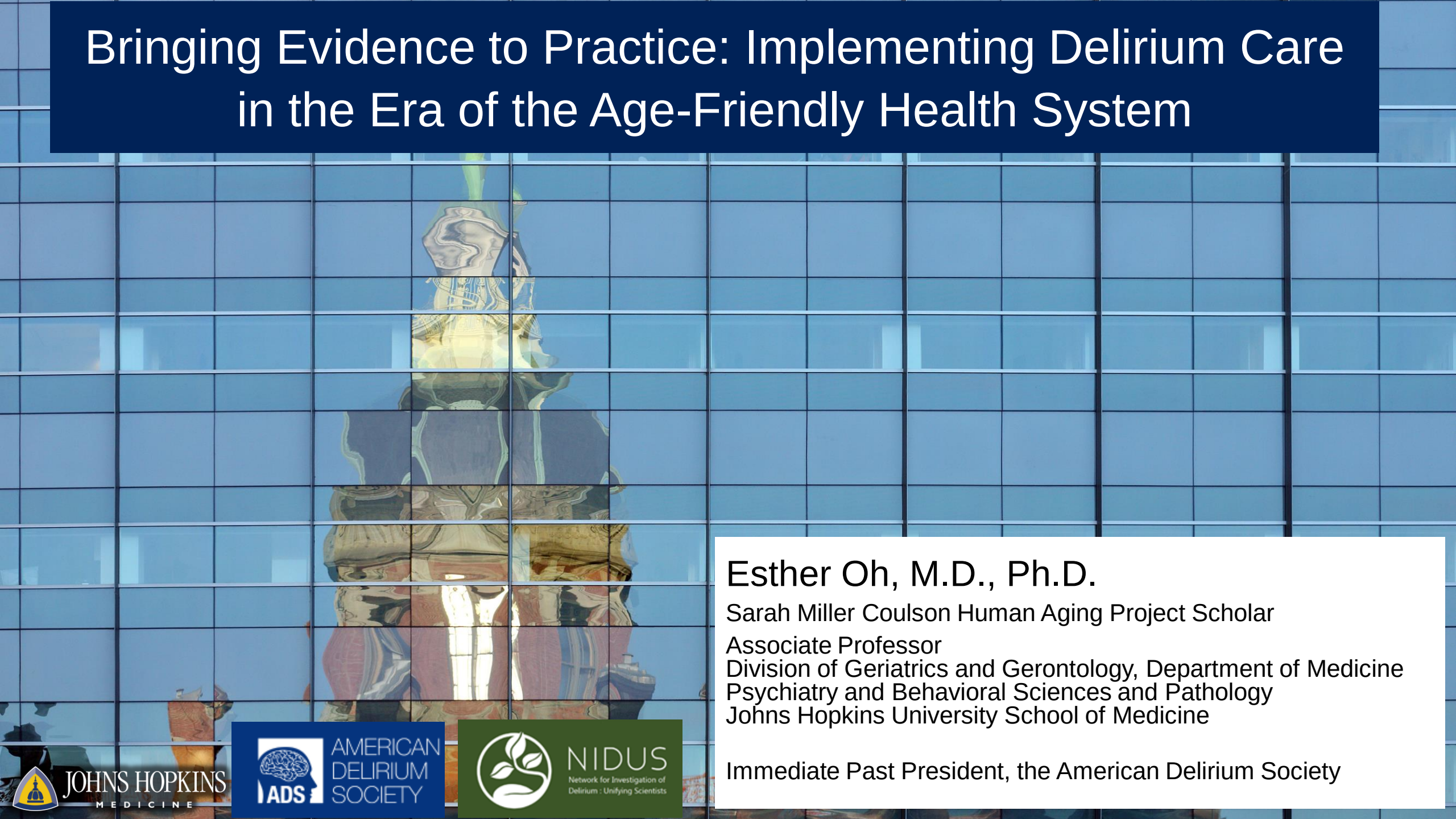
Bringing Evidence to Practice: Implementing Delirium Care in the Era of the Age-Friendly Health System



