IHI Expedition
Improving Care for Frail Older Adults with Complex Needs Session 3

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

Today’s Host

Max Cryns, Project Assistant, Institute for Healthcare Improvement (IHI), assists programming activities for hospital settings including Expeditions (two to four month web-based educational programs), Passport memberships, and mentor hospital relations. He also supports IHI’s networking and knowledge efforts. Max is currently in the Co-Operative Education Program at Northeastern University in Boston, Massachusetts, US, where he majors in Business Administration with concentrations in Entrepreneurship and Marketing. He enjoys professional and collegiate sports, playing basketball, music, the beach, and trivia.
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
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

- Introductions
- Insights from Action Period Assignment
- Building, Developing, and Implementing a Different Kind of Care Plan
- Action Period Assignment for Next Session
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

Action Period Assignment: Assessment

- Review your current assessment process
  - Is the assessment process in your facility inclusive of all the domains (and subdomains) discussed? Could your process benefit from inclusion of any of the information provided?
  - How does your assessment process influence your conversation about the patient’s/client’s needs, preferences, and goals of care?
  - What’s working and what isn’t working? How does your process need to be adapted?
  - What, if any, are your obstacles to providing the assessment you feel your patients/clients need?

- Adapt your assessment and try it on one to two patients/clients (or family members)
  - Compare what you learned to what is in the current record
  - What surprised you? What delighted you? What confused you?
  - How can you use what you learned to improve?
Action Period Assignment: Assessment (Optional)

Optional: There are a variety of available assessment tools.

- What tools are you using? Describe how they are helpful or not helpful.
- Describe specific areas of assessment where you feel you are lacking useful assessment tools.

Questions?

- Raise your hand
- Use the Chat
Guest Presenter

Holly L. Stanley, MD, is a Senior Policy Analyst for the Center for Elder Care and Advanced Illness at the Altarum Institute and has been active in the American Geriatrics Society’s activities surrounding health care policy and reform activities for elderly adults. She is a career geriatrician who has practiced in a wide array of different settings with a focus on Comprehensive Geriatric Assessment and has been recognized by her peers for her clinical expertise.

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.
Building, Developing, and Implementing a Different Kind of Care Plan

Driver Diagram

Primary Drivers

- Identify the frail older population
- Establish person's current situation and likely course with various care plans
- Develop and implement a negotiated care plan (perhaps, "personal health and well-being plan")
- Make services appropriate and integrated for frail elders in the health care system, at home, and in the community (includes home care, housing, personal care, nutrition, and other supportive services)
- Manage a trustworthy, effective, responsive local service production system with a competent, thinking workforce

Secondary Drivers

- Assess risk for illness, disability and death for individuals and populations
- Develop administratively feasible criteria
- Use opt-in or opt-out individual/family agreement to use special frailty care
- Understand the affected person's wishes and priorities at this stage of life (multi-dimensional assessment)
- Understand family and caregiver capabilities and willingness
- Outline options and predict likely future courses
- Develop a shared understanding of what is the most desirable service plan
- Implement the plan, monitor and adapt
- Evaluate the care plan against preferences and values, not just against professional standards
- Routinely evaluate care plans and learn from the evaluation
- Provide comprehensive support at home
- Follow geriatric qualitative principles and priorities
- Enable promise-making and reliability
- Support caregivers and relationships
- Organize volunteers: family, friends, and neighbors

- Provide information system to monitor supply, predict goals, and quality
- Enable governance of the local care system in the interest of frail elders
- Develop appropriate numbers and skills of workforce, reasonable values and career ladders
- Reflect appropriate priorities: feasibility, continuity, endurance, dignity
Driver Diagram

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.

Develop and implement the care plan (perhaps, “Personal health and well-being plan”).

Develop a shared understanding of what is the most desirable service plan.

Implement the plan, monitor, and adapt.

Evaluate the care plan against preferences and values, not just against professional standards.

Routinely evaluate care plans and learn from the evaluation.

Tell about care plans in your world…

- What counts as a care plan?
- Frustrations? Limitations?
- Any good tales?
- What gets left out?
- What happens across settings?
- Who has care plans in their EMR?
- Anyone have a standard format?
- Anyone have a regular mode for evaluation?
Questions?

Raise your hand

Use the Chat

What’s essential in developing a good care plan?

1.
2.
3.
4.
5. …
What’s essential in developing a good care plan?

- Thorough understanding of the patient/family situation (last session)
- Reasonable prognostication of how things will turn out for “patient” and “family” with various strategies
- Accurate knowledge of the availability and acceptability of services
- Effective communication, sensitive but honest, timely and evolving
- Patient (and family) priorities, fears and hopes
- Involvement of all key service providers (perhaps asynchronously)
- Discussion/ negotiation - Addressing all critical issues, making compromises, accepting risks, using time-limited trials
- Setting time and event triggers for re-evaluating
- Documenting (especially for transitions in care team and setting)

How important is a good care plan to the “patient” and “family?”

