



AGE-FRIENDLY HEALTH SYSTEM MENTATION – OUTPATIENT ASSESSMENT

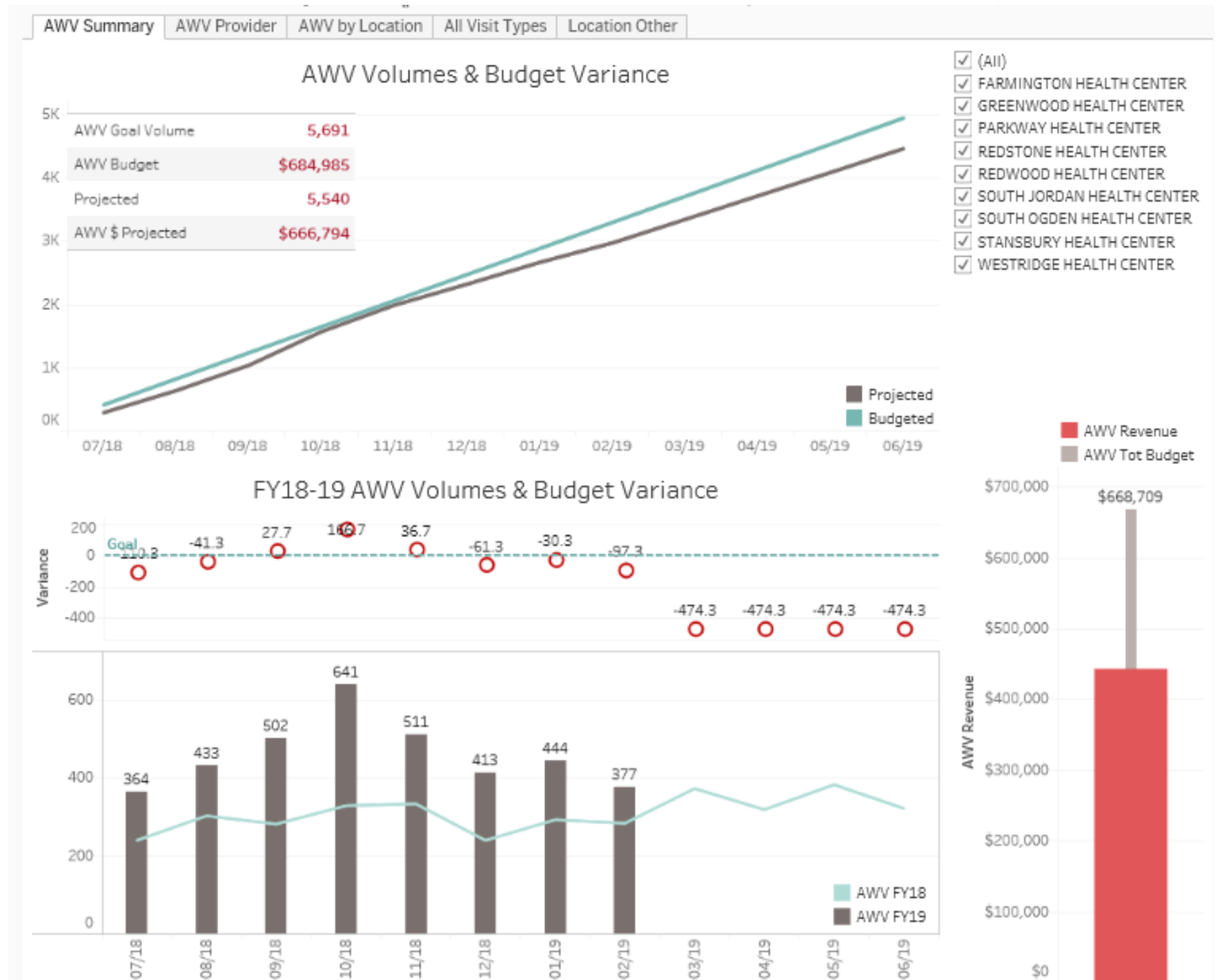
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UNIVERSITY OF UTAH HEALTH COMMUNITY CLINICS - REDSTONE
EPIC AMBULATORY CHAMPION