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JOHNS HOPKINS MEDICINE

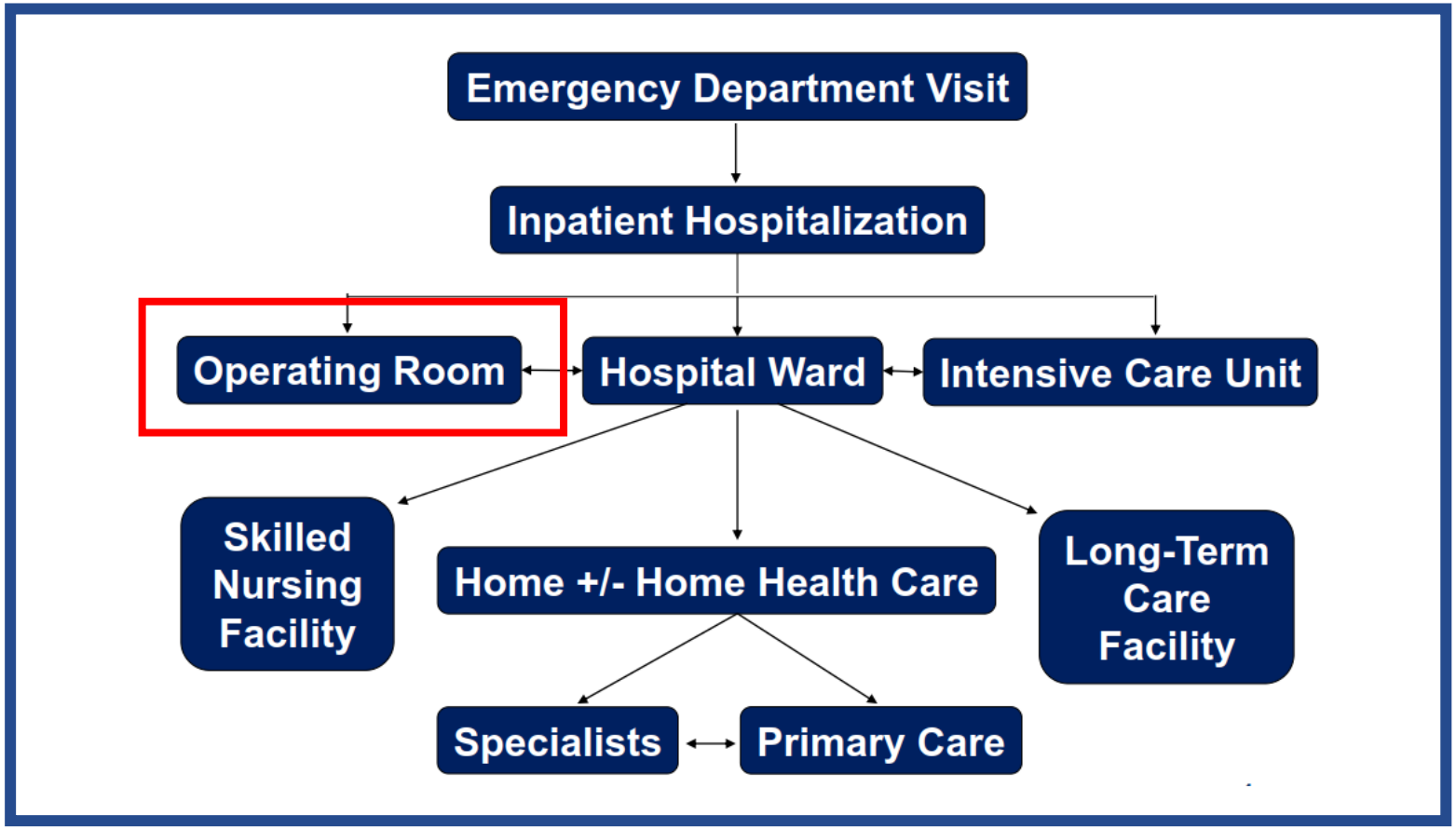
AMERICAN DELIRIUM SOCIETY

NIDUS
Network for Investigation of Delirium : Unifying Scientists

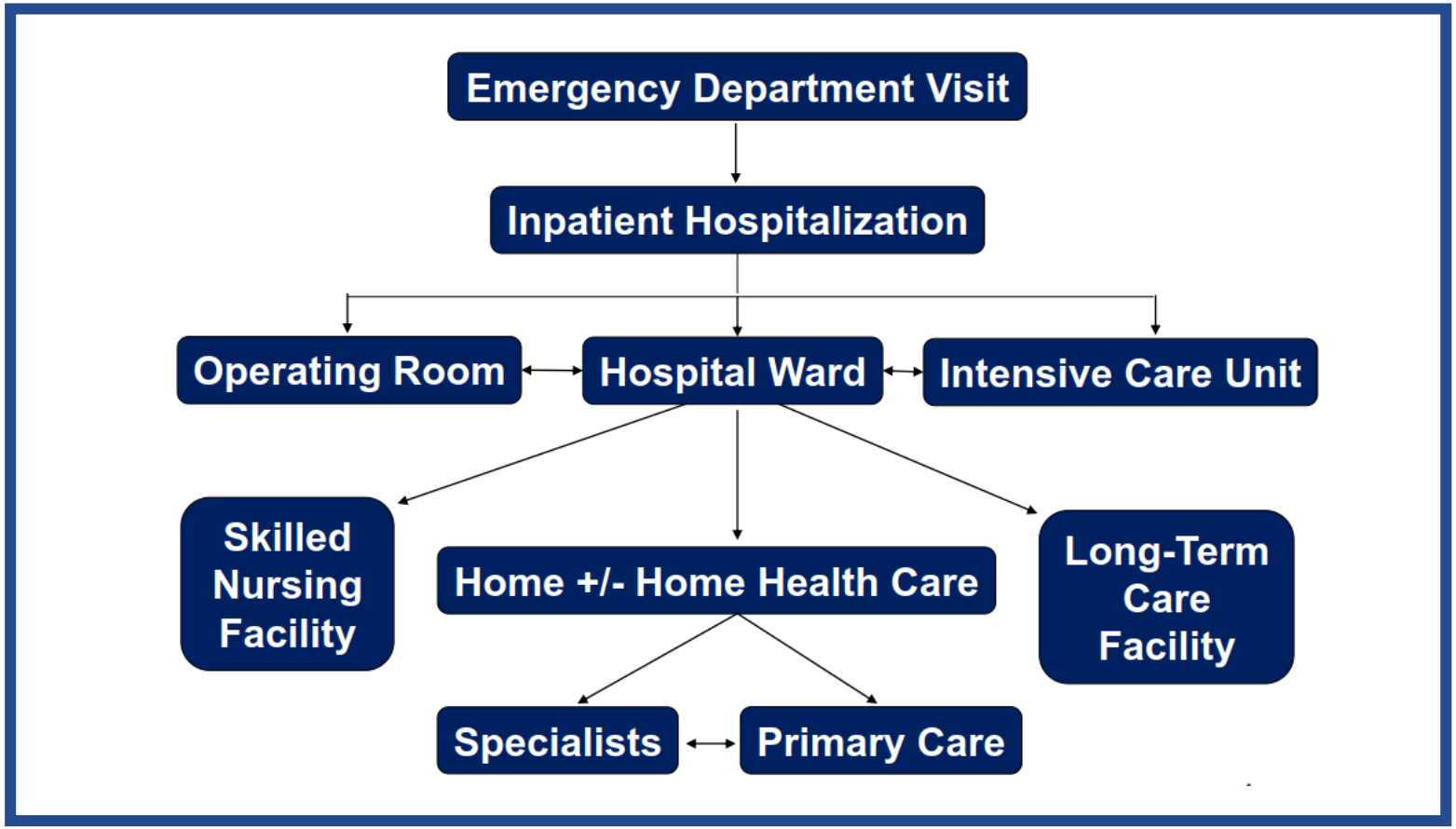
Disclosures

- NIA/NIH

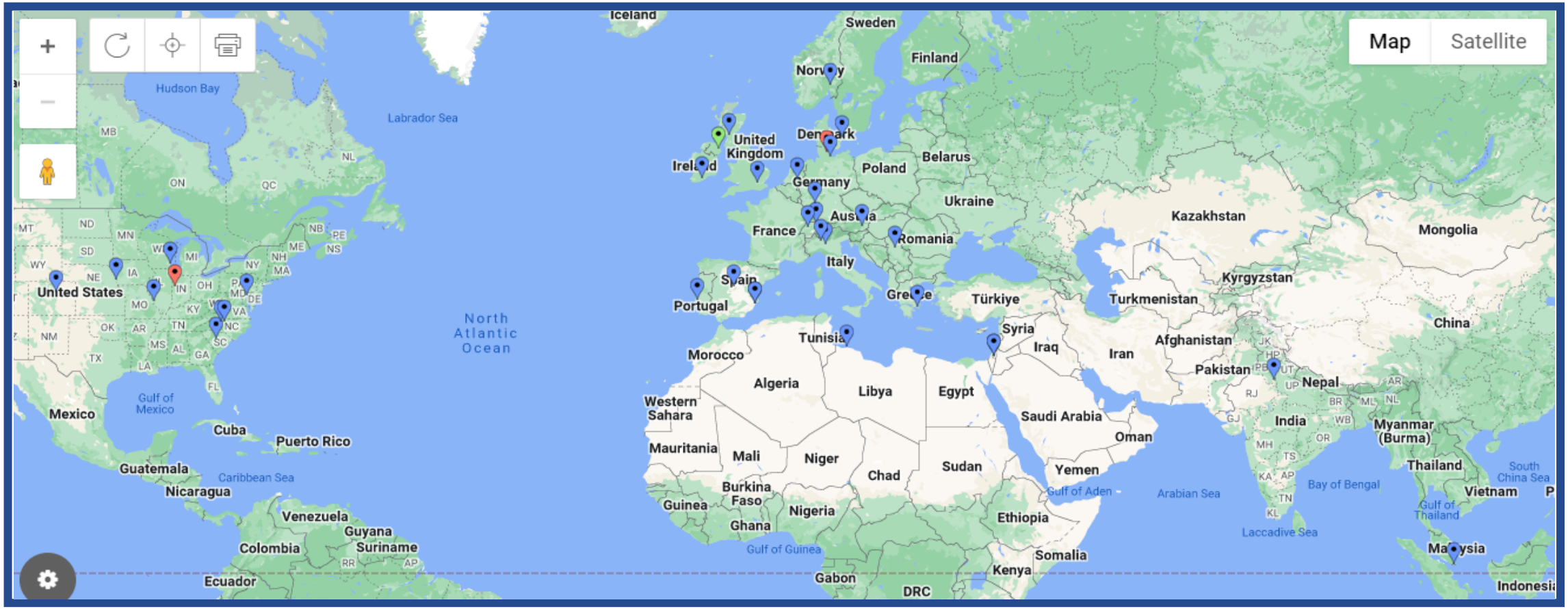
Siloed Approach to Addressing Delirium in a Complex Web of Medical System



Interrelationship of Delirium Across Care Settings



World Delirium Awareness Day (WDAD)



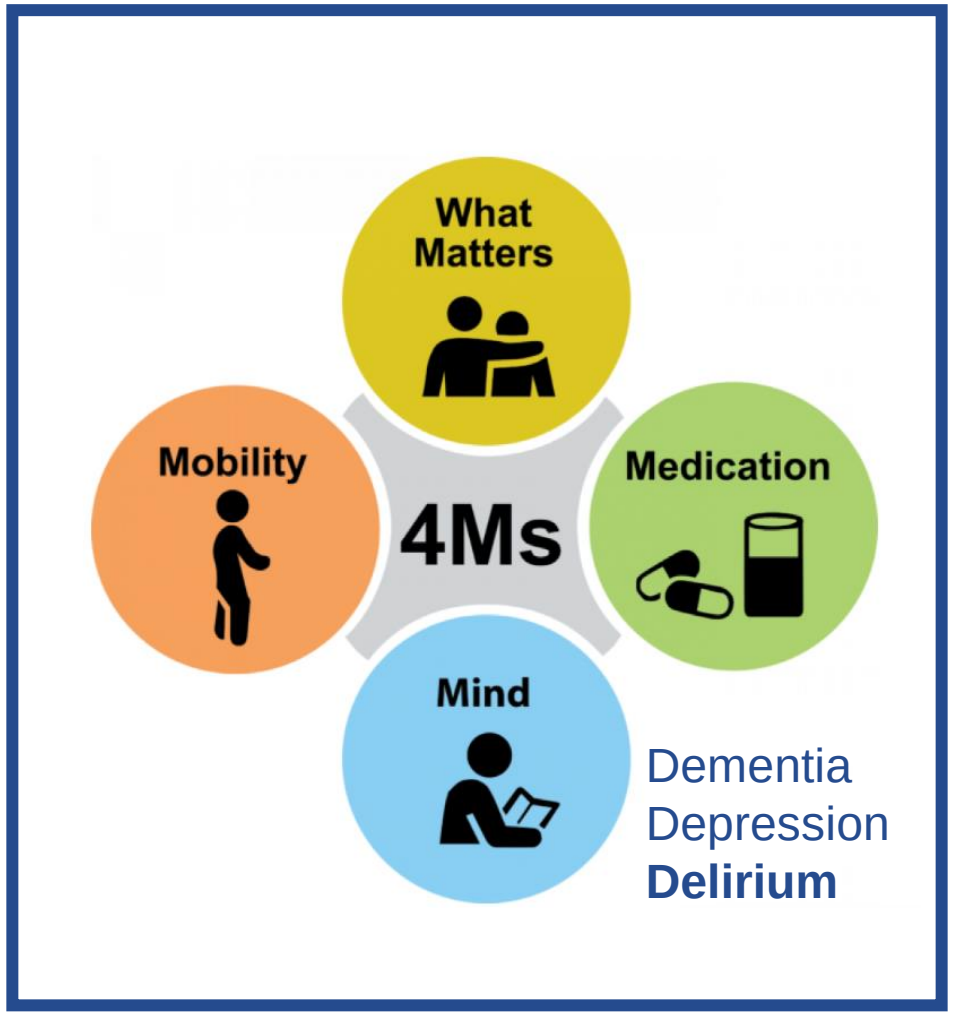
World Delirium Awareness Day (WDAD) delirium prevalence study
World-wide >44 countries; > 36,000 delirium screening

Lindroth et al., manuscript in preparation

The Scale of Problem

- 34 million hospitalizations in 2021
  - 13.2 million in older adults ≥ 65
- Upwards of 2.4 million adults ≥ 65 experience delirium
- One older adult develops delirium every 5 minutes

Harnessing the Momentum of a Social Movement Age-Friendly Health System (AFHS)



John A. Hartford Foundation and Institute for Healthcare Improvement

An essential set of evidence-based practices which causes no harm and aligns with What Matters to the older adults (4Ms)

Two key drivers of AFHS – Assess and Act On

https://www.johnahartford.org/grants-strategy/current-strategies/age-friendly/age-friendly-health-systems-initiative#:~:text=Rapid%20Growth,Excellence%20as%20of%20October%202023.

