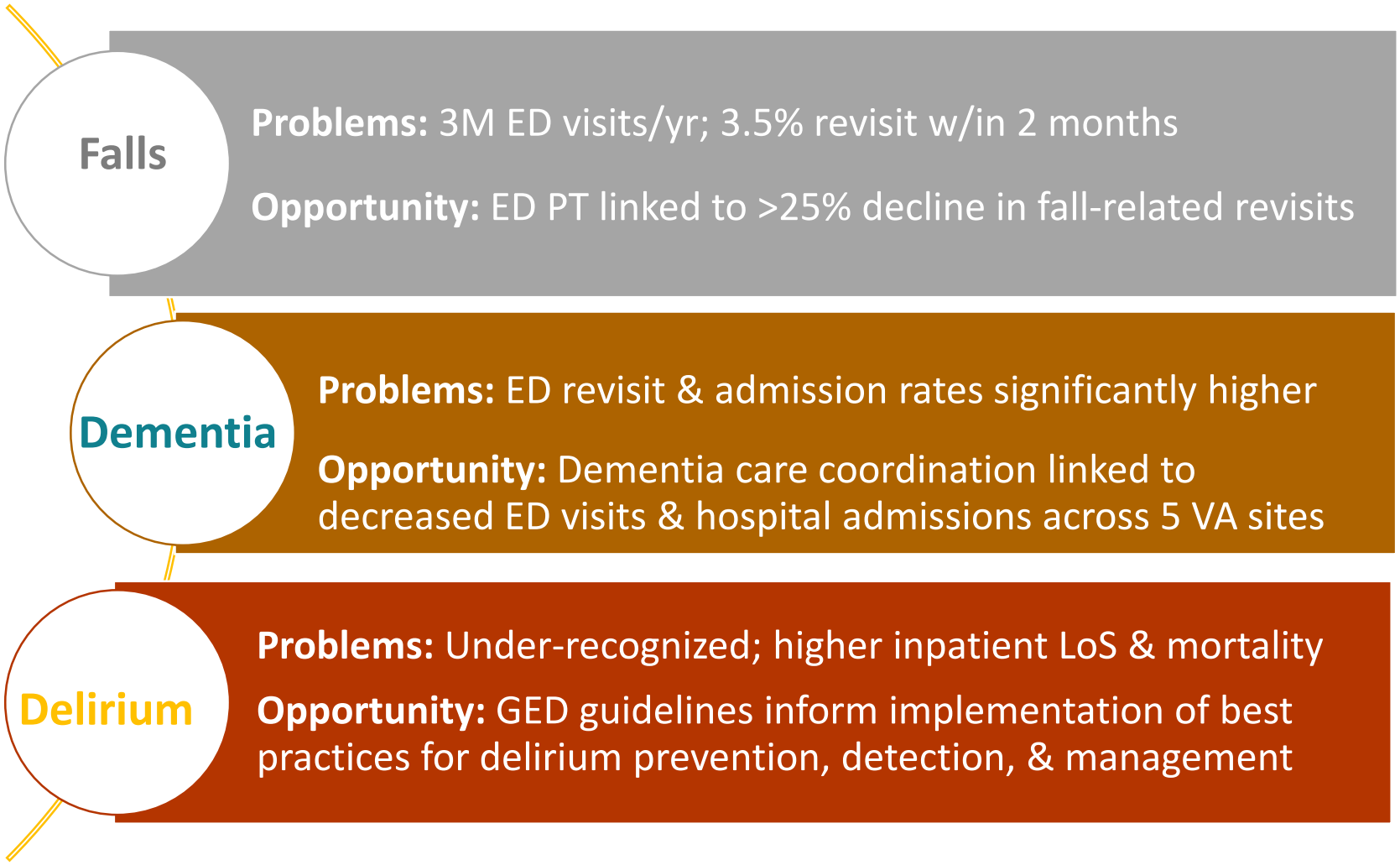
- GED revisit within 30 days of discharge from an index ED visit
- Total length of stay (in mins) in the GED



Other outcomes from the EHR: LOS in obs, LOS inpatient, revisit rates at 3, 10 and 30 days, case management consults, social work consults, specialist consults, discharge to home health or SNF, cost

Return On Investment Analysis




Falls
Problems: 3M ED visits/yr; 3.5% revisit w/in 2 months
Opportunity: ED PT linked to >25% decline in fall-related revisits
Dementia
Problems: ED revisit & admission rates significantly higher
Opportunity: Dementia care coordination linked to decreased ED visits & hospital admissions across 5 VA sites
Delirium
Problems: Under-recognized; higher inpatient LoS & mortality
Opportunity: GED guidelines inform implementation of best practices for delirium prevention, detection, & management

Patients

- Patients and families can make more informed decisions when choosing a facility by searching for GEDs.
- Transparency in services provides in the ED
- Screening/detection for geriatric syndrome which might've otherwise been missed

Hospitals

- Improved care for older adults, improves care for all
- Market differentiation for growing segment of the population
- Adaptable model of care to fit your institutions needs

Payers

- Defined set of measurable criteria, standardized to improve quality of emergency care for older adults
- Prioritize higher vs. lower performing EDs
- Cost to implement can vary depending on budget
- Improved care coordination, reducing more costly downstream utilization

GEDs can reduce high-cost care utilization

Decreased risk of admission at index visit

- Risk of admission decreased by up to 16.5% in a 3-site GED study

Decreased patients' total Medicare costs

- 2-site GED study shows savings of approx. $3,000/patient at 30 days post-discharge

Reduced or delayed SNF admission

- Transitional care at 2 EDs lowered SNF admissions for high-risk patients at 120 days (3% vs. 10%)