

Improving Public Health and Health Care for Older Adults:

The Three Keys to Cross-Sector Age- Friendly Care

Implementation Guide and Workbook

This work was convened by the Institute for Healthcare Improvement in collaboration with the Michigan Health & Hospital Association and Trust for America's Health

Funded by

**MICHIGAN HEALTH
ENDOWMENT FUND**



Authors

Laura Howell Nelson, Senior Project Manager, Institute for Healthcare Improvement (IHI)

Cayla Saret, Senior Managing Editor, Institute for Healthcare Improvement (IHI)

Contributors

Thank you to the core team members who worked on this project and contributed to this work:

- Deborah Bamel
- Dulce Legaria
- Ewa Panetta
- Leslie Pelton
- Christina Southey
- Megan Wolfe

Acknowledgments

The development and validation of this framework was funded by the Michigan Health Endowment Fund (the Health Fund). The mission of the Health Fund is to improve the health of Michigan residents, with special emphasis on the health and wellness of children and seniors, while reducing the cost of health care.¹ To develop this framework, three partners were selected to work together: the Institute for Healthcare Improvement (IHI), the Michigan Health & Hospital Association (MHA), and Trust for America's Health (TFAH). The three core partners bring distinctive experience, relationships, and expertise in systems improvement, health care, public health, and the state of Michigan. These partners bring deep knowledge of the valuable age-friendly work that has been done in their respective areas of expertise.

We also want to thank the older adults, caregivers, and stakeholder organizations in Michigan who contributed their experiences and stories during interviews and feedback sessions. Thank you for sharing your experiences openly and honestly. We are grateful to Jennifer Culbert of IHI for her support in designing and editing this document.

How to Cite This Document: Nelson LH and Saret C. *Improving Public Health and Health Care for Older Adults: The Three Keys to Cross-Sector Age-Friendly Care*. Boston: convened by the Institute for Healthcare Improvement; 2023. (Available at www.ihl.org/agefriendly)

Institute for Healthcare Improvement

For more than 30 years, the Institute for Healthcare Improvement (IHI) has used improvement science to advance and sustain better outcomes in health and health systems across the world. We bring awareness of safety and quality to millions, accelerate learning and the systematic improvement of care, develop solutions to previously intractable challenges, and mobilize health systems, communities, regions, and nations to reduce harm and deaths. We work in collaboration with the growing IHI community to spark bold, inventive ways to improve the health of individuals and populations. We generate optimism, harvest fresh ideas, and support anyone, anywhere who wants to profoundly change health and health care for the better. Learn more at ihl.org.

© 2023 Institute for Healthcare Improvement. All rights reserved. Individuals may photocopy these materials for educational, not-for-profit uses, provided that the contents are not altered in any way and that proper attribution is given to IHI as the source of the content. These materials may not be reproduced for commercial, for-profit use in any form or by any means, or republished under any circumstances, without the written permission of the Institute for Health

Contents

| | |
|---|----|
| Introduction | 4 |
| Implementation Guide | 7 |
| Workbook | 23 |
| Appendix A: Care Journey Maps | 41 |
| Appendix B: Driver Diagram | 43 |
| Appendix C: Change Ideas | 44 |
| Appendix D: Process & Outcome Measures | 48 |
| Appendix E: Methods | 51 |
| Appendix F: Stakeholder Organizations Interviewed | 54 |
| Appendix G: Partner Organizations | 56 |
| Appendix H: Project Timeline & Outcomes | 57 |
| References | 58 |



Introduction

Improving Public Health and Health Care for Older Adults: The Three Keys to Cross-Sector Age-Friendly Care Implementation Guide and Workbook contains resources designed to improve how public health and health care organizations work across the care continuum. An ideal system “provides a comprehensive range of health services, so that care can evolve with the patient over time.”² Our goal is that all older adults can age in optimal health, in a setting that is aligned with their wishes, receiving care from a system that is supportive and equitable.

Every day, 10,000 Americans turn 65. According to the US Census Bureau, the US population aged 65+ years is expected to nearly double, from 43.1 million in 2012 to an estimated 83.7 million in 2050. As people age, care tends to become more complex, and the health care and public health systems have not adequately prepared for the growth of the older adult population. These challenges are further compounded by an inadequately supported workforce in both sectors. To reliably provide evidence-based care and services to every older adult at every interaction, both sectors need to elevate healthy aging as a core function, with a foundational focus on equity.³

The challenge of providing age-friendly care and services is an example of an “adaptive problem” — in which “the answer is not known, and even if it were, no single entity has the resources or authority to bring about the necessary change.”⁴ By gaining the commitment of leaders to the common goal of age-friendly care, public health and health care can tackle this complex issue together. Through a review of the literature, stakeholder interviews with organizations, older adults, and caregivers, we have developed the Three Keys to Cross-Sector Age-Friendly Care to support you in this work.

In this document, you will find:

- **Implementation Guide:** The Three Keys to Cross-Sector Age-Friendly Care and descriptions of the components that fuel cross-sector collaboration across the care continuum.
- **Workbook:** A step-by-step approach for public health and health care organizations to jump into action using the Three Keys.
- **Appendix:** A set of [Care Journey Maps](#) that illustrate the experiences of older adults and their caregivers, paired with a driver diagram of the Three Keys with practical ideas to improve health care and public health systems.

Use these materials to steer your age-friendly journey, improve collaboration across sectors and the care continuum, and center older adults and equity throughout the process. The model, originally developed through a pilot project in Michigan, is intended to be adaptable to your community or state and can be customized based on the older adults within your geographic area.

Our aim is to bring together two movements — **Age-Friendly Health Systems (AFHS)** and **Age-Friendly Public Health Systems (AFPHS)** — to align strategies and recommendations for communities and states that are specific to older adult health and well-being. The authors

acknowledge that other systems and sectors engage in providing indispensable care and services for older adults, including the aging services network and community-based organizations. Although these sectors are not a primary focus of this document, health systems and public health agencies must necessarily connect with them as part of a complete care journey.



About Age-Friendly Health Systems

[Age-Friendly Health Systems](#) is an initiative of The John A. Hartford Foundation and the IHI, in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA).

Age-Friendly Health Systems aim to:

- Follow an essential set of evidence-based practices (4Ms);
- Cause no harm; and
- Align with What Matters to the older adult and their family caregivers.

Becoming an Age-Friendly Health System entails reliably providing a set of four evidence-based elements of high-quality care, known as the “4Ms,” to all older adults in your system: **What Matters, Medication, Mentation, and Mobility**. IHI recognizes clinical care settings that are working toward reliable practice of evidence-based interventions for all older adults in their care known at either level 1 (Participant) or level 2 (Committed to Care Excellence).

- Level 1 (Participant) teams have successfully developed plans to implement the 4Ms.
- Level 2 (Committed to Care Excellence) teams have three months of data for older adults who received 4Ms care.⁵

About Age-Friendly Public Health Systems

To facilitate the transformation of the current public health system, TFAH, in partnership with The John A. Hartford Foundation, developed the 6Cs Framework for Creating [Age-Friendly Public Health Systems](#) (AFPHS). This 6Cs refer to six areas of age-friendly public health activities:

1. **Creating and leading** policy, systems, and environmental changes to improve older adult health and well-being.
2. **Connecting** and convening multisector stakeholders to address the health and social needs of older adults through collective impact approaches focused on the social determinants of health.
3. **Coordinating** existing supports and services to help older adults, families, and caregivers navigate and access services and supports, avoid duplication, and promote an integrated system of care.

4. **Collecting, analyzing, and translating** relevant and robust data on older adults to identify the needs and assets of a community and inform the development of interventions through community-wide assessment.
5. **Communicating** important public health information to promote and support older adult health and well-being, including conducting and disseminating research findings and emerging and best practices to support healthy aging.⁶
6. **Complementing** existing health-promoting programs to ensure they are adequately meeting the needs of older adults.

To further incentivize the adoption of healthy aging as a core public health function, TFAH developed an AFPHS Recognition Program that aims to honor engagement in healthy aging at three levels: AFPHS Champion Individual, AFPHS Recognition Departmental, and AFPHS Advanced Departmental.⁷ State, territorial, tribal, and local health departments are eligible for this recognition.



Implementation Guide

How to Use This Guide

This Guide answers the question: How can the public health and health care sectors each contribute to an age-friendly ecosystem? It includes change ideas and measures to drive both the process and outcome of achieving the Three Keys to Cross-Sector Age-Friendly Care. These components were developed to help health care and public health systems and leaders accelerate improvements across the care continuum.

The Guide leverages cross-sector collaboration as a vital tool to bring together public health and health care organizations and other partners outside of these sectors across the care continuum. Some of the components of the model presented in this Guide may apply within one sector only, while others apply across multiple sectors, including health care, public health, and social services. In some cases, the suggested change ideas can be tested and implemented within one organization alone, while others intentionally focus on collaboration across sectors and require building partnerships and relationships. We encourage you to structure your journey towards cross-sector age-friendly care based on the scope of your organization's work, and then assess how and where to build partnerships with aligned visions to improve care for older adults together.

You may already be doing parts of this work in your system, some or all of the time. You will not be implementing all of the components at once. Once you've reviewed the Guide, start by picking one change idea to test and measure. Then, build on your progress — by strengthening that piece of work so it becomes a reliable part of your processes, or by adding a second change idea. The Workbook takes you through how to test these change ideas, step by step.

The Three Keys to Cross-Sector Age-Friendly Care

The Three Keys are: **What Matters**, **Supportive System Structures**, and **Financial Structures & Policy Landscape**. Each of these function at different levels of the system, drawing on the framework of upstream and downstream approaches in public health. Downstream interventions are micro-level strategies that focus on issues of equitable access to care and providing resources to those in need, and upstream interventions are macro-level strategies tied to structural determinants of health — i.e., those related to the root causes of inequitable distribution of wealth, resources, and opportunities in a given population (National Collaborating Centre for Determinants of Health, 2014).⁸

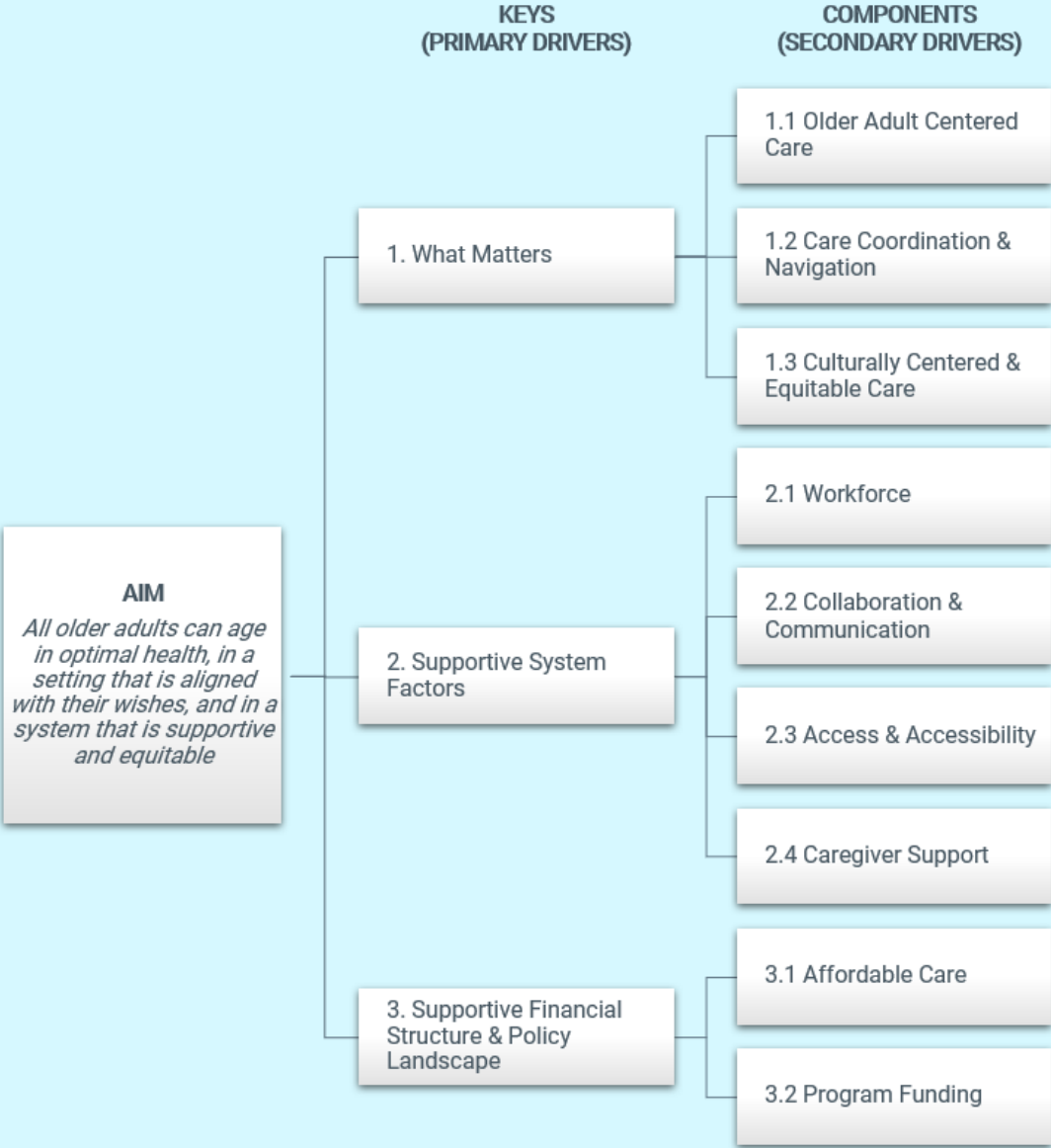
- **What Matters** aligns with downstream approaches and works to address the experience of older adults and caregivers and improve care across the continuum.
- **Supportive System Structures** aligns with the middle of both of these approaches, addressing the systems and processes that organizations and entities have the power to address.

- Financial Structures & Policy Landscape** aligns with upstream approaches that change policies and the macro-environment conditions that affect organizations, communities, systems, and people.

These Three Keys represent the levels at which change to the current system will take place (Figure 1). This framework was derived from examining the current landscape and from conversations with organizational stakeholders, older adults, and their caregivers.

In your role, you won't be addressing every Key or every change idea or collecting all measures; that's not sustainable. You can pick and choose the change ideas that matter to your organization or sector to test, measure, and sustain improvements.