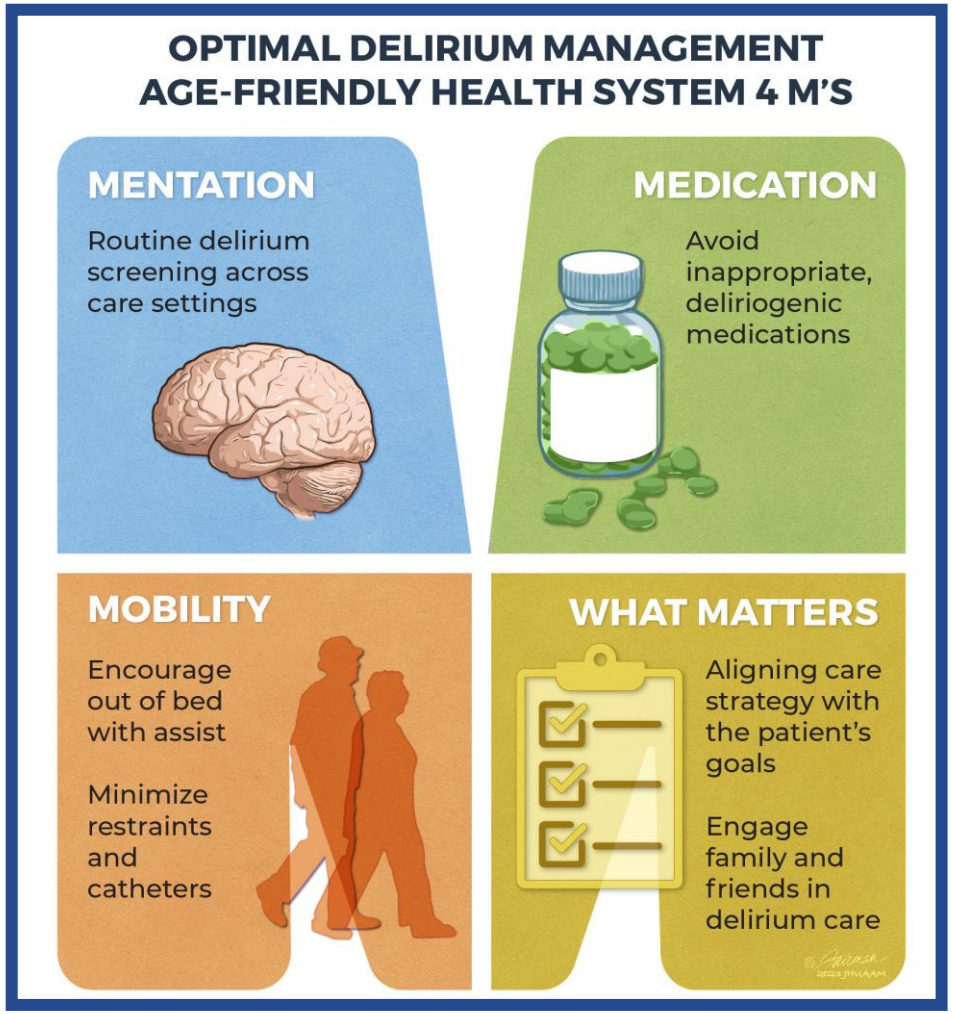
Opportunities and Synergism

American Hospital Associations (AHA) Hospital Statistics 2023
Total number of all US hospitals
- 6,129

Institute for Healthcare Improvement (IHI) has recognized 3,400 hospitals as Age-Friendly Health Systems as of October 2023

https://www.johnahartford.org/grants-strategy/current-strategies/age-friendly/age-friendly-health-systems-initiative#:~:text=Rapid%20Growth,Excellence%20as%20of%20October%202023.

Delirium as Part of the Age-Friendly Health Systems



DOI: 10.1111/jgs.18631

SPECIAL ARTICLE

Journal of the American Geriatrics Society

Optimizing delirium care in the era of Age-Friendly Health System

Min Ji Kwak MD, MS, DrPH[1] | Sharon K. Inouye MD, MPH[2,3] |
Donna M. Fick PhD, RN, GCNS-BC[4] | Alice Bonner PhD, RN[5,6,7] |
Terry Fulmer PhD, RN, FAAN[8] | Emily Carter MD[9] | Victor Tabbush PhD[10] |
Kerri Maya MSL, RN, NPD-BC[11] | Nicholas Reed AuD, PhD[12,13] |
Christine Waszynski DNP, APRN, GNP-BC[14] | Esther S. Oh MD, PhD[7,15,16,17]

Kwak et al., JAGS 2023

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Integration of Age-Friendly Concepts into the ADAPT Program

Actions to enhance **D**elirium **A**ssessment **P**revention and **T**reatment

Christine M Waszynski DNP, APRN, GNP-BC, FAAN
Hartford Hospital; Hartford, CT

ADAPT- Making Delirium Awareness a Priority

- Began in 2011
- Supported by hospital administration
- Inter-professional Team (representation across departments and disciplines n=42)
- Plan for structure (delirium care pathway)
  - Build supports in EHR to guide documentation and gather data
  - Education (classroom/CESI/bedside)
  - Adjunct Support (volunteer programs; therapeutic activities)
  - Quality / research/ feedback

Building Blocks For A Delirium Program

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Strategies for Buy-in For Age-Friendly Delirium Care

Define how the 4 Ms framework of delirium care:

- Aligns with organization's mission/vision and values
- Fits into the balanced score card and quality measures
- Promote optimal wellness/recovery and eliminate patient harm
- Provide optimal patient/family experience
- Support the staff

Strategies for Buy-In for Age-Friendly Delirium Care

- Seek executive sponsors from various disciplines
- Identify existing resources
  - Geriatric and psych liaison services
  - Active volunteer department
  - Available data and research expertise
- Identify opportunities
  - Philanthropy
  - Use own data to demonstrate issue and impact over time
  - Involve front line staff in identifying the issues and solutions

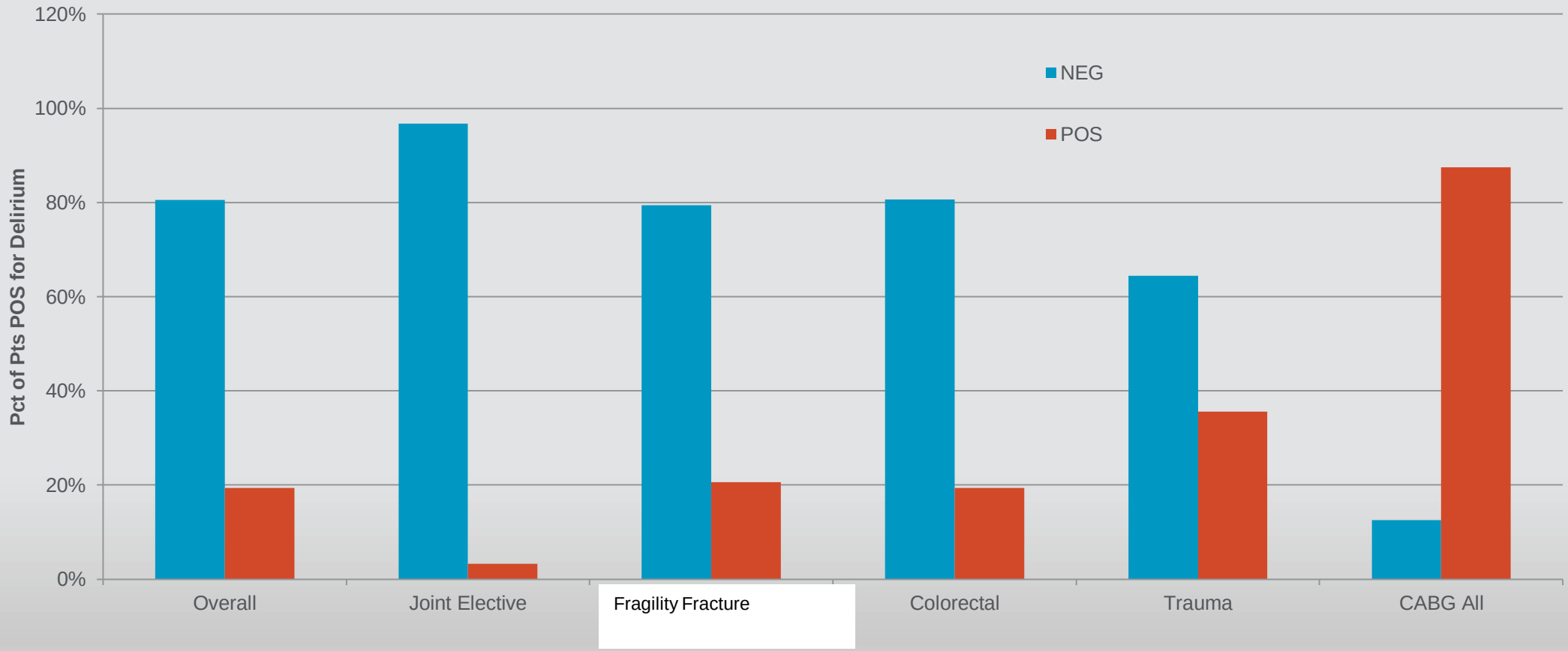
Screening for Delirium is the Key to Prevention

- **Screening starts in the Emergency Department** where all persons 65 and older are assessed and triaged with SQID question and attentional test.
- **All patients** admitted to Hartford Hospital are **screened by their nurse each shift** (3 or more times daily utilizing the CAM* or CAM-ICU) for the duration of their stay and have **prevention strategies** employed for those at high risk of delirium.
- Once an abnormal screen is identified, **protocols** guide evaluation and management.
- This process has allowed us to create a **registry** of patients based upon their screening results.
- Since the start of this project 12 years ago, we have screened over 450,000 patients, with over 7 million assessments completed.

*CAM' = Confusion Assessment Method (Inouye),CAM-ICU (Ely), considered the 'gold standard' screening tool for the detection of delirium.

