# Welcome

# The Next Building Block:

## Implementing the 4M Age-Friendly Framework for Better Care of Older Adults and People Living with Dementia

## Mid Point Meeting

November 15th, 2023

# Agenda

| Topic / Presenter(s) | Duration |
|---|---|
| **Welcome & Introductions**<br>*Victoria Parker, RIDOH*<br>*Christine Ferrone, RI Geriatric Education Center* | 2 mins |
| **Fundamental Patient Priorities Care: Framework for Eliciting and Aligning Care with the What Matters M of Age-Friendly Care**<br>*Dr. Angela Catic, Baylor College of Medicine* | 35 mins |
| **Practice PDSA's**<br>*Brown Medicine, Charter Care, Drs Brennan Cronin & Associates, PACE RI, University Internal Medicine* | 20 mins |
| **Questions, Next Steps**<br>*Suzanne Herzberg, Brown Primary Care* | 3 Mins |

# Welcome To Our Subject Matter Expert!

## Dr. Angela Catic

**Associate Professor in the Section of Geriatrics and Palliative Medicine at Baylor College**

PatientPrioritiesCare.org

# Fundamental Patient Priorities Care:

## Framework for Eliciting and Aligning Care with the What Matters M of Age-Friendly Care

*Rhode Island Learning Collaborative*

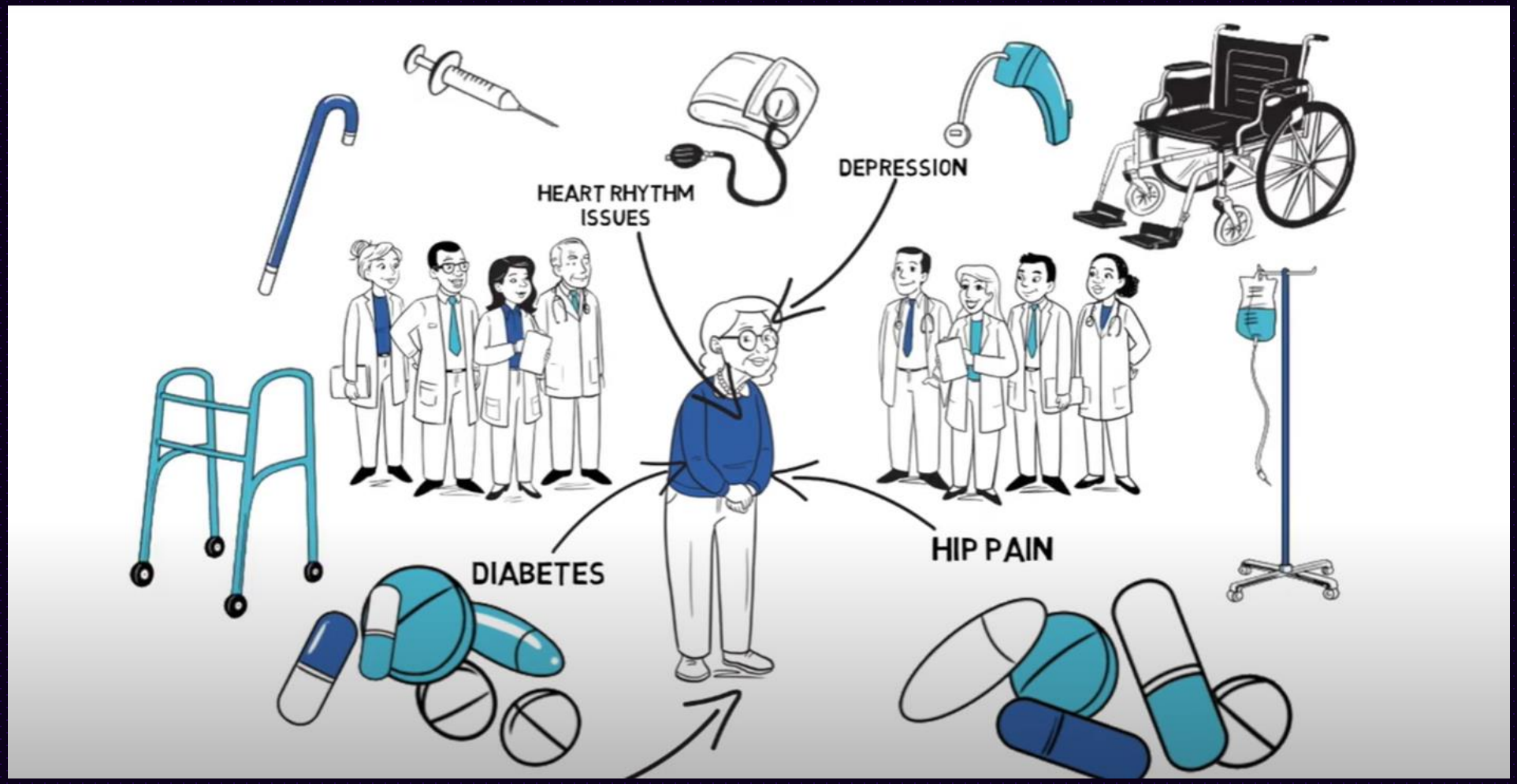
*November 15, 2023*

# Learning Objectives

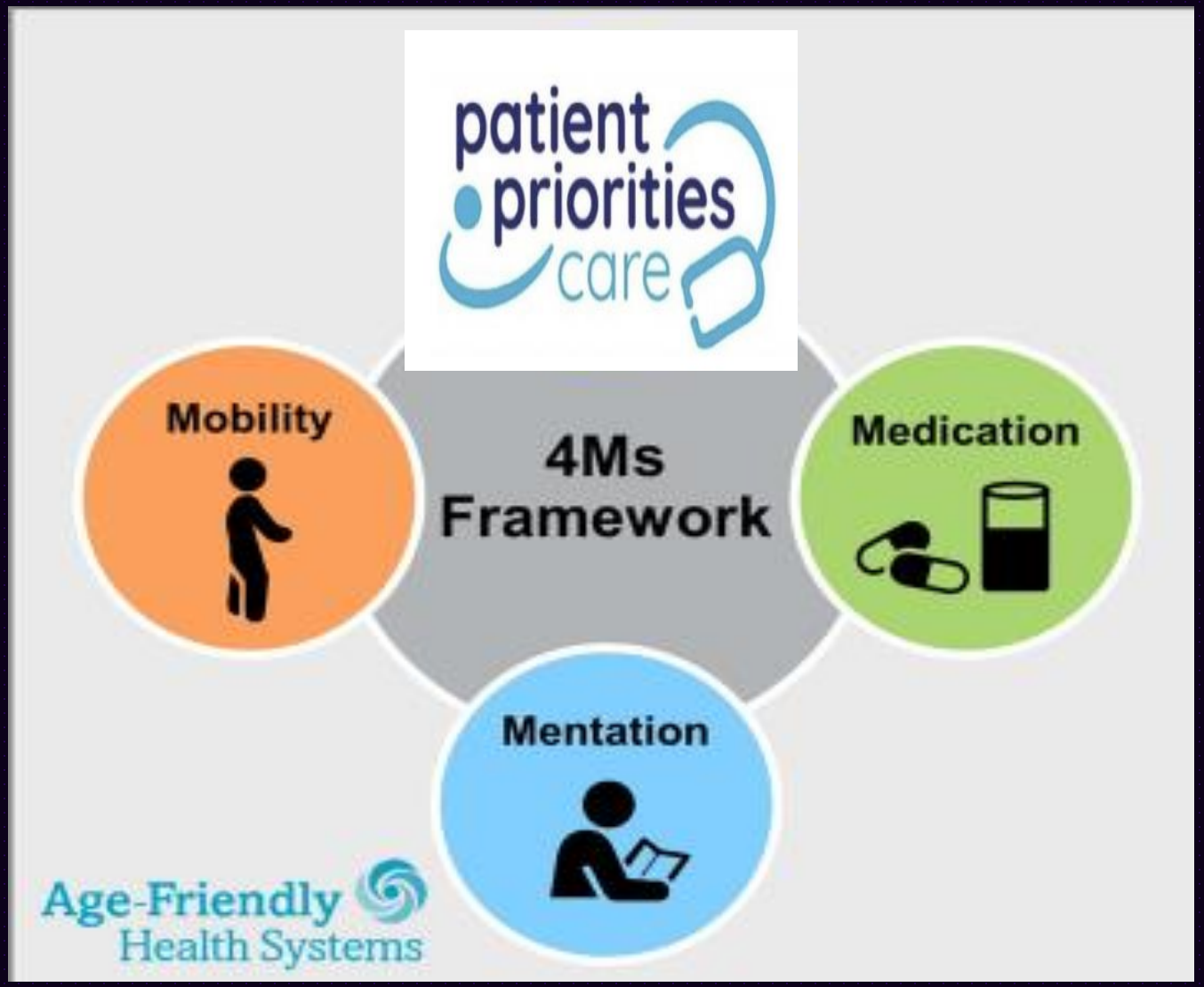
At the conclusion of this presentation, attendees will

