IHI Expedition

Caring for Frail Older Adults with Complex Needs Session 1

Karen Baldoza, MSW
Joanne Lynn, MD, MA, MS

nothing to disclose

Expedition Coordinator

Kayla DeVincentis, CHES, Project Coordinator, Institute for Healthcare Improvement, currently manages web-based Expeditions and the Executive Quality Leaders Network. She began her career at IHI in the event planning department and has since contributed to the State Action on Avoidable Rehospitalizations (STAAR) Initiative, the Summer Immersion Program, and IHI’s efforts for Medicare-Medicaid enrollees. Kayla leads IHI’s Wellness Initiative and has designed numerous activities, challenges, and educational opportunities to improve the health of her fellow staff members. In addition to implementing the organization’s first employee health risk assessment, Kayla is certified in health education and program planning. Kayla is a graduate of Northeastern University in Boston, MA, where she obtained her Bachelors of Science in Health Science with a concentration in Business Administration.
**WebEx Quick Reference**

- Welcome to today’s session!
- Please use chat to “All Participants” for questions
- For technology issues only, please chat to “Host”
- WebEx Technical Support: 866-569-3239
- Dial-in Info: Communicate / Join Teleconference (in menu)

---

**When Chatting…**

Please send your message to All Participants
Chat Time!

What is your goal for participating in this Expedition?

Join Passport to:

- Get unlimited access to Expeditions, two- to four-month, interactive, web-based programs designed to help frontline teams make rapid improvements.
- Train your middle managers to effectively lead quality improvement initiatives.

... and much, much more for $5,000 per year!

Visit www.IHI.org/passport for details.
To enroll, call 617-301-4800 or email improvementmap@ihi.org.
What Is an Expedition?

ex•pe•di•tion (noun)
1. an excursion, journey, or voyage made for some specific purpose
2. the group of persons engaged in such an activity
3. promptness or speed in accomplishing something

Expedition Support

- All sessions are recorded
- Materials are sent one day in advance
- Listserv address: OlderAdultsExpedition@ls.ihi.org
  - Sends an email to all participants and faculty
  - Use only for questions relevant to all participants
  - To add yourself or colleagues, email us at info@ihi.org
Karen Baldoza, MSW, Executive Director, Institute for Healthcare Improvement (IHI), currently leads IHI’s body of work aimed at improving care for frail older adults with complex needs. As a trained Improvement Advisor and Lean Facilitator, she also leads and coaches staff in improvement within IHI. Previously, Ms. Baldoza was the Continuum of Care Portfolio Operations Director overseeing IHI’s work that addresses the patient journey in health and chronic disease care outside of acute care settings. She also managed relationships with strategic partners and several large strategic initiatives, such as Pursuing Perfection. Prior to joining IHI in 2000, she worked for the Commonwealth of Massachusetts as an assistant director in the Executive Office of Elder Affairs, and in public health prevention and policy efforts. She received her Master of Social Work degree from Boston College, focusing on community organizing, social policy and planning, and not-for-profit administration.
Today’s Agenda

- Ground Rules and Introductions
- A Vision for Improvement
- Assignment for the Next Session
- Using the Model for Improvement

Ground Rules

- We learn from one another – “All teach, all learn”
- Why reinvent the wheel? – Steal shamelessly
- This is a transparent learning environment
- All ideas/feedback are welcome and encouraged!
Overall Program Aim

The aim of this Expedition is to understand the components and processes needed for a community-based, highly reliable, highly efficient system of care for frail older adults with complex needs, and to begin to build this more ideal system of care.

