Generational Health

Patient-Centered Care for Older Adults

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SHARP

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Executive Summary

The U.S. health care system has not evolved at the same pace as changing demographics, resulting in a need to rethink approaches to care for the largest patient population: older adults. The status quo of a one-size-fits-all approach is no longer adequate to care for older adults who are at risk for geriatric syndromes, frailty and other social determinants that are not well served in traditional health care settings.[1, 2, 3] Sharp HealthCare developed Generational Health as an approach that promotes systematic use of patient-centered best practices across the continuum — care that accounts for individual needs and ensures optimal outcomes for patients and providers. In partnership with the West Health Institute, Sharp HealthCare has extended and accelerated the reach of Generational Health at Sharp Memorial Hospital and is sharing its success on a national stage to ensure care is optimized for this population.

The Generational Health approach was developed to ensure older adult patients receive the highest quality of care aligned with their goals, age-specific risks, needs and life circumstances. A variety of different pathways and programs have been developed under this approach, including:

- **Advanced Illness Management (AIM)** — Nursing-driven team dedicated to establishing and documenting goals of care.
- **Appropriate Care Committee** — Support group for providers and families struggling with the current clinical circumstances of their patients or loved ones.
- **Community** — Pathway developed to promote health post-hospitalization and to ensure post-hospitalization success.
- **Geriatric Emergency Department (GED)** — An accredited emergency department (ED) that is designed to respond to the emergency care needs of older adults, and that serves as the entry point for decision-making and initiating geriatric-focused programs.
- **Healthy Aging** — Program focused on maintaining strength and cognition in independent patients.
- **Geriatric Surgery** — Program focused on perioperative issues affecting older adults.
- **Geriatric Trauma** — Program focused on patient-centered care for injured older adults.
- **Prehabilitation** — Program focused on strength training and whole-body optimization ahead of surgical intervention.

Through implementation of Generational Health, Sharp has achieved remarkable success in improving patient outcomes, such as reducing delirium, maintaining physical function, completing advance care planning, reducing length of stay, and lowering costs. This approach has elevated the standard of care to proactively incorporate what matters most to patients and to identify and respond to patient vulnerabilities, which directly impact the outcomes of care.

This is happening in every department, unit and team at Sharp Memorial Hospital. They have proved that providing great care to older adults can occur in tandem with effective and efficient hospital operations using facility-wide, interdisciplinary collaboration.

As the growth of the older adult population continues, hospitals are challenged to meet the needs of the largest population served. West Health Institute and Sharp are advocating that hospitals embark on a similar journey to meet this urgent imperative. Transforming the current state from a one-size-fits-all approach for this complex population is vital for both patient safety and hospital efficiency.

Introduction

Traditional care delivery settings have not evolved at the same pace as the growing older adult population. Health care teams may not be ready, prepared or trained to consider age-specific needs, including geriatric syndromes, frailty and other commonly occurring circumstances, that place older adult patients at risk. In partnership with West Health Institute, Sharp HealthCare has extended the reach of Generational Health through program acceleration at Sharp Memorial Hospital and is sharing its success on a national stage. West Health has collaborated with Sharp to develop tools and resources to scale similar programs to hospitals nationwide. This document serves as a primer on Generational Health concepts and programs.

Older adult patients may experience psychosocial, cognitive, nutritional and functional factors that create unique needs. The scope of potential age-related risk factors is broad and affects millions of hospitalized patients each year. For example:

- Each year, over 3 million older adults in the U.S. are treated in emergency departments for fall-related injuries, many resulting in hospitalization for hip fracture or traumatic brain injury.[4]
- Approximately one-third of older admitted patients experience delirium, of which a further one-fifth experience significant complications[5] that can increase their length of stay, loss of independence and mortality.[6]
- Approximately 25% of older adults experience social isolation, putting them at risk for other health-related complications.[7]
- Almost half of older adults are at risk for malnutrition,[8] which is associated with increased mortality,[9] risk of falls,[10] and length and cost of hospital stay.[11]
- Over 1 million older adults are managing a substance use disorder,[12] and an estimated 14% of older adults experience depression, which is often underdiagnosed or unrecognized.[13, 14]

All health care organizations and communities must identify older adults at risk for suboptimal health outcomes and the systems and processes ill-equipped to serve them. By identifying and understanding these factors, many basic solutions will emerge to better account for these needs in the development of care plans.