- Appreciate fundamental Patient Priorities Care (PPC) as a preferred framework for eliciting and aligning care with the What Matters M of Age-Friendly Care
- Help patients identify the One Thing, the one problem they want to focus on in order to achieve their health outcome goal
- Be comfortable using patients' health priorities as the focus of communication and decision making about their care

# Complexity Typically Increases with Aging



# What Matters- The Bedrock of Age-Friendly

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## IDENTIFY HEALTH PRIORITIES

- Values (What Matters most to the patient)
- Actionable, specific, realistic health outcome goals
- Health care preferences (which care the patient finds helpful and which burdensome) and any tradeoffs
- "One Thing" - the health problem (burdensome symptom, health care task, or medication) the patient most wants to address to help them achieve their health goal.

## ALIGN CARE WITH HEALTH PRIORITIES

### Consider if current and potential care is:

- Consistent with health outcome goals including patient's "One Thing"?
- Consistent with care preferences?

### Use the patient's priorities:

- As the focus for communication with the patient
- As the goal for serial trials to start, stop or continue interventions
- To prioritize care decisions, especially where differing perspectives exist

Update components as needed

# Health Priorities Identification

- Framework to identify the What Matter M of the Age-Friendly Health System Initiative
- Process can be completed by older adult independently or with assistance from caregiver using http://myhealthpriorities.org
- If older adults need assistance with priorities identification, can be guided through framework by any member of the interdisciplinary healthcare team