AWV IS THE WAY TO DO 4MS

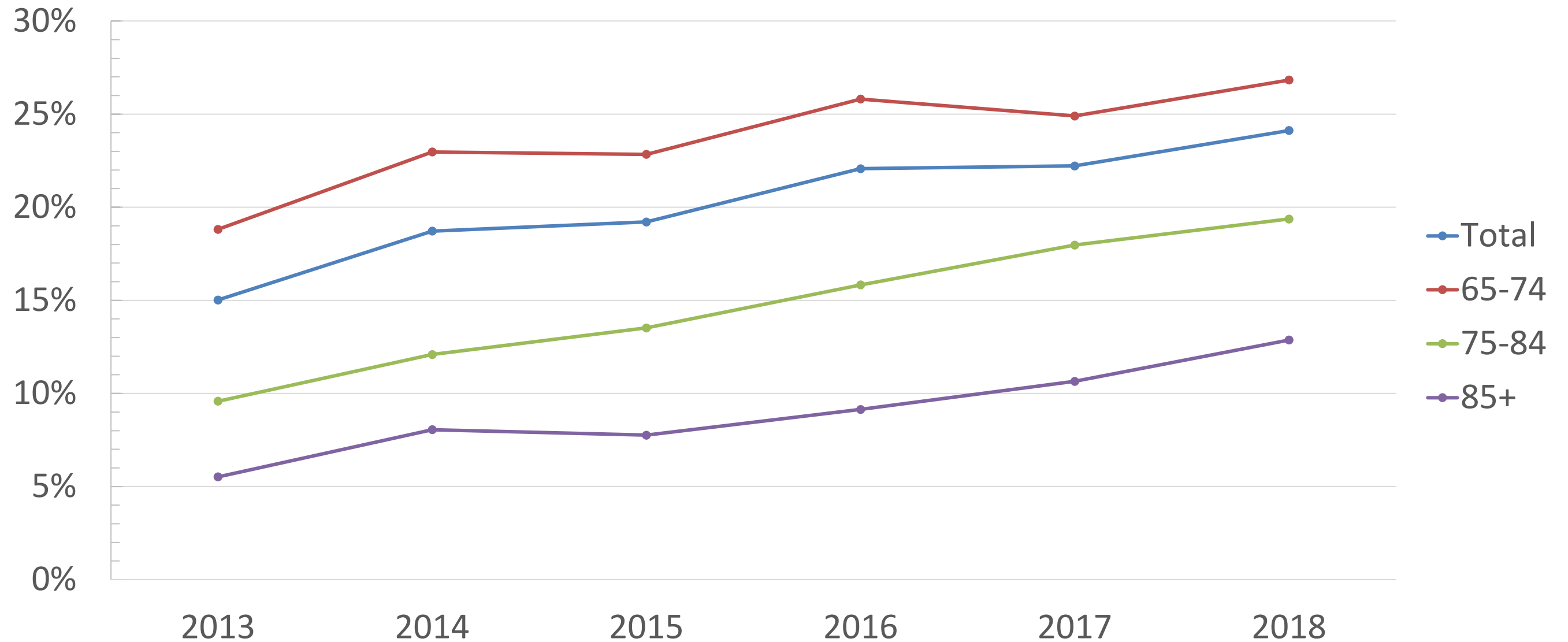
- Mentation: Mini Cog embedded in template
- What Matters:
 - Personalized Plan of Preventive Services (PPPS)
 - Review Advanced Care Planning documents
 - Input “Patient Entered Wishes”
- Medications: Medication Reconciliation
- Mobility:
 - ADLs and IADLs
 - Health Risk Assessment (HRA)

