Institute for Healthcare Improvement

Improving Public Health and Health Care for Older Adults:

The Three Keys to Cross-Sector Age-Friendly Care

Care Journey Maps

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

Version 1.0 March 2023
ihi.org/AgeFriendly

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.ihi.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 ihi.org.

Introduction to the Care Journey Maps

- Journey mapping, sometimes referred to 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 illustrate the complexity and impact of the current system.
- 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 address the system factors that currently inhibit older adults from living their healthiest lives 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 has 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 those key partners who work with and support older adults across the care continuum. Steps for setting up your team can be found in the **Workbook**, page 22.
- 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. The **Appendix E: Methods** contains helpful steps and information to lead these stakeholder interviews.

Current & Future State

- **Current State:** 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 preventative services for older adults
- **Future State:** Qualitative data from the stakeholder interviews and older adult interviews were used to establish the **future state** and how systems can come together to improve care across the continuum.

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

Disclaimer

These Care Journey Maps capture common themes that we heard in interviews with organizational stakeholders, older adults, 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.

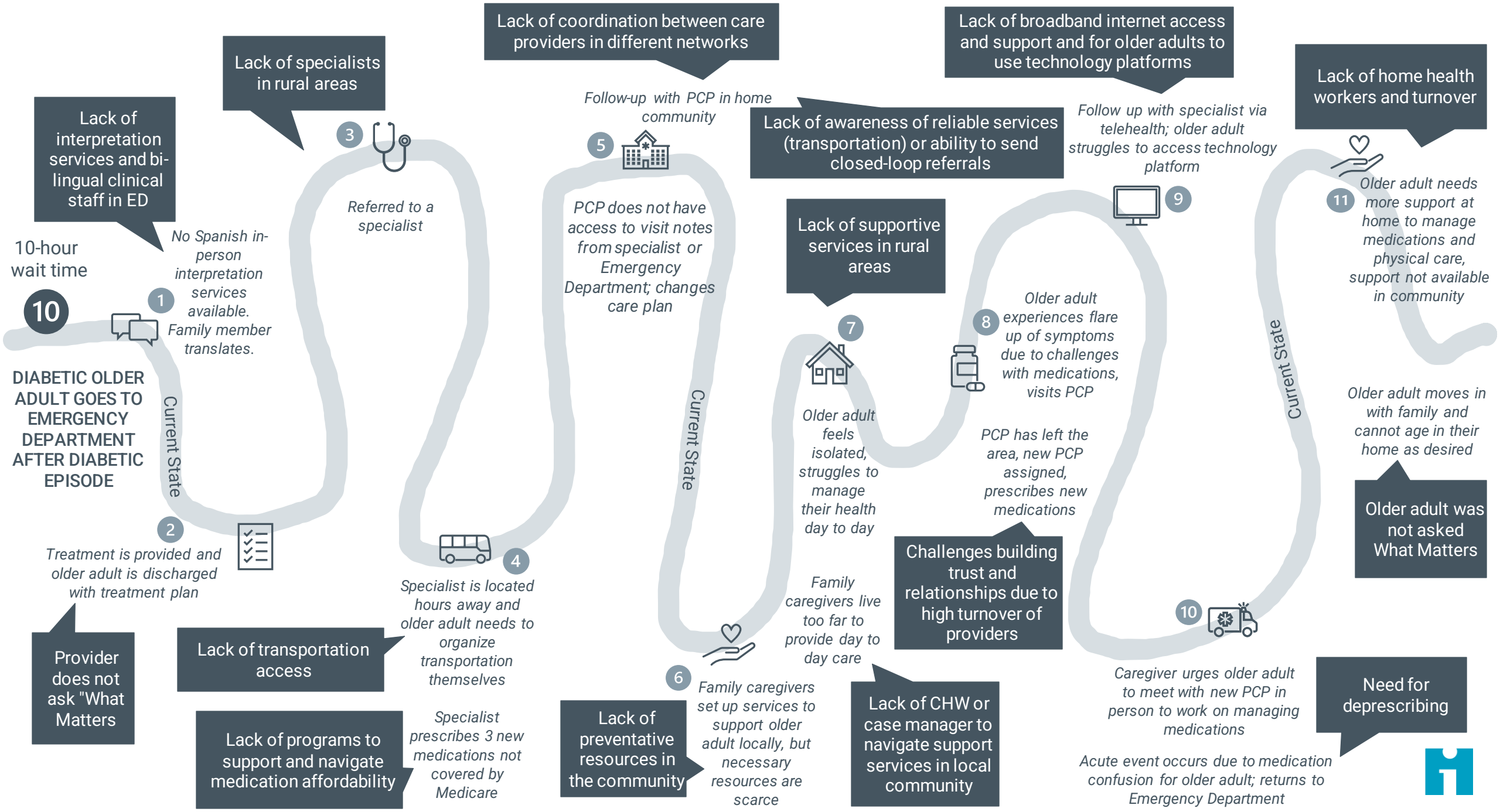
Care Journey Map Sets

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


Lack of coordination between care providers in different networks
Lack of broadband internet access and support and for older adults to use technology platforms
Lack of specialists in rural areas
Lack of home health workers and turnover
Lack of interpretation services and bi-lingual clinical staff in ED
Follow-up with PCP in home community
Lack of awareness of reliable services (transportation) or ability to send closed-loop referrals
Follow up with specialist via telehealth; older adult struggles to access technology platform
3
Referred to a specialist
5
PCP does not have access to visit notes from specialist or Emergency Department; changes care plan
Lack of supportive services in rural areas
9
11
Older adult needs more support at home to manage medications and physical care, support not available in community
10-hour wait time
10
1
No Spanish in-person interpretation services available. Family member translates.
7
8