Identify What Matters Most to You

Set Your Health Goal

Identify Health or Other Problem Getting in the Way of Your Goal

Choose The One Thing to Focus On

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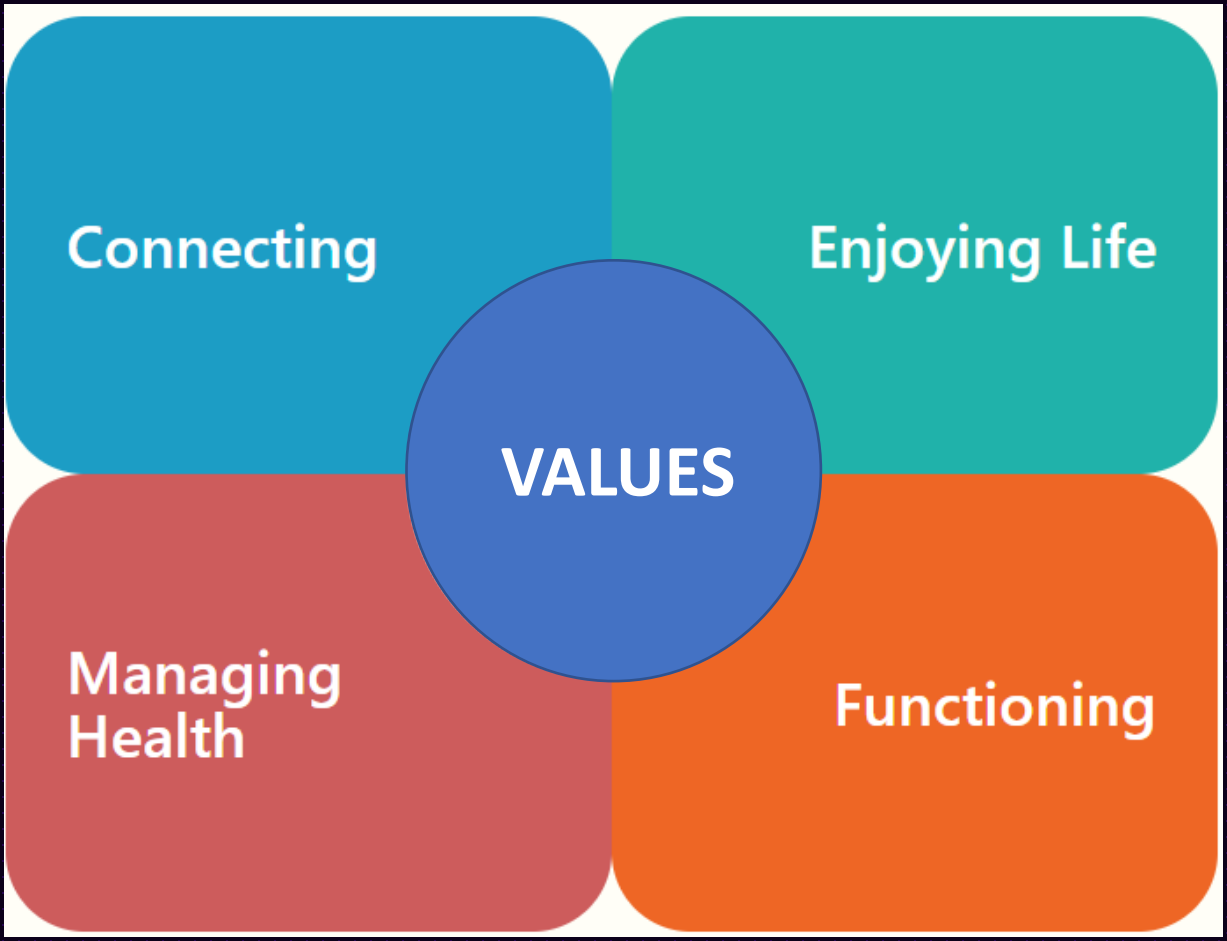
Health Priorities Identification

# 1. Identify what Matters Most to You (Values)




- What gives your life meaning, joy, purpose or satisfaction
- Even with life and health changes, values tend to remain stable over lifespan

ValuesConversationStarters_box-image_ek-7-30-21.pdf (patientprioritiescare.org)

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Health Priorities Identification

# 2. Set Your Health Goal

Ways that people put their ***values into action*** and are activities they want their ***health care to help them achieve***

Goals should

1. Be linked to what matters most
2. Be specific
3. Realistic within the context of life and health
4. Be actionable (something the clinical team can assist with achieving )

**Health Goal:** I want to (*Action)* _____ for/in/over (*frequency, duration)*_____.

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# Exercise: Specific or Realistic Health Goals?

| Goal | Specific? | Realistic? |
| --- | --- | --- |
| I want to be healthier. | ✗ | ✓ |
| Starting this week, I'll watch my grandchildren after school 2-3 times per week. | ✓ | ✓ |
| I will start jogging a mile every day before breakfast. | ✓ | ✗ |

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# Specific and Meaningful Health Goals: Tips

- Goals should always be linked to what matters most to the patient
- If goals are unrealistic
  - Identify an achievable goal that addresses the underlying value
  - Explore if there is an activity they can do more easily that still shows what matters most to them

| Unrealistic Goal | Value | Realistic Goal |
|---|---|---|
| Get driver's license back to be able to go shopping | Functioning, self-sufficiency | Research vision and hearing aids to better use computer to order things online |
| Get driver's license back to be able to visit friends | Connection | Ride the bus to the senior center 2x/week |
| Get driver's license back to be able to go for a drive | Enjoyment/recreation | Walk in neighborhood for 10 minutes, 3x/week |

