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COMMENTARY

HSR Health Services Research

Age-Friendly Health Systems: Improving care for older adults in the Veterans Health Administration

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1 | INTRODUCTION

The number of Americans over age 65 is projected to soar to 94.7 million by 2060, and the population of those 85 years and older is expected to double in the same time frame.[1] In addition to meeting the demands of an ever-growing older adult population, many health systems are unprepared to meet the complex care needs of older adults, often emphasizing cure over care. Older adults routinely receive unwanted treatment that does not align with their priorities, miss necessary evidence-based care, undergo functional decline when mobility is not encouraged, experience avoidable delirium and cognitive decline, and are harmed by high-risk medications.[2] To address these challenges, The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI) launched the Age-Friendly Health Systems (AFHS) initiative in 2017.[3] AFHS aims to introduce a framework of evidence-based practices, known as the "4Ms" (what matters, medication, mentation, and mobility), across clinical care settings to improve care and reduce harm for older adults. Additionally, AFHS aims to provide person-centered care aligned with what matters to older adults and their family members or caregivers, and builds the foundation for healthier aging for all.[3]

The AFHS movement benefits older adults by customizing care based on each person's unique health goals and care preferences, improving quality-of-care, and delivering care in a more cost-effective manner with the potential to reduce the risk of preventable complications, hospital readmissions, and emergency department (ED) visits.[4–10] IHI offers two levels of recognition for clinical care settings: Level 1, Participant recognition is achieved when teams create a plan to implement the 4Ms, and Level 2, Committed to Care Excellence is awarded to teams that have successfully implemented these practices and submitted 3 months of counts on the number of older adults impacted by 4Ms care.

As of October 2022, IHI has recognized more than 2900 participants in the AFHS movement.[3] Both levels of recognition are important milestones for teams; however, health systems are challenged to build on the initial success of individual care settings to scale and spread the 4Ms system-wide. To accomplish this, health systems may leverage action communities, 7-month virtual learning communities, to accelerate the adoption of the 4Ms through monthly webinars and peer-to-peer learning.[3,11] Alternatively, health systems may develop an enterprise-wide plan for sharing knowledge about 4Ms care for older adults and supporting 4Ms implementation across the system. While IHI does not offer a system-level recognition, IHI encourages leaders and sponsors in the movement to set an aim to guide the entire health system on their age-friendly journey.

As the number of older Americans surges, health systems nationwide are challenged to meet their needs. Nearly half of Veterans enrolled in VA health care are over age 65 compared to 21% of civilians.[12] The number of Veterans aged 85 and older is anticipated to increase by 38% between 2019 and 2039 thus necessitating the involvement of the Veterans Health Administration (VHA) in initiatives such as AFHS to better meet the needs of our oldest Veterans.[13] The VHA set the aim to become the largest age-friendly health system in the U.S. As of November 1, 2022, 152 care settings across 78 VA Medical Centers (VAMCs) have been recognized by IHI with more than a third of those teams earning Level 2 recognition. VHA is reaching older Veterans across the system with 4Ms care in diverse settings, including inpatient units, outpatient primary care, surgical and

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specialty care clinics, Home Based Primary Care (HBPC), hospital at home,[14,15] spinal cord injury units, emergency departments (ED), the Caring for Older Adults and Caregivers at Home (COACH) dementia support program, Geriatric Resources for Assessment and Care of Elders (GRACE) care management,[16] and Community Living Centers (CLCs, analogous to nursing homes). This commentary highlights how VHA is working toward system-wide spread and offers key insights in this special journal issue.

2 | AGE-FRIENDLY CARE WITHIN THE VETERANS HEALTH ADMINISTRATION (VHA)

VHA is the largest integrated health care system in the U.S., providing services to over 9 million enrolled Veterans at 1298 health care facilities.[17] VHA accepted the AFHS call to action to enhance the care of older Veterans, considering their health care preferences, aims, and priorities to improve care quality and safety. Joining the AFHS movement has offered VHA a unique opportunity to introduce the 4Ms across many types of care settings and integrate these practices with existing initiatives. For example, AFHS supports VHA's journey to become an enterprise-wide high reliability organization (HRO) with a goal of achieving "zero harm."[18] AFHS is also consistent with the cultural transformation embodied by Whole Health, an enterprise-wide approach in which Veterans are empowered to discover their mission, aspiration, or purpose (what matters) and take charge of their health and well-being through clinical care and complementary and integrative health.[19]

Although AFHS is aligned with VHA's efforts for HRO and Whole Health, this initiative is nationally led by the VHA Office of Geriatrics and Extended Care (GEC). GEC has a designated national lead for AFHS to coordinate efforts at the system level and with individual teams. This helps to align AFHS with the strategic goals of the system and with existing programs and services that facilitate providing 4Ms care to all older adults. Since March 2020, VA teams have joined the AFHS movement through the self-paced Do-It-Yourself (DIY) pathway to recognition or through voluntary enrollment in an action community led by IHI, the American Hospital Association (AHA), or the VHA.

