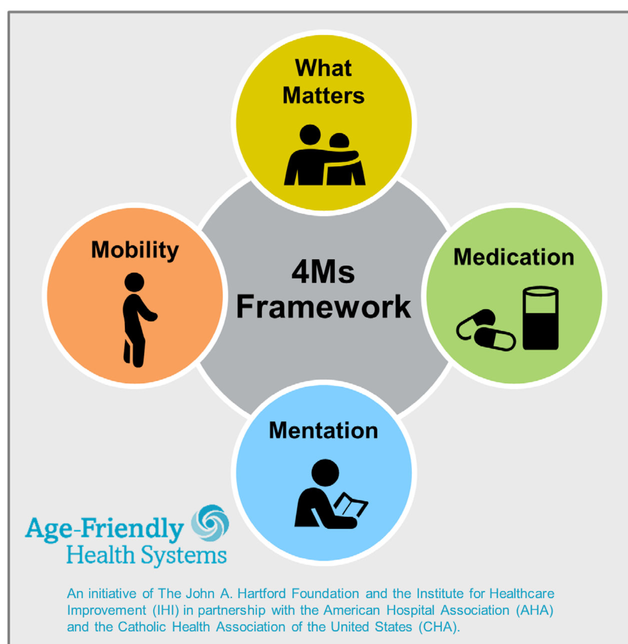
Age-Friendly Health Systems

Lessons Learned and Best Practices from Completed Pre-work

Thank you to the New York Age-Friendly Health Systems Action Community teams that completed the 2023 Age-Friendly Pre-work packets! Based on your responses, we prepared this document highlighting lessons learned and best practices to support the implementation of age-friendly 4Ms care.



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.

LESSONS LEARNED

- Ask one or more *What Matters* questions. Questions cannot focus only on end-of-life forms.
- Minimum frequency is once per stay (for inpatient), at admission (for nursing homes), at least annually (for ambulatory care) **and** upon significant change in condition.
- The care plan must align with *What Matters* to the patient.

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BEST PRACTICES

- View guiding questions from the [“*What Matters*” to Older Adults toolkit].
- *What Matters* questions can be added to goals of care conversations with patients.
- If a patient has cognitive impairment, include family/caregivers in *What Matters* conversations.
- The interdisciplinary care team (including care management, pharmacy, physical therapy and medical care providers and staff) review and discuss *What Matters* and the care plan regularly.
- *What Matters* conversations extend beyond the geriatric attendings. Educate providers and staff across the health network.
- Current goals of care conversations may focus only on medical/health issues. Educate patients and caregivers about why *What Matters* to the patient is important to their overall care. Consider asking patients about additional topics, such as spiritual preferences, emotional support, activity options and their personal goals for the next six months.
- Identify a consistent place in the electronic health record to document *What Matters* to the patient and be sure providers and staff across the health network are aware of the location. One team added a “Patient Values” tab to their EHR to include this and other information pulled from various care notes and the patient portal.
- Improve communication of *What Matters* to next level of care providers (internally or outside the health system).
- Consider adding social determinants of health screening along with *What Matters* questions.
- Engage patient experience volunteers to ask *What Matters* and be sure there is a way to document answers in the EHR.

LESSONS LEARNED

- Older adults’ medication lists must be screened for high-risk medications, as defined by the AGS BEERS Criteria®.
- Minimum frequency is once per stay (for inpatient), at admission (for nursing homes), at least annually (for ambulatory care) **and** upon significant change in condition.
- Deprescribe (includes both dose reduction and medication discontinuation).

BEST PRACTICES

- Educate providers about high-risk medications for older adults and provide the AGS BEERS Criteria® pocket guide.
- Include herbal supplements and over-the-counter medications in medication review.
- Review for polypharmacy.
- Include a pharmacist on the interdisciplinary care team.
- Ensure that a pharmacist is available not only for peer-to-peer consultation but also to answer patients’ questions.

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BEST PRACTICES (CONT.)