Delirium Rates Vary by Service

ADAPT Data



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Delirium has Serious Consequences

ADAPT DATA

	Without Delirium	With Delirium
Hospital Length of Stay (Average)	4 Days	12 Days
Discharge Back to Home	70%	30%
Mortality	<1%	10%

Delirium Patients Have Poorer Outcomes at Care Transition

ADAPT DATA

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Delirium Increases Healthcare Costs

- Nationally
  - Hospital cost > $8 billion annually
  - Post-hospital costs ~ $100 billion; direct and indirect (SNF & Home care)

- At Hartford Hospital (ADAPT DATA): Attributable cost July 2015- June 2016
  - 35,700 delirium attributable hospital days.
  - Total attributable cost estimate $96 million
  - 2000 patients D/C to SNF were attributable to delirium.

Delirium is Associated with Higher Costs for Colon Surgery

ADAPT DATA

Avg daily cost NO Delirium	**$2,224.73**
Avg daily cost ANY Delirium	**$2,797.79**
Avg Daily Attributable Cost - Delirium	**$573.06**

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Application of Universal Evidence-Based Best Practice Strategies

- Information in **Patient Handbook** –patient and family to report S/S of delirium promptly. **Family** encouraged to participate in care
- Delirium assessment integrated into **rounds and handoffs**
- **Early mobilization/noise reduction/ sleep enhancement** efforts
- Personalized care "**Hartford HealthCare Cares About Me**" poster
- Creation of a **sensory modulation room** for patients and families
- **Volunteer programs** that focus efforts towards patient experiencing or at high risk for delirium
  - Keeping in Touch Volunteer Visiting Program; Meal Mates; Activity Cart; Safety Volunteers; Mobility Volunteers
- Activated **EHR alerts** on medications that may cause delirium
- Standardized **provider order sets**
- **Nurse experts/consultants** to coach frontline staff at the bedside
- **Provide data driven feedback** to change practice

PROVIDER

PATIENT

NURSES

1 Deter

- No harmful drugs*
- Avoid abrupt discontinuation* (Drugs, ETOH, nicotine)
- Avoid/limit Devices (catheters, lines, leads)

2 Detection

- Review CAM/CAM-ICU & RASS/mRASS Scores
- Daily cognitive assessment
- Determine baseline mental status

3 Diagnosis / Do

- Physical exam
- Med review
- Determine potential causes*
- Differential diagnosis
- Document acute encephalopathy
- Activate Delirium order set in EPIC
  - Diagnostics
  - Drugs for hyperactive pts (RASS/mRASS ≥ +2)
    - Haldol IV or Seroquel PO per delirium order set
    - If contraindicated consult pharmacist
  - Scheduled acetaminophen

5 Daily Visit

- Cognitive assessment
- F/U Diagnostics
- Review meds-adjust prn

7 Discharge

- Document course and cause of Delirium if known
- Degree of resolution
- Discontinue unnecessary psychotropics
- Follow up for Delirium if not resolved
- Document on W10/After Visit Summary

Risk Factors

- Age > 65
- **D**ementia
- Substance **D**ependency
- Hx **D**elirium
- ICU/S**D**
- Impaired vision/hearing

- ED screen of pts age >65
- Attention screen
- SQID?

CAM or CAM-ICU Positive

4 Discuss

- Provider + Nursing
  - +/- Pharmacist
- Huddle
- Make Plan

6 Daily Dialogue

- Provider + Nursing
  - +/- Family
- Progression Rounds
- **Is Patient Improving?**

YES

NO

YES

Age > 65:

- Geriatric medicine consult

Age < 65 or major psychiatric Dx:

- Psychiatric consult
- Family meeting

1 Deter

- Mobilize to maximum
- Uninterrupted night-time rest (noise, bundle care, eye shields, earplugs)
- Eyeglasses/hearing aids
- Whiteboard up to date
- Daily goals of care
- Calendar/clock/familiar items
- Assist with food/fluids
- Comfort
- “HHC Cares About Me” poster
- Family as partners
- Volunteers for social interaction

2 Detection

- CAM every 8 hours and prn
- Determine baseline mental status
- Notify provider immediately of first positive CAM or CAM-ICU and activate “Acute Confusion” CPG

3 Do

- Fall prevention
- Discontinue/ Disguise devices
- Family teaching - brochure
- Provide Distractors (music, flashball, animal)
- T-A-D-A (Tolerate, Anticipate, Don’t Agitate)[1]
- Reassurance
- Individualize plan of care in EPIC
- Nurse - Nurse handoff
- Nurse - PCA handoff

5 Daily Care

- CAM or CAM-ICU every 8 hours + prn
- Comfort/calm/consistent
- Toileting
- Feed/hydrate
- Mobilize to maximum
- Maintain normal sleep/wake cycle
- Touch/backrub
- Assess response to medications
- Family & volunteer involvement
- Alternative therapies (Reiki, Pet, Art, Music)
- Document progress

7 Discharge

- Document successful strategies
- Discuss ongoing needs
- Discharge with one time use Distracters (doll, animal)
- Discuss follow-up with family
- Document individualized care needs on W10/After Visit Summary

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*see back of brochure for more information

[1] Flaherty, 2011

Confusion Assessment Method (CAM© or CAM-ICU©)

Element 1

Acute onset of mental status change from baseline or fluctuating mental status

AND

Element 2

Inattention

AND either

Element 3

Altered level of consciousness Rass ≠ 0

OR

Disorganized thinking

Element 4

⊕ Positive = 1 + 2 + 3 OR 4

Unable to assess = *RASS or mRASS -4 or -5*

Modified Richmond Agitation Sedation Scale (mRASS)

+4	Combative	No attention, overly combative, violent, immediate danger to staff
+3	Very Agitated	Pulls tube(s) or catheter(s); fights environment/not people, difficult to get patient to pay or sustain attention
+2	Agitated	Frequent non-purposeful movement, uncooperative, loses attention rapidly
+1	Restless	Anxious but movements not aggressive or vigorous, cooperative, pays attention most of the time
0	Alert and Calm	Pays attention, makes eye contact, responds immediately
-1	Wakens Easily	Not fully alert, but has sustained awakening > 10 sec. Slightly drowsy
-2	Wakens Slowly	Briefly awakens with eye contact to voice < 10 sec. Very drowsy
-3	Difficult to Awaken	Movement or eye opening to voice but no eye contact
-4	Can't Stay Awake	No response to voice but displays movement or eye opening to physical stimulation. Arousable but no attention
-5	Unarousable	No response to voice or physical stimulation

(Chester, Harrington & Rudolph, 2012)

Potential Etiologies of Delirium

Drugs
Eyes, ears, environment, emotions
Liver failure, low PO_2 (MI, PE, anemia, CVA)
Infection, immobility
Restraints, respiratory
Injury, ictal state
Unfamiliar surroundings, under hydration
Metabolic

Deliriogenic Drugs to Limit/Avoid

Diphenhydramine *(Benadryl)*	*Alternative for allergic Rx is Claritin (Loratadine)*
Lorazepam *(Ativan)*	*Use only in patients dependent upon benzodiazepines or with potential ETOH withdrawal or terminal delirium*
Zolpidem *(Ambien)*	*Use 2.5 mg at bedtime if nonpharmacological measures fail*
Metaclopramide Promethazine Prochlorperazine *(Reglan, Phenergan, Compazine)*	*Alternative is Ondansetron (Zofran)*
Famotidine *(Pepcid)*	*Alternative is PPI except with Plavix, or Pantoprazole (Protonix)*
Fentanyl	*Alternative is Hydromorphone (Dilaudid), Acetaminophen (Tylenol), or Tramadol (Ultram)*

Medications to Not Stop Abruptly

- Acetylcholinesterase inhibitors
- Antiepiletics
- Benzodiazepines
- Opioids/narcotics
- Sedatives/hypnotics
- SSRIs
- Steroids

Delirium and Acute Encephalopathy are associated with Death, Disability, Deterioration and Discharge Difficulties