GEC has leveraged the experience and expertise of early adopters through monthly office hours, following IHI's "all teach, all learn" model,[20,21] creating a learning environment in which all contributions are valued. During office hours, new recognitions are celebrated, and teams are invited to share recent challenges and successes. Positive peer pressure from enthusiastic champions has helped recruit sites that may be hesitant to join. Between monthly office hours, the national lead provides 1:1 coaching to teams as requested, walking sites through the recognition process with IHI. By simplifying the steps to putting the 4Ms into practice, teams are encouraged to seek IHI recognition to celebrate the high-quality care they are already providing while addressing any gaps to reliably assess and act on all 4Ms.

At the system level, GEC has promoted the AFHS movement by highlighting the success of early adopters and empowering VA teams to choose their own implementation strategy for 4Ms care. Many VA teams choose to get started in clinical care settings that already have an interdisciplinary team with geriatrics training in place, such as the CLC, HBPC, or a geriatric primary care clinic. These teams can rapidly build on their current workflows where one or more of the 4Ms is often already assessed and acted on. The 4Ms framework allows teams to customize their plan and timeline for implementation, gaining buy-in from frontline staff and Veterans to make improvements to their workflows. This approach has increased the likelihood that staff are invested in their team's success in securing recognition from IHI.

Each year, GEC creates a communications plan and sets annual goals for AFHS. These annual goals are informed by a national steering committee comprised of champions across the VHA. To achieve these annual goals, the steering committee creates any needed workgroups. For example, the electronic health record (EHR) workgroup was formed in August 2021 with the goal of creating a national 4Ms note template for all care settings and disciplines providing 4Ms care across VHA. With the new national 4Ms note template in place, VHA can track the number of care settings documenting 4Ms care, removing the need for manual chart audits for Level 2 recognition, and gaining an understanding of the number of Veterans impacted by 4Ms care annually.

Another area of focus for GEC has been planning the first VA Action Community, now underway from October 2022 through April 2023. To accomplish this, additional resources were obtained for staffing. With these resources, the national team has grown to include one diffusion specialist, one clinical consultant, and two project coordinators. To spread awareness about the VA Action Community, GEC provided a memorandum to VAMC leadership, announcing VHA's commitment to the AFHS movement and offering optional enrollment for interested sites. GEC also presented AFHS and the VA Action Community on several national calls to leadership at all levels. As a result, enrollment was met with an overwhelming response. Upon the close of registration, there were a total of 145 teams enrolled from 69 VAMCs, and the online Age-Friendly Community of Practice grew to over 900 members from July to November 2022.

3 | THE 4MS ACROSS CLINICAL CARE SETTINGS: OPPORTUNITIES FOR LEARNING FROM THE VHA

The breadth of AFHS offers an essential opportunity for VHA and other health systems to build on multiple notable but isolated pilots. This journal issue highlights the work of three VHA research teams and their evaluation of AFHS in geriatric EDs and geriatric telemedicine. To gain a better understanding of goal concordant care and missed opportunities, Cogan[22] completed a cross-sectional survey of over 1 million VHA enrollees by age group to evaluate disparities in addressing what matters (e.g., health goals), mentation (e.g., depression, stress, personal problems), and medications. The team found that lower rates of assessing and acting on what matters and mentation were missed opportunities for age-friendly care.[22]

McQuown[23] found that emergency medicine providers were addressing medication using a polypharmacy screen, mobility using a screening tool, or fall risk assessment, and mentation was assessed using delirium and cognitive impairment screening instruments.

However, the team lacked a formalized way to assess and act on what matters. McQuown[23] notes that due to the nature of the ED, integration of the 4Ms in this setting is challenging, particularly in addressing what matters in an efficient, yet thoughtful, and appropriate manner. The team found that combining telemedicine and home visits after a geriatric ED visit helps to identify unmet care needs, support caregivers, and address what matters.