- Build alerts and/or flags into the EHR to identify if any high-risk medication is prescribed or ensure pharmacy reviews all medication orders to identify high-risk medications before orders are filled.
- Consider modifying one-click dosages and removing one-click orders (e.g., nightly) for high-risk medications. If a clinician believes a higher dose is necessary, this prompts a conversation with the pharmacist.
- Ensure medication management post-prescribing (e.g., ability to self-administer, purchase, follow-up blood work and what to do about side effects).
- Work with local university pharmacy students to support medication reviews.
- Have a pharmacist monitor orders and educate clinicians as needed about high-risk medications.
- Review the EHR's ability to document deprescribing efforts to ensure the extended care team has a full picture of the medication plan of care.
- Beds-to-meds programs provide prescriptions to patients' bedside before being discharged along with personalized discharge counseling on medications by the pharmacist.

LESSONS LEARNED

- Required screenings vary by care setting: delirium screening (for inpatient); delirium, cognitive and depression screening (for nursing homes); and cognitive and depression screening (for ambulatory care).
- Recommended screening tools include:
  - Delirium – UB-CAM, CAM, 3D-CAM, CAM-ICU, bCAM, Nu-DESC (for inpatient); UB-CAM, CAM (for nursing homes).
  - Cognitive impairment screening – Mini-Cog (for nursing homes or ambulatory care).
  - Cognitive impatient assessment – SLUMS, MOCA (for nursing homes or ambulatory care).
  - Depression – PHQ-2/PHQ-9, GDS (for nursing homes or ambulatory care).
- Minimum frequency is every 12 hours (for inpatient), at admission (for nursing homes), at least annually (for ambulatory care) **and** upon significant change in condition.
- Delirium prevention strategies include:
  - Ensure sufficient oral hydration.
  - Orient older adults to time, place and situation on every nursing shift, if appropriate.
  - Ensure older adults have their personal adaptive equipment (e.g., glasses, hearing aids, dentures, walkers), if applicable.
  - Prevent sleep interruptions; use non-pharmacological interventions to support sleep.
  - Avoid high-risk medications.
- Cognitive impairment assessment results should be shared with the older adult and behaviors managed using non-pharmacological approaches and/or refer to an appropriate community organization for education and support.
- Depression screening results should be shared with the older adult and factors relating to depression managed using non-pharmacological approaches; and/or consider an anti-depressant.

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BEST PRACTICES

- Discuss mentation during interdisciplinary team meetings.
- Document screenings in one place in the EHR (and be sure clinicians and care teams throughout the health system are aware of the location).
- Create standard order sets to respond to positive screens.
- Establish baseline levels and build prompts into the EHR for reassessment.
- Ensure large analog clocks and calendars are visible; orient older adults to time and place regularly.
- For nursing homes, white boards should include the date, routine of the day and current events.
- For inpatients, consider moving patients screening positive near the nurses' station for closer monitoring.
- For ambulatory care, connect patients and caregivers to community organizations for support.
- Consider making activity boxes or stuffed animals available for patients with cognitive impairment.
- Collaborate with the Alzheimer's Association for clinician and care team education.

LESSONS LEARNED

- Older adults must be assessed for their highest level of mobility; merely asking about their falls history is not sufficient.
- Recommended screening tools include: TUG, JH-HLM, POMA (for inpatient, nursing homes and ambulatory care).
- Minimum frequency is every 12 hours (for inpatient), at admission (for nursing homes), at least annually (for ambulatory care) **and** upon significant change in condition.
- Older adults should be mobilized three times a day and/or as directed (for inpatient and nursing homes).
- A multifactorial fall prevention protocol (e.g., STEADI) should be implemented (for ambulatory care).

BEST PRACTICES

- Educate clinicians, care teams and health system leadership on the importance of early, frequent and safe mobility, appropriate screening and referrals to physical therapy.
- Evaluate home safety and refer to home care or community organizations if needed.
- Document the baseline level of mobility, set goals and track progress (on whiteboards and in the EHR) for older adults requiring assistance. Personal goal cards with pictures support patients' work toward goals.
- Build alerts into the EHR for recommended cadence for rescreening.
- Engage patients through education, particularly during September, which is Falls Prevention Awareness Month.

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