Expedition Objectives

At the end of the Expedition each participant will be able to:

- Describe an ideal system of care for frail older adults with complex needs that aims at living meaningfully and comfortably at a lower total cost in a well-designed service delivery system
- Develop strategies to identify this population in your geographic community
- Develop a comprehensive understanding of the client’s situation and a health and well-being plan driven by the goals and preferences of the client and the family
- Modify health care services to match needs
- Develop strategies to integrate social supports, long-term services, and health care for individuals and for the entire local community
Schedule of Calls

Session 1 – A Vision of the System You Want and the Changes that Get Us There  
Date: Tuesday, October 1, 2:30-4:00 PM ET

Session 2 – Identifying Your Population and Understanding Needs, Resources, Goals, and Preferences  
Date: Tuesday, October 15, 3:00-4:00 PM ET

Session 3 – Building, Developing, and Implementing a Different Kind of Care Plan  
Date: Wednesday, October 30, 3:00-4:00 PM ET

Session 4 – Changing Your Health Care Services and Integrating Social Supports  
Date: Tuesday, November 12, 3:00-4:00 PM ET

Session 5 – Monitoring and Managing the Continuum of Care  
Date: Tuesday, November 26, 3:00-4:00 PM ET

Faculty

Joanne Lynn, MD, MA, MS, directs the Center for Elder Care and Advanced Illness at the Altarum Institute. She has been a faculty member with the Institute for Healthcare Improvement, a researcher at RAND, and a Professor of Medicine and Community Health at Dartmouth Medical School and the George Washington University. Her work has focused on shaping American health care so that every person can count on living comfortably and meaningfully through the period of serious illness and disability in the last years of life, at a sustainable cost to the community. She has published more than 250 articles, and her dozen books include The Handbook for Mortals, a guide for the public; The Common Sense Guide to Improving Palliative Care, an instruction manual for clinicians and managers seeking to improve quality; and Sick to Death and Not Going to Take It Any More!, an action guide for policy makers and advocates. She is a member of the Institute of Medicine and of the National Academy of Social Insurance, a Fellow of the American Geriatrics Society and The Hastings Center, and a Master of the American College of Physicians.
Driver Diagram

Primary Drivers
- Identify the frail population
- Assess risk for doing, disability and death in individuals and populations
- Develop administrative mandates criteria
- Establish person’s current situation and likely courses with various care plans
- Develop and implement case plan (policies, financial health and well-being plan)
- Make services appropriate for frail aging, including health care, housing, personal care, nutrition, and other supportive services
- Manage multidisciplinary, effective, affordable, responsive health services/patient system with a complaint, sharing reimbursement

Secondary Drivers
- Understand the frail person and their priorities at this stage of life
- Understand family and caregiver capabilities and preferences
- Define options and predict likely future courses
- Provide comprehensive support at home
- Follow geriatric palliative principles and processes
- Enable patient-facing and reliability
- Support caregivers and relationships
- Define appropriate needs and stages of wellness, reasonable services, and care settings
- Reflect appropriate priorities: reliability, conformity, autonomy, dignity

Five key drivers:
- Identification of Frail Elder Population
- Establishing person’s current status
- Developing and Implementing Negotiated Care Plan (Personal Health and Well-Being Plan)
- Appropriate and Integrated Services in the Health Care System, at Home, and in the Community
- Trustworthy, Effective, Responsive System
- Management and competent, Thriving Workforce

Chat Question

What do we want most when we are frail and old?

Raise your hand

Use the Chat
What do we most want when we are frail and old? – Possibly…

- Comfort
- Meaningfulness
- Staying as independent and valued as possible
- Keeping up relationships, including spirituality for many
- Limiting burdens on family and friends
- Staying home, as long as possible
- Having trustworthy services, comprehensive enough
- Knowing enough about the future to shape it and make peace with it

Chat Question

What do you see happening to people who are frail and old? Good and bad…

Raise your hand

Use the Chat
Salient Facts about Frail Older People

- Tied to their residence
- Aging Boomers will double prevalence of frailty within 20 yrs
- Survival time may increase (and thus increase prevalence)
- With LTSS, frailty costs half of lifetime health care costs
- Few have savings, insurance, or family to cover those costs
- Therefore, long-term care will require societal investments
- Current practices incur unnecessary fear and suffering
- Current practices incur unnecessary costs
- Policy and practice distorted by reticence to deal with death

Who are the “frail older adults?”