Specially trained and accredited geriatric EDs may serve as an entry point for care and provide an opportunity to identify high-risk older Veterans who would benefit from comprehensive screening guided by the 4Ms. Postdischarge monitoring is traditionally completed by telephone or a face-to-face follow-up visit in primary care. As an alternative, geriatric ED aftercare may be provided via telemedicine and/or home visits 48–72 hours after discharge to reduce hospital readmissions, their associated costs, and increase patient satisfaction.[23–25]

McQuown[23] and Dryden[26] explore the benefits of and health outcomes from AFHS through the Geriatric Research, Education, and Clinical Center (GRECC) Connect (geriatric telemedicine), and the Supporting Community Outpatient, Urgent Care, and Telehealth Services (SCOUTS) programs. These programs align with the AFHS model and are associated with the expanded geriatric "5Ms" (adding multi-complexity) as described by the American Geriatric Society's Health in Aging Foundation.[27] Both programs provide opportunities to improve care and support caregivers, particularly in rural areas, and they met an unexpected surge in need during the height of the COVID-19 pandemic.[23,26]

National shortages of geriatricians and mental health professionals combined with access disparities (e.g., long travel distance to health care, mobility, or visual challenges) are barriers to meeting the needs of older adults, and telemedicine is helping to bridge that gap for Veterans. GRECC Connect uses telemedicine to improve care quality and patient experience and focus on (a) what matters by planning care with patient and caregiver goals and care preferences in mind, (b) completing a thorough review of medication options and deprescribing high-risk medications when appropriate, (c) assessing and acting on mentation providing advice about activities to improve mood and cognition, (d) facilitating delivery of needed adaptive equipment, home safety evaluation, and physical therapy referral to address mobility to maintain function and safety, and (e) providing care coordination, caregiver support, and education to meet the multi-complexity needs of each older Veteran.[26] Dryden reported the following AFHS outcomes related to geriatric specialty telemedicine: reduced polypharmacy (medication), improved physical and cognitive well-being (what matters, mobility, and mentation, for example, lower blood pressure, better sleep quality, improved memory, less anxiety, lower fall risk), and improved adherence to their treatment regimen.[26]

Challenges noted by the Dryden and McQuown research teams include setting patient and caregiver expectations upfront and acknowledging the limits of what is known about cognitive impairment and its progression, awareness of racial and socioeconomic disparities in rural settings (e.g., reliable internet access), and meeting the complex needs of patients with hearing, visual, and cognitive impairment who may have difficulty absorbing and recalling information and connecting through telemedicine.[23,26]

4 | DISCUSSION

Reliably incorporating the 4Ms into care for older adults can help address coordination across programs and initiatives, address disparities in discussing health goals, support 4Ms documentation, and measure health outcomes associated with age-friendly care. However, there is still work to be done as age-friendly care only reaches a portion of older adults who would benefit and there are challenges associated with dissemination and scale and spread across an entire system.[4]

The COVID-19 pandemic provided a unique opportunity to find other ways to connect with patients and caregivers, and telemedicine met that need. However, there is a need for additional research on the effectiveness of 4Ms care across clinical care settings and the impact of increased access to geriatricians and mental health providers through telemedicine. There is also a need to improve our understanding of the impact of psychological health (e.g., posttraumatic stress disorder and depression), cognitive impairment, and hearing and visual impairment on missed opportunities to provide age-friendly care.

Evaluation of AFHS implementation includes measurement of the extent of implementation and whether it improved patient care and safety. Questions may include: (a) what proportion of older adults received age-friendly 4Ms care? (b) did the age-friendly interventions produce relevant health outcomes? (c) did the interventions become standard of practice? (d) was age-friendly care delivered with high fidelity? (e) is the age-friendly practice sustainable? and (f) what is the effect of age-friendly 4Ms care on caregiver burden and nursing home utilization?[11,28]

5 | RECOMMENDATIONS FOR MEANINGFUL CHANGE

Over 60% of health care organizations fail to successfully implement change.[29] For health systems working to implement AFHS, leaders are encouraged to (a) set an aim for the organization that clearly presents an age-friendly vision, (b) build a coalition of champions supported by dedicated national staffing, (c) promote the value of 4Ms care, and (d) incorporate the 4Ms into the EHR to make this information accessible and measurable over time. We believe the principles of AFHS should be regularly communicated with teams and leaders at all levels of the organization, highlighting impactful stories from patients and staff. Health systems should designate a lead for the movement and add additional staff as the initiative grows to continue to support the teams involved. One consideration might be to lead an action community for the organization. Health systems should begin planning early on in their age-friendly journey on how to document 4Ms care in the EHR. It is important to make information about what matters to older adults accessible to all members of the care team. When documentation of all 4Ms is being captured consistently in the EHR, health systems may further explore the link between each M, positive health outcomes for older adults, and opportunities for improvement to ensure equitable access to age-friendly care.

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CONFLICT OF INTEREST

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