Dartmouth Centers for Health & Aging

Long Term Services & Support & The 4M's

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Disclosures

- I have no financial conflicts of interest to disclose

Learning Objectives

1. Summarize the 4Ms of an Age-Friendly Health System.
2. Describe one example of how to bridge primary care and LTSS using the AWV
3. Identify one model focusing on “What Matters Most” in the community.

Age-Friendly Health System

An Age-Friendly Health System (AFHS) is an initiative of:

- The John A. Hartford Foundation
- Institute for Healthcare Improvement (IHI)
- In partnership with the:
  - American Hospital Association
  - Catholic Health Association of the United States

Source: https://www.johnahartford.org/age-friendly-health-systems-initiative

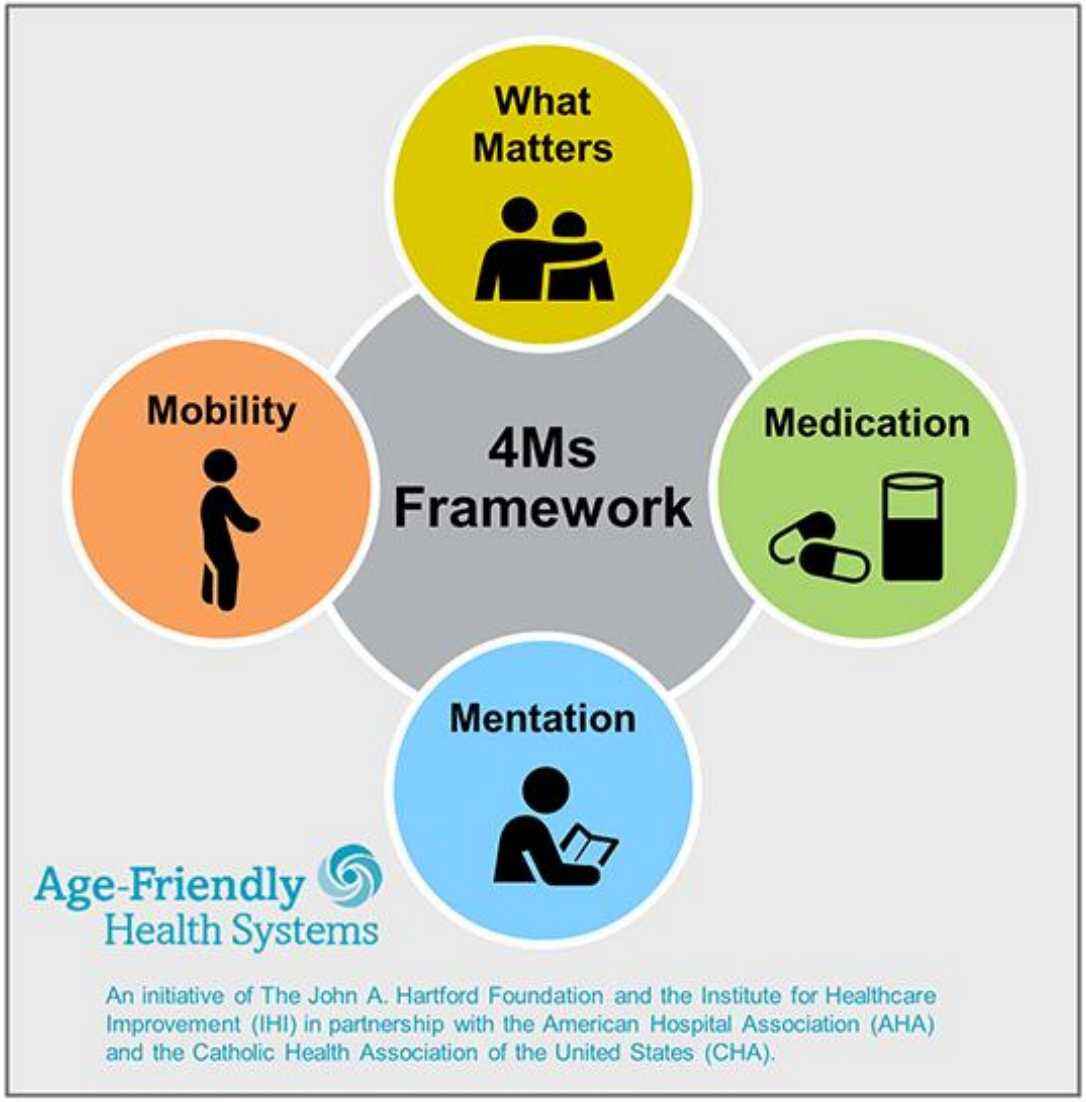
Age-Friendly Health System

- An Age-Friendly Health System is one in which every older adult:
  - Gets the best care possible;
  - Experiences no health care-related harms; and
  - Is satisfied with the health care they receive.
- In an Age-Friendly Health System, value is optimized for all — patients, families, caregivers, health care providers, and the overall system.
- Initial focus on acute care/large health systems
- Moving into LTSS

Source: https://www.johnahartford.org/age-friendly-health-systems-initiative

What Does it Mean to Be Age-Friendly?

You do these 4 things (4Ms) together:



Source: http://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/default.aspx

The 4Ms

- 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.

Source: www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/default.aspx

The 4Ms

- Mentation
  - Prevent, identify, treat, and manage delirium across settings of care.
- Mobility
  - Ensure that each older adult moves safely every day to maintain function and do What Matters.

Source: www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/default.aspx