Sharp is at the forefront of rewiring the health system to serve older adult patients. Its approach is focused on proactively serving the older adult population and has evolved into a care movement called Generational Health. This strategy puts what matters most to patients at the forefront of care and empowers them with education, information and support to age with dignity.

What Is Generational Health?

The Generational Health approach was developed to ensure that older adult patients receive the highest quality of care aligned with their goals, age-specific needs and life circumstances. It provides a "health care for all ages and stages of life" approach to investigate and offer interventions that are commensurate with tolerance, endurance, stamina, strength and recovery trajectory. To accomplish this, Generational Health:

- Matches patients with a care plan that upholds their goals and values.
- Identifies and addresses individual circumstances in the plan of care and recovery.
- Considers any medical inflection point.
- Ensures patient understanding of interventions and recovery.
- Aligns health care missions with community.

The approach prioritizes individuals in the context of illness or injury by organizing resources for all aspects of care across the health care continuum, respecting medical inflection, frailty and individual needs. The Generational Health Program was developed to ensure careful and empathetic attention was paid to patients, and that the difficult topics and conversations required for provision of comprehensive care were normalized. It breaks down silos in different specialties and empowers care providers to consider care in the context of each older adult patient. Because the efforts established under this program have overlapping principles and priorities, they can synergistically improve care.

Case example: A 93-year-old man arrived at the preoperative/pre-anesthesia surgical clinic accompanied by his daughter. He entered using a walker and the assistance of his daughter for balance. The nurse noted that he takes several high-risk medications, including a benzodiazepine, an anticoagulant, and medications for urinary retention. The nurse noted that he had a BMI of 17, and that he was engaged in conversation but unable to articulate the planned procedure. This patient was referred for a comprehensive geriatric assessment noting numerous risk factors, including mobility, cognition, limitations in activities of daily living (ADLs), polypharmacy, malnutrition and delirium. What mattered most to the patient was being able to stay at home with his daughter. His risks for potential outcome divergent to his wishes were shared with the surgeon, and the patient was enrolled in a preoperative strength and nutrition program. During his participation, he noted he was not progressing with any aspect of optimization and understood that post-operatively, anticipated recovery would be even more difficult. Because of his identified risks and geriatric syndrome, the surgeon, patient and family made the decision to proceed with an alternative, less invasive, supportive care plan that better aligned with the patient's goals and life stage.

Why is Sharp's Generational Health approach a model for others?

It is time to reevaluate the health care process. The aggressive and invasive nature of medical care can result in unintended functional or cognitive decline for older adult patients with progressive vulnerability. Where other hospitals are siloing care, Sharp's approach is breaking down silos and creating a culture where every discipline prioritizes age-specific needs. Along with the aging population, challenges in health care systems are growing exponentially and immediate action is required to manage rapidly changing needs.

Generational Health Programs

Generational Health is an approach to care that has allowed Sharp to identify programs that meet the needs of its older adult population. Sharp is committed to efforts, such as Geriatric Emergency Department (GED) accreditation, Advanced Illness Management (AIM), Geriatric Surgery, and the Healthy Aging Team, that advance geriatric care goals. While some of these endeavors are cross-departmental, such as AIM and Healthy Aging, others are unique to one department, such as the GED. At Sharp, these efforts did not require extension of full-time employees or staff numbers, but rather growth toward "top of license" practice and healthy teamwork to ensure success. Other organizations adopting the Generational Health approach may select different programs, structures or efforts.