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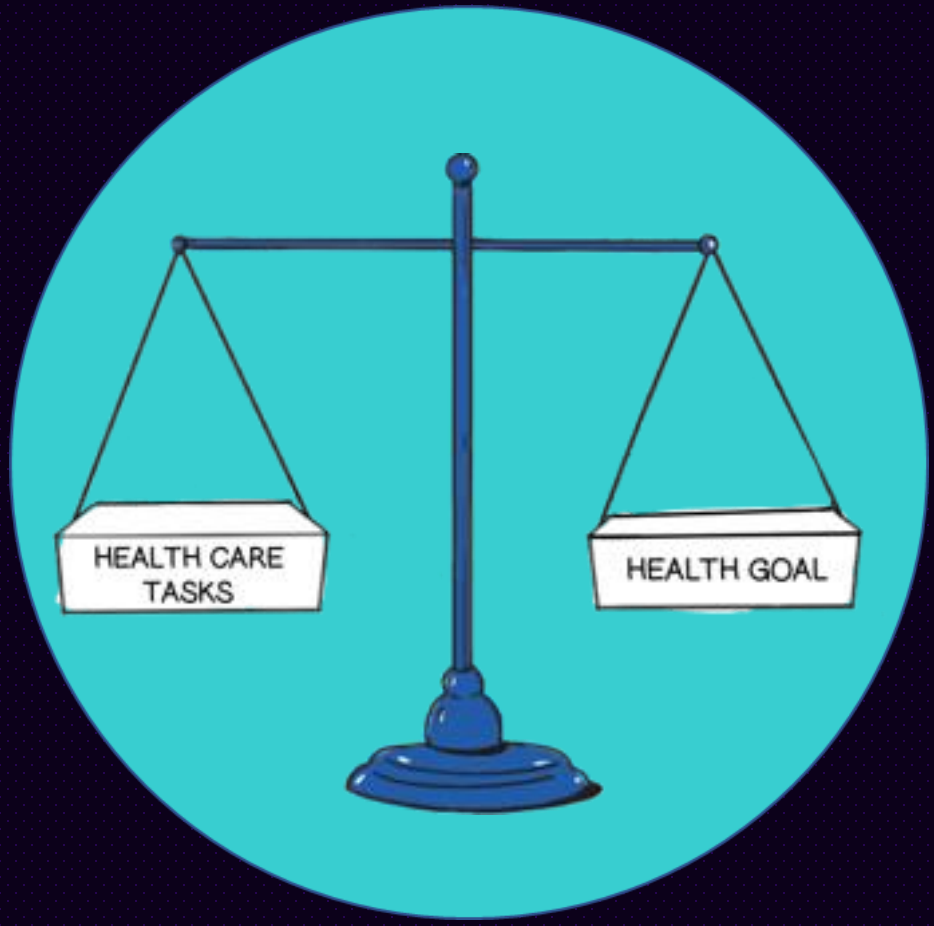
Health Priorities Identification

# 3. Identify Health or Other Problem Getting in the Way of Your Goal

Considering the health goal identified, is there one thing about your health or health care that is most bothersome to you or most interfering with your goal?

- Condition and symptoms
- Burdensome healthcare task
- Life/social circumstances

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Health Priorities Identification