Older adult experiences flare up of symptoms due to challenges with medications, visits PCP
Current State
Current State
Current State
DIABETIC OLDER ADULT GOES TO EMERGENCY DEPARTMENT AFTER DIABETIC EPISODE
Older adult feels isolated, struggles to manage their health day to day
PCP has left the area, new PCP assigned, prescribes new medications
Older adult moves in with family and cannot age in their home as desired
Older adult was not asked What Matters
Challenges building trust and relationships due to high turnover of providers
2
Treatment is provided and older adult is discharged with treatment plan
4
Specialist is located hours away and older adult needs to organize transportation themselves
Family caregivers live too far to provide day to day care
10
Provider does not ask "What Matters
Lack of transportation access
6
Family caregivers set up services to support older adult locally, but necessary resources are scarce
Lack of preventative resources in the community
Lack of CHW or case manager to navigate support services in local community
Caregiver urges older adult to meet with new PCP in person to work on managing medications
Need for deprescribing
Lack of programs to support and navigate medication affordability
Specialist prescribes 3 new medications not covered by Medicare
Acute event occurs due to medication confusion for older adult; returns to Emergency Department

DIABETIC OLDER ADULT GOES TO EMERGENCY DEPARTMENT AFTER DIABETIC EPISODE

1

Patient is seen by provider in less than an hour

Availability of translation services

1

Requested language interpretation services in Spanish are available through an in-person translator

2

Care plan is made with care coordinator to address any older adult and caregiver concerns

Providers ask "What Matters" to older adults

Availability of Care Coordination Services

CHW or Case managers to navigate support services in local community

CHW who speaks Spanish is identified for older adult in their community

3

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

Care Coordinator coordinates follow-up appointment with specialist and organizes reliable transportation to and from the office

4

5

Specialist prescribes new medications that will help meet older adult's care plan goals

Support for medication management

Future State

Communication between care providers; effective interoperability of healthcare data

Older adult visits PCP, who can access notes from care coordinator and specialist, and they co-design plan for medication management

6

7

Care Coordinator connects older adult to program that can provide medications at a sliding scale

Availability of programs to support and navigate medication affordability for both the older adult and their caregivers

8

Follow up with specialist via telehealth.