Incorporating individual needs into all settings and care decisions

Any road map for geriatric care should include consideration of geriatric vulnerability. Vulnerability can be any factor that affects health outcomes or influences life outside of health care. For older adults, individual needs encompass age-specific risk factors that, if not readily identified and optimized, could result in an unfavorable outcome for a vulnerable adult. Identifying risks as soon as possible proactively prevents harm and promotes success. The Generational Health team found it useful to partner with other organizations also concerned with geriatric vulnerability. The team aligns closely with San Diego County priorities by working with organizations like West Health and the county's first ever Chief Geriatric Officer. For example, with the support of West Health Institute, San Diego County aligned with the California Master Plan for Aging to address the needs and vulnerabilities of older adults through Geriatric Emergency Department accreditation. This has ensured that every emergency department within the county is GED-accredited and provides access to programs and services that address social isolation, nutritional needs, and availability to mental health teams for older adults.

Figure 1. Common age-specific risk factors in the older adult population

What are potential age-specific needs that all health care providers and organizations should be aware of?

Mobility, psychology, physiology, and social or economic factors may influence decline or disruption and can negatively impact medical recovery (Figure 1).

The presence of vulnerabilities can have significant impact on geriatric patients' recovery, on their concerns for hospitalization and discharge, and potentially on every other aspect of their lives. Other important concepts in the evaluation of older adults include:

- **Frailty** — Function, resistance, ambulation or mobility, illness/comorbid disease, weight loss, protein calorie malnutrition or sarcopenia that indicate the presence of geriatric syndrome.
- **Geriatric syndrome** — A health condition that describes an area of frailty commonly occurring with age in association with medical conditions, treatment options and recovery.
- **Medical inflection** — The point at which medical intervention may not yield a therapeutic outcome.

Health care is most collaborative with patients and families when the care team focuses on these individual needs, such as psychosocial and physiological threats to medical care, and considers medical inflection during options counseling.

Sharp's Generational Health Program is meant to be illustrative (Figure 2) and is described below. After reviewing these examples, consider what similar or related aspects of care may be in place to build on. The components include:

- John M. Sachs Family Center for Generational Health (GED), located within the Cushman Emergency Department and Trauma Center
- Healthy Aging
- Geriatric Surgery
- Geriatric Trauma Program
- Advanced Illness Management (AIM)
- Non-programmatic components
  - o Appropriate care
  - o Community