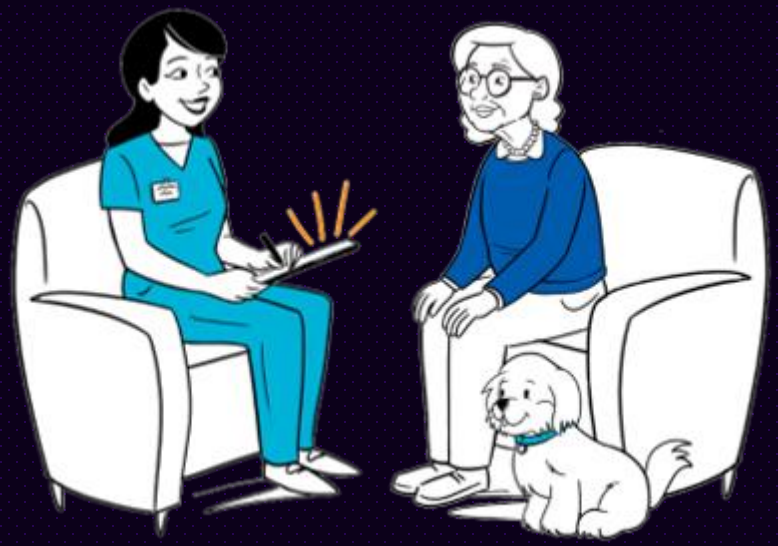
# 4. Chose the One Thing to Focus On

The One Thing is the one troublesome issue the older adult most wants to focus on so they can reach their health goal. It provides a starting place for clinicians when making decisions based on what matters most to the patient.

The one symptom, health problem, healthcare task, or medication I most want to focus on is _____ so that I can *(insert health goal)* _____more often or more easily.

# Align Care with Health Priorities- Taking the Next Step in What Matters

- Patient feels listened to, engaged, and motivated which increases adherence
- Offers an anchor in the face of uncertainty, tradeoffs, lack of one best answer
- Achieving patients' health priorities becomes ***the measure*** for treatment effectiveness
- Directs everyone to same target



Care Alignment

# 1. When Reviewing Identified Priorities, Consider:

- Which conditions, symptoms, treatments, life circumstances contribute to the bothersome problem impeding their health goal?
- If the most bothersome thing is a symptom or complaint, which of the current conditions could be contributing to that?
- What current or potential medical, rehabilitative, socioenvironmental or other interventions might address the contributing factors you identified?
- Select 2-3 of these interventions to discuss starting, stopping, or continuing Also consider if interventions patients finds burdensome can be changed or stopped, particularly if unlikely to help most bothersome problem or goal achievement.