CHW assists older adult with internet access and tech platform

Support for older adults to use technology platforms

Availability of supportive and preventative services in the local community

CHW works with older adult to manage care and connect to preventive services in community—e.g., Meals on Wheels, local senior center

9

Future State

Older adult can manage chronic conditions, medications, and can age in their home as desired because that's What Matters to them

10

Family caregiver can access a database of local supportive resources from the CHW

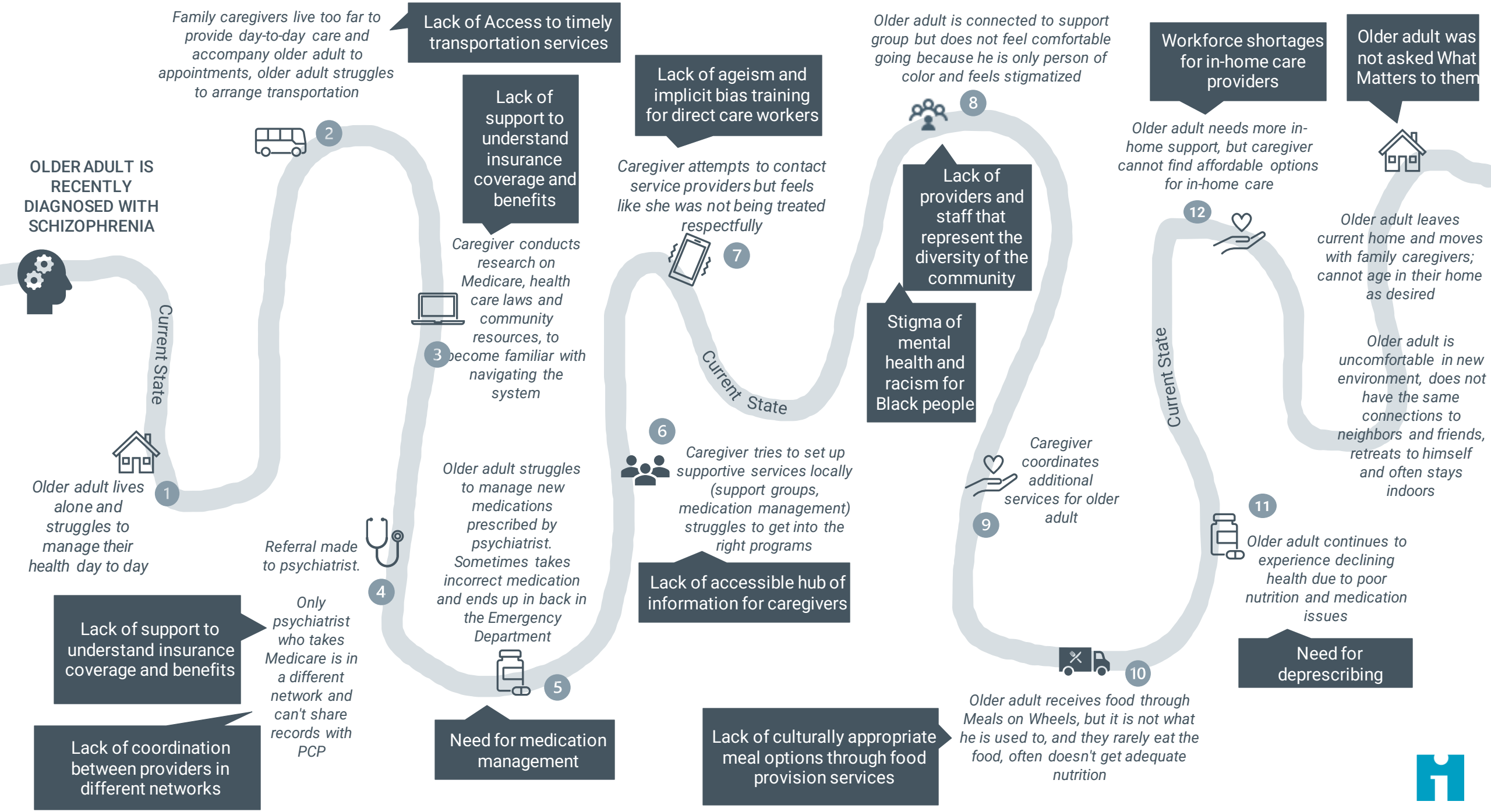
Existence of technology platforms to locate available support services