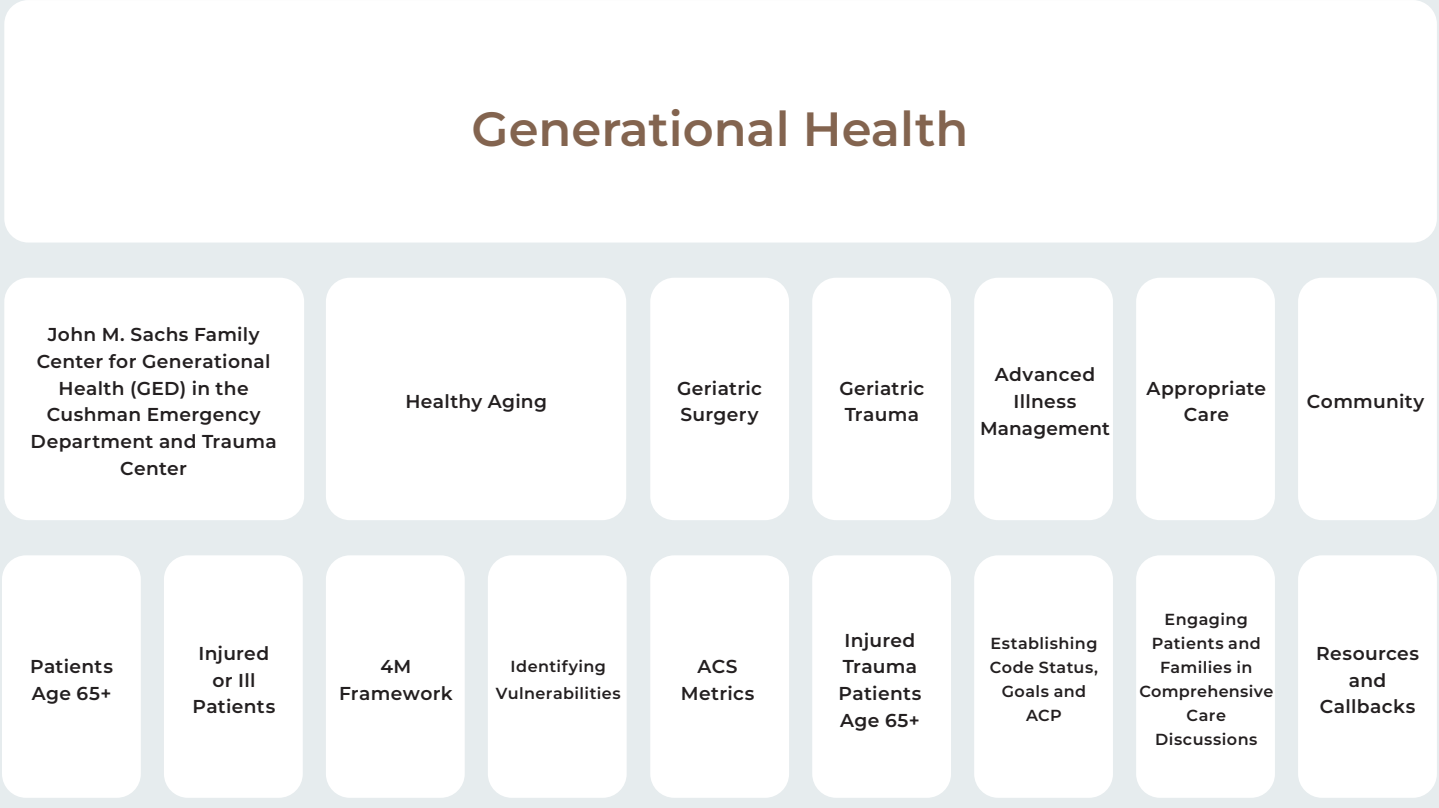

Figure 2. Generational Health structure at Sharp HealthCare

Geriatric Emergency Department

Sharp Memorial's Geriatric Emergency Department (GED) provides tailored services for older adults by integrating geriatric best practice care into the existing ED. Older adult patients who present to the GED are triaged to assess their acute care needs, receive screenings for common geriatric syndromes, and benefit from numerous geriatric-specific policies and protocols in place to provide the highest standards of care. Key components of GED services include:

- Geriatric care processes to ensure optimal care for all older adult patients. Outcomes and tracking of emergency care, with a focus on reducing risk and harm to vulnerable patients.
- A uniquely adapted space within the ED to support older adults' needs for sensory modification, including access to natural light, non-slip floors, and appropriate equipment and supplies, such as mobility aids.
- ED-initiated geriatric psychiatric interventions for symptom management or direct transfer to the inpatient behavioral health unit.
- Links to other Generational Health elements, such as AIM and Healthy Aging.

Why was the GED established?

The GED at Sharp Memorial was established because traditional EDs do not always adequately address the unique needs of older adults. Older adults are often vulnerable to the chaotic ED environment. By leveraging the concepts of Generational Health and maintaining GED accreditation, Sharp Memorial ensures that patients receive care by staff who are dedicated to emergency care tailored for older adults.

GED accreditation and its requirements align with existing inpatient Generational Health processes and leverage this entry point into the health system to identify and serve patients made vulnerable by their health status or hospital environment to maximize health outcomes. Generational Health pieces are implemented immediately in the ED and carried over to the observation or inpatient unit, including RN mobility assessment followed by initiation of the Healthy Aging pathway by the nursing assistant, initiating early mobility protocol, delirium prevention, and what matters most interventions.

Outcomes to date

- Shorter ED length of stay
- Decreased mortality rate
- Increased use of palliative care and reduced need for aggressive medical intervention, where appropriate
- Increased enrollment in inpatient programs for admitted older adult patients with focus on what matters most
- Earlier ambulation in the ED

Patient experience: An 82-year-old woman who lives alone presented to the Emergency Department for weakness. An RN performed a triage assessment, and the emergency medicine physician evaluated her and initiated a workup. The primary ED RN performed an initial FRAIL assessment and initiated a nurse-driven Healthy Aging order set to promote the 4M Framework in the ED.

A geriatric-trained RN completed a comprehensive geriatric assessment, including a vulnerability assessment. During this evaluation process, the patient articulated that she was not seeking a long hospitalization. She wanted to treat symptoms and return to her "fur babies." Due to her symptoms, she was deemed unsafe for immediate discharge and needed some optimization interventions prior to returning home. The RN reconciled with the ED team that included pharmacy, social work and case management.