Geriatric Interprofessional Team Transformation – Primary Care (GITT-PC)

- Transform primary care:
  - Teams
  - QI
- Implement 4 Medicare Codes:
  - AWV
  - CCM
  - TCM
  - ACP

Annual Wellness Visit (AWV)

Description

- Medicare Part B
- Free yearly visit
- Health promotion and disease detection
- Not a hands-on exam
- Does not address new or existing chronic medical conditions

- **G0438** – NFP $174; RVU 2.43
- **G0439** – NFP $118; RVU 1.50

Components

- Health Risk Assessment
- Medical & family history
- Medication review including high risk and opioid use
- Providers & suppliers
- Height, weight, Body Mass Index, blood pressure
- Cognitive assessment
- Depression assessment
- Level of safety/falls assessment
- Screening schedule
- Risk factors
- Personalized health advice
- Advance care planning

Workforce

- Schedulers / exit secretaries
- Rooming staff
- Nursing (can bill incident-to)
- Physician / non-physician practitioner

NFP = Non-Facility Price
RVU – Relative Value Units
Source: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_Chart_ICN905706.pdf
Source: https://www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx

Referrals to the Community

Referral to Aging Resource Center — ✓Accept | ✕Cancel

Class	Internal Ref	Internal Referral	External Referral	
Referral	By Provider:	Moran, Daniel S [1278]		
	To Department:	ARC Shared Decision	ARC Shared Decision	
	To Provider:			
	Reason:	Specialty Services	Specialty Services Requested	
	Priority:	Routine	Routine	Urgent
	# of visits:	1		

Service Requested

☐ Caregiver Support ☐ Dementia/Memory – Support ☐ Dementia/Memory – Education ☐ Memory Cafe
☐ Hoarding Resources ☐ Spiritual Care ☐ Bereavement ☐ Advance Care Planning ☒ **Falls Prevention**
☐ Parkinson's Resources

Process Inst.: If no progress note charted, please enter Clinical details in comments.

Referral: ✚ Add Comments (F6)