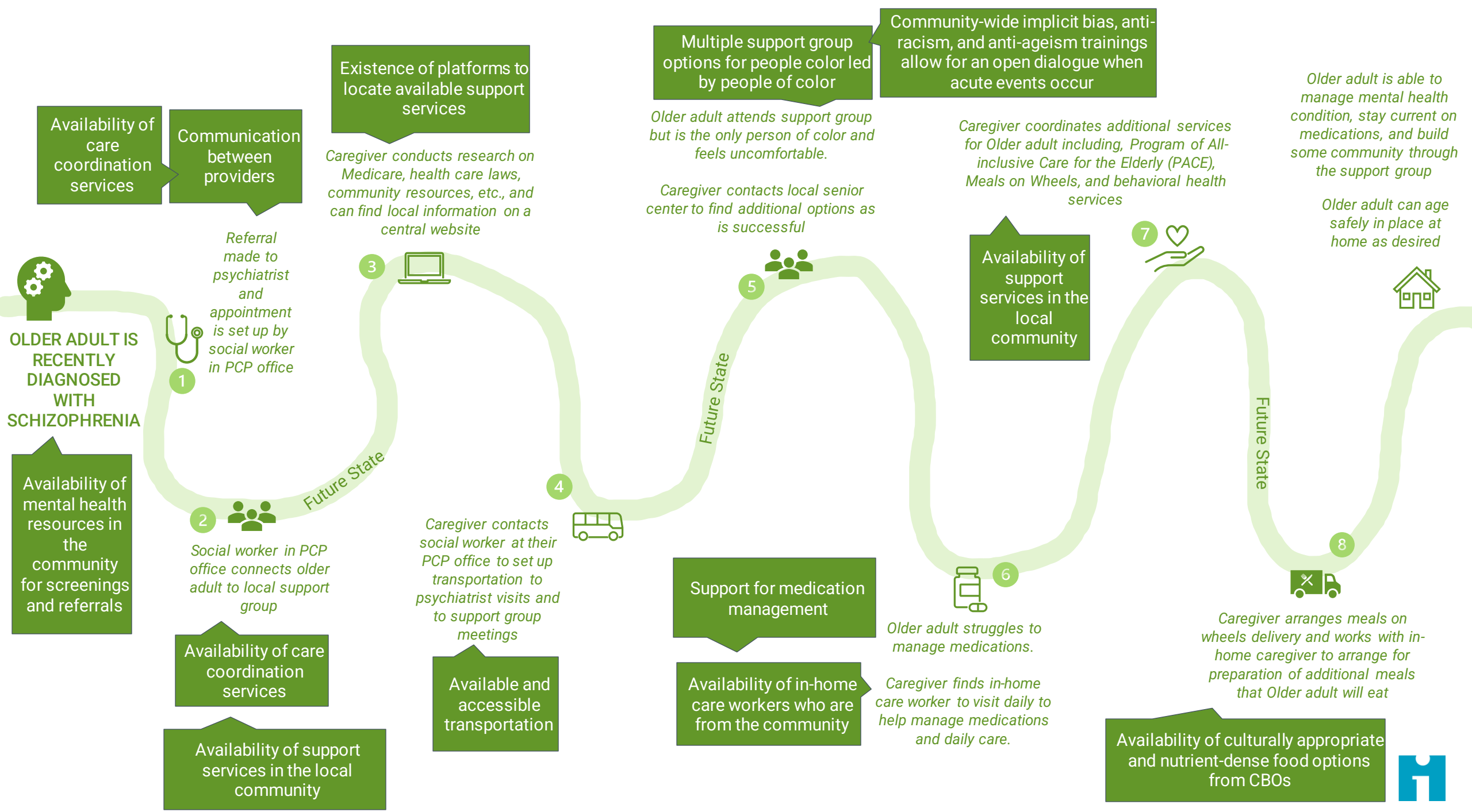
Care Journey Map Set 2

"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
Current State
1
Older adult lives alone and struggles to manage their health day to day
2
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
3
Caregiver conducts research on Medicare, health care laws and community resources, to become familiar with navigating the system
Lack of support to understand insurance coverage and benefits
4
Referral made to psychiatrist.
Only psychiatrist who takes Medicare is in a different network and can't share records with PCP
Lack of support to understand insurance coverage and benefits
Lack of coordination between providers in different networks
5
Older adult struggles to manage new medications prescribed by psychiatrist. Sometimes takes incorrect medication and ends up in back in the Emergency Department
Need for medication management
6
Caregiver tries to set up supportive services locally (support groups, medication management) struggles to get into the right programs
Lack of accessible hub of information for caregivers
7
Caregiver attempts to contact service providers but feels like she was not being treated respectfully
Lack of ageism and implicit bias training for direct care workers
Current State
8
Older adult is connected to support group but does not feel comfortable going because he is only person of color and feels stigmatized
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
Lack of culturally appropriate meal options through food provision services
Current State
11
Older adult continues to experience declining health due to poor nutrition and medication issues
Need for deprescribing
12
Older adult needs more in-home support, but caregiver cannot find affordable options for in-home care
Workforce shortages for in-home care providers
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
Older adult was not asked What Matters to them