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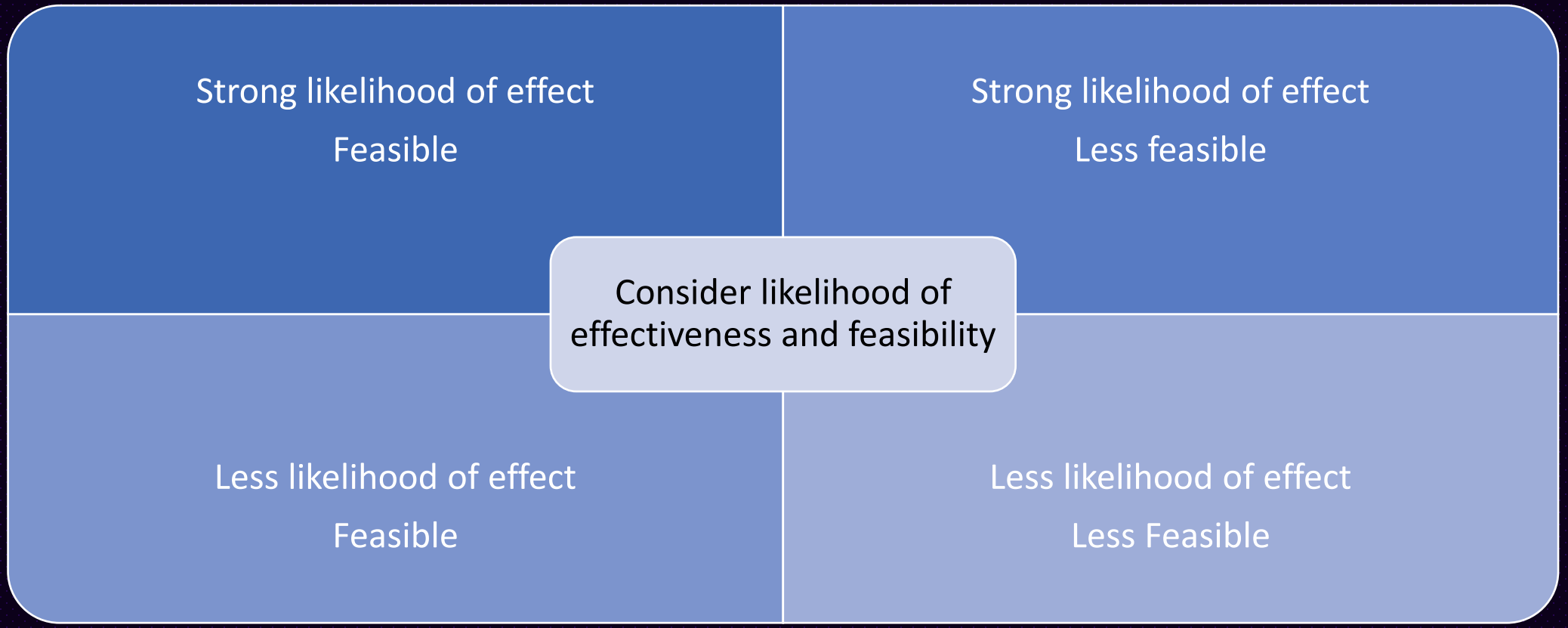
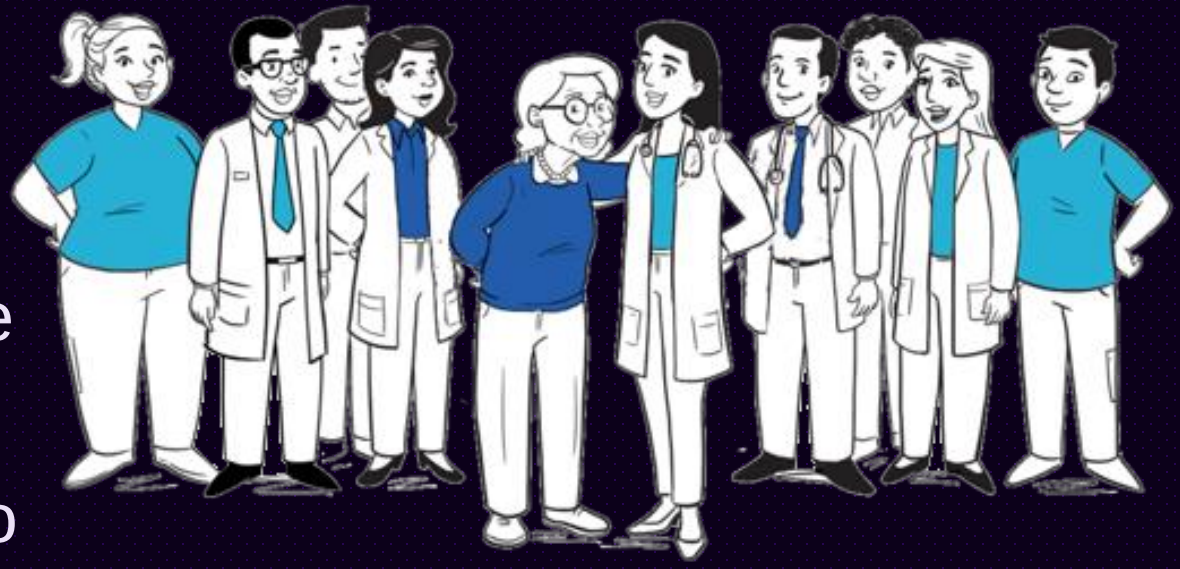
# Consider-Where to start changes?



Care Alignment

# 2. Use Health Priorities as Focus of Decision Making and Communication

- Discuss health interventions in relation to patient's health priorities not just disease-based tradeoffs.
- Use patient priorities to guide trials of starting, stopping or continuing interventions over time (serial trails).
- Acknowledge uncertainty and that it is not always possible to identify one obvious best treatment.
- When talking with their other health professionals, use health priorities to align decisions, especially where differing perspectives or recommendations exist.



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Care Alignment

# 3. Document

Document changes in care related to patients' priorities (What Matters)

"after reviewing the patient's health priorities, I have made the following changes"

# Resources

- https://patientprioritiescare.org
- http://myhealthpriorities.org
- Troubleshooting http://decisionguide.patientprioritiescare.org/
  - Health outcome goals are likely not achievable with interventions the patient is willing or able to adhere to?
  - Health outcome goals are not achievable and realistic given health status?
  - Patient makes a decision you don’t agree with?