Figure 1: The Three Keys to Cross-Sector Age-Friendly Care



Closing Equity Gaps

Systemic factors that affect the health of older adults are broad, complex, and interconnected. Studies have found that lower socioeconomic status and systemic racism are associated with poorer health outcomes and reduced lifespan. For example, in the US, Alzheimer’s disease is more common among Black and Hispanic racial groups.⁹

To advance systems change, both AFPHS and AFHS take a health equity approach within their respective initiatives. Health equity is achieved when every person in every community has the opportunity to achieve optimal health. Optimal health means not only lack of disease or illness, but a state of complete physical, mental, spiritual, and social well-being that is essential for individuals to reach their full potential across the life course.

To narrow down the scope of this project, the team chose the following characteristics around which to develop the framework:

- Race and ethnicity
- Geography type (urban, rural, suburban)
- Health conditions or status
- Insurance status

In applying this framework across Michigan and beyond, health care and public health organizations are encouraged to incorporate demographics relevant to their setting and to the older adults they serve. Use the list below as a starting place:

- Race
- Ethnicity
- Gender
- LGBTQIA+ identity
- Insurance status
- Religious preferences
- Geography type
- Tribal communities
- Immigration status
- Language or dialect spoken
- Cognitive ability
- Physical ability
- Health conditions or status
- Literacy level

Equity is central to improving the systems that affect the health of older adults, in Michigan and beyond. Embodying age-friendly approaches across the health and public health continuum is vital, not only to improve health equity for current older adults, but also for future generations of people as they age. To integrate equity into your cross-sector age-friendly work, follow the steps in this Guide and ask questions such as: “How are older adults considered and engaged in conversations about inequities in care? What is the historical relationship between your sector and older adults in traditionally marginalized populations in your community? How might this relationship affect care today?”¹⁰

Understanding the Three Keys

The sections below walk through the drivers of change, illustrating key actions you can take to drive improvements in health for older adults across the care continuum. More support for moving to action can be found in the [Workbook](#). A description of each of the Three Keys and its components is followed by a list of process measures and a table of associated change ideas. A change idea – a “general notion or approach to change that has been found to be useful in developing specific ideas for improvement” – is a catalyst to accelerate improvement.¹¹ Some of the proposed change ideas may apply to individual organizations in public health or health care in their role as part of the age-friendly ecosystem, while others require partnering within, across, or outside of these sectors. Finally, a suggested list of outcome measures across all Three Keys allows for tracking results.

You can download the complete driver diagram that includes all elements of the Three Keys in [Appendix B](#). To learn more about the research and details of the Michigan-based pilot project that supported this work, refer to [Appendix E](#).

1. What Matters

The first Key, **What Matters**, builds upon the definition of “What Matters” from Age-Friendly Health Systems. The Age-Friendly Health Systems initiative defines “What Matters” as knowing and aligning care with each older adult’s specific health outcome goals and care preferences, including, but not limited to, end-of-life care, and across settings of care. Health outcome goals relate to the values and activities that matter most to an individual, help motivate the individual to sustain and improve health, and could be impeded by a decline in health – for example, babysitting a grandchild, walking with friends in the morning, or volunteering in the community. This Key also refers to autonomy in choosing how to age; factors associated with social connection and meaning; and how older adults experience their health, care, and community-based services.

The components of this Key include:

- Older Adult Centered Care
- Care Coordination & Navigation
- Culturally Centered & Equitable Care

As you test the change ideas for each component of What Matters, use the following process measures to track your progress, or develop your own.

Process Measures for 1. What Matters

- Number (or %) of adults who report that their care is in alignment with their goals (measured by collaboRATE tool)
- Number (or %) of older adults receiving services from a care coordinator or enrolled in case management program
- Wait time for services: average number of days between referral made and when services start

- Patient experience questions from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey (select the measures most relevant to your work)

1.1 Older Adult Centered Care

The **Older Adult Centered Care** component reinforces What Matters¹³ to older adults and their caregivers (including family or chosen family) in the experience of their care across the public health and health care continuum. This can include how care is coordinated and ensuring that care is culturally appropriate and aligns with the demographic characteristics of the older adult. This component addresses the individual-level factors that affect the health of an older adult and the experience of their caregivers.

McLaren Healthcare Caro Region asks all older adults “What would make tomorrow a really great day?” upon their hospital stay

McLaren Healthcare 4Ms Care Description (January 30, 2020)¹²

Older Adult Centered Care includes:

- Asking and acting on What Matters in all care settings
- Education and training for older adults to navigate technology tools and platforms
- Supporting older adults to advocate for their needs and wishes

The table below lists proposed change ideas for **Older Adult Centered Care**. The changes are organized by the sector with which they are most aligned.

Table 1. Older Adult Centered Care: Change Ideas

| | Public Health | Health Care |
|--|---------------|-------------|
| Check with older adults regarding their comfort navigating key technology supports such as MyChart and telehealth | | X |
| Include older adults and their caregivers in community health needs assessments to understand needs of the community and integrate needs into state and community health improvement plans | X | |
| Partner with Area Agencies on Aging (AAA) to identify supportive services for aging in place in local communities | X | |
| Partner with community-based organizations to raise awareness about or create a local database or hub for available resources in individual communities or regions (No Wrong Door) | X | |
| Reconcile medications at key touch points and look to deprescribe medications where appropriate | | X |

| | | |
|--|---|---|
| Support older adults and caregivers to advocate for their needs and wishes in all care settings | X | |
| Train staff to provide older adults with options about care settings and discuss where they would prefer to age | | X |
| Utilize What Matters tools and toolkit from Age-Friendly Health Systems as part of care delivery in all settings | | X |

1.2 Care Coordination & Navigation

The **Care Coordination & Navigation** component is an intentional approach to aligning, sharing information, and communicating across sectors. It’s important to understand “What Matters” to the older adult and their caregivers as part of the care coordination process so that the information can be used to achieve better, safer, and more effective care and outcomes across the continuum.

The Community Care Transition Initiative utilized CHWs to reduce hospital readmissions at Ascension St. Mary’s to 3%

Community Care Transition Initiative update¹⁴

Currently, there is fragmented communication and lack of alignment between health care organizations and community-based programs and services, and there is a significant need for more resources to help navigate transitions between settings. Community Health Workers (CHWs) or Patient Navigators that provide services such as health promotion and education, patient outreach and follow-up, navigation of the health care system, and care coordination or case management¹⁵, are vital to this component.

This component includes:

- Effective discharge and transition planning between facilities and community or home-based services
- Medication management (including deprescription across settings of care)
- Provider and caregiver awareness and navigation of existing supports and resources
- Supportive and trusting provider relationships

The table below lists proposed change ideas for **Care Coordination & Navigation**. The changes are organized by the sector with which they are most aligned.

Table 2. Care Coordination & Navigation: Change Ideas

| | Public Health | Health Care |
|---|---------------|-------------|
| Create standard tools and checklists for discharge planning | | X |
| Connect older adults with community-based organizations that provide counseling on the options available for care and support | X | |
| Ensure older adults and caregivers have support to access follow-up services as needed upon discharge | X | |
| Hire community health workers (CHWs), case managers, and patient navigators as core members of older adult's care team | X | |
| Identify and incorporate electronic health record (EHR) features to support care coordination | | X |
| Test follow-up processes to ensure care supports are received and adequate after discharge or transitions from services | X | |

1.3 Culturally Centered & Equitable Care

The **Culturally Centered & Equitable Care** component integrates the culture, language, and other important racial, ethnic, tribal, or other demographic factors that matter to the older adult and their caregivers in the delivery of the care, as well as resources needed to maintain or improve their life.¹⁶ Culture can be defined by the “personal identification, language, thoughts, communications, actions, customs, beliefs, values, and institutions that are often specific to ethnic, racial, religious, geographic, or social groups.”¹⁷ This component builds upon standard approaches in the health and public health systems, such as patient- or person-centered care.¹⁸ It aims to center What Matters to build trust and respect between service providers and older adults, as well as to address systems of racism and discrimination that affect health and well-being. This component also ensures that all elements of an older adult’s services or care are reflective of their culture and what matters to them, including race and gender, language and dialect, and dietary preferences, to name a few examples.

This component includes:

- Designing programs with equity in mind to accommodate and support older adults from all races and cultures
- Processes to recognize and address implicit bias and interpersonal and systemic racism at all levels of the care system
- Readily available translation of services and materials

The table below lists proposed change ideas for **Culturally Centered & Equitable Care**. The changes are organized by the sector with which they are most aligned.

Table 3. Culturally Centered & Equitable Care: Change Ideas

| | Public Health | Health Care |
|---|---------------|-------------|
| Collect and publish data on health disparities and link to quality and outcome measures | | X |
| Conduct anti-ageism trainings | | X |
| Ensure that all materials are provided in an older adult’s primary language | | X |
| Ensure that in-person translation services are provided in an older adult’s and/or caregiver’s primary language | | X |
| Ensure processes exist for response and reconciliation in the event of discriminatory treatment | | X |
| Provide implicit bias trainings for health care providers and staff and community service staff | | X |
| Stratify health data by race and ethnicity, as well as other demographic factors relevant in your setting (such as religion, income level, and geography) | | X |

2. Supportive System Structures

The second Key, **Supportive System Structures**, addresses the system-level factors that affect the health care and public health systems, leading to how care is delivered to older adults across the care continuum. These systems refer to the entities and organizations, people, and actions that promote health across the care continuum.

The components of this Key include:

- Workforce
- Collaboration & Communication
- Access & Accessibility
- Caregiver Support (individual and system-level)

As you test the change ideas for each component of Supportive System Structures, use the following process measures to track your progress, or develop your own.

Process measures for Supportive System Structures

- Staff breakdown by race, ethnicity, and language (compared to wider community)
- % of older adults who leave the hospital with referral or warm handoff to desired support services in their community (or % of older adults connected to appropriate community support within 30 days of discharge)
- % of older adults in the community, service area, or public health jurisdiction who are able to access telehealth services (or % of visits for older adults being provided via telehealth)
- % of patients with caregiver identified in chart

2.1 Workforce

The **Workforce** component pertains to the people who are at the front line and at the heart of the health care and public health systems. Significant workforce shortages make the provision of care for all who need it difficult. There is currently a shortage of direct care workers, and not enough funding to support family caregivers to care for older adults wherever they call home.

The Direct Care Workforce Coalition led by the IMPART Alliance aims to achieve a direct care workforce in a systematic, integrated, sustainable way

www.impartalliance.org¹⁹

This component includes:

- Adequate staffing for health care and home-care settings
- Diverse workforce that reflects communities in which older adults live
- Education and training on aging and older adult care
- Living wages, benefits, and career paths for frontline staff across sectors

The table below lists proposed change ideas for **Workforce**. The changes are organized by the sector with which they are most aligned.

Table 4. Workforce: Change Ideas

| | Public Health | Health Care |
|---|---------------|-------------|
| Advocate for state licensing and certification requirements to include education on geriatric care and/or age-friendly care | | X |
| Develop low-cost ways to translate documents | | X |
| Develop systems for provider retention in all geographies for health care and home-care settings | | X |

| | |
|---|---|
| Develop tools and trainings for staff that work with older adults (for example, Geriatrics workforce training) | X |
| Hire multilingual providers and staff (including care navigators and coordinators) | X |
| Partner with postsecondary education programs to incorporate training on aging and older adult care within educational or program curriculums (physician, nursing, social work, etc.) | X |
| Recruit and retain local staff to reflect diversity and language needs of the community | X |

2.2 Collaboration & Communication

The **Collaboration & Communication** component relates to how health care and public health organizations and entities communicate, collaborate across sectors, share information, transition older adults seamlessly across the care continuum, and provide the right resources for older adults and their caregivers, at the right time. There is a significant need for more care coordination resources to help navigate transitions between settings.

This component includes:

- Information sharing between facilities and community-based service providers to facilitate effective transitions
- Involving older adults, especially with marginalized identities, in the process of improving collaboration
- Supportive partnerships between organizations across sectors

The table below lists proposed change ideas for **Collaboration & Communication**. The changes are organized by the sector with which they are most aligned.

Table 5. Collaboration & Communication: Change Ideas

| | Public Health | Health Care |
|--|---------------|-------------|
| Coordinate with community-based organizations to ensure access to or develop educational materials about available community resources for older adults in provider offices and senior centers | | X |
| Partner with aging services or community-based organizations to enhance or develop a trusted referral system that allows health care organizations to share data across sectors | | X |
| Develop structures to close referral loops | | X |
| Collaborate with partners from other sectors in funding opportunities | | X |

| | |
|--|---|
| Utilize existing referral networks such as the Michigan Health Information Network (MiHIN) or Care Connect | X |
|--|---|

2.3 Access & Accessibility

The **Access & Accessibility** component pertains to the ability to navigate and access (either physically or through technology) the available services and supports. Many programs and services exist, but determining what is available and to whom is difficult and cumbersome. Important services to maintain or improve include help in the home, transportation, food delivery services, preventive services, social and support groups, assistance with navigating insurance and payment, emergency services, primary care, inpatient services, and physical and occupational therapy. While assessing this component, consider physical (e.g., hearing and vision) and cognitive abilities.

This component includes:

- Accessibility of physical spaces where older adults live and receive care
- Accessible and timely transportation
- Availability of telehealth and remote care services
- Existence of services and facilities in local community

The table below lists proposed change ideas for **Access & Accessibility**. The changes are organized by the sector with which they are most aligned.

Table 6. Access & Accessibility: Change Ideas

| | Public Health | Health Care |
|---|---------------|-------------|
| Center age-friendly practices in communicating information with older adults, e.g., have information written down and tailored to older adults and/or caregivers with varying literacy levels | | X |
| Conduct a walk-through of spaces with older adults and caregivers to identify and address barriers to access or risk of injury based on physical or cognitive ability | | X |
| Connect older adults and caregivers with training opportunities on how to use telehealth resources from a home health worker or community health worker | | X |
| Connect older adults with providers of the appropriate equipment to access technology platforms, when required | X | |
| Consider hub-and-spoke models to extend reach of services to rural and remote locations | | X |

| | | |
|---|---|--|
| Partner with aging services or community-based organizations for transportation supports as required so that older adults can access services regardless of location and physical ability | X | |
| Partner with aging services or community-based organizations to provide access to multigenerational tutoring to set up and use technology | X | |

2.4 Caregiver Support

The **Caregiver Support** component pertains to the individual- and system-level supports that caregivers provide for older adults. As defined by AFPHS, “Caregiving is assistance with the activities of daily living given either by a paid provider or, more frequently, by a family member. The provision of such assistance to older adults is often the factor that allows them to remain in their homes.”²⁰ A caregiver is “a person who tends to the needs or concerns of a person with short- or long-term limitations due to illness, injury, or disability. The term ‘family caregiver’ describes individuals who care for members of their family of origin, but also refers to those who care for their family of choice. This could be members of their congregation, neighbors, or close friends. Family caregivers play a significant role in health care, as [among other reasons] they are often the main source of valuable information about the patient.”²¹ AFPHS notes that today, these informal caregivers “are the largest sources of support for older adults in this country, but changes in family structure and social roles present challenges for many family members in providing that support.”²²

This component includes:

- Caregiver training and ability to support older adults
- Discharge planning and support for caregivers to navigate care transitions
- Support options for those without familial caregiver support

The table below lists proposed change ideas for **Caregiver Support**. The changes are organized by the sector with which they are most aligned.