Show Additional Order Details

Next Required — ✓Accept | ✕Cancel

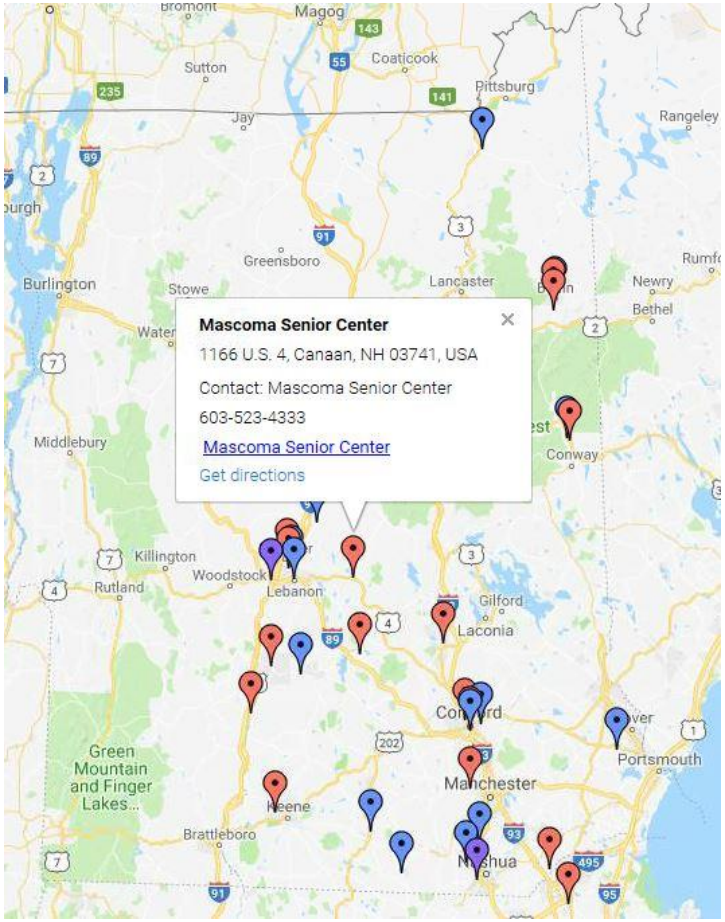
NH Falls Prevention Network Hub

Dartmouth Centers for Health & Aging

NH Falls Prevention Network Hub

- Provide training, program referral, technical assistance, quality assurance, and administrative support for population-based falls prevention programs
- Create a centralized registry for people at high falls risk for falls and for falls prevention programs
- Connect various community partners and the larger health care systems throughout the state
- Provide additional infrastructure to assist sites in recruitment and marketing their programs

Hub Contact and Program Site Information



NEW HAMPSHIRE
FALL PREVENTION HUB

NH Falls Prevention Hub Contact Information:

603-653-3415

Falls.Prevention@hitchcock.org

new hampshire falls risk reduction task force

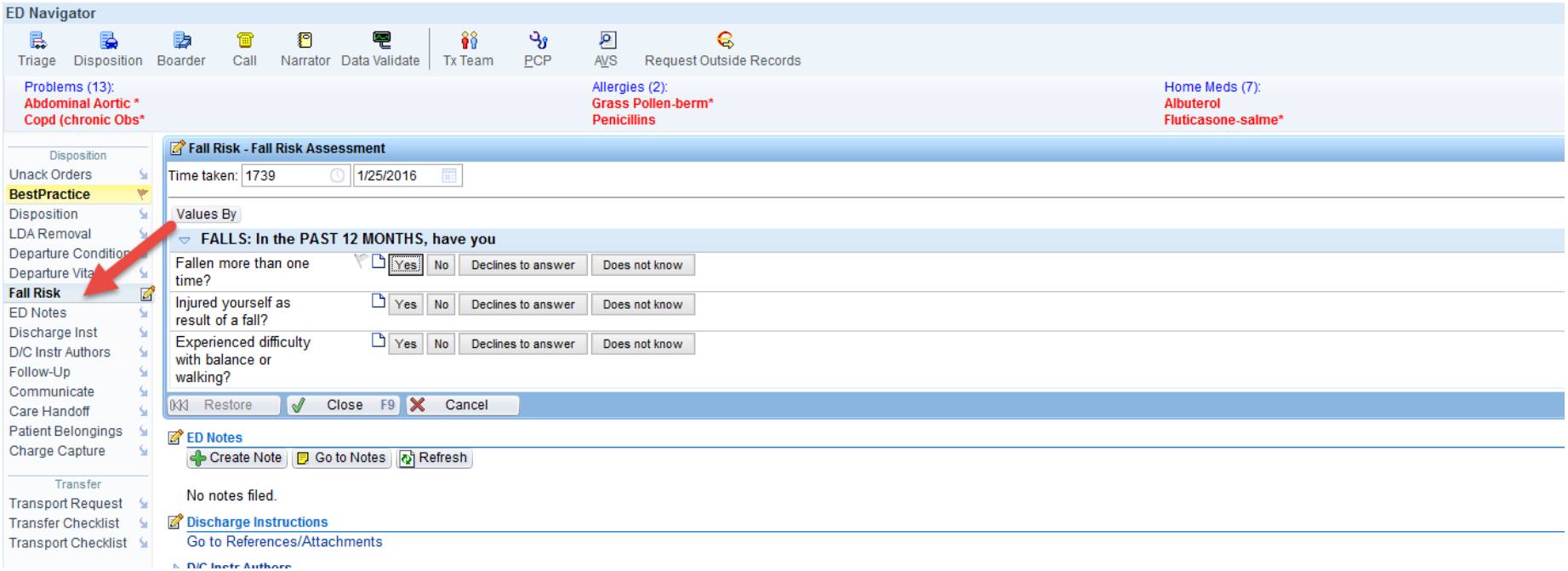
Program Map and Class Information

www.NHFalls.org

Hub Referral Sources

- Balance Day
- Community based
  - Aging Resource Center catalog
  - Aging Resource Center walk-in
  - Word of mouth
- NH Falls Task Force website
- Healthcare organizations
  - Medical provider
  - Physical therapy
  - Emergency Department
  - Falls clinic

Three Falls Screen Questions in DH-H EMR



Screening Results

Primary Care

39.3%

Screened Positive for Falls Risk

Emergency Department

53.6%

Screened Positive for Falls Risk

Direct D-H EMR Referral to Community Based Programs

- Providers refer directly to Dartmouth-Hitchcock Aging Resource Center within EMR
- Aging Resource Center triages referrals and directs to appropriate community based program contact
- Aging Resource center “closes the loop” and communicates with provider

Referral to Aging Resource Center

✓Accept ✕Cancel

Class: Internal Ref | Internal Referral | External Referral

Referral

By Provider: Moran, Daniel S [1278]

To Department: ARC Shared Decision | ARC Shared Decision

To Provider:

Reason: Specialty Services | Specialty Services Requested

Priority: Routine | Routine | Urgent

# of visits: 1

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Next Required

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2020-2023 Administration for Community Living Falls Prevention Grant

Collaborating with 2 GWEPS
- Baystate
- Rhode Island

Implement the **Dartmouth Falls Prevention Program**

Primary Care Screening & Referral to Community Based Organizations

Balance Days

Build Capacity
- Tai Chi Quan Moving for Better Balance

“What Matters Most”
RAFT: Reducing Avoidable Facility Transfers

GOAL: Reduce unwanted and unwarranted ED visits and hospitalizations for residents of Skilled Nursing Facilities

A previous local model at a CCRC

- Small group of like-minded clinicians providing primary and on-call care
- Systematic Goals of Care elicitation/documentation
- Health Center
- Socioeconomically advantaged population
- Significant reduction in ED visits and hospitalization

SNF residents: The ED and hospital

- ED transfers/hospitalizations are common
- 25-60% are avoidable
- High rates of iatrogenesis
- Stays are more likely to be long and expensive
- Limiting care is challenging despite patient wishes

Before Acute Event

SNFists
All scheduled and off-hours patient care managed by small pool of providers familiar with SNFs.

Routine Goals of Care Meeting
Typically held with provider shortly after admission or establishment of care with completion of expanded Advance Directives.

Expanded Advance Directives

- DPOA-HC Name and Activation Status
- POLST completion
  - Overall Care Goals: Full, Limited or Comfort
  - Orders re Resuscitation
  - Orders re IV hydration
  - Orders re Feeding Tube
  - Orders re antibiotics
- Acute Care Plan
  - Hospitalize - Unlimited Interventions
  - Hospitalize - No "heroics"
  - Do Not Hospitalize – Treat in Place
  - Do Not Hospitalize – Comfort Focused Care
- Hospice Status

During Acute Event

"Call Us First"
Early and active involvement of provider directly with family and staff.

Goal Informed Decision Making
Providers are aware of Advance Directives during acute events and make recommendations in this context.

After Acute Event

Bimonthly Case Review of all ED transfers
Was there something the provider team could have reasonably and safely done differently to have prevented this transfer?

Advance Directive Completion Report
Regular report and review of Advance Directives completion rate by provider and by facility.