AWV IS A VALUE ENHANCEMENT HEALTH SYSTEM GOAL



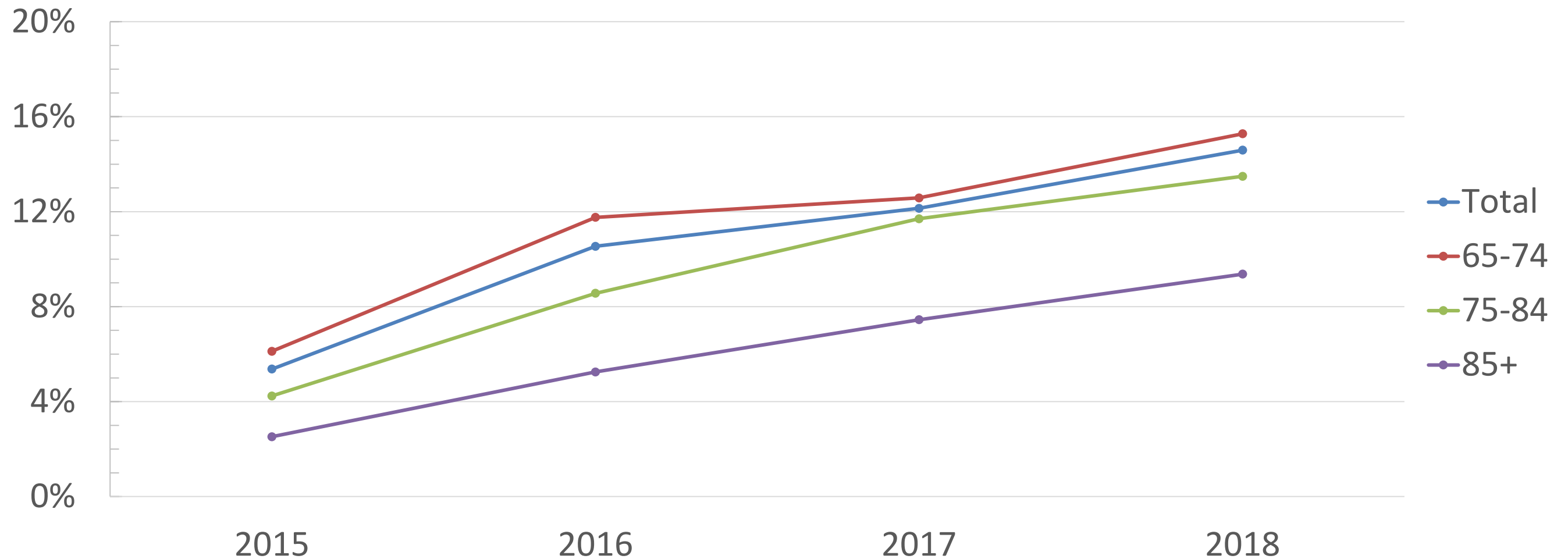
COMMUNITY AWWV OVER TIME (% OF AGE > 65)

Percentage of Patients with AWWV



COMMUNITY AWV AND MINI-COG OVER TIME (% OF AGE > 65)

Percentage of Patients with AWV and Mini-Cog



ACP SCANNED DOCUMENTS

Patients will have the ability to submit their own scanned ACP documents (Advance directives, power of attorney, living will etc), as well as to submit answers to a questionnaire about their wishes via MyChart .

- Submitted documents are reviewed by a pool in HIM and validated if appropriate. They appear in the ACP Documents section of the ACP navigator.
- Questionnaire responses appear in the **Patient Entered Wishes** section of the ACP navigator.

The screenshot displays the 'Advance Care Planning' section of the MyChart interface. On the left, a sidebar menu lists various options, with 'ACP Documents' and 'Patient-Entered...' highlighted in green. Arrows point from these menu items to the corresponding content areas on the right. The 'Documents' section shows a table of scanned documents, and the 'Patient-Entered Wishes' section shows a questionnaire response.

Document Type	Status	Effective Date	Expiration Date	Received On	Received By	Description
Advance Directive	Received			02/13/19	Batch Job, Mychart	Introduction to SmartTool Configuration Workbook (3).pdf
Living Will	Received			02/20/19	Batch Job, Mychart	LivingWillSample.pdf

Patient-Entered Wishes

▼ Patient-Entered Wishes for Advance Care Planning

This documentation does not take the place of any legal documents regarding advance care planning.

What experiences has the patient had with serious illness or death and how has that influenced their wishes and values?