The patient was placed in the observation unit for further monitoring and resource assessment, due to positive screenings on the comprehensive assessment. The patient was provided with education on vulnerabilities, and her care was maximized to go back home to her dogs, meeting exactly what mattered most to her. Resources included fall and injury prevention education, wellness checks with home health, education on hydration and nutrition, and a follow-up phone call a day later from the Healthy Aging team to ensure all her needs had been met and that an appointment with primary care was in place.

Healthy Aging

The Sharp HealthCare Healthy Aging team works to prevent cognitive and physical decline during hospitalization by promoting sleep hygiene and early mobility across every unit in the hospital.

Healthy Aging is designed to prevent physical and cognitive decline through strength maintenance activities and sleep hygiene. The program requires an operational workflow that consolidates diagnostics and therapeutics into daytime hours instead of a standard workflow that may involve frequent night interruptions for labs, personal care assistance or general cleaning. When caregivers are not prioritizing patients' wake and sleep routines, nor encouraging wakefulness similar to the pattern at home, patients are more at risk for developing delirium and extending their hospital stay. Healthy Aging enables patients to maintain better cognitive and physical function, increases their ability to achieve care goals, and leads to patients being able to leave the hospital sooner. Eligible patients are those who are either acutely or chronically ill, are age 65 or older, and demonstrate independence immediately prior to their illness. Healthy Aging is the foundation upon which other components of Generational Health are built and has been deployed across all hospital units and floors. The Healthy Aging team includes clinical staff and ancillary service experts.

Healthy Aging responds to patients' needs and provides interventions to older adults by focusing on a care schedule that is safest for them. To reinstate the patient's voice in the care plan, Healthy Aging uses patients' goals to align scheduling of daytime activities focused on promotion of sleep, directed therapy sessions for age-specific needs, delirium mitigation, medication management, patient-centered care, and focusing on individual goals. For example, changes may include increasing exposure to natural light during the day, additional interactions with staff, and improving sleep hygiene by avoiding clinical processes that disrupt sleeping hours. Tasks such as housekeeping, labs and vitals are rescheduled during non-sleeping hours. After an acute hospitalization, patients are also supported with follow-up phone calls and assurance that there is a plan for each identified area of need.

At Sharp, this is a cross-departmental effort and requires a champion within each participating unit. This role does not require a new staff position but may reassign an existing nurse champion who has a vested interest in geriatric care. Important characteristics for the selected nurse include having a passion for caring for older adults, a dynamic personality, and skills to quickly build rapport to motivate patient success. If a dedicated staff member is not available for Healthy Aging, an alternate strategy is to have all clinical team members participate in early mobilization activities. This includes having a comprehensive nursing assistant team wherein constant out-of-bed mobility and human connection can be offered. The role of the nursing assistant is to orient the patient to the program and the 4Ms, as well as establish a program pathway with the patient that is focused on mobility (e.g., mobilization schedule), sleep hygiene, addressing what matters in life and in health, delirium prevention with conversation, opening blinds, and maintaining a daily routine. Nursing assistants also lead mobilization of patients daily.

In Healthy Aging, patients' initial mobilization safety plans are conducted by the bedside nurse. Physical therapy consultations are reserved for patients who have demonstrated a need for a higher level of intervention, such as skilled therapy. This shift in practice addresses the risk of inactivity for older adults. This approach also avails the physical therapist to focus on patients with greater needs.

> *"I can take a 25-year-old patient and put them in an MRI machine at 3 a.m. without consequences to sleep-wake hygiene, or their cognition or function the following day. You cannot do the same thing for a frail, vulnerable or cognitively impaired patient without consequences to sleep-wake hygiene or cognition. Once delirium develops, the patient loses the ability to participate in active rehabilitation and loses ground with functional recovery."*
>
> **— Diane Wintz, MD, Medical Director for Generational Health and Trauma at Sharp Memorial Hospital**

Why was Healthy Aging established?