Table 7. Caregiver Support: Change Ideas

| Change Idea | Public Health | Health Care |
|--|---------------|-------------|
| Include caregivers in all discharge education and planning conversations | | X |
| Provide information about and access to training, resources, and support groups for caregivers | X | |
| Utilize caregiver resources from Age-Friendly Health Systems | | X |

3. Supportive Financial Structure & Policy Landscape

The third Key, **Supportive Financial Structure & Policy Landscape**, describes the system-level financial and policy structure for programs and services that maintain or improve the health of older adults.

The components of this Key include:

- Affordable care
- Program funding

As you test the change ideas for each component of Supportive Financial Structure & Policy Landscape, use the following process measures to track your progress, or develop your own.

Process Measures for Supportive Financial Structure & Policy Landscape

- % of older adults who report being able to afford medications each month
- % of older adults who report not being able to get the care they need due to financial reasons
- % of programs supporting older adults that are on year-to-year or short-term grant funding

3.1 Affordable Care

The **Affordable Care** component pertains to a complex system and policy environment that should support older adults and their caregivers in understanding the types of coverage, benefits, and resources that are available at any given time and the ability to pay for the services, such as dental coverage, and other resources needed to live a healthy life. This also pertains to specific attributes of the health and public health systems, such as medication affordability.

This component includes:

- Access to supplemental benefits to meet individual needs
- Medication affordability
- Support for older adults to understand their coverage and benefits

The table below lists proposed change ideas for **Affordable Care**. The changes are organized by the sector with which they are most aligned.

Table 8. Affordable Care: Change Ideas

| | Public Health | Health Care |
|--|---------------|-------------|
| Ask older adults and caregivers about affordability of their medications and other care needs and coordinate support as required | | X |

| | | |
|--|---|---|
| Connect older adults with simplified tools for payment and insurance options and step-by-step caregiver guidance (for example, a community passport) | X | |
| Ensure access to or develop a website that assesses coverage and cost for services based on the older adult’s insurance coverage | X | |
| Partner with advocacy organizations to build support for payment models that reimburse for or include care coordination across sectors | | X |
| Partner with aging services organizations (such as AARP and AAAs) to connect older adults with tools and resources to navigate their insurance coverage and benefits, considering varying language and literacy levels | | X |

3.2 Program Funding

The **Program Funding** component describes funding for programs and services that support older adults, which, in their current state, are fragmented and siloed. Programs that should be working together are instead competing for a limited funding pool. This lack of aligned common vision affects the way organizations measure improvement, hindering engagement of older adults in research and influencing the way “challenges” are defined. There is also a lack of funding for programs and services that could allow adults to age in place.

This component includes:

- Adequate program funding to cover needs
- Longer-term funding to support sustainability

The table below lists proposed change ideas for **Program Funding**. The changes are organized by the sector with which they are most aligned.

Table 9. Program Funding: Change Ideas

| | Public Health | Health Care |
|--|---------------|-------------|
| Advocate for long-term or multi-year age-friendly collaborations across sectors to promote strategic alignment and funding sustainability that reaches the local level | X | |
| Identity resources to help organizations navigate the complex funding landscape and relieve administrative burden | X | |
| Prioritize funding to projects and programs that are multi-disciplinary and will support collaboration between health care and public health entities (vs. siloed funding) | X | |

Outcome Measures for the Three Keys

In addition to process measures, making meaningful change to the current system requires a set of outcome measures that public health and health care organizations can use to track improvement across the continuum, together. Two suggested outcome measures to use in this work are listed below:

1. % of older adults who agree or strongly agree with the statement, “I get the care, supports, and services that I need and want when I need and want them”
2. % of older adults who report being able to age in their desired setting

Details on how to collect these measures, as well as the process measures for each Key and component, can be found in the [Workbook](#).

Conclusion

This project brings together teams that have already begun working on Age-Friendly Health Systems and Age-Friendly Public Health Systems, as well as important age-friendly community stakeholders. While many people and organizations have been working within one of these areas, no groups in Michigan or other states (to the best of our knowledge) have brought all of these entities together to align their missions, visions, and values and to move forward together. The result will be a strong and sustainable infrastructure that can be scaled and spread to other areas in Michigan and beyond.

This Implementation Guide and Workbook provide a model that is replicable beyond the specific geographic area of the pilot program in Michigan.

Call to Action

Healthy aging requires that all sectors join together through an alignment in vision and scope to collectively support the health and well-being of all individuals across the life course. The health care and public health sectors play a crucial role to ensure that policies and systems are in place to maximize physical, mental, and social well-being, and that equity is embedded across these systems. Collective and aligned improvements to the health care journey across multiple sectors will not only improve the lives of older adults, their families, and their caregivers, but will also be cost-effective and could potentially reduce the burden to the health care system.

Adoption and implementation of the change ideas included in this Guide will help move the US health system toward one that is high-quality, respectful, accessible, and fair. However, policy changes are needed to support multisector partnerships between public health, health care, and community-based stakeholders to address the broader needs of the growing older adult

population. Such policies should include a focus on the social determinants of health and preventive measures to improve the foundation for good health.

Although this project has had a Michigan focus, the Care Journey Maps and change ideas are applicable across all communities and states.



Workbook

This Workbook is designed to be used with the Guide to help teams prepare for, test, and implement the Three Keys to Cross-Sector Age-Friendly Care. It includes examples relevant for public health and health care settings, including:

- **Public health:** federal, state, and local public health agencies as well as the governmental public health system
- **Health care:** hospitals, nursing homes, ambulatory care, or convenient care clinics

“Becoming age-friendly is a journey. It’s a culture change that continues to evolve over time.” - St. Lawrence Health

The Workbook includes step-by-step recommendations and worksheets for team members to use to deliver age-friendly care and services for individual older adults. It also offers support to iteratively improve, sustain improvements, and spread these practices throughout the community.

The six steps are:



1. Get Started



2. Form a Cross-Sector Team



3. Understand the Current State



4. Set an Aim



5. Measure Improvement



6. Sustaining Improvements

1. Get Started

As a first step on starting your journey to work across sectors, your organization will work to become recognized as age-friendly within your sector. Use the resources below to familiarize yourself with the two age-friendly initiatives that come together across sectors in this Workbook.

About Age-Friendly Initiatives

| Age-Friendly Public Health Systems | Age-Friendly Health Systems |
|---|---|
| <ol style="list-style-type: none">1. Age-Friendly Public Health Systems website2. Age-Friendly Public Health Systems guide | <ol style="list-style-type: none">1. Age-Friendly Health Systems website2. Age-Friendly Health Systems guides:<ul style="list-style-type: none">• Guide to Using the 4Ms in the Care of Older Adults in Hospitals and Ambulatory Practices• Guide to Care of Older Adults in Nursing Homes and Workbook |

If you're reviewing this Workbook, you are likely already practicing many of the principles of delivering age-friendly care. You can find information on becoming recognized as an Age-Friendly Health or Public Health System below.

After becoming recognized (or, if your organization is already recognized, increasing your recognition status), review the materials for age-friendly initiatives across sectors.



Becoming Recognized as Age-Friendly

| Age-Friendly Public Health Systems | Age-Friendly Health Systems |
|---|--|
| <p>TEAH offers opportunities for recognition at three levels:</p> <p>AFPHS Champion (individual): Recognizes public health professionals who have committed to building their own knowledge and expertise and have a desire to lead their departments in becoming age-friendly.</p> <p>AFPHS Recognition (departmental): Recognizes public health systems that have applied foundational changes in policies and practice that address the social determinants of health.</p> <p>AFPHS Advanced (also departmental): Recognizes public health systems that have completed at least one activity in each of the 6Cs within two years of AFPHS Recognition.</p> <p>Learn more about recognition.</p> | <p>IHI recognizes clinical care settings at two levels (see below) that are working toward reliable practice of evidence-based interventions – known as the 4Ms (What Matters, Medications, Mentation, Mobility) – for all older adults in their care.</p> <p>Level 1 (Participant) teams have successfully developed plans to implement the 4Ms.</p> <p>Level 2 (Committed to Care Excellence) teams have three months of data of older adults who received 4Ms care.</p> <p>Clinical care settings include hospitals, ambulatory practices, nursing homes, and convenient care clinics. Learn more about the recognition process and the supports for putting the 4Ms into practice.</p> |

“What we really liked about the recognition process was that it helped us connect the ‘what’ we were doing with the ‘why it was important.” - Florida Department of Health in Sarasota

Use the Implementation Guide

Throughout your journey, refer to the Implementation Guide for details about the Three Keys to Cross-Sector Age-Friendly Care. Use the change ideas in the Implementation Guide to drive how you can work across sectors and improve systems for the health of older adults in your community.

2. Form a Cross-Sector Team

To align care across the continuum, it's important to build a cross-sector team. This section includes steps and tools to gather your team, build relationships, set norms, and align working styles to accelerate and advance age-friendly principles across sectors.

Select a Population or System

Whose health and well-being do you intend to improve? Below are suggestions to help you answer this question in order to strengthen and focus your efforts. You may start with one “who” and then, over time, expand to others. Consider adding other categories that are relevant to your organization.

Population defines a population of older adults who hold a similar identify or demographic. **System** refers to the system factors, parts of a system, or processes, that you can zoom in on to address during your improvement work.

| Population | System |
|---|--|
| <ul style="list-style-type: none"> • Race • Ethnicity • Gender • LGBTQIA+ identity • Insurance status • Religious preferences • Geography type • Tribal communities • Immigration status • Language or dialect spoken • Cognitive ability • Physical ability • Health conditions or status • Literacy level | <ul style="list-style-type: none"> • Hospital or emergency services discharge processes • Population health care coordination • Case management • Preventive services • Care planning |

Team Roles

Communicate early and often about your hopes and plans. By sharing stories about the importance of age-friendly principles, you can build awareness, identify potential team members, and generate engagement and investment in the work across the organization and community. For key members of your team consider people who are opinion leaders in a sector, whom others seek out for guidance, who are close to the point of care, and/or who are not afraid to test and implement change.

Team roles might include the following. Depending on your chosen population or section of the system you're working to improve, think about community-based organizations, social services, or other sectors that should be integrated into your team. Add the names of your team members to the table:

| Role | Key Responsibilities | Name(s) | Contact Information |
|---|--|---------|---------------------|
| Public health leaders (individual champions or public health departments) | <ul style="list-style-type: none"> • Provide public health leadership and capacity building • Develop or contribute to an action plan • Understand the public health policy landscape, systems, and environment where you are testing • Engage with or become a subject matter expert on Age-Friendly Public Health Systems and the 6Cs | | |
| Frontline health care staff (including RNs, MDs, NPs, PAs, pharmacists, nutrition professionals, PTs, OTs, SWs, CNAs, mental/behavioral health providers, others) | <ul style="list-style-type: none"> • Collaborate with health care providers and staff, other technical experts, and leaders • Make recommended changes • Sustain changes that result in improvement • Consider the manager of the unit where changes are being tested • Have or develop good working relationships with colleagues • Be interested in driving change to achieve cross-sector collaboration | | |
| Frontline health care staff responsible for care coordination (patient navigator, care | <ul style="list-style-type: none"> • Engage with or become a subject matter expert on Age-Friendly Health Systems and the 4Ms | | |

| | | | |
|--|---|--|--|
| coordinator, case manager) | | | |
| Health care facility staff (including chaplains, environmental services, transportation drivers, front desk staff, others) | | | |
| Community health workers (financially supported by either a health system, home-based care organization, or a separate entity) | <ul style="list-style-type: none"> • Acts as liaison between cross-sector team and older adults and caregivers • Make recommended changes • Sustain changes that result in improvement • Be familiar with Age-Friendly Health Systems and/or Age-Friendly Public Health Systems | | |
| Community-based organizations or non-profits | <ul style="list-style-type: none"> • Engage with or become a subject matter expert on the social determinants of health for the older adult population selected for testing | | |
| Older adults (including those living independently, with caregivers, or in nursing homes) | <ul style="list-style-type: none"> • Bring critical expertise • Identify key issues based on their unique experience • Older adults and caregivers may only attend general calls/meetings or those related to their own care or services, not those of other older adults | | |
| Caregivers, family, and friends of older adults | <ul style="list-style-type: none"> • Additional information about appropriately engaging older adults and care partners in improvement efforts can be found on the Institute for Patient- and Family-Centered Care website and Valuing Lived Experience: Why Science Is Not Enough | | |
| Leader or sponsor | <ul style="list-style-type: none"> • Champion, authorize, and support team activities • Engage senior leaders and other groups to remove barriers and support implementation and scale-up efforts | | |

| | | | |
|---|---|--|--|
| | <ul style="list-style-type: none"> • Build a case for change that is based on strategic priorities and the calculated return on investment • Encourage the improvement team to set goals at an appropriate level • Provide the team with needed resources, including staff time and operating funds • Ensure that improvement capability and other technical resources are available to the team • Develop a plan to scale up successful changes from the improvement team to the rest of the organization | | |
| <p>Other roles (depending on your view of the system or community)</p> <ul style="list-style-type: none"> • Improvement coach • Data analyst/EHR analyst • Finance representative • Age-Friendly Ecosystem sectors, such as Universities or Employers • Consider payers or insurers (e.g., care navigators or care managers, accountable care organization representatives) • Students (with faculty) from health professions, public health, or other educational programs • Government officials, policymakers | | | |

Arrange Meeting Times and Locations

Ask team members which days of the week and times are most convenient for them to attend the meetings. Consider rotating days/times to accommodate different schedules.