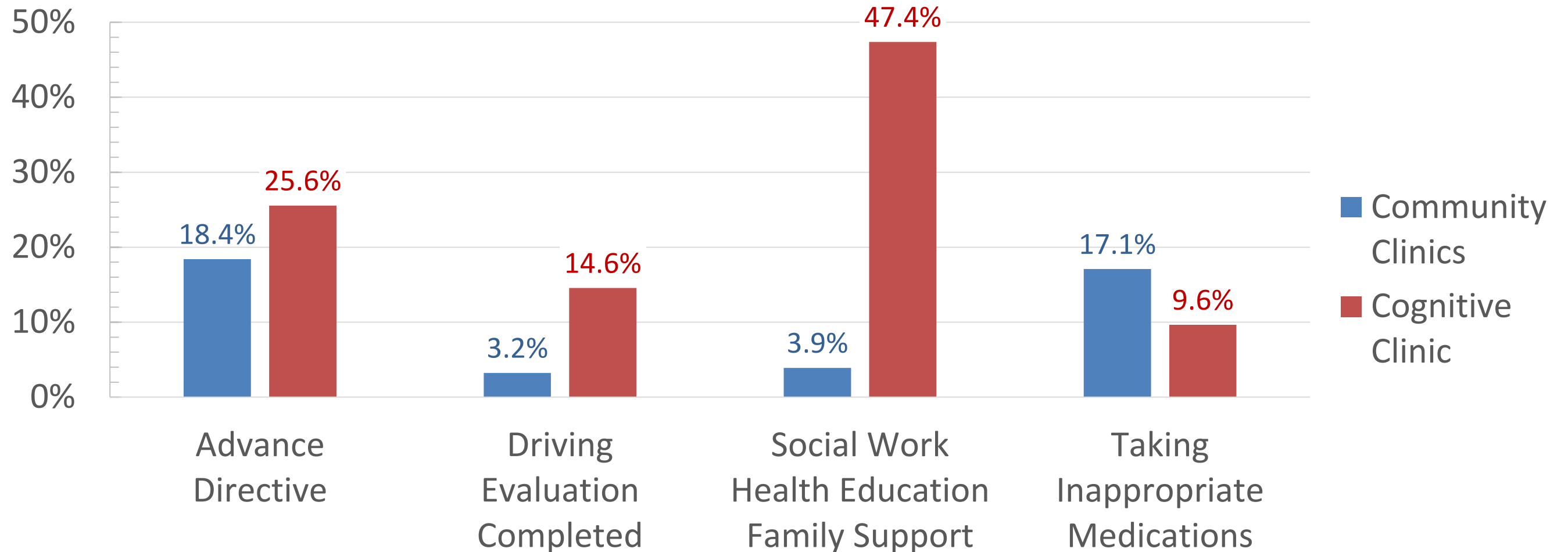
Test 1

IMPROVEMENT IN AWV LOGISTICS

- Patient questionnaire through patient portal
- MA rather than RN driven with NP, PA or MD review of findings
- Decrease appointment times from 1 hour to 20 minutes
- Provider panel for AWV completion

POTENTIAL TO IMPROVE PATIENT-CENTERED OUTCOMES 2018

Outcomes Comparison



POPULATION HEALTH TOOL

My Patients on the Primary Care Adult Risk Due for AWV (Medicare Annual Wellness Visit) [9435538] as of Thu 3/28/2019 3:49 PM

Filters Options Chart Encounter Communication Track Pt Outreach HM Modifiers Add to List Questionnaire Series

All Patients Refresh Selected

General Risk	Patient	MRN	ASCVD Risk (%)	Hosp or ED Adm Risk (%)	Sex	Last Appt With Me	HM Topics Due	Next PCP Visit	HCC Score Gap	Care Manager	Anxiety Screen?	Care Plan?	Pt Comm Pref	Registries
1			?	1.3	Male	01/10/2018	Colorectal Cancer Screening Dtap/Tdap/Td Shingrix (Shortage Only Give If 2nd Dose) Pneumococcal 65+ Years Pt Plan Of Care Medicare Annual Wellness Visit	3/29/19	0				MyChart	Hypertension Registry, Wellness Registry: All, HCC Registry, Primary Care Adult Risk, Chronic Care Management
1			N/A	1.5	Female	04/04/2018	Mammogram Dxa Medicare Annual Wellness Visit		0.33				MyChart	Hypertension Registry, Wellness Registry: All, HCC Registry, Primary Care Adult Risk, Chronic Care Management
4			5.3	3.3	Female	04/10/2018	Mammogram Colorectal Cancer Screening Dxa Influenza Dtap/Tdap/Td Shingrix (Shortage Only Give If 2nd Dose) Pneumococcal 65+ Years		0					Wellness Registry: All, HCC Registry, Primary Care Adult Risk, Chronic Care Management Optum ACO Current