- Can ensure that all critical issues are considered (and often, many “nice to have” issues)
- Can coordinate the various complicated aspects of living with chronic diseases and disabilities, making it practical
- Can address fall-backs, respite, caregiver issues, finances, abuse, and other usually-ignored issues
- Can assure patients and caregivers of coherence and control
- Can require honesty about real options (which can be painful, but not to confront reality is infantilizing or patronizing)
How important is it?

A good care plan at all times is the keystone of good care

Services without a plan are reactive, dangerous, and terrifying

How can you regularly produce good care plans?

- PACE has interdisciplinary team, building from comprehensive assessment, and involving client and family
- Similarly – hospice, home-based primary care teams in the VA system
- Sweden requires accord of outpatient care coordinator and patient/family before patient can be discharged from hospital
- How to trigger? Consider transitions, major events, new critical diagnoses, new finding of ADL dependency
What process steps are essential?

- Actual involvement of patient/client and family/caregiver
- Service delivery providers involved – at least key players
- Service providers working as a team with the client/family
- Accord as to goals, priorities of the patient/client
- Respect for meanings and relationships, honesty with sensitivity
- Simple guidance –
  - Sit down. Have an appropriate venue. Structure the time. Teach-back.
  - Good group process management. Settle shared goals. Surface and deal with important misunderstandings. Work with family dysfunction.
  - Translate language as needed – both foreign and medical/technical
  - Accept a process over time, compromise, flexible on taking risks

The next step – implement!

- Family or patient often provides the coordination
- Increasingly often now, someone provides a care coordinator – sometimes too many, or too biased or conflicted, or just too little experience and training – but a good coordinator/navigator/manager can be a big help
- 24/7 and rapid response is essential for coordinator or back-up to patient/family – with care plan in hand
- Care plans must go across settings smoothly
- Revisions as scheduled, desired, or precipitated
And then evaluate

- For individuals – what would you evaluate?
- For systems – what would you want to know?
And then evaluate

- For individuals —
  - Presence of a care plan for each frail elderly person
  - Known by all affected, continues across settings, implemented
  - Satisfaction with the process
  - Patient/client report that the care plan is helping to pursue goals
  - Patient/client report of confidence (how many times in the last week have things felt out of control or frightening?)
  - Outcomes (life lived) evaluated against priority values

- For systems —
  - Regular performance for individuals
  - Feedback upstream – self-correcting process
  - [use of care plans to manage the service supply and quality – in our 5th seminar]
Patient-Reported Pursuit of Goals – uneven interval, multiple reporting strategies

<table>
<thead>
<tr>
<th>Date</th>
<th>Score</th>
<th>Ideal Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/1/2012</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>8/3/2012</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>8/8/2012</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10/12/2012</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>2/28/2013</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>3/2/2013</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5/23/2013</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>6/1/2013</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6/30/2013</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

Of a possible 48 month-points, this patient reported that the care system achieved about half.

URGENT NEEDS for CARE PLANS

▲ Develop demand for multi-dimensional understanding of the situation, and person-centered care plans

▲ Develop processes that regularly produce them

▲ Develop feedback loops for real-time evaluation of merits

▲ Develop quality measures that assess system performance

▲ Use good care plans in system design
What about an "Advance Care Plan?"

▲ Natural to consider lifespan and dying as part of care planning
▲ Include emergency plans like POLST
▲ Designate surrogate decision-maker(s)
▲ Document along with care plan
▲ Update and feedback as for other plan elements

Questions?

Raise your hand

Use the Chat
Action Period Assignment: Care Planning

- Review your current care plan and care planning process and compare them to the examples shared and the criteria described in Session 3
  - Is the one in your facility comprehensive/multidimensional?
  - What’s working and what isn’t working? How does your care plan and/or process need to be adapted?
  - What, if any, are obstacles to creating the care plans you feel your patients/clients need?
- Adapt your care plan process and try it on one to two patients/clients (or family members). Try to write out a good care plan for one complicated patient/family.
  - Compare what you learned to what’s in the current record
  - What surprised you? What delighted you? What confused you?
  - How can you use what you learned?
- Discuss what it would take to implement this care plan
- How could you give constructive feedback to earlier providers about care planning?
- Share your answers via listserv or be prepared to share at the next session

---

Driver Diagram

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.

- Develop and implement the care plan (perhaps, “Personal health and well-being plan”)
- Develop a shared understanding of what is the most desirable service plan
- Implement the plan, monitor, and adapt
- Evaluate the care plan against preferences and values, not just against professional standards
- Routinely evaluate care plans and learn from the evaluation
Model for Improvement

- 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

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


Act

- Decide changes to make
- Arrange next cycle

Plan

- Compose aim
- Pose questions/predictions
- Create action plan to carry out cycle (who, what, when, where)
- Plan for data collection

Study

- Complete data analysis
- Compare to predictions
- Summarize learning

Do

- Carry out the test and collect data
- Document what occurred
- Begin analysis of data
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, November 12, 3:00-4:00 PM ET
Session 4 – Changing Your Health Care Services and Integrating Social Supports