Delirium & Acute Encephalopathy Care Pathway

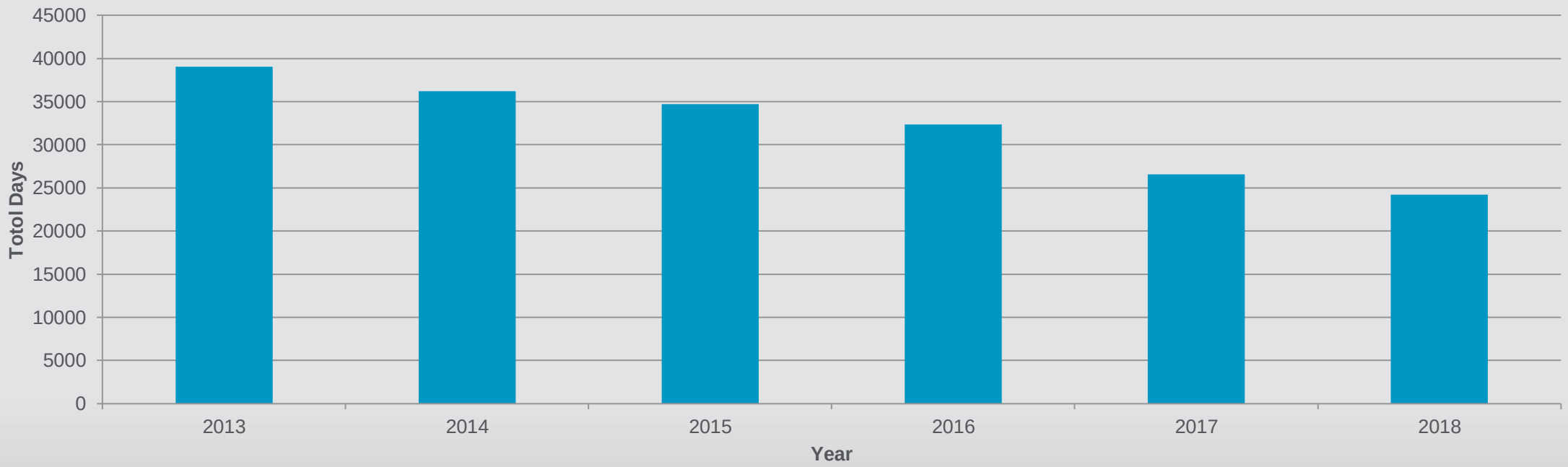
Save a Brain

Sponsored by ADAPT
Actions for Delirium Assessment Prevention & Treatment

Hartford Hospital
A Hartford HealthCare Partner

Hartford HealthCare

Delirium Attributable Days



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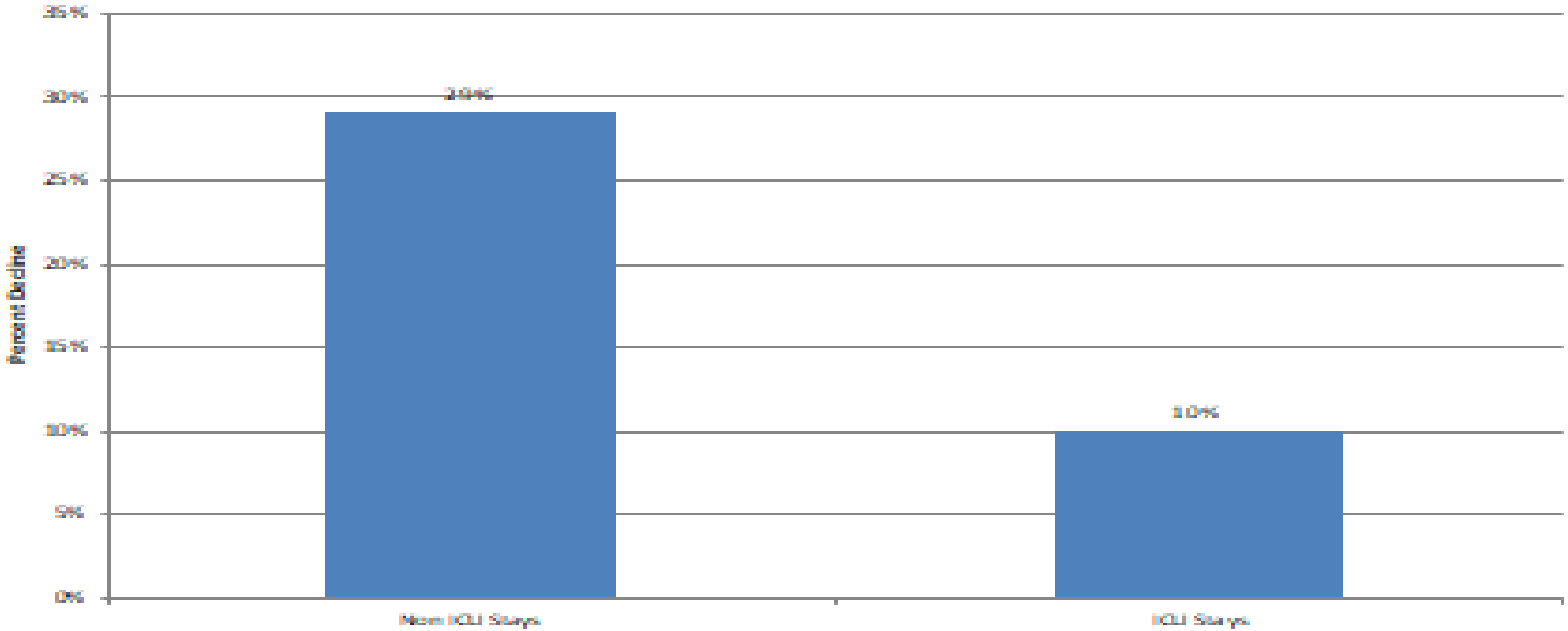
Integration of 4M Age-friendly Health System Framework



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ROI Calculator Applied to ADAPT

1 | 2 | 3 | 4 | 5 | Scenarios | Scenario Name: No PAC | Find Levels (Target ROI)

1. Start	Acute Care for Elderly

2. Population & 4M Period	
Number of annual admissions	31,000
Amortization period (Years)	5

3. 4M Costs		Per Year
Launch - one time only expenses	$10,000	$2,000
Fixed expenses		$0
Variable cost per admission	$20	$620,000
Total annual cost of program		*******

5. Case cost from coding & payment for HAC	
Revenue per case detected (code modification)	$3,050
Detection & coding effectiveness (% cases)	50.0%
Case cost revenue offset (by detection %)	**$1,525**

Results		
	Total Cost Avoided	********
	4M Costs	$622,000
	Net Benefit	********
	ROI	934.1%
	Years Given Back	12.23

Levels	
Target ROI	300%
Delirium Effectiveness	20.4%
Delirium Incidence (%)	10.1%
Total Program Cost	$686,249

Simulation Results (ROI)	
Max	388.5%
Min	578.2%
Average	491.5%
% Below Target	0.0%

4. Key Metrics	Estimates/Values	Delirium	HAPU'S	Other Condition
	Incidence (%)	12.0%	0.0%	0.0%
	Total cases	3720	0	0
	4M program effectiveness	15.0%	0.0%	0.0%
	Cases avoided	558	0	0

HA Condition	Type of stay	Length of sta	Cost per day	Length of sta	Cost per day	Length of sta	Cost per day
	Normal	5.0	$2,000	5.0	$2,000	5.0	$2,000
	Extended due to condition	5.2	$260	0.0	$0	0.0	$0
	ded hospital case cost		**$13,052**		**$0**		**$0**

- hospital and PAC combined	**$13,052**	**$0**	**$0**
st adjusted for revenue offset	**$11,527**	**$0**	**$0**
Costs avoided	**$6,432,066.00**	**$0**	**$0**

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Additional Quality Measures To Track

Process Measures

- Mobility (ambulation)
- Accuracy of delirium screening
- Avoidance of deliriogenic medications
- Use of one-to-one sitters
- Opportunities for family caregivers
- Use of non-pharmacological interventions

Outcome Measures

- Preventable Falls with Injury
- Delirium rates
- Restraint use
- Length of Stay
- Mortality Rates
- Discharge Disposition (home vs facility)
- Unintentional Weight Loss
- Patient & Family satisfaction

Barrier

- Failure to appreciate delirium as prevalent and costly
- Failure to make delirium prevention, detection and action a priority
- Time and resource constraints to implement non-pharmacological interventions

Approach

- Implement universal delirium screening and analyze facility data
- Implement a delirium care pathway with coaching and accountability
- Recruit volunteers; philanthropic funds to purchase items; supply chain integration; bedside experts to coach staff

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Summary

- Link 4M based Delirium Care to organizational goals
- Involve executive sponsors to demonstrate organizational commitment
- Use your data to identify the impact of delirium
- Use your data to demonstrate improvement in quality measures
- Support your staff with resources required for excellent delirium care
- Celebrate successes!

Maine Medical Center
MaineHealth

Implementing the 4Ms

Specialized Care to Sustainable Systems

January 17, 2024

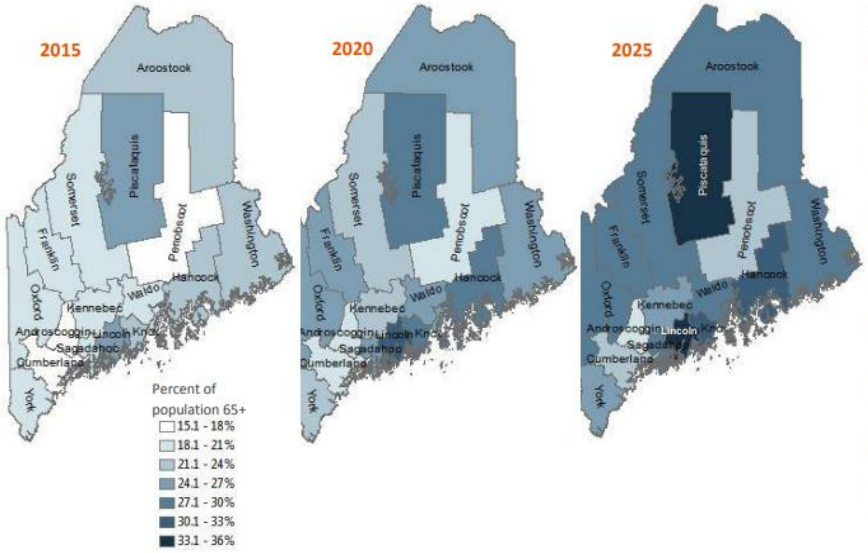
Emily Carter, MD
Medical Director, Hospital Elder Life Program (HELP)
Associate Director of Inpatient Programs
Division of Geriatrics, Maine Medical Partners

Disclosures

- None

Background

- Maine is the oldest state in the nation according to the U.S. Census Bureau, with 22.5% of the population over 65 years of age (2022).

