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

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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)

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Introduction to the Care Journey Maps

- 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 illustrate the complexity and impact of the current system.
- There are six maps in total representing individuals with the following characteristics:

<table>
<thead>
<tr>
<th>Map Set</th>
<th>Race/Ethnicity</th>
<th>Geography</th>
<th>Health Status</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older Adult 1 (Maps 1 &amp; 2)</td>
<td>Latinx/Hispanic</td>
<td>Rural</td>
<td>Diabetes and Chronic health conditions</td>
<td>75</td>
</tr>
<tr>
<td>Older Adult 2 (Maps 3 &amp; 4)</td>
<td>Black/African American</td>
<td>Urban</td>
<td>Mental and behavioral health challenges</td>
<td>65</td>
</tr>
<tr>
<td>Older Adult 3 (Maps 5 &amp; 6)</td>
<td>White</td>
<td>Suburban</td>
<td>History of falls and mobility challenges</td>
<td>80</td>
</tr>
</tbody>
</table>
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
DIABETIC OLDER ADULT GOES TO EMERGENCY DEPARTMENT AFTER DIABETIC EPISODE

1. Provider does not ask “What Matters”.
2. Lack of transportation access.
3. 10-hour wait time.
4. Specialist is located hours away and older adult needs to organize transportation themselves.
5. PCP does not have access to visit notes from specialist or Emergency Department; changes care plan.
6. Family caregivers set up services to support older adult locally, but necessary resources are scarce.
7. Older adult feels isolated, struggles to manage their health day to day.
8. PCP has left the area, new PCP assigned, prescribes new medications.
9. Follow up with specialist via telehealth; older adult struggles to access technology platform.
10. Older adult needs more support at home to manage medications and physical care, support not available in community.
11. Older adult moves in with family and cannot age in their home as desired.

Follow-up with PCP in home community.

Challenges building trust and relationships due to high turnover of providers.

Lack of supportive services in rural areas.

Lack of awareness of reliable services (transportation) or ability to send closed-loop referrals.

Lack of specialists in rural areas.

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 programs to support and navigate medication affordability.

Lack of supportive services for older adults.

Lack of CHW or case manager to navigate support services in local community.

Lack of preventative resources in the community.

Lack of awareness of services or ability to send closed-loop referrals.

Older adult was not asked What Matters.

Need for deprescribing.
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

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

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

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

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

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

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

Caregiver coordinates additional services for older adult.

Lack of accessible hub of information for caregivers.

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.

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

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

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.

Need for medication management.

Lack of coordination between providers in different networks.

Lack of access to timely transportation services.

Lack of support to understand insurance coverage and benefits.

Lack of ageism and implicit bias training for direct care workers.

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

Stigma of mental health and racism for Black people.

Workforce shortages for in-home care providers.

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.

Need for deprescribing.

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

Older adult is not asked What Matters to them.
OLDER ADULT IS RECENTLY DIAGNOSED WITH SCHIZOPHRENIA

1. Caregiver contacts social worker at their PCP office to set up transportation to psychiatrist visits and to support group meetings.

2. Social worker in PCP office connects older adult to local support group.

3. Referral made to psychiatrist and appointment is set up by social worker in PCP office.

4. Caregiver contacts social worker at their PCP office to set up transportation to psychiatrist visits and to support group meetings.

5. 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.

6. Older adult struggles to manage medications. Caregiver finds in-home care worker to visit daily to help manage medications and daily care.

7. Community-wide implicit bias, anti-racism, and anti-ageism trainings allow for an open dialogue when acute events occur.

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.

- Caregiver finds in-home care worker to visit daily to help manage medications and daily care.
- Caregiver arranges meals on wheels delivery and works with in-home caregiver to arrange for preparation of additional meals that older adult will eat.

- Caregiver coordinates additional services for older adult including, Program of All-Inclusive Care for the Elderly (PACE), Meals on Wheels, and behavioral health services.

- 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.

- Older adult can age safely in place at home as desired.

- Caregiver is able to manage mental health condition, stay current on medications, and build some community through the support group.

- Caregiver is successful in finding local information on a central website.
“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

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

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

3. 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.

4. Older adult is discharged from facility, referral made to PT.

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

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

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.

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.

Current State

9. Workforce shortages of in-home care providers

10. Workforce shortages among home health care workers

Current State

11. Lack of available beds in health care facilities

12. Lack of risk assessment and fall prevention programs in the community

Current State

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

14. Lack of care coordination across sectors

Current State

15. Lack of social programs for older adults with mobility challenges

Current State

16. Lack of accessible and timely transportation

Current State

17. Lack of platforms to locate available support services

Current State

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

Current State

19. Health care affordability

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

21. Workforce shortages of in-home care providers

Current State

22. 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

Current State

23. Lack of availability of services in local community

Current State

24. Lack of platforms to locate available support services

Current State

25. Lack of preventive services in local community (food assistance, fall prevention programs)
While at the rehabilitation facility, care coordinator works with caregiver to arrange a rehabilitation facility that will be covered by Medicare.

Older adult experiences a fall while alone at home and is taken by ambulance to the emergency department.

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

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.

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

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

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.

Care coordinator connects caregiver to facilities that will be covered by Medicare.

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

Hospital staff and direct care workers ask older adults what matters to them.

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

Available beds in health care facilities.

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

Existence of platforms to locate available support services.

Support for caregivers to navigate available services.

Future State.

Future State.

Future State.

Future State.

Future State.

Support to navigate insurance coverage and benefits.

Care Coordination.

Sustainably funded programs for older adults offered in local community.

Support for caregivers to navigate available services.

Older adult admitted to the hospital for surgery.

Future State.

Future State.