Proposed day(s) of the week/time(s): _____

Proposed location(s): _____

- Consider how to engage older adults and caregivers in the planning process and team discussions.
- Provide coverage as much as possible so that frontline staff (such as CHWs, public health professionals, CNAs, nurses, case managers, and other interested staff) may attend meetings.
- Ask team members about how they prefer to meet: video/phone calls, in person, or a combination. Consider how you can remove barriers to participation for all team members.

Strengthen Your Cross-Sector Team

Building an effective team requires collaboration and commitment. The resources below can support you in this work. Choose the ones that are most relevant to your situation.

| Team-Building Work | Resources |
|--|--|
| Clarifying roles and responsibilities for decision-making | <ul style="list-style-type: none"> • Accountable, Responsible, Participant, and Advisor (ARPA) Framework • DARE Decision Making Model |
| Developing team norms for working together | <ul style="list-style-type: none"> • Touchstones for Collaboration • Team Member Working Styles Matrix (QI example) |
| Ideas for kicking off each meeting and getting to know one another | <ul style="list-style-type: none"> • Use icebreakers (such as these Chaotic Icebreakers) and other relationship-building exercises to build trust across team members and sectors |

3. Understand the Current State

The Three Keys to Cross-Sector Age-Friendly Care were developed through a pilot project in Michigan. The team conducted interviews with organizations, older adults, and caregivers to identify successes and gaps in the health care and public health systems. Questions explored bright spots, barriers to accessing resources, and recommendations to improve the health of older adults (see Appendix E for details).

It’s important for your team to understand how age-friendly care and services are currently in action (or not) in your area. Your team may not know all of this information yet! Write down what the team knows now.

“Access to healthy aging data has allowed the Washington State Department of Health and our partners to understand the health challenges facing older adults living in both rural and urban areas of our state.” - Marci Getz, Director, Healthy Aging Initiatives

Know the Older Adults in Your Community

In the last month, estimate the number of older adults you reached in each of these age categories:

Table 1. Older Adults Served in the Last Month (by Age Group)

| Strata | Number | Percent of Total |
|-------------------------------------|--------|------------------|
| 65–74 years | | |
| 75–84 years | | |
| 85+ years | | |
| Total number of older adults | | 100% |

Using available data, such as EHRs or community-level data, learn about the language, race, ethnicity, and other demographic characteristics of the older adults in your care, as well as other factors that matter to your organization. Don't worry about having perfect data. This is about getting to know your patient population using what you have access to. You can create separate tables to track each category. For example:

Table 2. Race/Ethnicity of Older Adults

| Race/Ethnicity | Percent of Total Older Adults Ages 65+ |
|----------------|--|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

Using the data: Once you have gathered available data, take a look at your tables. What patterns do you notice? How might you start to increase equity and improve outcomes for all older adults?

Dig Deeper to Understand the Current State

It takes time to work together as a team and across sectors to understand the current state of the system you are working in. The resources below can support you in this work. Choose the ones that are most relevant to your situation.

| Understanding Elements of the Current State | Resources |
|--|--|
| Lead focus groups or interviews with older adults, caregivers, and stakeholders across sectors | <ul style="list-style-type: none"> • Appendix E: Methods |
| Partner with older adults and caregivers who have lived experience of inequities | <ul style="list-style-type: none"> • Appendix A: Care Journey Maps • “What Matters” to Older Adults? A Toolkit for Health System to Design Better Care with Older Adults • AFPHS Caregiving Publications & Resources • 100 Million Healthier Lives Engaging People with Lived Experience Tools |
| Illustrate existing processes | <ul style="list-style-type: none"> • Walk-through Tool • Flowchart (part of the Quality Improvement Essentials Toolkit) |
| Identify the causes of a problem | <ul style="list-style-type: none"> • 5 Whys worksheet • Cause and effect diagram (part of the Quality Improvement Essentials Toolkit) • RCA²: Improving Root Cause Analyses and Actions to Prevent Harm |
| Explore the history and landscape, including existing assets | <ul style="list-style-type: none"> • Research similar organizations and programs in your community or geography to learn what has been done in the past to inform how you design your work for the future • Create an inventory or grid of health systems, public health organizations, and community-based organizations that have age-friendly goals as part of their mission or as a strategic priority • Asset mapping template • 3-part data review |

4. Set an Aim

As we like to say at IHI, “Some is not a number, soon is not a time.” An improvement plan helps create a shared understanding of what comes next. Look through the Implementation Guide and driver diagram (Appendix B). As a team, choose a Key to focus on. Within that area, select one change idea that your team will test together. You might choose an idea that the team has lots of energy for, or an area where there’s already some age-friendly work happening.

Use your review of the current state of age-friendly care and services to help you decide. Later, you can expand to more areas.

Then, select an individual or team to try out this idea with one or a few older adults. Remember to start small. This will help you learn what works in your setting – and what doesn’t – so you can adapt accordingly.

Let’s walk through an example together. Our example teams – both a public health team and a health care team – will each be focusing on the **Collaboration & Communication component** and on information sharing between facility and community-based service providers. Both teams will be focusing on the change idea *Develop structures to close referral loops*. Each team chooses someone to do the first test:

- **Public health:** The nurse educator who is part of the age-friendly team
- **Health care:** The case manager who works with older adults on Tuesdays

Aim Statement

Using the change idea you selected, consider your aim. As you do, keep in mind the larger aim of this cross-sector work: **All older adults can age in optimal health, in a setting that is aligned with their wishes, and in a system that is supportive and equitable.**

We know from the science of improvement that setting a clear, actionable aim is key for making change. Your aim should clearly answer these questions:

- How much? In numbers, how much will care and services improve?
- By when? Set a date.

Start Small

“Start somewhere and learn as you go. There will be bumps in the road...you will have to adapt and that is OK. Doing something is better than doing nothing.” - UW Health

Begin with one change idea. Then ask, how can you improve care or services for one encounter with one older adult? For example: “What can you do by next Tuesday?”

Here is an example. The team selected the change idea: *Test follow-up processes to ensure care supports are received and adequate after discharge or transitions from services* (1.2 Care Coordination & Navigation). They decided to test ensuring that CHWs were included to facilitate better transitions when older adults are discharged from the hospital, in order to ultimately reduce readmissions. The team set this aim:

- **Include a CHW as part of the hospital discharge process to reduce hospital readmissions by 10% before June 2023.**

This is just one example. You might adapt this aim to focus on patient navigators or social workers – or you might choose a different change idea altogether.

How do you start small with this idea? The team in the example will start by including a CHW as part of the hospital discharge process for all adults 65 and older on Tuesday and collecting feedback from members of the care team and older adults and caregivers.



Plan & Aim Setting

It takes time to work as a team to understand the current state of the system you are working in. The resources below can support you in this work. Choose the ones that are most relevant to your situation.

| Planning & Aim Setting | Resources |
|--|---|
| Document a test of change with the Plan-Do-Study-Act (PDSA) tool | <ul style="list-style-type: none"> • PDSA Worksheet • PDSA video • 100 Million Healthier Lives: Using Improvement Science to Accelerate Community Transformation |
| Map out goals and next steps | <ul style="list-style-type: none"> • Project Planning Form and Aim Statement Worksheet (part of the Quality Improvement Essentials Toolkit) • Project Charter and video |

5. Measure Improvement

It is important to look at data over time to know whether or not your work is making an improvement. Plotting data on a run chart can help you see patterns in your data, identify trends, and determine if your changes are making an impact in the long term.

Measurement is a critical part of testing and implementing changes; measures tell a team whether the changes they are making actually lead to improvement, and then teams can use that information to spread, discard, or adapt the changes. Measurement for improvement should not be confused with measurement for research or measurement for judgment.

Testing Change Ideas

Try the change idea with one older adult. As you do, take notes. If something doesn't go as planned, be sure to write that down – it will be helpful information for next time.

| | |
|--|--|
| Date | |
| Which older adult is participating, and why? | |
| Which team member is testing the change, and why? | |
| Which change idea was selected, and why? | |
| What happened when we tried it? How did the older adult respond? | |
| What went well? | |
| What will we do differently next time? | |
| Where does the team keep notes about this work? | |
| Other notes | |



Process Measures

Process measures help answer the questions: Are the parts/steps in the system performing as planned? Are we on track in our efforts to improve the system? Keep track of the process measures for your Key.

For example, as a process measure for their work on **Care Coordination & Navigation** (1.2), our example team chose to track:

- Number (or %) of older adults receiving services from a CHW during the discharge process

Over time, try other change ideas and other Keys. Continue to take one step at a time, setting an aim, collecting data, and seeing what works best in your setting.

Stratify your data by demographics or population segments, including race and ethnicity as well as other factors relevant to the older adults you serve, to understand existing gaps. Use this data to select and test changes to increase equity in care or services across all groups of older adults. Remember, there is no quality without equity.

A table of the process measures associated with the Three Keys to Cross-Sector Age-Friendly Care can be found in [Appendix B](#).

Outcome Measures

Outcome measures help us ask: How is your work making care and services better for older adults in your community?

It may take time to observe improvements in long-term outcomes for your improvement project. Record these measures to track your results:

- % of older adults who agree or strongly agree with the statement, “I get the care, supports, and services that I need and want when I need and want them”
- % of older adults who report being able to age in their desired setting

Measurement & Data Collection

Measuring for improvement is an iterative process to collect data and learn from testing the changes you’ve selected. Consider using a run chart – a simple and effective graph of data over time to help you determine whether the changes you are making are leading to improvement. The resources below can support you in this work. Choose the ones that are most relevant to your situation.

| Measurement & Data Collection | Resources |
|---|--|
| Plot measures over time with run charts | <ul style="list-style-type: none"> • Run Chart Toolkit • Run Chart video |
| Build and track driver diagrams, change ideas, and measures | <ul style="list-style-type: none"> • Appendix B. Driver Diagram • Appendix C. Change Ideas • Appendix D. Process & Outcome Measures • Project Planning Form and Aim Statement Worksheet (part of the Quality Improvement Essentials Toolkit) |
| Use data for improvement and share across organizations/sectors | <ul style="list-style-type: none"> • 3-part data review • University of Wisconsin/Robert Wood Johnson Foundation: County Health Rankings & Roadmaps Approach |
| Apply design thinking principles | <ul style="list-style-type: none"> • 100 Million Healthier Lives: Using Improvement Science to Accelerate Community Transformation |

6. Sustain Improvement

Congratulations! You are on your way to providing age-friendly care or services. You have gone through planning, reflection, testing, and learning.

As you continue to do this work, continue to take notes. Ask yourself: **What went well? What will we do differently next time?**

When a change idea is successful, pick one way to expand it. You might test it with another team member or with another older adult.

Sustaining Changes

The table below is a method to track change ideas as part of your improvement plan. You may be reliably doing some of these things, but not others. Please note, to sustainably implement changes, only select 1-3 of changes ideas to test at a given time. For each change idea, use an “X” to indicate the current status of testing.

| Key | Change Idea | Not Yet Tested | Plan to Test | Currently Testing | Implemented |
|-----|-------------|----------------|--------------|-------------------|-------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Sharing Stories

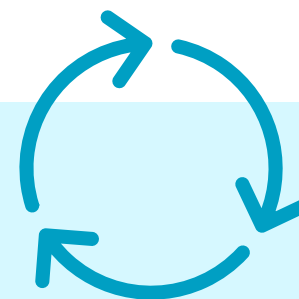
We all learn from others’ experiences with testing and implementing changes in the real world – who should be on the team; what measures were tracked; which changes worked best or didn’t work at all; and what lessons were learned.

Use a template such as the [CDC Storytelling Template](#) to share the story of your community and improvement work.

Sustainability

Sustaining the changes and improvements from your work is key to the improvement process and long-term ability to do the work. The resources below can support you in this work. Choose the ones that are most relevant to your situation.

| Sustainability | Resources |
|--|--|
| Share, celebrate, and learn from your improvement story | <ul style="list-style-type: none">• Celebrate learnings by sharing an improvement story or case study such as the Age-Friendly Health Systems case study examples |
| Build partnerships to advocate for policies across sectors | <ul style="list-style-type: none">• Build relationships with political figures, government officials, or advocacy organizations like an AARP Chapter to embed changes you've tested into policies across sectors |
| Plan for long-term sustainability | <ul style="list-style-type: none">• Sustainability planning worksheet• Leading for Abundance: Approach to Generative Sustainability |



Appendix A: Care Journey Maps

Background

Journey mapping, sometimes referred to as patient-journey mapping in the health care field, involves the creation of a visual narrative depicting the multidimensional relationship between an individual and a service. The maps center the experience of the older adults and their caregivers to show the importance of acting on and assessing what matters to an older adult and the complexity and impact of the current system.

Characteristics of the older adults and caregivers interviewed were combined to create three personas represented in the Care Journey Maps. Qualitative data from the older adult and caregiver interviews were used to understand the **current state** and subsequent systems factors that were impeding quality, reliable care, and preventive services for older adults. Qualitative data from the stakeholder interviews and older adult interviews was used to establish the **future state** and how the public health and health care systems can improve care across the continuum.

There are six maps in total representing individuals with the following characteristics:

| Map Set | Race/Ethnicity | Geography | Health Status | Age |
|----------------------------|------------------------|-----------|--|-----|
| Older Adult 1 (Maps 1 & 2) | Latinx/Hispanic | Rural | Diabetes and chronic health conditions | 75 |
| Older Adult 2 (Maps 3 & 4) | Black/African American | Urban | Mental and behavioral health challenges | 65 |
| Older Adult 3 (Maps 5 & 6) | White | Suburban | History of falls and mobility challenges | 80 |

How to Use the Care Journey Maps

The Care Journey Maps developed as part of this pilot project address the system factors from the health care and public health sectors that currently inhibit older adults from living their healthiest life and present a path forward to providing a better future state for older adults and their caregivers. As a cross-sector team, your role is to address the system factors in the **current state** maps by testing **change ideas** to improve the systems across the care continuum. If you are a direct care worker, you can also use the Care Journey Maps as a tool for dialogue with older adults and caregivers about their experience navigating services across the care continuum and what matters most.

Think about which system factors your team or organization have control over, and how you might partner across sectors to improve the systems impacting older adults. Include community-based organizations or social services as one of many key partners across the care continuum. Steps for setting up your team can be found in the [Workbook](#).

You can develop your own set of Care Journey Maps by interviewing organizational leaders, older adults, and caregivers from your community or a segment of the population that matters to you. Appendix E contains helpful steps and information to lead these stakeholder interviews.