Healthy Aging was established to prevent these types of avoidable harms and requires reconceptualization of care processes to best serve patient needs as opposed to organizational conveniences (e.g., late-night lab draws and baths). Many older adult patients experience preventable physical and cognitive decline during hospitalization, especially those with some degree of frailty. Without daily mobilization, functional decline can set in quickly, and that lack of movement and pattern maintenance can prompt the onset of confusion or the development of delirium.

Outcomes to date

- Task-shifted early mobilization to nurses from physical therapy without an increase in falls
- Reduced length of stay with increased likelihood of discharge to home
- Reduced delirium from over 20% to less than 10%
- Saved $1,731 on average per patient (over $500,000 in 2022)

Case example: One memorable Healthy Aging patient is a retired professional dancer in her 70s who arrived with abdominal pain. She had recently undergone abdominal surgery and had a history of ovarian cancer. She was seen by the admitting team, which developed a plan of care. The Healthy Aging team was consulted at admission and identified that while the existing transition plan entailed going to a skilled nursing facility, the patient preferred to go directly home. Through participation in Healthy Aging, she set a goal to return home and be able to dance again, motivating herself with an old photo of herself on the cover of a record. The nursing assistant was assigned to supplement the standard of care — in-hospital mobilization, strict adherence to a mobility schedule, and human connection or interaction through walking and talking — with Healthy Aging components. On the patient's first day post-op she walked 20 feet, and by day three she was walking laps around the unit. At the end of her stay, she was successfully discharged home and was ready to put on her dancing shoes.

Geriatric Surgery Program

What is the Geriatric Surgery Program?

Sharp is focused on optimizing perioperative care for older patients. Geriatric Surgery is a programmatic organization dedicated to preoperative evaluation of vulnerability, establishment of goals of care, and perioperative communication among team members to reconcile the vulnerable findings. Sharp applies standards and expectations to ensure that surgical care focuses on what matters most, preoperative risk screening, and interdisciplinary postoperative care to prevent complications. Sharp surgeons and teams are dedicated to surgical success and have implemented high-risk evaluation, multidisciplinary focus, and geriatric-focused pre- and perioperative care plans to achieve outcomes. Of note, the American College of Surgeons defines metrics and offers formal Geriatric Surgery Verification.[15]

Why was the Geriatric Surgery Program (GSP) established?

GSP seeks to ensure that tailored standards of care for the geriatric surgical population are systematically implemented and continuously challenged to improve. Older surgical patients can expect care that is consistent with their individual goals and what matters most to them. Risk factors are assessed preoperatively, and patients and their loved ones collaborate with their surgeons to create a pre- and postoperative treatment plan addressing these risks to minimize the potential for complications. Quality of life is prioritized with goals of care discussions, inclusion in programs dedicated to maintaining cognition and function, and optimization of nutritional reserve.

Establishing a GSP also created an opportunity to offer prehabilitation to presurgical patients. Prehabilitation is multidisciplinary skilled therapy and nutritional and social assessment that occurs ahead of surgical intervention. Because the perioperative evaluation is better organized with the introduction of GSP, there is adequate time to offer prehabilitation, giving patients the opportunity to optimize their vulnerabilities before undergoing surgery. Prehabilitation has been shown to improve surgical outcomes.[16]

Outcomes to date

- Identification of high-risk geriatric surgical patients
- Structured interdisciplinary case review committee to improve quality and safety
- Prehabilitation program established to improve capacity to withstand surgical stressors

- Improved collaboration of surgical and medical teams
- Generational Health physician and nurse practitioner consultative service

Case example: A 95-year-old woman had recently moved across the country to live with her family due to progressive cognitive and functional decline, both of which were still considered mild. She fell and sustained a hip fracture requiring surgery. The patient met with a Generational Health nurse practitioner prior to surgery and was given time to articulate her own wishes for the hospitalization. She understood that she needed surgery and was able to weigh the consequences of deferring surgery versus undergoing immediate surgical intervention. The speech language pathologist was able to complete a preoperative assessment for cognition and a functional in-bed assessment, whereas prior to the initiation of GSP, this assessment may not have been completed preoperatively. That valuable information regarding preoperative cognitive baseline may not have been available to the patient or family ahead of the surgical challenge. Instead, in the GSP, the cognitive baseline was one factor in consideration of risk in recovery. The patient was taken to surgery later that day after having several critical bedside meetings with experts in a variety of therapy fields who explained goals of recovery and expectations. She was fully informed and able to make the right decision for herself regarding surgical intervention.