Primary Care Visit Planning Plan of Care

Telephone

High Risks

Past Visit Information

Referral to Care Management	Not on file
Referral to Social Work	Not on file
Referral to Pharmacist	Not on file
Last Care Manager Visit	Not on file
Last Clinical Pharmacist Visit	Not on file
Last Social Work Visit	Not on file

General

Treatment Goals - 1 = "Yes", 0 = "No" 0

1/4/2019

Primary Coverage

Payor	Plan
UNITED HEALTHCARE MEDICARE	AARP MEDICARE COMPLETE OPTUM CARE PLAN 1 & 2

Chronic Care Management Status

General

Eligible for CCM enrollment	Yes
CCM Enrollment Status	Not on file

Current as of: 3/24/2019 8:08 PM ?

Medicare Advantage Diagnoses Requiring Refresh

HCCs Requiring Refresh

Care/Risk Scores

General Risk Score	4	⚠
ASCVD 10-Year Risk Score	5.3	⚠
Preventive Care Gap Score	2	⚠
Risk of Admission or ED Visit	3.3	✓

Patient Care Team

Melissa S Briley, PA-C

Relationship: PCP - General
Specialty: FAMILY MEDICINE
Start: 2/8/18

Julie L O'Brien, APRN

Relationship: Nurse Practitioner



AGE-FRIENDLY HEALTH SYSTEM MENTATION – INPATIENT ASSESSMENT

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HOSPITAL ELDER LIFE PROGRAM (HELP) DELIRIUM PREVENTION



UNIVERSITY OF UTAH HOSPITAL ELDER LIFE TEAM:

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DELIRIUM

- Also called: Acute confusional state, altered mental status, toxic metabolic encephalopathy
- Pathophysiology is poorly understood
 - neurotransmitter imbalance
 - neuroinflammation
- Associated with poor outcomes
 - longer hospital stay
 - increased average daily cost
 - increased risk of institutionalization
 - falls
 - developing dementia
 - death



25% are HYPERactive, 75% are HYPOnactive

OVERVIEW OF THE HOSPITAL ELDER LIFE PROGRAM

- A comprehensive, evidence-based, program for the prevention of delirium for older adults
- Innovative staffing model
 - Volunteer force (40)
 - Elder Life Specialist (ELS)
 - Elder Life Nurse Specialist (ELNS)
 - Geriatricians
 - Geriatric Pharmacist
- Enroll 450 inpatients each year (>70 years old)



HELP ADDRESSES 4MS FOR ENROLLED INPATIENTS

- Enrollment assessment includes:
 - **Mentation:**
 - Delirium (Confusion Assessment Method)
 - Cognition (Mini-cog)
 - **Medication** review for deliriogenic medications
 - **What matters:** review ACP documents
 - **Mobility** promotion

HELP VOLUNTEER INTERVENTIONS

INTERVENTIONS

1. Daily visitor program
2. Targeted activities
3. Early Mobilization
4. Feeding assistance
5. Hearing and vision protocol
6. Non-pharmacological sleep protocol