- What defines that group?
- What frameworks do we use to “see” this group?
- How does it relate to “high cost” or “MCC” or “end of life?”
Pragmatic Definition of Frail Elders

And any of these:
- ADL>1
- Constant supervision
- Diagnosis likely to meet above criteria within a year or two

If at least one of these, Unless opt out

Frail Elder Cohort, Needing MediCaring*

Or, >84yo

If None of Those

With Opt In

>64yo

*MediCaring™ denotes comprehensive services customized to frail elders, including care planning, continuity, 24/7 on-call, services to the home, caregiver support

Imagining Frailty
Not just MCC or high-cost
What We Really, Really Need…

1. The Cohort – Frail elderly
2. The Care Plan – For each frail person, at all times
3. The Services – Adapted; in-home, supportive
4. The Scope – Social services equally important
5. Local Monitoring & Management

AND THE WILL TO MAKE THESE CHANGES!

My Mother’s Broken Back
“The Cost of a Collapsed Vertebra in Medicare”

Action Period Assignment: Identifying Your Population

Identify your population using one (or more) of the following approaches:

- Threshold approach
- Clinical knowledge
- Predictive modeling
- Use opt-in or opt-out?
Threshold Approach: Include all individuals who meet certain criteria

- Test simple identification criteria (singly or in combination), such as
  - ≥85 years old and preferring comprehensive supportive services
  - ≥65 years old and having two unplanned admissions for incurable chronic conditions within a year
  - ≥65 years old and having one or more ADL from a diagnosis expected to worsen
- If long-term care facility resident, use MDS to identify functional decline, weight loss, pressure ulcers
- Consider:
  - Entire vulnerable populations such as the uninsured, those eligible for both Medicare and Medicaid (dual-eligible), or those with mental health needs
  - People with multiple chronic conditions and functional impairment
  - Elderly persons with advanced illness but no advance directive
  - Persons using high-risk drugs
  - Persons with diabetes, CHF, CKD, or COPD out of control
- Focus on people with progressive dementia or with depression resistant to initial treatment
- Consider also simple social determinants such as having family support, health literacy, self-efficacy, personal report of health and satisfaction with health

Threshold Approach: Include all individuals who meet certain criteria

- Apply criteria at certain “sentinel events”
  - Hospital or nursing home discharge
  - Injury or significant psychosocial impact
  - Welcome to Medicare exam
  - Annual Medicare preventive services exam
  - Enrollment in community social services
  - Coming to the emergency department
- Engage with other “hotspots” in the area – e.g., church, employers, senior centers, Meals on Wheels, ADRC/AAA, barber/beauty shops – to find additional eligible people
- Using the EHR or administrative records, produce a daily/weekly list of people who probably qualify for special frail elder services
- Use registries, pharmacies, labs, imaging centers to supplement or to substitute for an area-wide health information exchange – e.g., those seeking high-risk medications, those with diabetes, CHF, recent hospitalizations, and/or emergency department visits (depending upon criteria being tested from above)
Clinical Knowledge: Ask a Clinician

- Ask providers to identify who they believe are the most complex or high-risk among their elderly clients
- The Surprise Question – Would you be surprised if this person died in the coming year? (Could also be – would you be surprised if this person needed nursing home care in the coming year?)

Predictive Modeling

- Use algorithms and screening criteria to identify patients
- Use formal models to estimate utilization and/or survival risk
Opt In: Individual/family agreement to use special frailty care – or Opt-out

- Implement public information and community awareness program about frail older adults needing special care that triggers self-identification (e.g., at the senior center, in primary care offices, and when changing residence)
- OR – If you have good records and a worthy set of service arrangements waiting, the care system could trigger notice to the person and family that a better, more helpful care system is available and that he/she should use that system now (MediCaring)

For Example

- Ask a physician to think about all the patients she sees for four days and ask themselves the surprise question
- Look at all patients in the hospital that are 85+, or those 65+ who have survived three or more hospitalizations in 6 months – see what their lives are like, what services they and their families need
Reflection Questions

- Which approach did you use? How easy or difficult was it to identify your population?
- What triggers might you put in place to identify someone in this population going forward?
- How large is your population?
- What do you know about them? Do certain segments emerge?
- Select one or two patients/clients (or family members) who would be willing to test ideas throughout this program