***Note:** These Care Journey Maps capture common themes that we heard in interviews with organizational stakeholders, older adult, and caregivers, and are not intended to be representative of every older adult's experience. They are a tool that can be used to demonstrate ways in which systems are not working, and what an older adult's care journey could look like if all sectors were effectively working together across the care continuum. The Care Journey Maps are not a fully comprehensive plan for how all of our systems work together. The environments in which we live, work, and receive care are complex, so sectors and components of an exhaustive system may not be included.*

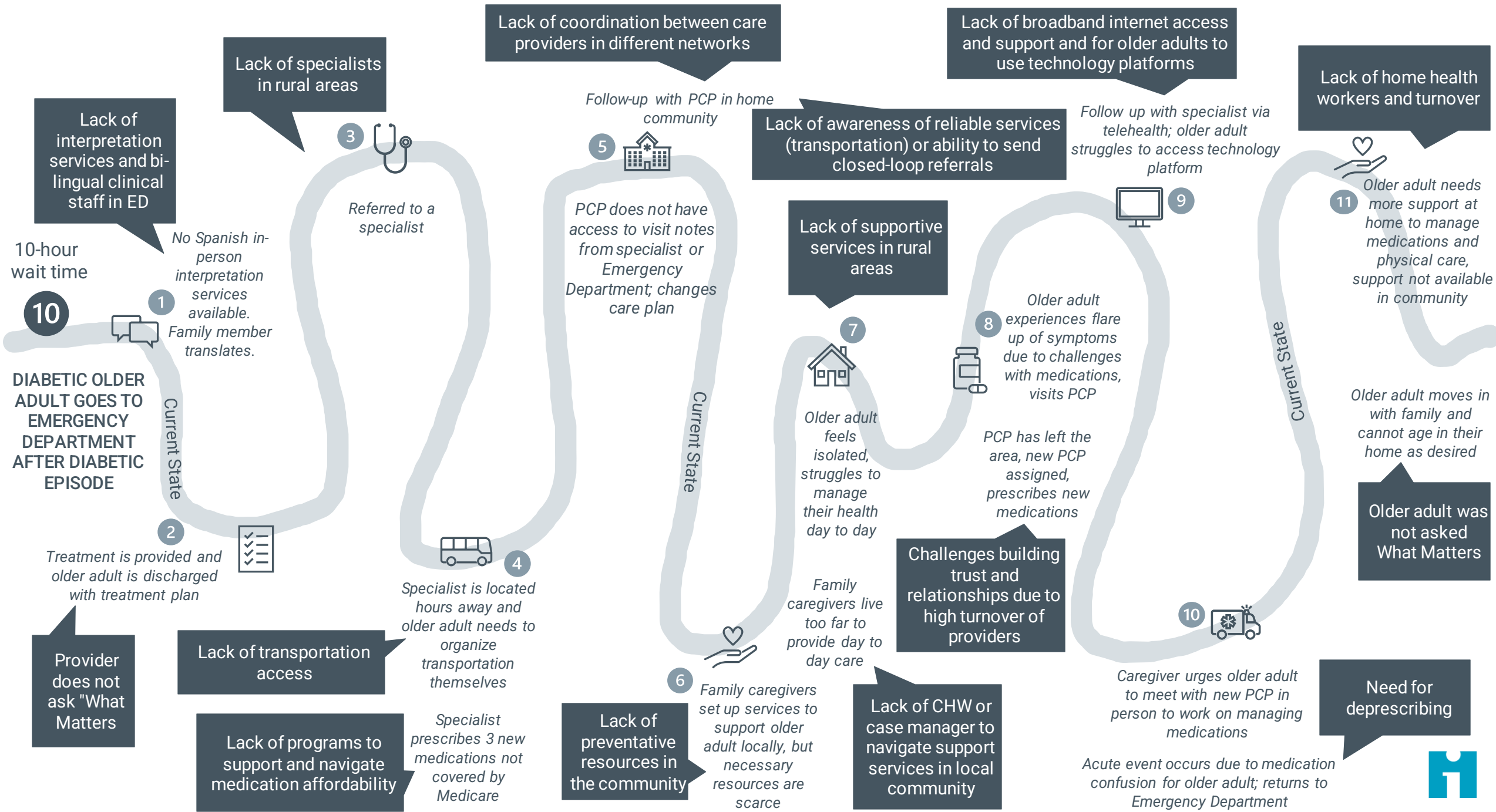
Care Journey Map Set 1

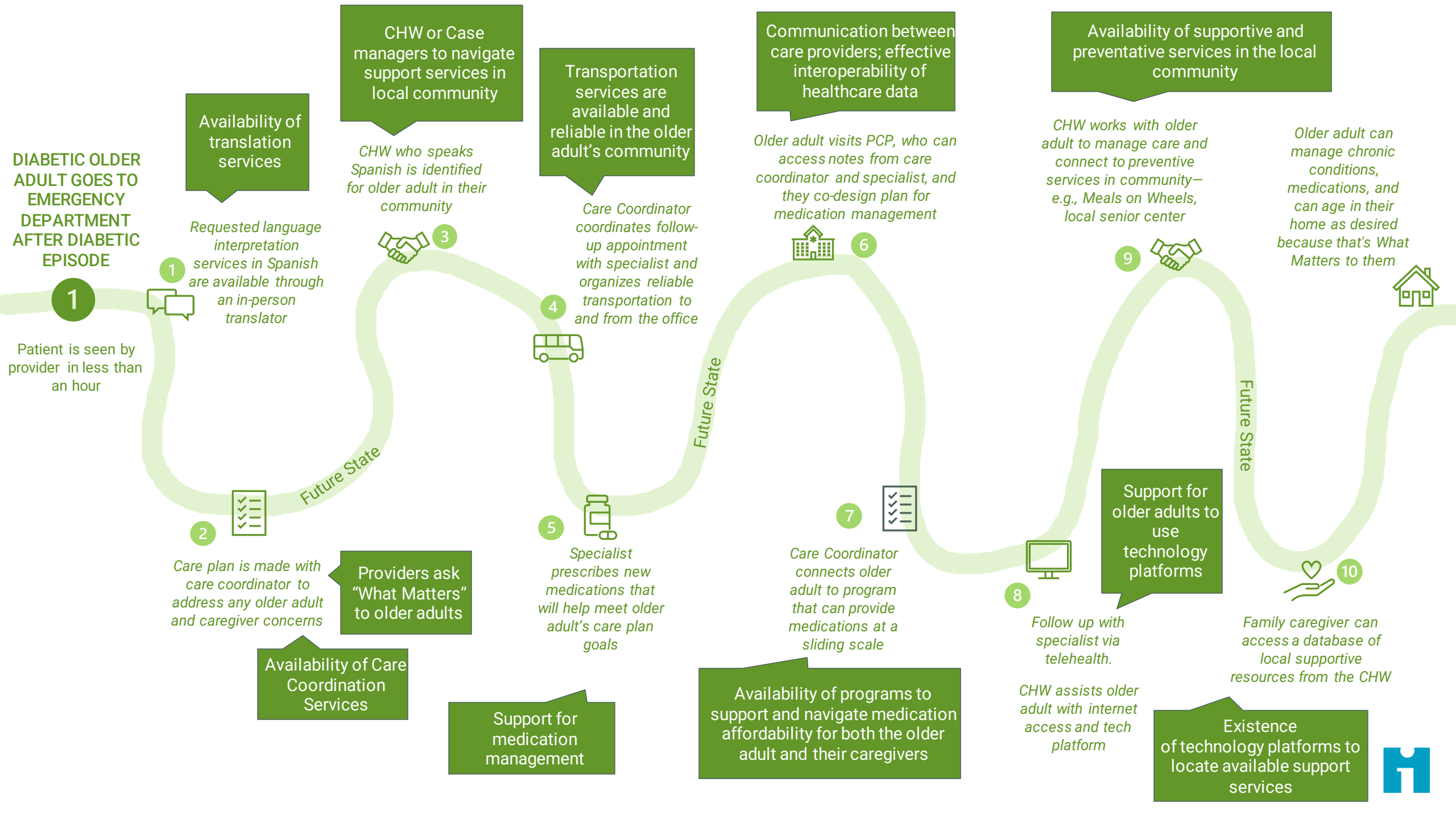
“I live in a **rural community**, identify as **Latinx or Hispanic**, I have **diabetes and other chronic health conditions**, and I am **75** years old. **What Matters to me** is to live in my home with my family and caregivers nearby.”



“I want my dad to be heard and seen by the health care system for his whole self.”

- Older adult's caregiver





Care Journey Map Set 2

“I live in an **urban community**, identify as **Black or African American**, I have **Mental health and other behavioral health conditions**, and I am **65** years old. **What Matters to me** is to live in the home that I grew up in and in a community that supports me”



“My brother deserves to stay where he’s comfortable and accepted, and to be seen for more than his health conditions”

- Older Adult’s caregiver

OLDER ADULT IS RECENTLY DIAGNOSED WITH SCHIZOPHRENIA



Family caregivers live too far to provide day-to-day care and accompany older adult to appointments, older adult struggles to arrange transportation

Lack of Access to timely transportation services



2

Current State

Older adult lives alone and struggles to manage their health day to day



1

Lack of support to understand insurance coverage and benefits

Lack of coordination between providers in different networks

Referral made to psychiatrist. Only psychiatrist who takes Medicare is in a different network and can't share records with PCP



4

Lack of support to understand insurance coverage and benefits



3

Caregiver conducts research on Medicare, health care laws and community resources, to become familiar with navigating the system

Older adult struggles to manage new medications prescribed by psychiatrist. Sometimes takes incorrect medication and ends up in back in the Emergency Department



5

Need for medication management

Lack of ageism and implicit bias training for direct care workers

Caregiver attempts to contact service providers but feels like she was not being treated respectfully



7

Caregiver tries to set up supportive services locally (support groups, medication management) struggles to get into the right programs



6

Lack of accessible hub of information for caregivers

Lack of culturally appropriate meal options through food provision services

Older adult is connected to support group but does not feel comfortable going because he is only person of color and feels stigmatized



8

Lack of providers and staff that represent the diversity of the community

Stigma of mental health and racism for Black people



9

Caregiver coordinates additional services for older adult



10

Older adult receives food through Meals on Wheels, but it is not what he is used to, and they rarely eat the food, often doesn't get adequate nutrition

Workforce shortages for in-home care providers

Older adult needs more in-home support, but caregiver cannot find affordable options for in-home care

12



11

Older adult continues to experience declining health due to poor nutrition and medication issues

Need for deprescribing

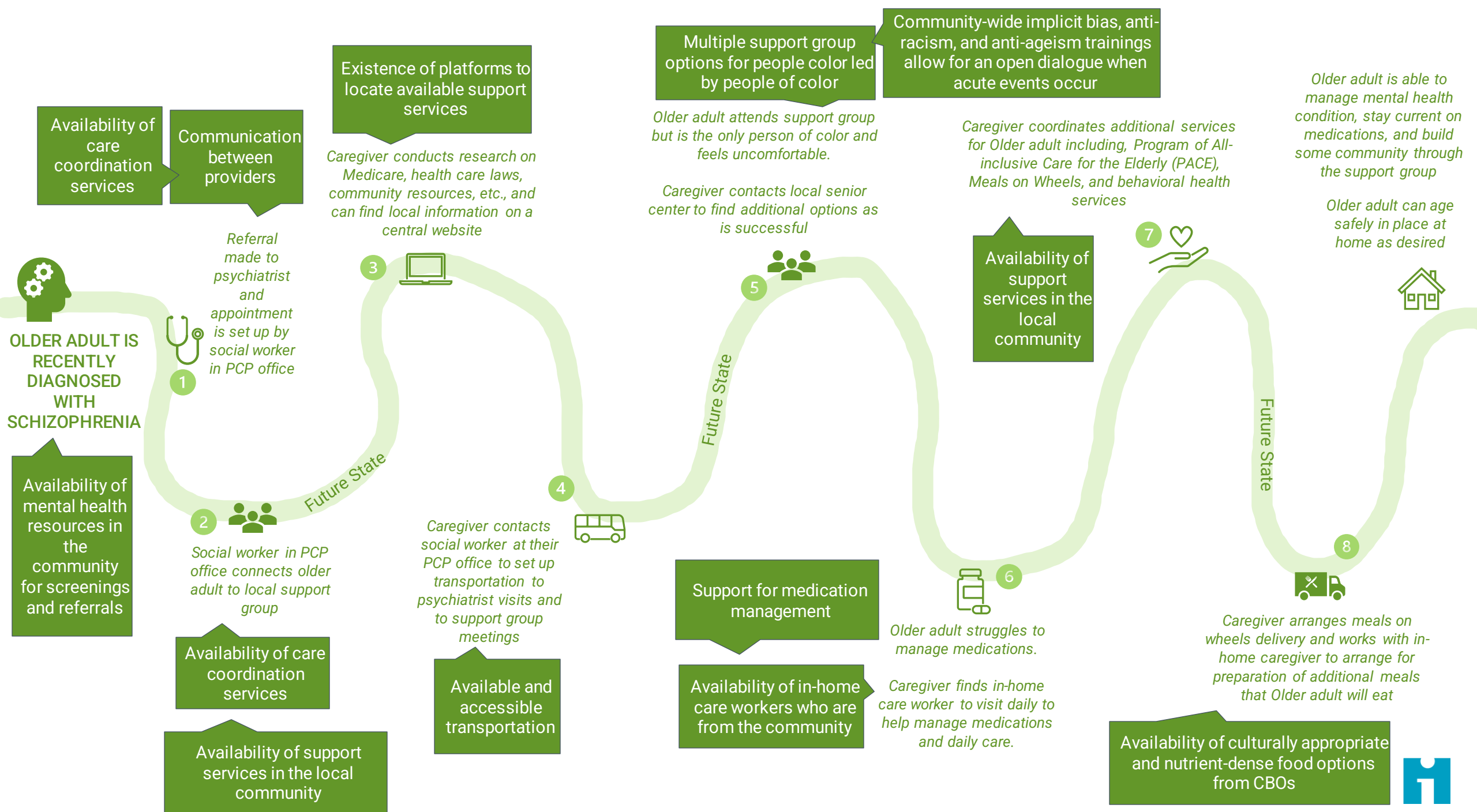
Older adult was not asked What Matters to them



Older adult leaves current home and moves with family caregivers; cannot age in their home as desired

Older adult is uncomfortable in new environment, does not have the same connections to neighbors and friends, retreats to himself and often stays indoors





Care Journey Map Set 3

“I live in a **suburban community**, identify as **White**, I have **a history of falls and mobility issues**, and I am **80** years old. **What Matters to me** is to keep my independence while I continue to age”



“I want my mom to do what she loves: live actively with her loved ones and be independent”

- Older Adult's caregiver



OLDER ADULT EXPERIENCES A FALL WHILE ALONE AT HOME AND IS TAKEN BY AMBULANCE TO EMERGENCY DEPARTMENT



Lack of risk assessment and fall prevention programs in the community

1



Older adult admitted to the hospital for surgery. Recovery will take 6-8 weeks and they will need full time caregiving support.