Reducing
Avoidable
Facility
Transfers

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Reducing
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Transfers

Before acute event

Advance Directives

- ❑ DPOA-HC Name, Contact Info and Activation Status
- ❑ POLST/COLST completion
  - ➢ Overall Care Goals: Full, Limited or Comfort
  - ➢ Orders regarding Resuscitation, Hydration, Feeding Tube, Antibiotics
  - ➢ Hospitalization Preferences
    - ○ Hospitalize - Unlimited Interventions
    - ○ Hospitalize - No "heroics"
    - ○ Do Not Hospitalize – Treat in Place
    - ○ Do Not Hospitalize – Comfort Focused
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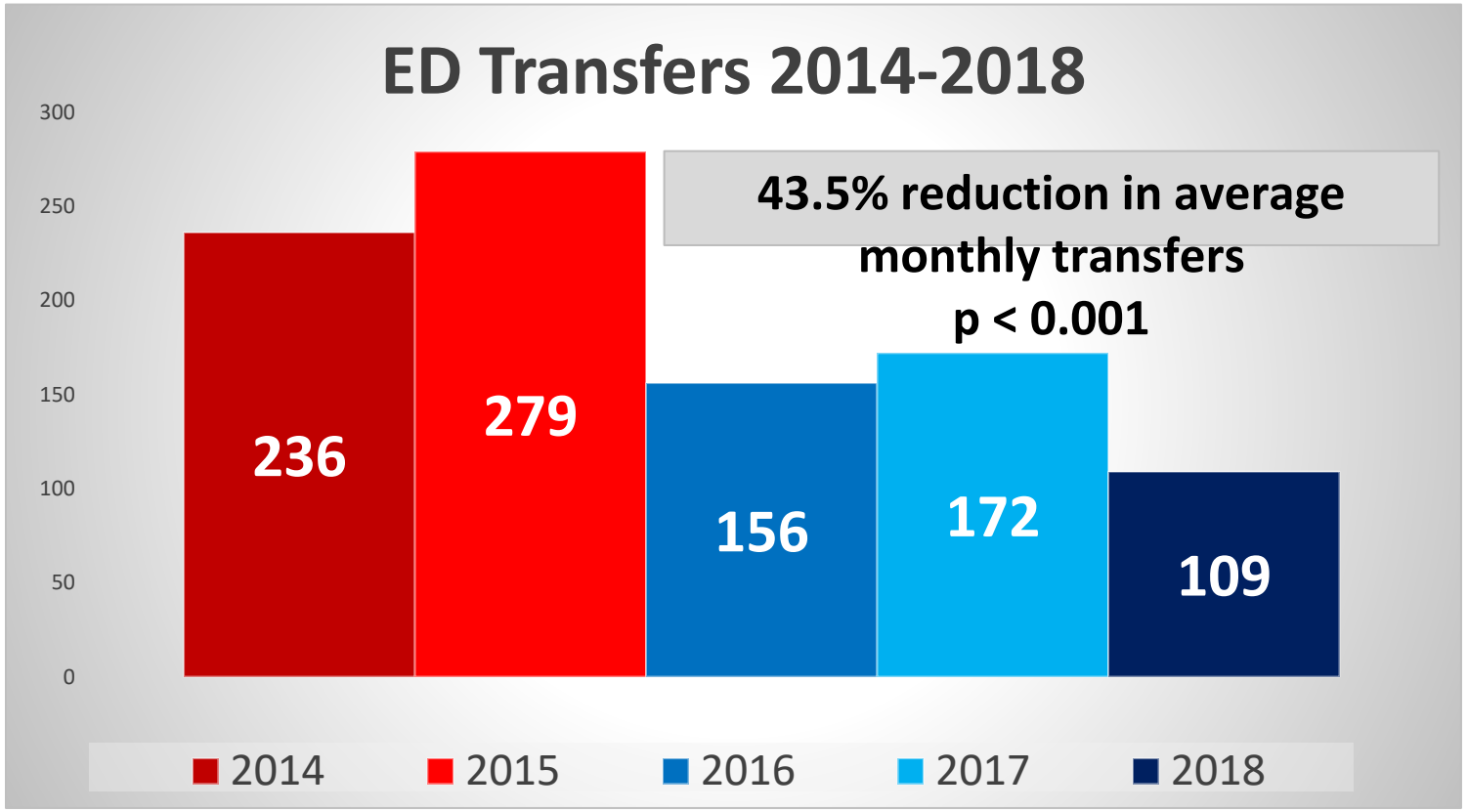

