# HARNESSING THE USE OF THE AGE FRIENDLY 4M FRAMEWORK IN A HOSPITAL AT HOME PROGRAM

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## Introduction

Our population is aging. The population of those over 65 will double over the next few decades within the United States.[1] Older adults often have **more chronic conditions** and **more hospitalizations**. The Redeemer Health System is situated in the third most populous county in the state. The community surrounding Holy Redeemer Hospital, located near Philadelphia, Pennsylvania is no different from the national picture. This surrounding population is aging in place. There are an abundant of naturally occurring retirement communities (NORCs) neighboring this community hospital.

- The Covid-19 pandemic was an accelerant for significant change for the entire healthcare ecosystem.
- Centers for Medicare & Medicaid Services (CMS), the major regulator and payer for healthcare among the elderly, took steps to enhance hospital capacity by developing a waiver which allowed acute care to be delivered outside the walls of the transitional hospital building –**in the home**.
- Redeemer Health launched its Hospital at Home Program (H@H) in **December 2022**.
- The **challenge** is by 2030 there will not be enough resources to care for the elderly, using the traditional Hospital Acute Care Model.[2]

## Objective

Incorporating the Age Friendly 4M framework, Redeemer will focus on what matters to the patient and family, medication safety, mentation, and mobility.[3] Providing education to physicians, staff, caregivers and the older adult is paramount to ensure improved health outcomes despite the challenges.

**"THE 4M's – WHAT MATTERS, MEDICATION, MENTATION, AND MOBILITY. IDENTIFY THE CORE ISSUES THAT SHOULD DRIVE ALL DECISION-MAKING WITH THE CARE OF OLDER ADULTS."** [3]

## Method

1. Staff, patients, and caregivers will receive in-depth education on the Age Friendly 4M Framework.
2. Participating clinicians learn where care can be improved and how to operationalize it.[4]
3. Patients who meet the H@H criteria will have care that focuses on what matters to the patient and family, including medication safety, mentation while ensuring patients are maintaining functional status and moving daily.
4. All H@H admissions 2022-2023 will be reviewed internally for quality indicators such as 30-day readmissions and adverse events.
5. Continue to educate stakeholders on the key successes related to Hospital at Home admissions.

## Conclusion

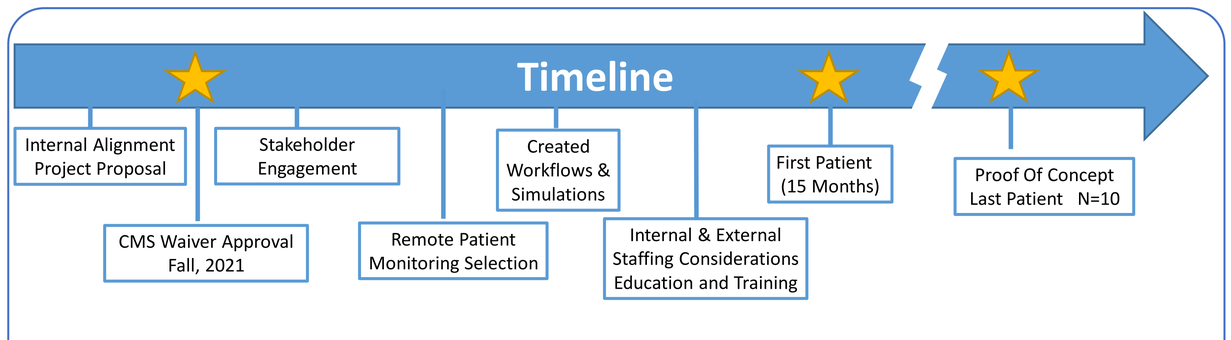
Using the traditional hospital Acute Care Model, the current healthcare ecosystem will not have the proper elements in place to adequately care for the aging population. [3] Incorporating the Age Friendly 4M framework, Redeemer Health will focus on what matters to the patient and family. The patient's recovery, when hospitalized, in a Hospital at Home program is paramount to ensure improved patient – centered health outcomes.