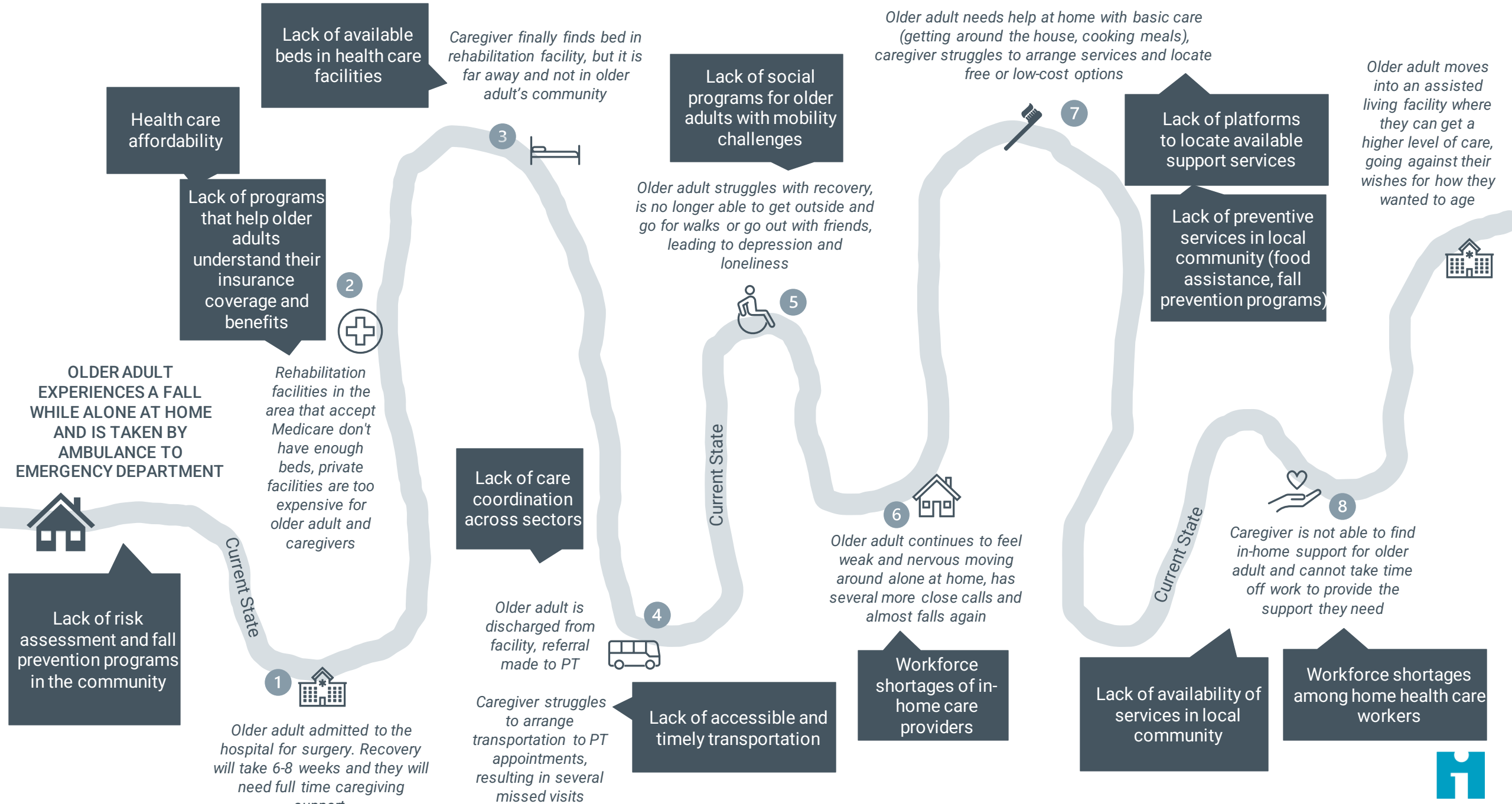

OLDER ADULT IS RECENTLY DIAGNOSED WITH SCHIZOPHRENIA
Availability of mental health resources in the community for screenings and referrals
1
Availability of care coordination services
Communication between providers
Referral made to psychiatrist and appointment is set up by social worker in PCP office
2
Social worker in PCP office connects older adult to local support group
Availability of care coordination services
Availability of support services in the local community
Future State
3
Existence of platforms to locate available support services
Caregiver conducts research on Medicare, health care laws, community resources, etc., and can find local information on a central website
4
Caregiver contacts social worker at their PCP office to set up transportation to psychiatrist visits and to support group meetings
Available and accessible transportation
Future State
5
Multiple support group options for people color led by people of color
Community-wide implicit bias, anti-racism, and anti-ageism trainings allow for an open dialogue when acute events occur
Older adult attends support group but is the only person of color and feels uncomfortable.
Caregiver contacts local senior center to find additional options as is successful
Support for medication management
Availability of in-home care workers who are from the community
6
Older adult struggles to manage medications.
Caregiver finds in-home care worker to visit daily to help manage medications and daily care.
Future State
7
Availability of support services in the local community
Caregiver coordinates additional services for Older adult including, Program of All-inclusive Care for the Elderly (PACE), Meals on Wheels, and behavioral health services
8
Caregiver arranges meals on wheels delivery and works with in-home caregiver to arrange for preparation of additional meals that Older adult will eat
Availability of culturally appropriate and nutrient-dense food options from CBOs
Older adult is able to manage mental health condition, stay current on medications, and build some community through the support group
Older adult can age safely in place at home as desired

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
Current State
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.
Health care affordability
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
3
Caregiver finally finds bed in rehabilitation facility, but it is far away and not in older adult's community
Lack of care coordination across sectors
4
Older adult is discharged from facility, referral made to PT
Caregiver struggles to arrange transportation to PT appointments, resulting in several missed visits
Lack of accessible and timely transportation
Current State
5
Lack of social programs for older adults with mobility challenges
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
6
Older adult continues to feel weak and nervous moving around alone at home, has several more close calls and almost falls again
Workforce shortages of in-home care providers
7
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
Lack of platforms to locate available support services
Lack of preventive services in local community (food assistance, fall prevention programs)
Lack of availability of services in local community
Current State
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

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

1

Older adult admitted to the hospital for surgery

2

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

Available beds in health care facilities

Future State

Support to navigate insurance coverage and benefits

Care Coordination

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

3

4

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

Future State

Support for caregivers to navigate available services

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

5

Existence of platforms to locate available support services

6

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

7

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

Availability of home risk assessment and home modification services

Sustainably funded programs for older adults offered in local community

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

8

Future State

Older adult has the supports needed to age in desired setting

9

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