Geriatric Trauma Program

The Geriatric Trauma Program (GTP) is one of the founding programs at Sharp dedicated to empowering older adult patients and focusing on the specific needs of trauma patients. GTP is for injured patients who can complete multiple sessions of skilled therapy per day and who, without that, would be unable to achieve their goal of successfully returning home. The initial pilot for the GTP started in January 2019 for patients age 65 and older with a traumatic injury who were previously functionally independent. The goal of the pilot was to provide therapy-intensive programs with physical, occupational and speech therapy sessions throughout the day, implement effective sleep hygiene protocols, and engage and empower the patient's voice for ongoing care. Now, Sharp Memorial Hospital's trauma team implements patient-centered care focusing on what matters and a robust therapy program during the day that allows the patient to rest at night, optimizing outcomes for geriatric trauma patients.

Why was GTP established?

The Sharp team determined that a change in practice was necessary to provide a more subtle approach to older adults who may be confused, disoriented and more sensitive to the abrupt approach of a large trauma activation team. The older adult patients who sustain a traumatic injury are among the most vulnerable patients a health care team encounters. Sharp Memorial Hospital's trauma team quickly identified an improvement process not only to activate a gentler response to these patients in the trauma bay on arrival, but also to deliver patient-centered care throughout their hospitalization and provide the best opportunity for patients to return home. While GTP is similar to the Healthy Aging program, non-trauma patients are not eligible to participate in GTP. GTP was thoughtfully designed by skilled therapists to enhance recovery and accommodation to new injury — one that happens unexpectedly and can have an immediate impact on independence.

Outcomes to date

- Earlier ambulation (goal set for first out-of-bed mobilization at eight hours from time of admission)
- Decreased prevalence of delirium (from over 20% incidence pre-pilot to 6% during pilot)
- Shorter length of stay (estimated one day shorter LOS during pilot for enrolled patients)
- Increase in discharge home (more than 60% of enrolled patients discharged home during pilot)

Patient case: A 91-year-old man with rib fractures and a concussion from a motor vehicle accident was brought in as a trauma activation and was immediately assessed for life-threatening injury. To avoid causing confusion and scaring the patient, rather than having the standard eight health care team members in the trauma bay, a smaller team of providers assessed the patient while providing reorientation and comfort interventions (e.g., a warm blanket, a calming voice and reassurance). Goals of care discussions were initiated for the patient and family to align on code status and level of care stratification. The patient was admitted to the neuro-trauma progressive care unit for the GTP with a specific set of physician orders, including specific interventions to promote and maintain the highest level of cognitive and functional status despite acute traumatic injury. Multiple sessions of physical and occupational therapy were ordered on a dedicated schedule. Speech language pathologists assessed the swallow reflex and cognitive baseline. The multiple daily sessions increased the patient's social interaction and access to skilled therapy. He was prepared for a homebound discharge through comprehensive skilled in-hospital evaluation and optimization. Numerous health care and support staff were actively involved in maximizing the patient's opportunity for timely recovery. The patient, who due to the nature of injury was in a vulnerable situation on admission, was able to successfully discharge home with home health.

Advanced Illness Management Program

The Advanced Illness Management (AIM) program serves any patient with a new or chronic diagnosis of an advanced or progressive illness that will affect their health trajectory. The AIM program puts a focus on patient priorities and provides education to each patient on their illness and how it will affect their life. This program ensures alignment of what matters to patients with their plan of care and that goals of care conversations are updated as conditions change. Key aspects of this nurse-led program are:

- Completing advance care planning, goals of care discussions, illness trajectory education, and symptom management and resource referrals, as well as ensuring that each patient understands when a palliative conversion may be appropriate
- Providing choices for treatment, code status stratification, and overall alignment with what is most important to patients and their loved ones
- Maintaining patient autonomy in their chosen health care plan while serving as a liaison with other providers to reinforce congruent goals of care
- Nurse-led goals of care conversations occurring in the Geriatric Emergency Department, often transforming the trajectory of care from aggressive therapies to patient-centered care

Why was AIM established?