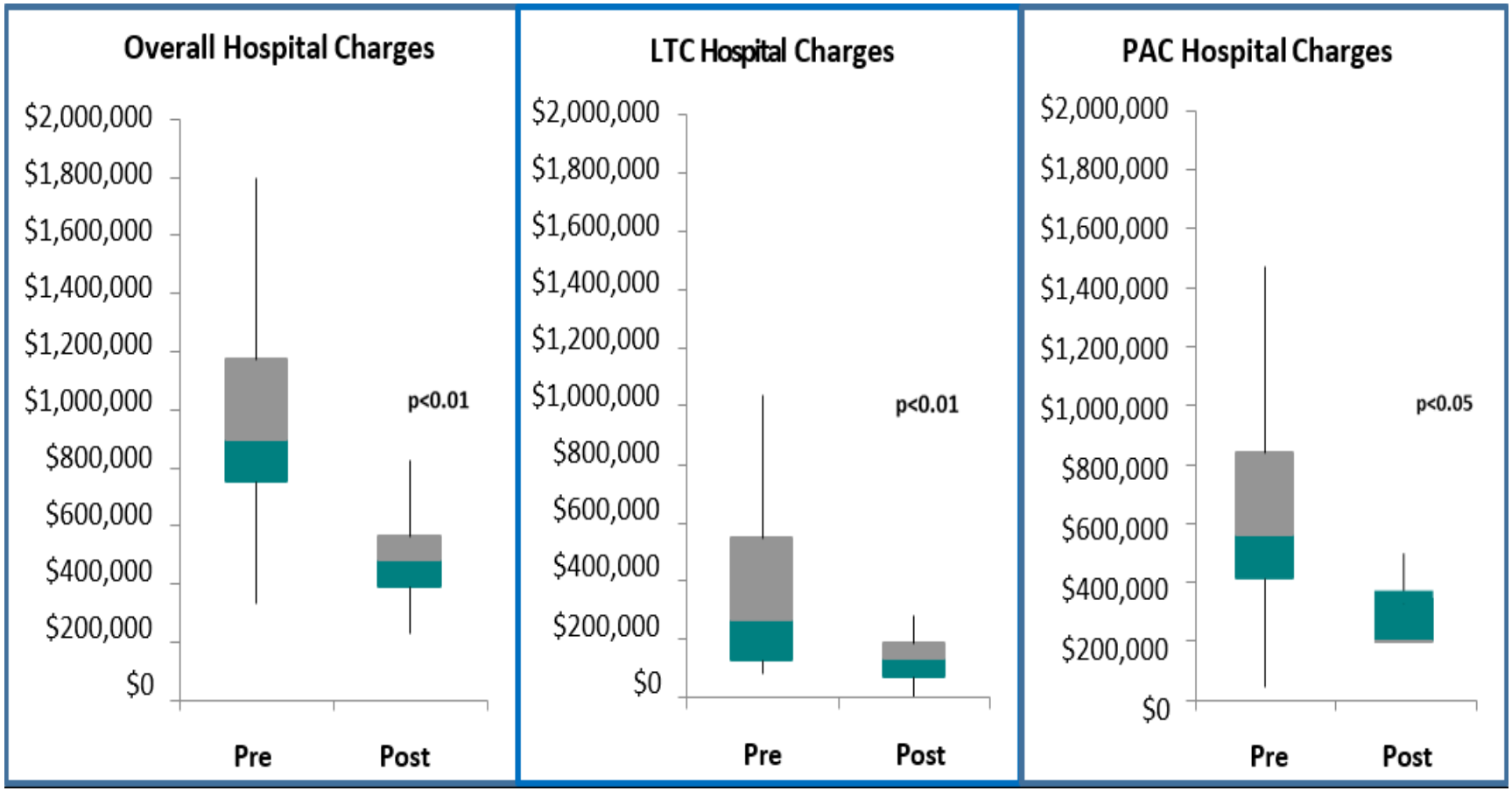

Summary

- 4M's together ensure best outcomes person centered care
- Bridging Primary Care & LTSS is challenging but necessary
- Mobility
  - Falls Prevention from Primary Care to LTSS
- "What Matters Most"
  - Focus on the most vulnerable
  - Understanding and systematically documenting goals of care is critical
  - Team approach to eliciting goals of care