Lack of programs that help older adults understand their insurance coverage and benefits

2



Rehabilitation facilities in the area that accept Medicare don't have enough beds, private facilities are too expensive for older adult and caregivers

Lack of available beds in health care facilities

Caregiver finally finds bed in rehabilitation facility, but it is far away and not in older adult's community

3



Lack of care coordination across sectors

Older adult is discharged from facility, referral made to PT

4



Caregiver struggles to arrange transportation to PT appointments, resulting in several missed visits

Lack of accessible and timely transportation

Current State



5

Older adult struggles with recovery, is no longer able to get outside and go for walks or go out with friends, leading to depression and loneliness

Lack of social programs for older adults with mobility challenges

Workforce shortages of in-home care providers

Older adult continues to feel weak and nervous moving around alone at home, has several more close calls and almost falls again

6



Lack of platforms to locate available support services

Older adult needs help at home with basic care (getting around the house, cooking meals), caregiver struggles to arrange services and locate free or low-cost options

7



Lack of availability of services in local community

Lack of preventive services in local community (food assistance, fall prevention programs)



8

Caregiver is not able to find in-home support for older adult and cannot take time off work to provide the support they need

Workforce shortages among home health care workers

Older adult moves into an assisted living facility where they can get a higher level of care, going against their wishes for how they wanted to age



Hospital staff and direct care workers ask older adults What Matters to them

Support to navigate insurance coverage and benefits

Care Coordination

Support for caregivers to navigate available services

Sustainably funded programs for older adults offered in local community

OLDER ADULT EXPERIENCES A FALL WHILE ALONE AT HOME AND IS TAKEN BY AMBULANCE TO EMERGENCY DEPARTMENT

Older adult admitted to the hospital for surgery

Care coordinator works with caregiver to arrange a rehabilitation facility that will be covered by Medicare

Care coordinator connects caregiver to agencies that can arrange for in-home care as needed for older adult

Older adult begins to feel more comfortable going out for short walks with support, can attend programs at local senior center and spend time outdoors

Older adult has the supports needed to age in desired setting

1



Recovery will take 6-8 weeks and they will need full time caregiving support

Available beds in health care facilities

Future State

3



While at the rehabilitation facility, care coordinator works with older adult and family to make a PT referral and arrange transportation to visits

Transportation services are available and reliable in the older adult's community

4



Existence of platforms to locate available support services

5



Future State

Caregiver is able to arrange additional services (transportation, support groups, Meals on Wheels) through a local website that aggregates services in the area

Fall prevention services offered in local community

6



Availability of home risk assessment and home modification services

7



PT connects older adult to a fall prevention support program in the community to assess their home and set up preventive measures

8



Older adult and their caregiver feel confident that the older adult can stay at home with supportive services and regular visits from a home health care worker

Availability of home health care workers

9



Map Navigation

Text Abbreviations

- ED = Emergency department
- CBO = Community-based organization
- CHW = Community Health Worker
- PCP = Primary Care Provider
- PT = Physical therapy or Physical Therapist

MAP VERSIONS

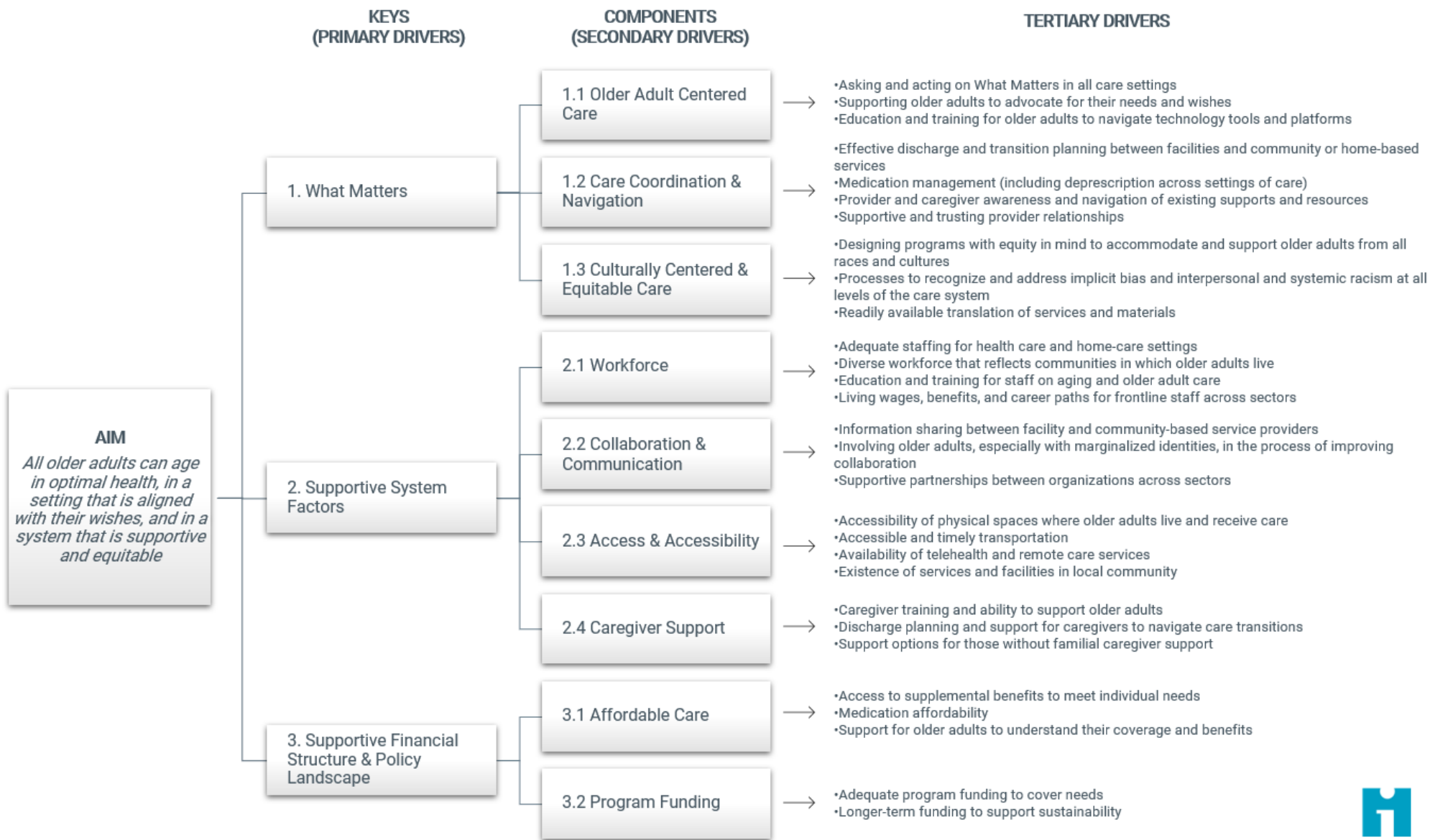


Current
State



Future
State

Appendix B: Driver Diagram



Appendix C: Change Ideas

| Key | Component | Change Ideas | |
|-----------------|------------------------------------|---|---|
| | | Public Health | Health Care |
| 1. What Matters | 1.1 Older Adult Centered Care | | <ol style="list-style-type: none"> 1. Check with older adults regarding their comfort navigating key technology supports such as MyChart and telehealth 2. Reconcile medications at key touch points and look to deprescribe medications where appropriate 3. Train staff to provide older adults with options about care settings and discuss where they would prefer to age 4. Utilize What Matters tools and toolkit from Age-Friendly Health Systems as part of care delivery in all settings |
| | | <p>Across Sectors</p> <ol style="list-style-type: none"> 1. Include older adults and their caregivers in community health needs assessments to understand needs of the community and integrate needs into state and community health improvement plans 2. Partner with Area Agencies on Aging (AAA) to identify supportive services for aging in place in local communities 3. Partner with community-based organizations to raise awareness about or create a local database or hub for available resources in individual communities or regions (No Wrong Door) 4. Support older adults and caregivers to advocate for their needs and wishes in all care settings | |
| | 1.2 Care Coordination & Navigation | | <ol style="list-style-type: none"> 1. Create standard tools and checklists for discharge planning 2. Identify and incorporate electronic health record (EHR) features to support care coordination |

| | | |
|---|--|---|
| | | <p>Across Sectors</p> <ol style="list-style-type: none"> 1. Connect older adults with community-based organizations that provide counselling on the options available for care and support 2. Ensure older adults and caregivers have support to access follow-up services as needed upon discharge 3. Hire community health workers (CHWs), case managers, and patient navigators as core members of older adult's care team 4. Test follow-up processes to ensure care supports are received and adequate after discharge or transitions from services |
| | <p>1.3 Culturally Centered & Equitable Care</p> | <p>Across Sectors</p> <ol style="list-style-type: none"> 1. Collect and publish data on health disparities and link to quality and outcome measures 2. Conduct anti-ageism trainings 3. Ensure that all materials are provided in an older adult's primary language 4. Ensure that in-person translation services are provided in an older adult's and/or caregiver's primary language 5. Ensure processes exist for response and reconciliation in the event of discriminatory treatment 6. Provide implicit bias trainings for health care providers and staff and community service staff 7. Stratify health data by race and ethnicity, as well as other demographic factors relevant in your setting (such as religion, income level, and geography) |
| <p>2. Supportive System Structures</p> | <p>2.1 Workforce</p> | <p>Across Sectors</p> <ol style="list-style-type: none"> 1. Advocate for state licensing and certification requirements to include education on geriatric care and/or age-friendly care 2. Develop low-cost ways to translate documents 3. Develop systems for provider retention in all geographies for health care and home-care settings 4. Develop tools and trainings for staff that work with older adults (for example, Geriatrics workforce training) 5. Hire multilingual providers and staff (including care navigators and coordinators) 6. Partner with postsecondary education programs to incorporate training on aging and older adult care within educational or program curriculums (physician, nursing, social work, etc.) 7. Recruit and retain local staff to reflect diversity and language needs of the community |

| | | | |
|--|---|--|--|
| | <p>2.2 Collaboration & Communication</p> | <p>Across Sectors</p> <ol style="list-style-type: none"> 1. Coordinate with community-based organizations to ensure access to or develop educational materials about available community resources for older adults in provider offices and senior centers 2. Partner with aging services or community-based organizations to enhance or develop a trusted referral system that allows health care organizations to share data across sectors 3. Develop structures to close referral loops 4. Collaborate with partners from other sectors in funding opportunities 5. Utilize existing referral networks such as the Michigan Health Information Network (MiHIN) or Care Connect | |
| | <p>2.3 Access & Accessibility</p> | <ol style="list-style-type: none"> 1. Connect older adults with providers of the appropriate equipment to access technology platforms, when required 2. Partner with aging services or community-based organizations for transportation supports as required so that older adults can access services regardless of location and physical ability 3. Partner with aging services or community-based organizations to provide access to multigenerational tutoring to set up and use technology | |
| | | <p>Across Sectors</p> <ol style="list-style-type: none"> 1. Center age-friendly practices in communicating information with older adults, e.g., have information written down and tailored to older adults and/or caregivers with varying literacy levels 2. Conduct a walk-through of spaces with older adults and caregivers to identify and address barriers to access or risk of injury based on physical or cognitive ability 3. Connect older adults and caregivers with training opportunities on how to use telehealth resources from a home health worker or community health worker 4. Consider hub-and-spoke models to extend reach of services to rural and remote locations | |

| | | | |
|---|-----------------------|---|---|
| | 2.4 Caregiver Support | | <ol style="list-style-type: none"> 1. Include caregivers in all discharge education and planning conversations 2. Utilize caregiver resources from Age-Friendly Health Systems |
| | | <ol style="list-style-type: none"> 1. Provide information about and access to training, resources, and support groups for caregivers | |
| 3. Financial Structure & Policy Landscape | 3.1 Affordable Care | | <ol style="list-style-type: none"> 1. Ask older adults and caregivers about affordability of their medications and other care needs and coordinate support as required 2. Partner with advocacy organizations to build support for payment models that reimburse for or include care coordination across sectors 3. Partner with aging services organizations (such as AARP and AAAs) to connect older adults with tools and resources to navigate their insurance coverage and benefits, considering varying language and literacy levels |
| | | <p>Across Sectors</p> <ol style="list-style-type: none"> 1. Connect older adults with simplified tools for payment and insurance options and step-by-step caregiver guidance (for example, a community passport) 2. Ensure access to or develop a website that assesses coverage and cost for services based on the older adult’s insurance coverage | |
| | 3.2 Program Funding | <ol style="list-style-type: none"> 1. Identify resources to help organizations navigate the complex funding landscape and relieve administrative burden | |
| | | <p>Across Sectors</p> <ol style="list-style-type: none"> 1. Advocate for long-term or multi-year age-friendly collaborations across sectors to promote strategic alignment and funding sustainability that reaches the local level 2. Prioritize funding to projects and programs that are multi-disciplinary and will support collaboration between health care and public health entities (vs. siloed funding) | |

Appendix D: Process & Outcome Measures

Process Measure Table

| Primary Driver | Secondary Driver | Measure | Numerator | Denominator | Reporting Frequency | Context to Consider |
|---------------------------------|--|---|-----------|-------------|---------------------|---------------------|
| 1. What Matters | 1.1 Older Adult Centered Care | <i>Number (or %) of adults who report that their care is in alignment with their goals (measured by collaboRATE tool)</i> | | | | |
| | 1.2 Care Coordination & Navigation | <i>Number (or %) of older adults receiving services from a care coordinator or enrolled in case management program</i> | | | | |
| | 1.2 Care Coordination & Navigation | <i>Wait time for services: average number of days between referral made and when services start</i> | | | | |
| | 1.3 Culturally Centered & Equitable Care | <i>Patient experience questions from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey (select the measures that are most relevant to your work)</i> | | | | |
| 2. Supportive System Structures | 2.1 Workforce | <i>Staff breakdown by race, ethnicity, and language (compared to wider community)</i> | | | | |

| | | | | | | |
|---|-----------------------------------|--|--|--|--|--|
| | 2.2 Collaboration & Communication | <i>% of older adults who leave the hospital with referral or warm handoff to desired support services in their community (or % of older adults connected to appropriate community support within 30 days of discharge)</i> | | | | |
| | 2.3 Access & Accessibility | <i>% of older adults in the community, service area, or public health who are able to access telehealth services (or % of visits for older adults being provided via telehealth)</i> | | | | |
| | 2.4 Caregiver Support | <i>% of patients with caregiver identified in chart</i> | | | | |
| 3. Financial Structure & Policy Landscape | 3.1 Affordable Care | <i>% of older adults who report being able to afford medications each month</i> | | | | |
| | 3.1 Affordable Care | <i>% of older adults who report not being able to get the care they need due to financial reasons</i> | | | | |
| | 3.2 Program Funding | <i>% of programs supporting older adults that are on year-to-year or short-term grant funding</i> | | | | |

Outcome Measure Table

| Measure | Numerator | Denominator | Reporting Frequency | Context to Consider |
|--|-----------|-------------|---------------------|---------------------|
| <i>% of older adults who agree or strongly agree with the statement, "I get the care, supports, and services that I need and want when I need and want them"</i> | | | | |
| <i>% of older adults who report being able to age in their desired setting</i> | | | | |

Appendix E: Methods

To understand the current state of existing resources from the perspective of health systems, public health, and communities, interviews were conducted with organizations, older adults, and caregivers to identify exemplars of care, as well as gaps, across health and public health systems.