Share your reflections via the listserv by Thursday, October 10, and be prepared to share at the next session

Reflection Questions - Optional

Getting to know your population and your system

- Take a typical patient/client profile in your work or one of your volunteers, and map how that individual moves through your system. Describe for that person:
  - How things did not work out despite what was seen as a good plan and what challenges were discovered. What went wrong and what would you have liked to have seen happen? What would the patient/client and family have liked to have seen happen?
  - How things worked out as planned and what were all the pieces that enabled success.
  - Ask, “how many times in the last week have things felt out of control or frightening (scale: Never to All the Time)?” Why? What would they like to happen?

Share your reflections via the listserv by Thursday, October 10, or be prepared to share at the next session
Driver Diagram

Primary Drivers

- Assess risk for illness, disability and death for individuals and populations
- Use in or opt-out: Individuals and family agreement to use special frailty care

Secondary Drivers

- Establishes current situation and study courses with various care plans
- Identify the frail elderly population

Five key drivers:

- Identification of Frail Elder Population
- Establishing person’s current status
- Developing and Implementing Negotiated Care Plan (Personal Health and Well-Being Plan)
- Appropriate and Integrated Services in the Health Care System, at Home, and in the Community
- Trustworthy, Effective, Responsive System

Management and competent, Thriving Workforce

Driver Diagram

Primary Drivers

- Assess risk for illness, disability and death for individuals and populations
- Use in or opt-out: Individuals and family agreement to use special frailty care

Secondary Drivers

- Establish the frail elderly population
- Develop administratively feasible criteria
- Use in or opt-out: Individuals and family agreement to use special frailty care

Also

Frail older adults with complex needs will live with the dignity and independence they want to have, with health care needs met reliably and well, and with a sense of well-being and inclusion in personal relationships and in the community – and with the costs being sustainable for families and for the larger society.
Questions?

Raise your hand

Use the Chat

Model for Improvement

- Aim of Improvement
- Measurement of Improvement
- Developing a Change
- Testing a Change

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

Act  Plan  Study  Do

Principles & Guidelines for Testing

- A test of change should answer a specific question
- A test of change requires a theory and prediction
- Test on a small scale
- Collect data over time
- Build knowledge sequentially with multiple PDSA cycles for each change idea
- Include a wide range of conditions in the sequence of tests
Repeated Use of the PDSA Cycle

Sequential building of knowledge under a wide range of conditions

Hunches, Theories, Ideas
Very Small Scale Test

Follow-up Tests

Wide-Scale Tests of Change

Implementation of Change

Spread

Changes That Result in Improvement

Aim: Implement Rapid Response Team on non-ICU unit

Cycle 6: Expand rounds to one unit for one shift seven days a week

Cycle 5: Have Nurse Practitioner respond to calls in addition to RT and RN

Cycle 4: Expand coverage of RRT on unit to one unit for one shift for five days

Cycle 3: Have Respiratory Therapist attend rapid response calls with ICU Nurse

Cycle 2: Repeat cycle 1 for three days

Cycle 1: ICU nurse responds to rapid response team calls on one unit, one shift for one day
Questions?

Raise your hand

Use the Chat

Action Period Assignment: Identifying Your Population

Identify your population using one (or more) of the following approaches:

- Threshold approach
- Clinical knowledge
- Predictive modeling
- Opt-in or opt-out?
Reflection Questions

- Which approach did you use? How easy or difficult was it to identify your population?
- What triggers might you put in place to identify someone in this population going forward?
- How large is your population?
- What do you know about them? Do certain segments emerge?
- Select one or two patients/clients (or family members) who would be willing to test ideas throughout this program

Share your reflections via the listserv by Thursday, October 10, and be prepared to share at the next session.

Expedition Communications

- Listserv for session communications: OlderAdultsExpedition@ls.ihi.org
- To add colleagues, email us at info@ihi.org
- Pose questions, share resources, discuss barriers or successes
Next Session

**Tuesday, October 15, 3:00-4:00 PM ET**

Session 2 – Identifying Your Population and Understanding Needs, Resources, Goals, and Preferences