Impact of HELP

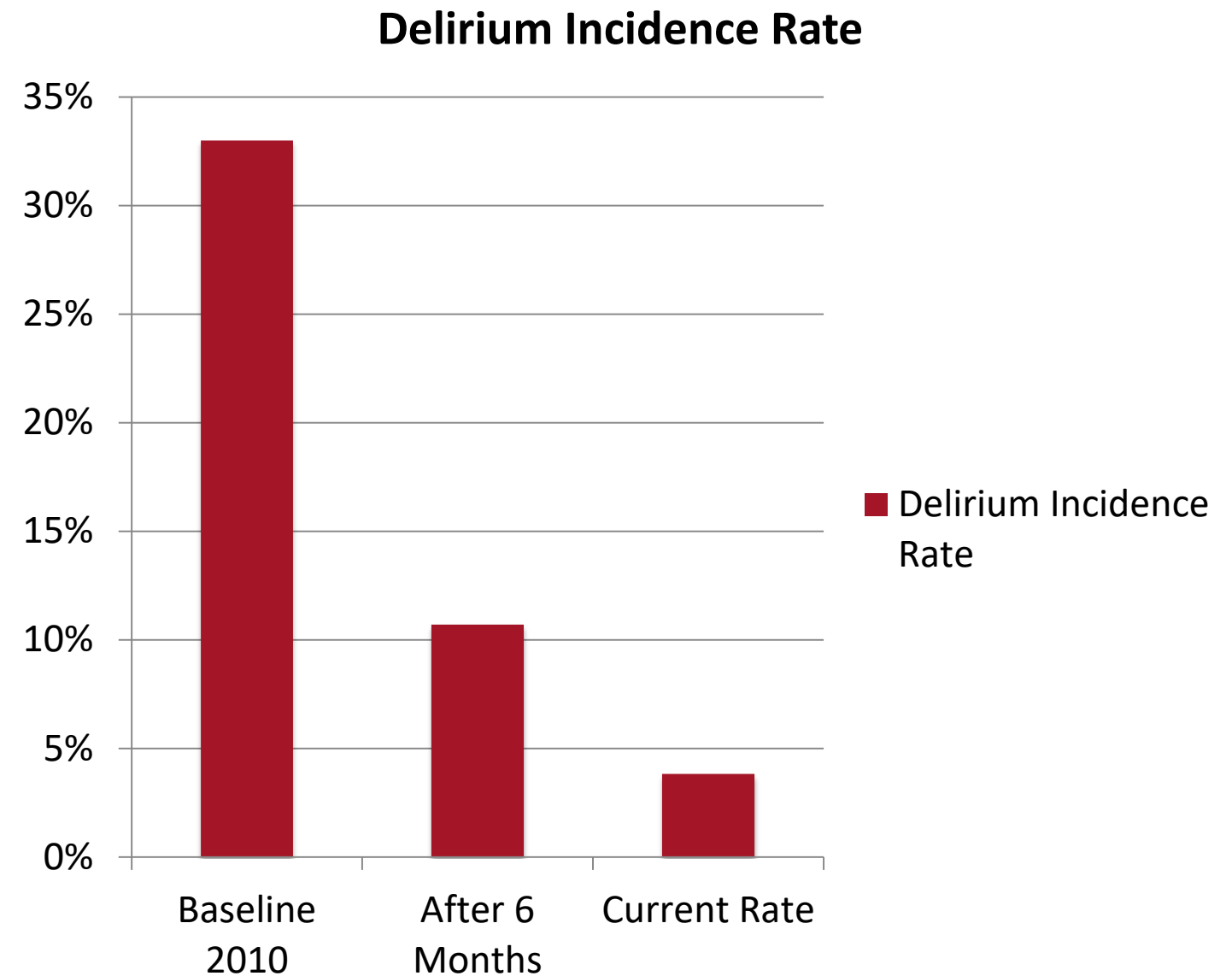
Specific Outcomes at
Our Hospital



U OF U HELP DELIRIUM DATA

Reduced delirium rate

- Pre-intervention: 33%
- Post-intervention: 10.7%
 - 9 of 84 enrolled patients
- Rate since HELP inception: 4.35%
 - 134 out of 3077 enrolled patients



INDEX ADMISSION LENGTH OF STAY

Mean \pm SD	HELP Enrolled (558)	Non-HELP (3,021)	P-Value
Days	4.5 \pm 4.2	5.3 \pm 3.9	< 0.0001

Discharge Disposition

(%)	HELP Enrolled (558)	Non-HELP (3,021)	P-Value
Home/Self Care	60.9	53.4	0.001
SNF/Rehab	33.7	38.8	0.02

30-DAY READMISSION RATE

	HELP Enrolled (558)	Non-HELP (3,021)	P-Value
30 day Readmission Rate (%)	15.4	20.3	P = 0.02

- Translates to a 25% reduction in 30-day readmission rate



SUMMARY

- Delirium prevention is a critical aspect of age-friendly inpatient care
- HELP decreases delirium and addresses 4M care for its enrolled patients
- Not all patients are routinely screened for delirium
- There is a need to expand the HELP program to enroll more at risk older inpatients