Today’s Host

Max Cryns, Project Assistant, Institute for Healthcare Improvement (IHI), assists programming activities for hospital settings including Expeditions (2-4 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, MA, 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
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When Chatting…

Please send your message to All Participants
Expedition Director

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
- Improving the Care System, Health Care, and Supportive Services
- 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

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.
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

Care Planning Assignment

- Kim from Cook county – your experiences – share your sense of what you do well and what escapes
- Others – do you do the same sort of things, or is it different for you?
Comments? Questions?

Raise your hand

Use the Chat

Changing Your Health Care Services and Integrating Social Supports
Primary 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

Secondary Drivers

- Understand the affected person and their priorities at this stage of life (multi-dimensional assessment)
- Understand family and caregiver(s) 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 plans 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/palliative principles and priorities
- Enable promise-making and reliability
- Support caregivers and relationships
- Organize volunteers: family, friends and neighbors
- Provide information system to monitor supply, practices, and quality
- Enable governance of the local care system in the interest of frail elders
- Develop appropriate numbers and skills of workforce, reasonable rewards and career ladders
- Reflect appropriate priorities: Reliability, continuity, endurance, dignity

Driver Diagram

Frail older adults with complex needs will live with 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.

Make services appropriate and integrated for frail elders in the health care system, at home, and in the community (includes health care, housing, personal care, nutrition, and other supportive services).
What’s Wrong with Services Now?

- Clinicians assume that strategies developed for 55 year olds work for 90 year olds – but – lower resilience, less energy, smaller reserves, shorter time frame for returns
- Also assume that clinician roles are central – ignore relationships
- Treatment plans, but rarely comprehensive care plans
- Inattention to burden (patient and caregivers), comfort, delirium, depression, and dementia – and finances
- Little honest prognostication – often even the physicians lack knowledge of the future (survival, function, costs)
- Few clinicians become expert in geriatrics care, or know principles
- Rare evaluation or feedback on performance

What’s Wrong with Medical Services?
What’s Wrong with Supportive Services?

- Unreliable – come and go, criteria and performance change
- Unexamined undersupply, oversupply, and quality
- Treated as trivial and “magical” by medical care providers
- Regularly require navigation, which is only sometimes available, e.g., through ADRC/AAA network
- Often over-navigated – multiple care coordinators with partial knowledge and no coordination among them
- Costly – patient/family pay until poverty in most cases
- Administered without coordination, from dozens of agencies and philanthropies

NorthStar – What to Aim For
NorthStar – What to Aim For

- Fully integrated and managed
- Feedback on performance
- Honest care plans
- Client/family perspective is paramount
- Supply of critical supportive services is adequate, access is clear
- Medical services routinely attentive to function, comfort, meaningfulness, lifespan, burden, complications of treatments – regularly available at home, 24/7

How to Get There #1: Promises

- “What promises do your patients/clients most need to hear?”
  “What keeps you from making those promises?”
- May need focus group, surveys, or deliberate feedback to get guidance from patients/clients
- Then being able to make the promises that matter usually requires making the system work across time and settings
How to Get There #2: Feedback Loops

▲ Ensure that downstream experience gets to upstream providers in salient ways
▲ Simple notification (e.g., of death and its circumstances, of other major transitions) (example: death certificate follow-back)
▲ Highly salient notification – YouTube, letters from family
▲ Potential role of care plans and their evaluation

How to get there #3: Positive deviants
How to Get There #3: Positive Deviants

- In almost every setting, someone is doing it just about right – a remarkable nursing home, a terrific hospice, a good geriatrics practice, a PACE program
- Find those “positive deviants” who are doing it right in the usual adverse incentives – and measure their performance and make their work visible – news stories count!
- Perhaps engineer competition to do as well
- Assure that the positive deviants do not fail and go away

How to Get There #4: Relationships

- Get service providers together – over care transitions, budgets, measurements, or just lunch!
- Follow some patients together – do some process mapping – get the “aha” phenomenon going
- Be sure to meet in less visible settings – nursing homes, senior centers, etc.
- Use name tags, keep minutes, provide contact information
- Be able to deliver on at least some requests for data – e.g., a chart review, a death certificate follow-back
How to Get There #5: Contracts

▲ Managed care and ACOs are quickly seeing that frail elders are a major financial challenge
▲ Even conventional FFS Medicare hospitals are beginning to see that compensation-costs
▲ Some are beginning to be willing to write at-risk or service contracts for supplemental services
▲ The process of negotiation and multi-provider contracting can help bring the issues into focus and forge commitment to resolve them

How to Get There #6: Other Options?

▲
Common Errors

▲ Culture clashes – community-based organizations and health care
▲ Language conundrums – client/patient, care plan/ service plan, family/caregiver, competition/cooperation
▲ Inattention to standardization (and celebration of customization to individuals)
▲ Too slow at scale up, allow pioneers to fail
▲ Lack of will – need to engender some outrage!

Action Period Assignment: Promises

● Ask one or two frail elderly people to think with you about what matters to them in the rest of their lives and what they would most want to be able to rely upon
  – You may need to suggest some options – e.g., to be with family, to live with minimal pain
  – Document this in a draft care plan as promises to the patient/client
  – Think through what it will take to keep those promises within your system (through to the end of life)? Can you do it even in your own organization’s scope?
● Identify one of your routine partners
  – For example, a skilled nursing facility with whom you frequently work
  – Ask what it would take to be able to keep those promises in their setting (through to the end of life)
  – Discuss how you might work together to keep those promises to the patient/client. What currently gets in the way in your work together caring for a patient/client? What would make it easier for them to implement a plan when they receive a patient/client from your organization, or for them to send a patient on to your team?
    Share your draft care plan with this partner and see what they would add or change
● Share your answers via listserv or be prepared to share at the next session
Action Period Assignment: Relationships

- Check on whether key people in health care know the people leading the community-based services
  - E.g., does the medical director of the clinic know the head of the Area Agency on Aging (AAA)? Or the LHIN in some Canadian provinces, or the equivalent elsewhere...
  - In the US, see if a community-based care transitions program is present in your community and if it is making a difference
- Talk with a leader of long-term services and supports in your community
  - Ask about the priorities he or she sees
  - In the US, compare those with the community benefit assessment by a non-profit hospital in the community
- Share your answers via listserv or be prepared to share at the next session

Questions?

Raise your hand

Use the Chat
What change can we make that will result in improvement?


- Plan
  - Decide changes to make
  - Arrange next cycle
- Study
  - Complete data analysis
  - Compare to predictions
  - Summarize learning
- Do
  - Carry out the test and collect data
  - Document what occurred
  - Begin analysis of data
- Act
  - Compose aim
  - Pose questions/predictions
  - Create action plan to carry out cycle (who, what, when, where)
  - Plan for data collection

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?
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

Final Session

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