Stakeholder Interviews

The purpose of the stakeholder interviews is to support the development of a cross-sector improvement project to help older adults in Michigan to thrive. Between January 31 and March 16, 2022, IHI, in partnership with the MHA Keystone Center, and TFAH, spoke with local stakeholders to understand and identify gaps in resources, care, and systems, with the goal of improving the health of older adults in Michigan.

For the 15 interviews held, the stakeholders were representative of the following sectors: academia, advocacy, public health, health care, and government. A detailed list of stakeholders interviewed can be found in [Appendix F](#).

The stakeholder interviews aimed to support our understanding of the current system. Questions were developed to assess the stakeholder's view of the current system based on their setting, any barriers and root causes that prevent older adults from accessing the resources they need to live a healthy life, and recommendations for a better, cross-sector care continuum to improve the health of older adults.

The following themes emerged from the experiences of organizational leaders across multiple sectors in Michigan. This list is not exhaustive, and the themes identified do not exist in silos. The themes interact with one another and emerge from systemic issues facing cross-sector collaboration efforts for organizations.

Older Adult & Caregiver Interviews

Centering the experience of older adults and hearing from them directly was vital to the success of this initiative. To do so, Care Journey Maps were developed using qualitative data from interviews with older adults and caregivers in Michigan.

Between May 10 and August 18, 2022, semi-structured qualitative interviews were conducted with 13 adults over the age of 60 and/or caregivers in Michigan, to understand and identify care gaps and challenges for older adults in the state. Thematic analysis was used as the main methodology for this project. This project draws on 13 qualitative interviews, representing Michigan's rural and urban areas and diverse communities. To obtain maximum variation in perspectives and experiences, recruitment occurred in five

Michigan cities and targeted White and BIPOC (Black, Indigenous, and people of color) residents. A diverse participant sample was obtained, with 38% of the participant sample (7 of 13 total participants) identifying as people of color, with diverse gender identities and socioeconomic statuses. Of the participant sample, the majority (53%) self-identified as White. Interviews included participants from rural (53%) and urban (38%) communities.

Due to the COVID-19 pandemic, 11 of 13 total participant interviews were facilitated telephonically or virtually, although two interviews were conducted in person. Virtual, semi-structured interviews were conducted via the Zoom platform by members of the team, with audio and video recordings captured. Virtual, telephonic, and in-person interview transcripts were reviewed for accuracy and de-identified. Interviews were open-ended, approximately 1 hour in duration. Participant demographics such as age, racial/ethnic identity, health status, location, and gender identity were all self-described by participants prior to starting the interview.

The older adult and caregiver interviews aim to support our understanding of the current system. Questions were developed to assess the older adult’s view of the current system based on their setting, social determinants of health, and challenges that prevent them from accessing the resources they need to live a healthy life.

Qualitative Analysis

For both sets of interviews, qualitative analysis was conducted to understand the impact of the current system, existing bright spots, and recommendations from those most affected or closest to the systems, for how to improve the system. Below are the themes from each set of interviews:

| Stakeholder Themes | Older Adult & Caregiver Themes |
|---|---|
| <ul style="list-style-type: none"> • Access and navigation of services • Cross-sector collaboration • Funding and payment structure • “What Matters” to older adults • Workforce | <ul style="list-style-type: none"> • Access and navigation of services • Affordability of care • Culturally centered care • Caregiver support • Care coordination & case management • “What Matters” to older adults • Workforce |

The data was also organized into the three categories below to dig deeper into the responses:

| Current State | Future State | Bright Spots |
|---------------|--------------|--------------|
| | | |

Interview Structure

Due to the COVID-19 pandemic and because the convening organization for these interviews were not based in Michigan, the stakeholder interviews were facilitated virtually using Zoom. Interviews ranged from 30-60 minutes. Below is an outline of the interview format.

| Agenda Item | Duration |
|----------------------|---------------|
| Introductions | 5 minutes |
| Context Setting | 3-5 minutes |
| Interview Questions | 20-30 minutes |
| Wrap-up & Next Steps | 5 minutes |

Example Interview Questions and Templates

The following documents are examples of the stakeholder interview templates developed for this pilot project to develop the Three Keys:

- Older Adults & Caregivers
- Stakeholder Organizations

Michigan Cross-Sector Age-Friendly Action Community

Interview Guide

| | |
|---|--|
| Interviewer(s) Name: | |
| Date and Time: | |
| Stakeholder Name: | |
| Stakeholder Type / Role / Organization: | |
| Sector of Work: | |

Project Team Organizational Roles

| Organization | Role | Details |
|--------------|---|---|
| IHI | Support the coordination and development of the standard materials for interviews, in addition to the analysis of the interview data. | <ul style="list-style-type: none">Team: Deborah Bamel, Laura Howell, Gabe Cenizal |
| MHA | Support the facilitation, coordination, outreach process, and provide the compensation (VISA Cards) to interviewees post-interview. | <ul style="list-style-type: none">Team: Ewa Panetta, Janice Jones |
| TFAH | Support the interview development and outreach process, leveraging local public health systems to identify older adults to interview. | <ul style="list-style-type: none">Team: Megan Wolfe |

INTRODUCTION FOR OLDER ADULTS/FAMILY CAREGIVER

The purpose of these conversations is to understand the experience of older adults in Michigan and their caregivers in navigating the resources that are needed to live a healthy life. From the interviews we are creating a diagram called a “Care Journey map” that will compile the experiences from the older adults we are talking with. Please note your experiences and identity will remain anonymous. We hope this work will benefit other communities and states across the U.S.

Do you have any questions about our goals or the purpose of this interview? (pause/check for understanding and questions)

Stakeholder Interview Questions

Interview Format

| Agenda Item | Duration |
|---|------------|
| Introductions | 10 minutes |
| Context Setting | 5 minutes |
| Interview Questions *Indicates a priority question | 30 minutes |
| Wrap up & Next Steps | 5 minutes |

Introduction

- Introduce yourself, your role
- Have teammates introduce themselves

Context Setting

- Share the purpose of this conversation (see intro above for organizations and older adults)
- Provide framing: the questions are intentionally broad so that you, the collaborator, can respond in any way that matters to you as it relates to postsecondary transitions

The purpose of these conversations is to understand the experience of older adults and their caregivers in Michigan in navigating the resources that are needed to live a healthy life. From the interviews we are creating a diagram called a "Care Journey map" that will compile the experiences from the older adults we are talking with. Please note your experiences and identity will remain anonymous. We hope this work will benefit other communities and states across the U.S.

Do you have any questions about our goals or the purpose of this interview? (pause/check for understanding and questions)

Interview Questions

- Remind participants that this conversation is confidential between you and the collaborator, information will be shared, but the participants identity will not. Remind them they also can stop the conversation at any time.

Wrap-up & Next Steps

- What's next?
 - Interviewing other adults to draft a map that compiles all of your experiences navigating resources for healthcare and other services into one map.
 - Would you be interested in providing feedback on our draft once created.
 - On completion of this interview, a VISA gift card of \$100 will be provided to you. Would you prefer we mail the VISA card to you or provide it electronically over email?
 - **Email:** What is your email address and back up email address?
 - **Mail:** Can you please provide your mailing address?

Older Adult:

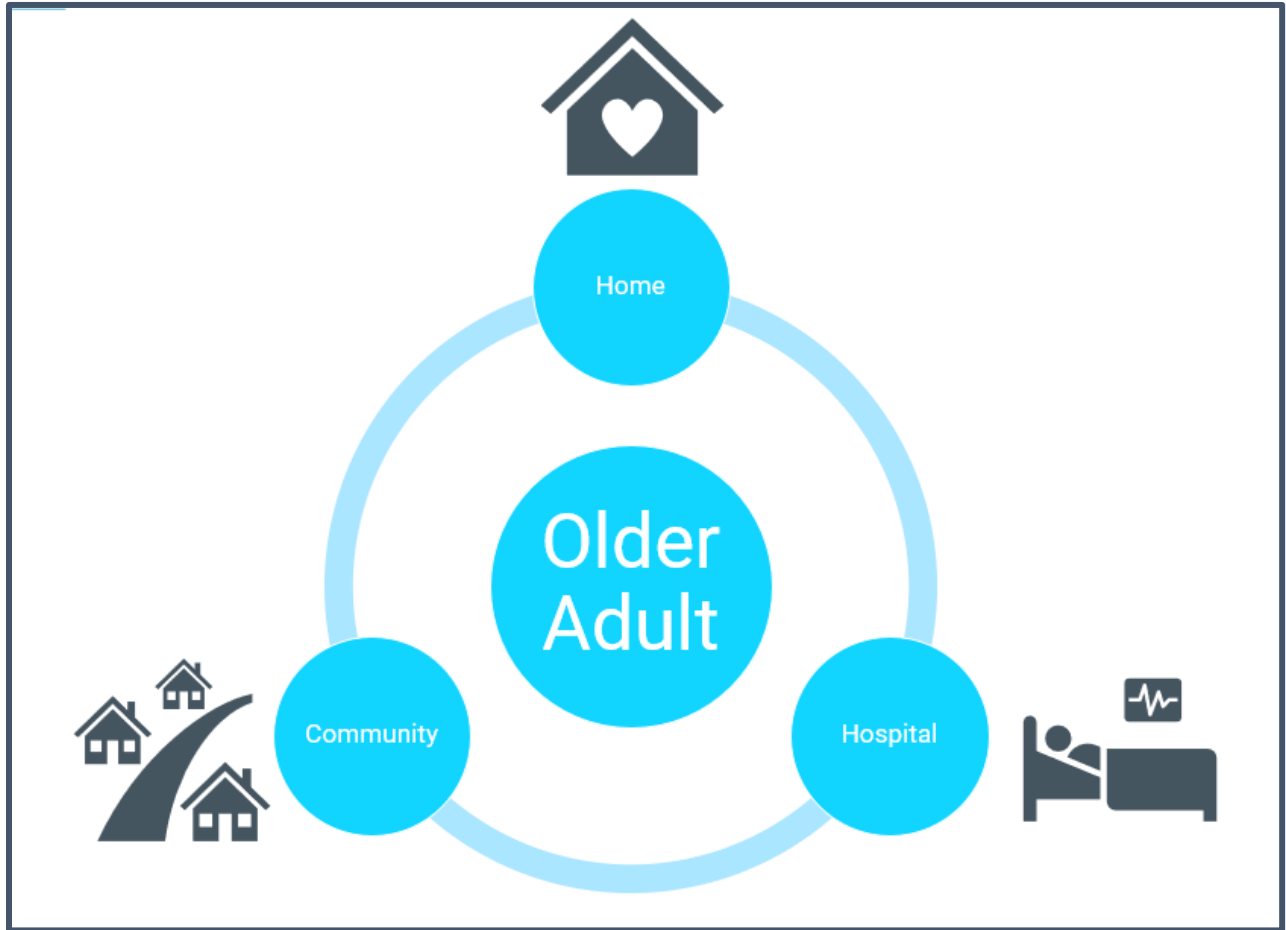
| Guiding Questions | Reflections/Cited Examples |
|--|--|
| <p>Before we start, would you be willing and comfortable sharing a few aspects of how you identify to support our understanding of how you experience care?</p> <p>If yes:</p> <ol style="list-style-type: none"> 1. What is your age? 2. How would you identify your race? (If not sure, provide the following racial categories): <ol style="list-style-type: none"> a. Hispanic b. White alone, non-Hispanic c. Black or African American alone, non-Hispanic d. American Indian and Alaska Native alone, non-Hispanic e. Asian alone, non-Hispanic f. Native Hawaiian and Other Pacific Islander alone, non-Hispanic g. Some Other Race alone, non-Hispanic h. Multiracial, non-Hispanic 3. Are you a Medicaid recipient? Are you a Medicare recipient? <ol style="list-style-type: none"> a. If yes: Do you have supplemental insurance in addition to having Medicare? 4. Do you have any chronic illness(es) or health conditions (i.e., diabetes, a respiratory condition, heart disease, etc.)? 5. Do you live in an area that you would call rural or urban? | <ul style="list-style-type: none"> • Age: • Race: • Insurance status (SES): • Chronic illness(es): • Rural or urban: |
| <p>Before we get started, we want to share an image with you that includes three areas in your community, what we call a care continuum: Your home, community services, and health care services. (<i>Show the older adult the image on page 6</i>). This image demonstrates the connections we are hoping to build between these three settings and how older adults navigate the resources necessary in these settings to live their fullest life.</p> <p>(<i>Check for understanding</i>): Do you have any questions about this image?</p> <p>Now, thinking about this image. Can you think about a time when you experienced a health event, (for example, an illness, a surgery or medical procedure, starting a new</p> | <p>Current state</p> <ul style="list-style-type: none"> • Home • Community • Hospital <hr/> <p>Future state</p> <ul style="list-style-type: none"> • Home • Community |

| | |
|---|---|
| <p>medication or using a new assistive device like a cane, wheelchair, hearing aid, etc.)</p> <p>[If no event, can you reflect on the experience of someone you care for or a loved one during their healthcare event]</p> <p>[If time, ask for a second event]</p> <p>Thinking about that event and looking at this diagram, can you walk us through how it went as your transitions through the different places where you or your loved one received care (in response to that event).</p> <ul style="list-style-type: none">• Home• Community• Hospital <p>1. What happened during that event?</p> <p>2. In a perfect world, how would that event have gone differently?</p> <p><u>Prompts for follow-up questions to get more detail</u></p> <p>Thinking about the health event you just described (see questions above) ...</p> <p>*What did you struggle with during that experience?</p> <p>Who helped / did not help?</p> <p>*What supports and services were helpful to you? Which ones were not helpful?</p> <p>*How did you feel?</p> <p>*What would you change about how that event went?</p> | <ul style="list-style-type: none">• Hospital <p>Follow-up questions:</p> <ul style="list-style-type: none">• What did you struggle with during that experience?• Who helped / did not help?• What supports and services were helpful to you? Which ones were not helpful?• How did you feel?• What would you change about how that event went? |
| <p>General Questions (after you are done with the health event questions)</p> <p>What supports and services do you or your loved one need to stay healthy and/or manage a particular health condition?</p> <p>*What do you worry about with regards to your or your loved one's health or ability to stay healthy?</p> | |

| | |
|--|--|
| <p>*Who or what helps / does not help you maintain a healthy life?</p> <p>*Where do you go to seek trusted information that supports you in making health decisions to maintain a healthy life?</p> <p>*What have I not asked you about that you think is important for me to know?</p> | |
|--|--|