**What Matters**
- On assessment identify "what matters" to the patient
- Document and share those findings with the entire care team
- What "matters most" to the patient is the ultimate objective

**Medication**
- Identify high risk medications, consider using Beer's criteria
- Use the teach back method for patient / family education
- Ensure medication reconciliation is a priority

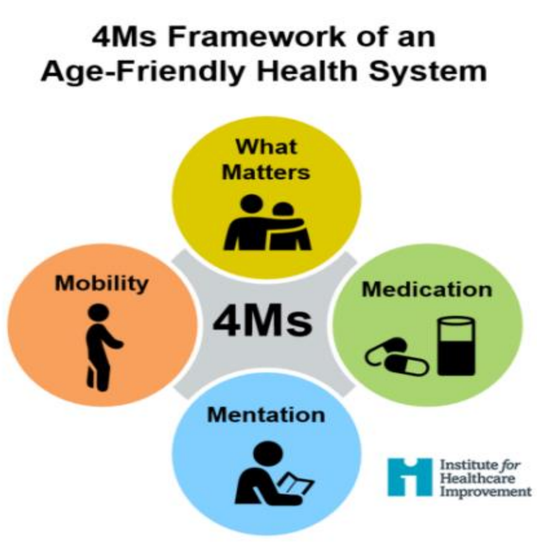
**Mentation**
- Be watchful for the 3 D's ~ depression, dementia & delirium
- Plan meaningful interactions with others ~ circumvent loneliness
- Hearing aides, dentures, walkers, clean eyeglasses are accessible

**Mobility**
- Screen for mobility limitations ~ avoid preventable falls
- Ensure use of patients own adaptive equipment
- Ambulate at least three times, encourage safe movement




## Next Steps

- Currently this program is limited by health insurance availability - Medicare (Government Payer) and selected commercial payers.
- Preference for inclusion of H@H in all payer contract renewals.
- This proof-of-concept analysis limited to medical-surgical patients. Expand to other populations (i.e.; Skilled Nursing).
- Limitations around staffing continue to persist and require flexibility.
- Continue to promote provider engagement and reduce barriers for admission.
- Seek identification of potential cases with automatic alerts on physician tracker.
- Expand adaptation of the 4M Framework in Redeemer's HealthSystem.




## Patient Story

JL is a 68-year-old women who lives with her husband at her son's home with his family including, two small children. Her cough and shortness of breath brought her to the Emergency Room. She was diagnosed with Respiratory Syncytial Virus (RSV) and admitted to the hospital for supportive care. JL had a lot of chronic respiratory problems. The first night in the hospital was anything but restful and by the morning she was exhausted. JL met the inclusion criteria as a candidate for the Hospital at Home program, when she moved from observation into an inpatient admission status.

When asked "**what Mattered**" most about her current admission, JL said that what she valued most was being in the comfort of her own home, surrounded by her family. When she transferred into the H@H program, she arrive home with her oxygen already set up! Her nurse, Carol, was there within an hour to review the monitoring system and education material with the patient and her husband. Each afternoon three meals were delivered to her home. JL just loved the chicken and soup! She was so excited to learn that dinner was also provided for her husband, because she did not want to burden him with extra work. Each morning her physician had a scheduled telehealth visit, which she appreciated. She stated she was so grateful to have her physician "visit" with her in her living room (via telehealth), with her husband by her side. They were able to ask questions together. **It mattered to her**!

JL was taking over twenty **Medications**. She received IV steroids in her home. Twice a day, Carol her nurse reviewed the drug list and interactions with the patient and her husband. While JL was receptive to learning, it was determined that several of the medications could be removed from her list due to a proactive medication review with pharmacy. JL was alert and oriented. Her family and grandchildren were the "bright spot" in her life, she noted. In the past however, JL suffered from depression, when she lived without her extended family. **Mentation** was an area that would have to be monitored closely. While JL stated she "moved around" all day, when reviewing the steps taken (viewed on the Biovital patch), it was revealed that JL was moving very little, only 50 steps a day! Her **Mobility** was identified as needing further investigation. A Physical Therapy (PT) consult was arranged. JL was afraid of falling, so she avoided ambulating. In home PT was arranged. With the use of an assistive device, a walker, and some gait and strength training, she was moving freely.

JL was discharged after four days in the H@H program, with follow up from home care and ongoing PT. JL stated, while she hopes she would not have to come back to the hospital again, if she did, she would ask for the H@H program, because it focused on her needs as an aging adult!

## References

1. U.S. Census Bureau (2020). 65 and Older Population Grows Rapidly as Baby Boomers Age. https://www.census.gov/newsroom/press-releases/2020/65-older-population-grows.html
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