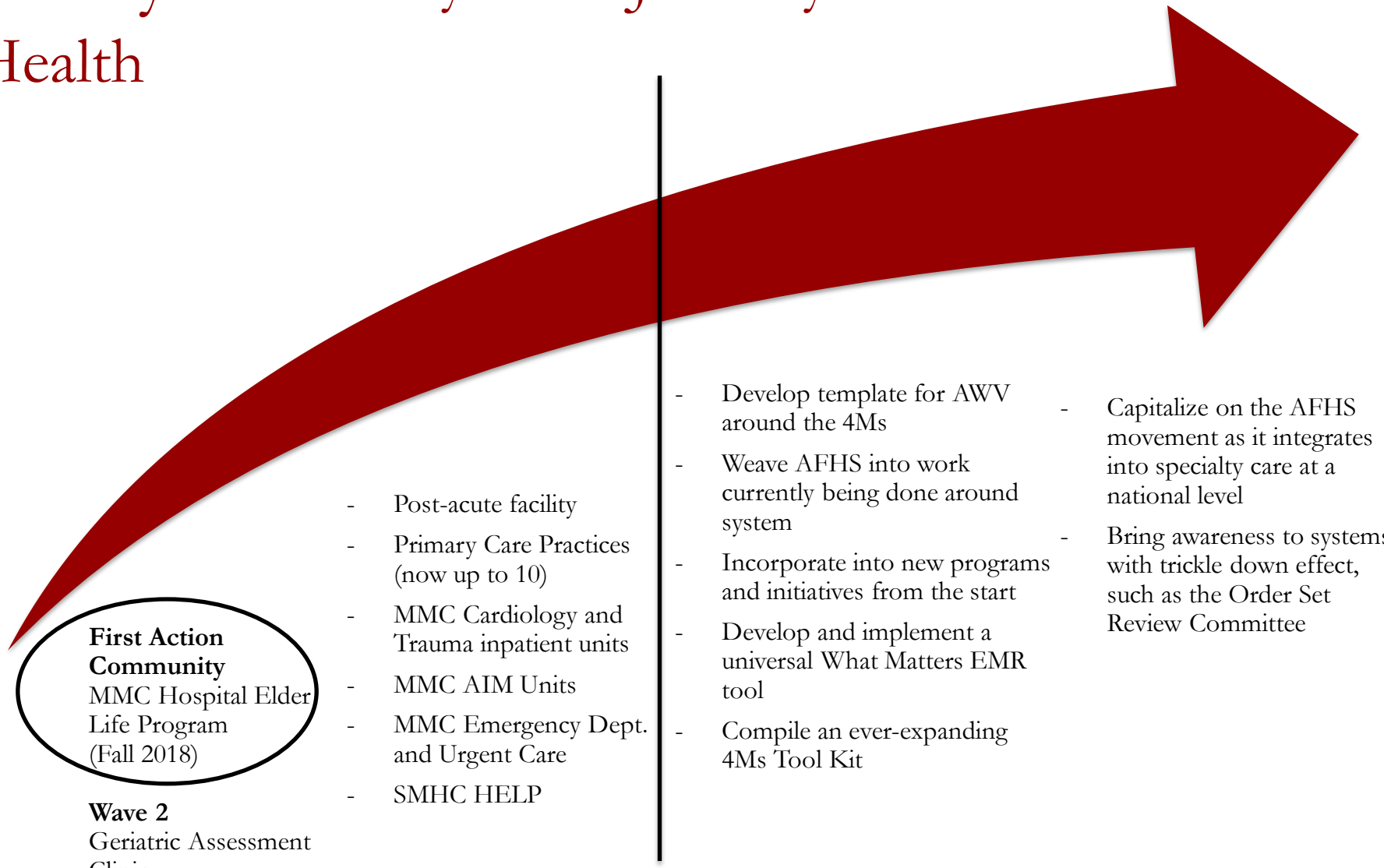


County	2015	2020	2025
Maine	19%	22%	26%
Androscoggin	16%	18%	21%
Aroostook	22%	26%	30%
Cumberland	17%	20%	23%
Franklin	20%	25%	29%
Hancock	23%	27%	31%
Kennebec	18%	22%	25%
Knox	23%	27%	31%
Lincoln	26%	31%	35%
Oxford	20%	24%	28%
Penobscot	17%	20%	23%
Piscataquis	25%	29%	35%
Sagadahoc	20%	24%	29%
Somerset	20%	23%	27%
Waldo	20%	24%	27%
Washington	23%	26%	30%
York	19%	22%	26%

http://muskie.usm.maine.edu/Publications/DA/Long-Term-Services-Supports-Use-Trends-Chartbook-SFY2014.pdf

- In FY19, MMC saw just under 13,000 patients age 65 and older, a 2% increase from FY18.
- We need a way to provide consistent, best practice care to all older adults who enter our health system.

Age-Friendly Health Systems Journey at MaineHealth



First Action Community
MMC Hospital Elder Life Program (Fall 2018)

Wave 2
Geriatric Assessment Clinic

- Post-acute facility
- Primary Care Practices (now up to 10)
- MMC Cardiology and Trauma inpatient units
- MMC AIM Units
- MMC Emergency Dept. and Urgent Care
- SMHC HELP

- Develop template for AWV around the 4Ms
- Weave AFHS into work currently being done around system
- Incorporate into new programs and initiatives from the start
- Develop and implement a universal What Matters EMR tool
- Compile an ever-expanding 4Ms Tool Kit

- Capitalize on the AFHS movement as it integrates into specialty care at a national level
- Bring awareness to systems with trickle down effect, such as the Order Set Review Committee

The AGS CoCare Hospital Elder Life Program (HELP) is an innovative model of hospital care designed to **prevent** delirium and functional decline in hospitalized older adults. HELP uses interdisciplinary staff and targeted intervention protocols to improve patients' outcomes and provide cost-effective care.

The primary goals of the program are:

- Maintaining cognitive and physical functioning of high-risk older adults throughout hospitalization.
- Maximizing independence at discharge.
- Assisting with the transition from hospital to home.
- Preventing unplanned hospital readmissions.

https://www.deliriumcentral.org/agshelp/

HELP at MaineHealth

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

Maine Medical Center

- 627-bed teaching hospital in Portland, ME
- HELP established in 2002, Center of Excellence in 2010

Southern Maine Healthcare

- 150-bed community hospital in Biddeford, ME
- HELP established in July 2021

Assess: What are we already doing?

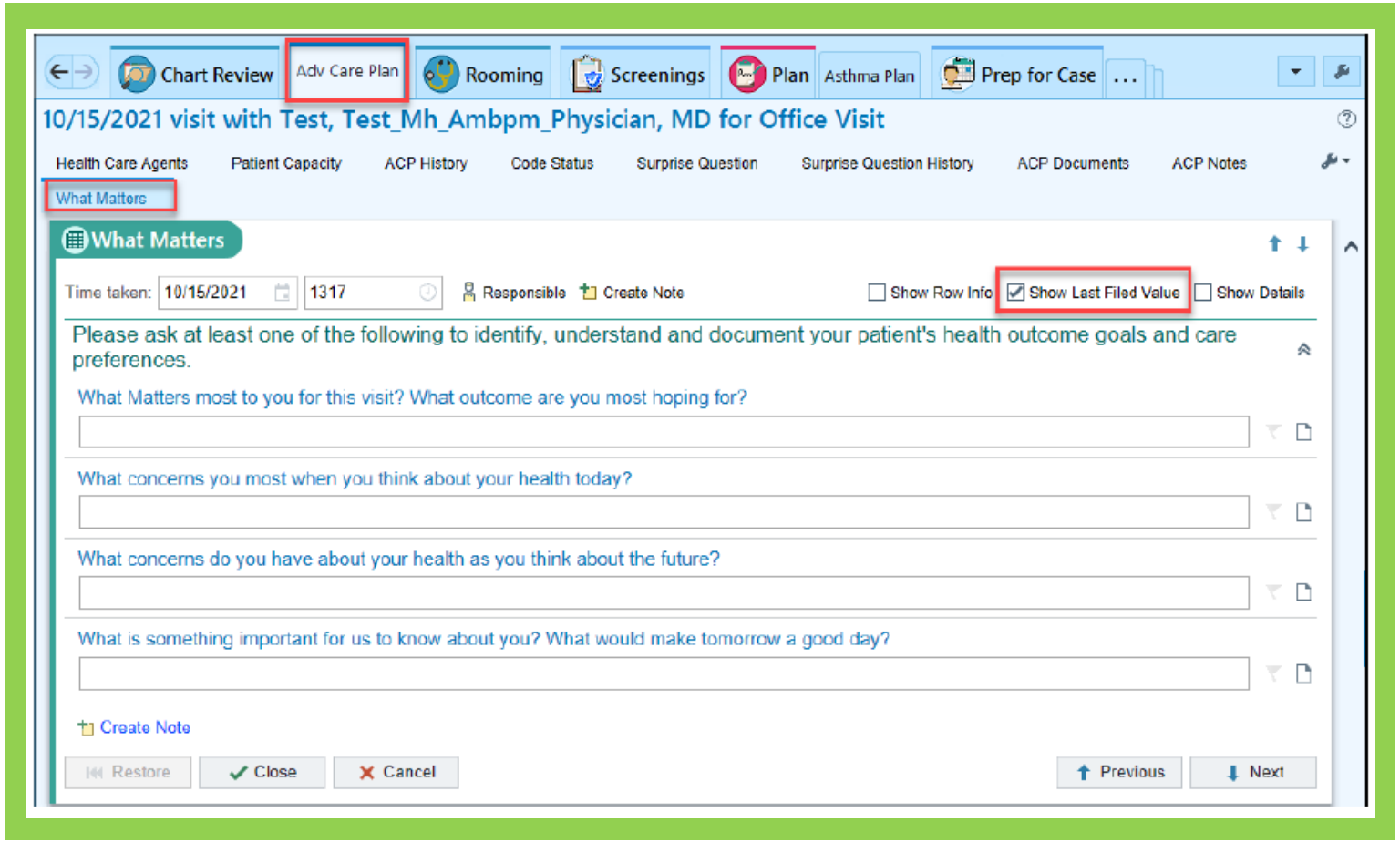
Age-Friendly Health Systems
Committed to Care Excellence for Older Adults