Family/Caregiver Only:

| Guiding Questions | Reflections/Cited Examples |
|---|----------------------------|
| *As a family member (or community member), what matters to you for the older adult(s) in your life (or your community)? | |
| *Are you familiar with the term 'age-friendly'? If so, what does 'age-friendly' mean to you? | |
| *As you think about your older adult's future, what supports and services are most critical? What's missing? | |
| As a caregiver, can you recall any instance in navigated the care journey and experienced difficulty? | |
| Are you aware of any organizations (like a health system or agency) that might benefit from participating in this initiative? | |
| Any geographies or communities? | |
| What have I not asked you about that you think is important for me to know? | |
| Additional Questions | |
| | |
| | |
| | |



| | |
|--|--|
| Interviewer(s) Name: | |
| Date and Time: | |
| Stakeholder Name: | |
| Stakeholder Type / Role / Organization: | |
| Sector of Work: | |

Interview Format

| Agenda Item | Duration |
|---|-----------------|
| Introductions | 3 minutes |
| Context Setting | 2 minutes |
| Interview Questions *Indicates a priority question | 20 minutes |
| Wrap up & Next Steps | 5 minutes |

Introduction

- Introduce yourself, your role
- Have teammates introduce themselves

Context Setting

- Share the purpose of this conversation

INTRODUCTION

The purpose of these conversations is to support the development of a cross-sector improvement community to support older adults in Michigan to thrive. We see an opportunity to bring together two movements: Age-Friendly Health Systems (AFHS) and Age-Friendly Public Health Systems (AFPHS) to align strategies and recommendations for communities and states that are specific to older adult health, well-being, and equity. We intend to connect public health departments and healthcare organizations that are active in their respective age-friendly movements, together with additional stakeholders across the healthcare, public health, and community sectors. We are speaking with local stakeholders, like yourself, to understand and identify gaps in resources, care, and systems to improve the health of older adults in Michigan. With this information, our goal is to create a coordinated care model, ready to be piloted, that is designed to bridge the gaps across sectors. The output will be a model that identifies interventions that public health departments, community-based organizations, and health systems can implement to collaboratively support older adults in whatever place they call home. These interviews aim to support our understanding of the current system. Do you have any questions about our goals or the purpose of this interview? (pause/check for understanding and questions)

- Provide framing: the questions are intentionally broad so that you, the collaborator, can respond in any way that matters to you as it relates to postsecondary transitions

Interview Questions

- Remind participants that this conversation is confidential between you and the collaborator, information will be shared, but the participants identity will not. Remind them they also have the opportunity to stop the conversation at any time.

| Guiding Questions | Reflections/Cited Examples |
|---|----------------------------|
| What does 'age-friendly' mean to you? | |
| What does 'age-friendly care' mean to you? | |
| What does providing successful older-adult care look like for you/your health system? How is that measured? | |
| What systemic gaps have you experienced or are aware of that inhibit you from providing optimal care for older adults? | |
| Can you provide any examples of difficult situations you have encountered while trying to provide care to an older adult(s)? | |
| Are you aware of any anchor institutions (like a health system or organization) that might be primed and ready to participate in this initiative? | |
| Any geographies or communities? | |
| What did I not ask you about that you think is important for me to know? | |
| Additional Questions | |
| | |
| | |
| | |

Wrap-up & Next Steps

- What's next?
 - Interviewing 25-30 stakeholders and using their experience to draft a cross-sector care continuum map
 - There's an opportunity to provide feedback on the draft in an expert meeting this spring – ***Are you interested?***

Appendix F: Stakeholder Organizations Interviewed

| Name | Role | Organization | Setting |
|--------------------|---|--|-------------------------|
| Clare Tanner | Director, Center for Data Management and Translational Research | Michigan Public Health Institute | Public health |
| Jo Murphy | Executive Director | Michigan Medicare & Medicaid Assistance Program | Government agency |
| Scott Wamsley | Deputy Director | Aging & Adult Services Agency (AASA), Michigan Department of Health and Human Services | Government agency |
| Michael Daeschlein | Long-Term Care Specialist | Michigan Elder Justice Initiative | Advocacy |
| Anne Hughes | Director | Michigan State University School of Social Work | Academic |
| Bruce Burger | President | Michigan Association of Senior Centers | Advocacy |
| Lisa Dedden Cooper | Manager of Advocacy | AARP, Michigan | Advocacy |
| Dawn Opel | Director, Research & Strategic Initiatives and General Counsel of the Food Bank Council of Michigan | Food Bank Council of Michigan/ Michigan State University | Academic, public health |
| Clare Luz | Director, Department of Family and Community Medicine | Michigan State University IMPART Alliance | Academic |
| Keith Morris | President | Elder Law of Michigan | Advocacy |

| | | | |
|------------------------|--|--|--------------------------|
| Robyn Rontal | Director, Policy Analytics | Center for Health and Research Transformation, University of Michigan | Academic |
| Alexis Travis | Senior Deputy Director, Public Health Administration | Michigan Department of Health & Human Services | Government agency |
| Michelle Moccia | Program Director, Senior ER | St. Mary Mercy | Health care |
| Leslie Grijalva | Community Health Worker | Henry Ford Health | Health care |
| Tracie Mason | Community Health Worker, Community Health, Equity, Wellness & Diversity | Henry Ford Health | Health care |

Appendix G: Partner Organizations

The three core partners bring distinctive experience, relationships, and expertise in systems improvement, health care, public health, and the state of Michigan. These partners bring deep knowledge of the valuable age-friendly work that has been done in their respective areas of expertise and a keen awareness of the experience of older adults and caregivers.

Michigan Health and Hospital Association (MHA) Keystone Center

The MHA Keystone Center was founded in 2003 with a charge to identify and implement practices that improve health care safety and quality while reducing costs. The MHA Keystone Center is a founding member of Superior Health Quality Alliance, a joint venture to support health care quality improvement efforts across the care continuum for the upper Midwest. Funded by the Michigan Health Endowment Fund (MHEF), the MHA Keystone Center launched a successful first cohort of the Age-Friendly Health Systems Action Community in 2019, bringing to bear local expertise to build on the original initiative developed by core founding partners.

Trust for America's Health

Trust for America's Health (TFAH) is a nonprofit, nonpartisan organization that promotes optimal health for every person and community and seeks to make the prevention of illness and injury a national priority. TFAH works with traditional (core public health at all levels) and nontraditional partners (organizations with which public health has not previously worked, e.g., aging services providers) on high-impact health issues. TFAH reports on and recommends evidence-based programs and policies that make prevention and health equity foundational to health and community systems at all levels of society.

Institute for Healthcare Improvement

The Institute for Healthcare Improvement (IHI) is an independent not-for-profit organization based in Boston, Massachusetts, USA. For more than 25 years, IHI has used improvement science to advance and sustain better outcomes in health and health systems across the world. Through IHI's convening partner role for the 100 Million Healthier Lives initiative, along with deep, outcomes-focused initiatives For more than five years, IHI has made it a strategic priority to redesign care to promote healthy aging and improve long-term care. IHI is the implementing organization for Age-Friendly Health Systems, which has expanded from five pioneer health systems to engage 20 percent of US health systems. Now in its third phase, the project is moving into outpatient care and post-acute care settings; and managing and growing the AFHS movement by engaging the macroenvironment to move beyond awareness to action. The AFHS movement is committed to care across the continuum – in the community, hospital, post-acute, and long-term care settings.

Appendix H: Project Timeline & Outcomes

The project, funded by the Michigan Health Endowment Fund (the Health Fund) started in September 2021 and ended in February 2023.

Outcomes & Key Activities:

The overall outcomes for the creation of a testable model include the following.

1. Literature review to identify exemplars of care, as well as gaps, across health systems, public health and communities
2. Identification of existing resources from the perspective of health systems, public health, and communities
3. Draft model for care of older adults across health systems, public health, and community-based organizations
4. Identification of outcome measures for testing across the Age-Friendly Ecosystem
5. Summary resources of findings, manuscript of learnings, and next steps for dissemination
6. Integration of learnings into Age-Friendly Health Systems and Age-Friendly Public Health Systems

References

- ¹ “Mission and History.” Michigan Health Endowment Fund. <https://mihealthfund.org/about/mission-and-history>
- ² *Continuum of Care: The Importance of Seamless, Uninterrupted Care*. MJHS Health System. <https://www.mjhs.org/resource/continuum-of-care-the-importance-of-seamless-uninterrupted-care/>
- ³ “About.” Age-Friendly Public Health Systems; 2023. <https://afphs.org/about/>
- ⁴ Loehrer S, McCarthy D, Coleman EA, for the Cross-Continuum Study Panel. Cross-Continuum Collaboration in Health Care: Unleashing the Potential. *Population Health Management*. 2015;0(0):1-3. https://greatplainsqin.org/wp-content/uploads/2015/06/crosscontinuum_collaboration_in_health_care.pdf
- ⁵ “Recognition.” Institute for Healthcare Improvement; 2023. <https://www.ihl.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/Recognition.aspx>
- ⁶ “About.” Age-Friendly Public Health Systems; 2023. <https://afphs.org/about/>
- ⁷ “Age-Friendly Recognition Program.” Trust for America’s Health; 2023. <https://www.tfah.org/story/afphs-recognition-program/>
- ⁸ *Let’s Talk: Moving Upstream*. Antigonish, NS: National Collaborating Centre for Determinants of Health, St. Francis Xavier University; 2014. <https://nccd.ca/resources/entry/lets-talk-moving-upstream>
- ⁹ “Goal F: Understand health disparities related to aging and develop strategies to improve the health status of older adults in diverse populations.” *The National Institute on Aging: Strategic Directions for Research, 2020-2025*. National Institutes of Health, National Institute on Aging. <https://www.nia.nih.gov/about/aging-strategic-directions-research/goal-health-disparities-adults>
- ¹⁰ Adapted from Southey C, Henriquez Garcia L. Ensuring equitable age-friendly care. *Healthcare Executive*. 2022 Nov;38(6):44-45. <https://www.ihl.org/resources/Pages/Publications/ensuring-equitable-age-friendly-care.aspx>
- ¹¹ *Quality Improvement Project Change Concepts Worksheet*. Institute for Healthcare Improvement. <https://www.ihl.org/resources/Pages/Tools/Quality-Improvement-Project-Change-Concepts-Worksheet.aspx>
- ¹² McLaren Healthcare Caro Region: 4Ms Care Description (Inpatient). Submitted to Institute for Healthcare Improvement; 2020 January 30.

- ¹³ DeBartolo K, Saret C, Webster P. *How to Have Conversations with Older Adults About “What Matters”: A Guide for Getting Started*. Boston: Institute for Healthcare Improvement; 2021. https://www.ihl.org/Engage/Initiatives/Age-Friendly-Health-Systems/Documents/AgeFriendlyHealthSystems_How-to-Have-Conversations-with-Older-Adults-About-What-Matters.pdf
- ¹⁴ “Community Care Transition Initiative Update.” American Automobile Association (AAA) Region 7. Presentation to Michigan Department of Health and Human Services (MDHHS). 2019 August 15.
- ¹⁵ “Medicaid Coverage of Community Health Worker Services.” Issue Brief. Washington, DC: Medicaid and CHIP Payment and Access Commission (MACPAC); 2022 April. <https://www.macpac.gov/wp-content/uploads/2022/04/Medicaid-coverage-of-community-health-worker-services-1.pdf>
- ¹⁶ “Culturally Centered Care.” Modern Health; 2023. <https://www.modernhealth.com/post/what-is-culturally-centered-care>
- ¹⁷ “Cultural Respect.” *Clear Communication*. National Institutes of Health, Office of Communications & Public Liaison; 2021 July 7. <https://www.nih.gov/institutes-nih/nih-office-director/office-communications-public-liaison/clear-communication/cultural-respect>
- ¹⁸ Latimer T, Roscamp J, Papanikitas A. Patient-centredness and consumerism in healthcare: an ideological mess. *Journal of the Royal Society of Medicine*. 2017 Nov;110(11):425-427. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5728618>
- ¹⁹ Impart Alliance. <https://www.impartalliance.org/>
- ²⁰ “Caregiving.” Age-Friendly Public Health Systems; 2023. <https://afphs.org/topics/caregiving>
- ²¹ Adapted from “What Is a Caregiver?” Johns Hopkins Medicine, Community Health at Johns Hopkins Bayview; 2023. https://www.hopkinsmedicine.org/about/community_health/johns-hopkins-bayview/services/called_to_care/what_is_a_caregiver.html
- ²² “Caregiving.” Age-Friendly Public Health Systems; 2023. <https://afphs.org/topics/caregiving>