AIM was developed to offer palliative alternatives to vulnerable patients and to ensure that what matters most to older adult patients is clearly understood, documented and integrated into their care plans. Because physicians balance many priorities, they depend on AIM nurses to ensure appropriate space and time to establish the patient's desired code status, while serving as a neutral source of information and education.

> Code status conversations are some of the most critical conversations we have. And yet physicians have barriers, including limited time, to address them.

Outcomes to date

- Consulted more than 5,000 patients per year to establish a plan of care, aligning patient goals of care with the multidisciplinary team
- Decreased unwanted or unnecessary diagnostics, procedures and hospital admissions
- Decreased length of stay, inpatient mortality and readmissions
- Increased advance care planning, including code status decisions and alignment on level of care
- Increased physician, patient and family satisfaction

Case example: An 86-year-old woman presented to the ED for increasing lethargy, failure to thrive, and underlying metastatic lung cancer with progression despite oncologic treatment. Initial goals of care were established upon earlier admission, and patient-directed wishes were to continue interventions appropriate to maintain quality of life with selective treatment. On subsequent admission to the ED, AIM was called due to deterioration of her health. A goals of care discussion was initiated with the patient, her family and surrogate decision-maker. The patient was ready to stop aggressive treatment. With thorough evaluation and discussion, a decision was made to forgo additional hospitalizations and initiate a comfort-focused treatment plan. AIM collaborated with the patient to support and educate on the process and philosophy of palliative and hospice care. AIM engaged with the ED and the patient's oncologist to formulate a plan for comfort care and hospice from the ED. The patient was discharged home with family care and hospice services with a full understanding of what to expect over time for the rest of her life.

Conclusion

Traditional hospital care does not consistently account for the unique needs of older adults. As the older adult population grows in the U.S., so will the need to improve geriatric care. Older adults will continue to be the largest population a hospital serves. And yet a reactive approach is still the standard, with geriatric care improvements often siloed within departments and teams. Sharp's Generational Health approach has elevated the standard of care to proactively incorporate what matters most to patients and to identify and respond to patient vulnerabilities, which directly impact the outcomes of care. As the growth of the older adult population continues, our hope is that other hospitals will follow suit to build on current standards of care to systematize best practices and patient-centered care for all older adults. Now is the time to prepare for a growing older adult population; to empower care teams to provide care aligned with patient goals; to consider the needs of patients of all ages; and to proactively address the needs of patients identified as most vulnerable.

Glossary

- **Advance care planning** — Discussing and preparing for future decisions about medical care, including code status and goals of care.[17]
- **Code status** — Indication of the decision to receive or forgo cardiopulmonary resuscitation in the event of cardiac arrest.[18]
- **Comprehensive geriatric assessment** — An interdisciplinary, multidimensional process to develop an integrated plan for treatment, rehabilitation and support for frail or older adults made vulnerable by their health or other circumstances.[19]
- **Frailty** — A geriatric syndrome characterized by age-associated declines in physiologic reserve and function across multiorgan systems, leading to increased vulnerability for adverse health outcomes.[20]
- **Geriatric Emergency Department (GED)** — The integration of best practices for older adults into an existing ED or separate ED space designated for older adults.[21]
- **Geriatric surgery** — A perioperative program that is designed to improve surgical care and outcomes for older adults through implementation of surgical standards.[22]
- **Geriatric syndrome** — Multifactorial conditions that are prevalent in older adults.[23]
- **Goals of care conversation** — A conversation about the patient's expressed preferences, values, needs, concerns and/or desires, through clinician-led discussion, professional guidance and support.[24]
- **Medical inflection point** — The point at which medical intervention may not yield a therapeutic outcome.
- **Sleep hygiene —** The use of various behavioral and environmental practices to ensure effective and restorative sleep.[25]
- **Vulnerabilities** — Characteristics that can influence medical care, access to treatment, and outcomes.[26]

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