Table 1. Crosswalk of HELP Protocols with 4Ms

HELP Protocols*	Age-Friendly Health Systems 4Ms†			
	What Matters	Medication	Mentation	Mobility
HELP Core Interventions				
Standardized Patient Screening	✓	✓	✓	✓
Patient Enrollment Procedures	✓	✓	✓	✓
Daily Visitor Program	✓	✓	✓	✓
Orientation Protocol	✓	✓	✓	✓
Therapeutic Activities Protocol	✓	✓	✓	✓
Sleep Enhancement Protocol	✓	✓	✓	✓
Early Mobilization Protocol	✓	✓	✓	✓
Vision Protocol			✓	✓
Blindness Protocol			✓	✓
Hearing Protocol			✓	
Feeding Assistance Protocol			✓	
Fluid Repletion Protocol			✓	
Chaplaincy Protocol	✓		✓	
Delirium Protocol	✓	✓	✓	✓
Dementia Protocol	✓	✓	✓	✓
Psychoactive Medications Protocol	✓	✓	✓	✓
Discharge Planning Protocol	✓	✓	✓	✓
Optimizing Length of Stay Protocol	✓	✓	✓	✓
Discharge Protocol	✓	✓	✓	✓
Post Discharge Assistance and Telephone Follow-Up	✓	✓	✓	✓
HELP Interdisciplinary Interventions				
Interdisciplinary Team (IDT) Rounds	✓	✓	✓	✓
Geriatrics Consultation	✓	✓	✓	✓
Community Linkages	✓	✓	✓	✓
NICE‡ to HELP Nursing Interventions				
Pain Management Protocol	✓	✓	✓	✓
Aspiration Prevention Protocol		✓	✓	
Prevention of Catheter Associated UTI Protocol			✓	
Constipation Protocol		✓	✓	✓
Hypoxia Protocol			✓	✓

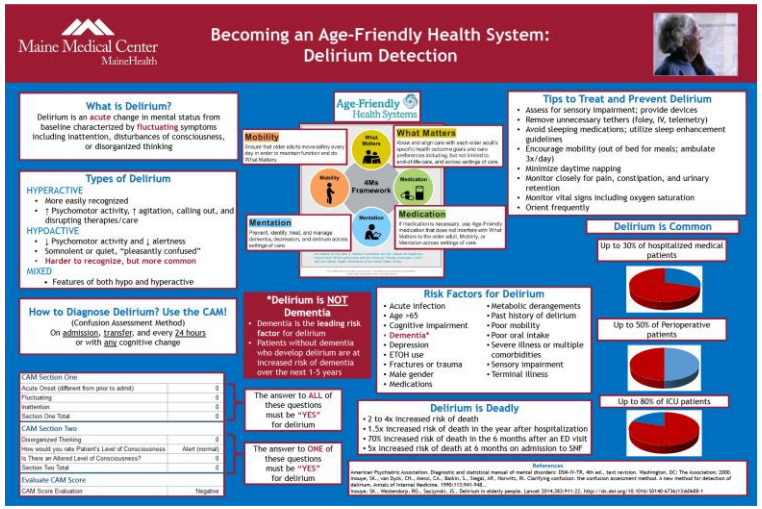
*AGS CoCare®: HELP Program January 2023: https://help.agscocare.org

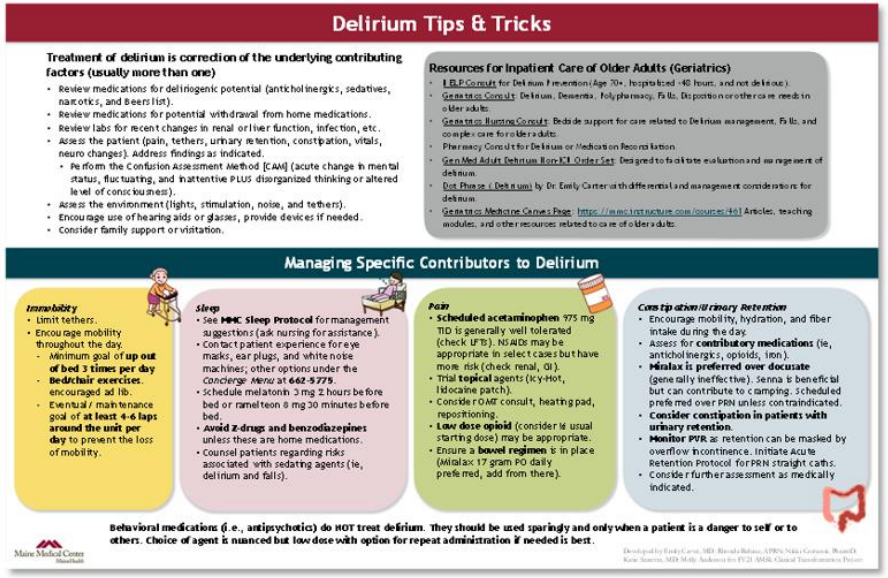
Act On: What Matters

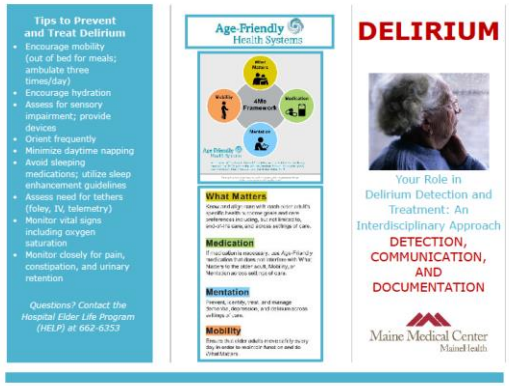


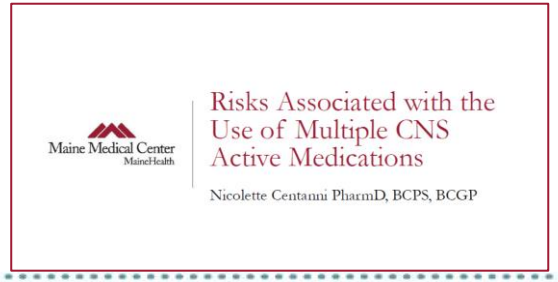
Next Steps

- Assess: Geriatrics Scorecard
- Act On: Partnership development (Trauma, Cardiology, Emergency Medicine, Adult Medicine); Interdisciplinary Engagement (providers, pharmacy, nursing, therapy, SW, care

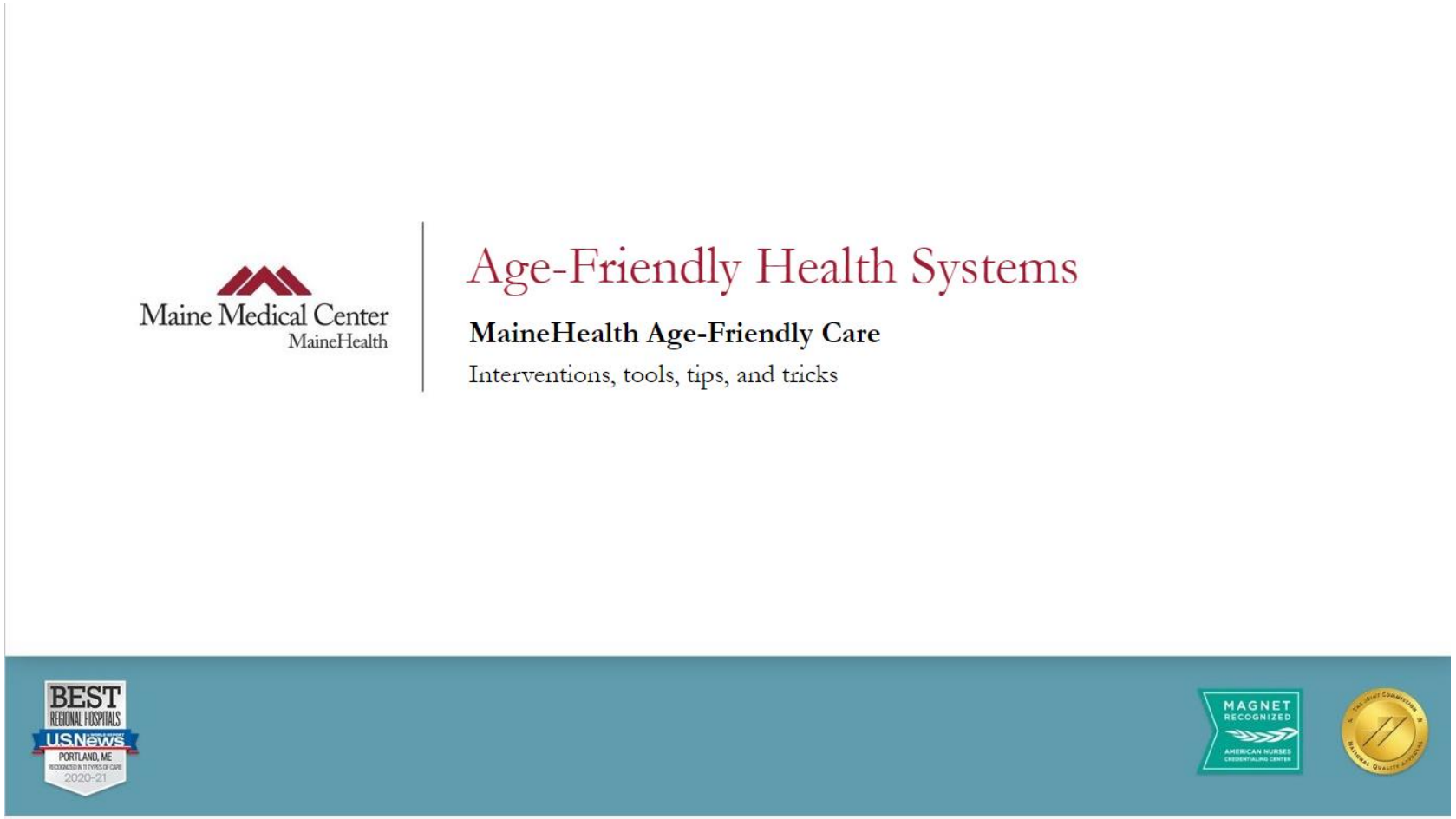








Tool Kit


Maine Medical Center
MaineHealth
Age-Friendly Health Systems
MaineHealth Age-Friendly Care
Interventions, tools, tips, and tricks
BEST
REGIONAL HOSPITALS
U.S.News
PORTLAND, ME
2020-21
MAGNET
RECOGNIZED
AMERICAN NURSES

What Matters Tools

Tool	Format	Purpose	Implemented
.traumaacp	Epic Dotphrase	Dotphrase for Trauma APPs to integrate asking What Matters into the Trauma Tertiary Survey done for each encounter	• MMC Trauma patients 65 and older on R6
What Matters Flowsheet	Epic Flowsheet	Flowsheet that is integrated into Care Management and Social Worker navigators to guide the asking of What Matters through four different, targeted questions.	• MMC Emergency Department • MMC Inpatient units
MH Nursing Home Smartblock	Epic Smartblock	Tool used in the post-acute setting to track the discharge disposition of patients and support the data capture of patients discharged home vs other facilities	• St. Joseph's Rehab and Residence
What Matters documentation	KPI	KPI used to track the documentation of an answered What Matters question by Care Management in the ED	• MMC ED

Mobility Tools

Tool	Format	Purpose	Where Implemented
Daily BMAT Assessment Measurement	KPI	Monitor and develop interventions to improve unit compliance with patients having a daily BMAT assessment performed	• P3CD, R2, R6, R7
3x/Day Ambulation	KPI	Monitor and develop interventions to improve unit achievement to ambulate patients at least 3 times a day	• P3CD, R2, R6
Mobilized in the last 4 hours indicator	Epic PAF Column	Patient List Column to visually indicate if a patient had been mobilized in the last 4 hours	• R6
Sara Stedy Platform Step	Equipment	Equipment procured by and training provided by Safe Patient Handling to safely move patients Platform step purchased to allow for rehabilitation therapy to simulate stairs	• R6, R7 • ED
Mobility Checklist in Hourly Rounding Smartblock	Epic Smartblock	Incorporate mobilization in ED hourly rounding process	• ED
Nursing Real Time Quality Dashboard	Epic RADAR Dashboard	Allows unit managers/leadership to review CAM/BMAT data on their units.	• P3CD, R2, R6, R7

Medications Tools

Tool	Format	Purpose	Where Implemented
Age-Friendly Patient List Template	Epic PAF Columns	Easy integration of Age-Friendly into daily patient care	• Adult Medicine
.opiateassessment	Epic Smartphrase	For Providers to evaluate concomitant benzo and opiate use	• SJR
Sleep in the Elderly	LMS Video Module	Video education training for all staff	• R6 • R7
CNS Active Medications	LMS Video Module	Video education training for all staff	• R6 • R7
Pharmacologic Management of Delirium	LMS Video Module	Video education training for all staff	• Adult Medicine

Mentation Tools

Tool	Format	Purpose	Implemented
Daily CAM Assessment	KPI	Monitor and develop interventions to improve unit compliance with patients having a daily BMAT assessment performed	• MMC P3CD, R2, R6, R7 MMC ED
CAM Assessment	Epic Flowsheet	** Intervention	• MMC ED, UCP
SNF CAM Assessment	PointClickCare	Documenting the CAM assessment in the post-acute EMR.	• St. Joseph's Rehab and Residence
.CAM	Epic Smartphrase	For provider use to document CAM negative or CAM positive when evaluating patients for altered mental status and confusion	• St. Joseph's Rehab and Residence
CAM Chart Audits	Manual Audit	Random audits of Bedside RN CAM assessment results	• MMC P3CD, R2, R6, R7
Delirium Badge Buddies	Badge Buddy	For care team members to quickly reference how to prevent delirium, what to do if delirium is suspected, and how to treat it	• MMC P3CD, R2, R6, R7 MMC ED
Delirium Poster	24"x36" Poster	Reference poster for charting rooms	• MMC P3CD, R2, R6, R7 MMC ED
Delirium Brochure	Trifold Brochure	Reference brochure for units	• MMC P3CD, R2, R6, R7
Delirium Tips and Tricks	11" x 17" Tablet Poster	Reference poster for charting rooms	• MMC P3CD, R2
Your Role in Delirium Detection and Treatment	LMS Video Module	Video education training assigned to Nursing staff for all new hires and re-training.	• MMC R6, R7
Positive Approach to Care: Strategies to Improve the Care of Patients Living with Dementia	Live or virtual class (contact [redacted]	This workshop helps learners understand and recognize the differences in "normal" and "not normal" aging and focuses on improving care for patients living with dementia using Positive Approach to Care "care partnering" techniques, including Positive Physical Approach™ (PPA) and Hand Under Hand™ (HUH). The learner will develop better observational skills to recognize and intervene effectively when behavioral challenges occur. Learners will also develop new skills related to approach, cueing, and ability to connect with people affected by dementia.	• RN Resources

Sustainable Systems

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

Mobility

Mentation

Medications

Room/Bed	Admission Date	Problem	Code Status	CAM Score	CrCl	Anticholinergic Score	Sedative Medications (Targeted)	Beers Medications (2012)	Diet Orders and Comments with Display Name	Last Bowel Movement	Foley Order	BMAT Mobility Level	Fall Risk Level	Mobility Check Four Times 24Hrs.
[redacted]		Sepsis (CMS-HCC)		Negative	92.6 mL/min	0	—	—	Diet cardiac sodium 2 gm	07/15/21	—	Level 4	Low Fall Risk	4
		Left displaced femoral neck fracture (CMS-HCC)		Negative	39.2 mL/min	0	—	—	Diet regular	07/15/21		Level 3	High Fall Risk	4
		Chronic atrial fibrillation		Positive	12.2 mL/min (A)	4	haloperidol Intravenous/Intramuscular 2 mg ...	—	Diet diabetic limit to 75 gm CHO/meal	07/15/21		Level 3	High Fall Risk	4
		Closed left hip fracture (CMS-HCC)		Negative	91.7 mL/min	3	ALPRAZolam tablet 0.5 mg	—	Diet regular	07/16/21	—	Level 3	High Fall Risk	—
		Spinal stenosis, lumbosacral region	—	Negative	43.6 mL/min (A)	0	—	amiodarone tablet 200 mg	Diet regular: Nurse may advance diet...	07/13/21		Level 3	High Fall Risk	4
		Acute on chronic respiratory failure with hypoxia...		Negative	111.1 mL/min (A)	0	LORazepam tablet 0.5 mg	—	Diet regular 1000 ml	07/15/21	—	Level 3	Moderate Fall Risk	—
		Closed fracture of right hip (CMS-HCC)		Negative	28.8 mL/min (A)	0	—	amiodarone tablet 100 mg	Diet regular	-- (PTA)	—	Level 1	High Fall Risk	—
		Closed fracture of neck of left		Negative	85.2 mL/min	3	—	metoclopramide injection 5 mg	Diet NPO Except for: Sips with	07/11/21	—	Level 1	High Fall Risk	4

What Matters

Age Friendly Order Sets

Practical Applications of Age Friendly Care for the Surgical Patient

Consider implementation of iPACE rounding with a 4Ms focus

Create an order set or add age adjustors to known order sets (I)

- Dose adjusted narcotics
- Pre-checked Miralax 17 grams PO daily vs Adult Medicine Bowel Regimen decision tree
- HELP consult (pre-checked)
- Geriatrics consult (not pre-checked)
- Option for WHILE AWAKE vitals or a time-linked option (build in the options for both)
- ?pre-check Delirium Precautions and Fall Precautions

Already in existence:

- Age Friendly Toolkit
- CAM BID (already standard of care) (IIIa)
- Pre-check HELP order on admission (IIIb,c,h, V)
- MMC Sleep Protocol—publicize this better? (IV)
- Mobility protocols—ERAS (IV, Vb)
- OOB for all meals—ERAS (VI)
- CM/SW if no Advance Directive on file
- Strict adherence to TIPS tool and daily discussions with team around mobility goals/barriers

Providers to add EPIC columns to their patient lists: Beers, Sedatives, Anticholinergic score and be mindful of agents in these columns. (IIa,b)

Providers to perform complete and accurate med recs on admission and be considerate of home agents with withdrawal risk. (IIa)

Providers to prescribe thoughtfully based on risk factors

- Pre-select lower range for narcotics (oxycodone 2.5-5/hydromorphone 1-2/0.2-0.5) (IIId,e)
- Adult Medicine Bowel Regimen decision tree (or just pre-select scheduled Miralax) (IIIf)
- Pre-select Tylenol 1,000 mg TID (0700, 1300, 2000) (IIId,g, IVa)

Providers to consider Vitals Q4hrs WHILE AWAKE—maybe build a time linked order for 3 days of Q4 vitals and then WHILE AWAKE? (IVa)

Providers to add What Matters link to note template

Geriatrics consult or use of the Non-ICU Delirium order set for assistance when delirium develops (VII)

Take Aways

- Age Friendly care IS delirium prevention; Delirium prevention IS Age Friendly care
- Start where you are, take your easy wins, gain momentum
- Assess and Act On the needs of you clinical partners
- Build systems to support sustainability (make it easy)
- Resources for support:
  - Institute for Healthcare Improvement (IHI) (including Action Communities)
  - John A. Hartford Foundation
  - American Geriatrics Society, including Age Friendly Resource Library
  - American Delirium Society