# Conclusion

- Fundamental Patient Priorities Care (PPC) can be effectively incorporated in health care to elicit and align care with the What Matters M of Age-Friendly Care
- The framework for identifying priorities can be used independently by older adults, or with assistance from caregivers or a member of the interdisciplinary healthcare team
- The One Thing is the one problem the older adult wants to focus on in order to achieve their health priority
- Fundamental PPC uses patients' health priorities as the focus of communication and decision making about their care

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# Let's learn together!

Question Mark Abstract Geometric - Free vector graphic on Pixabay

# Charter Care

## Dr. Hugo Yamada

**Summary of PDSA:**

We will begin to record caregiver information within the adapted template and begin using the modified care index as a means of identifying caregiver stress.

**Barriers/successes**

1. Modified care index has been integrated into template to identify caregiver burden
2. MAs not yet trained in using it due to staffing concerns

**What strikes us as most interesting or valuable about this work?**

Caregiver burden has been recognized for a long time. We want to create a path to support services to relieve some of that burden.

# PACE Rhode Island

## Kriss Auger

### Summary of PDSA:

Our goal is to identify the caregiver vs emergency contact and to improve ability to distinguish caregiver level of engagement. We sent invites to identified caregivers on 9/29 for an 11/1 listening session. We're hoping to get ideas of what would help caregivers. We also want ideas about what information would be helpful for a caregiver/dementia resources section on our website.

### Barriers/successes

We're providing transportation for people who need it to listening session. We're limited to English speaking caregivers at this time. Ten caregivers have agreed to attend!

### What strikes us as most interesting or valuable about this project?

Including caregivers is key, as well as including different types of caregiving (long-time caregivers v. new caregivers, people who have expressed concerns). We're also looking forward to introducing caregivers to each other.

# University Internal Medicine

## Cheryl Davis

**Summary of PDSA:**

We are addressing how we identify caregivers and where we will record that information.

**Barriers/successes:**

- deciding where to put the information so that it's convenient for everybody
- we decided to create a separate form for identifying caregivers of patients with dementia. We will scan the forms into the EMR and record that in the demographic section, which allows for just one caregiver.

**What strikes us as most interesting or valuable about this work?**

It's needed! It's something that everyone will need to have a plan in place for. We want to prevent caregiver burnout and help the patient.

# Drs. Brennan, Cronin and Associates

## Kaylee Mehlman

**Summary of PDSA:**

We began to identify patients with dementia and recorded caregiver information on five patients, both on a chart and in the EMR. We also recorded caregiver status in the EMR so that all staff can be aware of the need for additional support for these patients. Next steps will be referring patients to our behavioral health clinicians and then providing additional referrals to the Alzheimer's Association or other organizations as appropriate.

**Barriers/successes**

**Success:** enthusiasm from all 5 providers to adopt this care model, involvement of entire care team

**Barrier:** We are using an EMR that isn't integrated across the ACO, so figuring out where to put information is difficult. We are still waiting for Epic updates. Time is a barrier – there's just too much to do overall.

## What strikes us as most interesting or valuable about this project?

The opportunity to take a step back and be able to look at patients more holistically – we get caught up in the day-to-day, and this is an avenue to look at our patients holistically.

# Brown Medicine

BROWN MEDICINE
BROWN PHYSICIANS, INC.

## Dr. Ashna Rajan

### Summary of PDSA

Patient 1: Evaluated decline and referred to hospice upon request, documented in SOAP note. Later discussed transition to hospice care, documented in telephone encounter.
Patient 2: discussed decline in status and recommended hospice referral, documented and referred in virtual visit.
Patient 3: discussed decline in status with caregiver, referred to psychiatric nurse practitioner, documented in SOAP note.
Patient 4: recognized caregiver by asking family, documented in progress template, screened for caregiver stress identified, offered social worker services, if needed in the future
Patient 5: caregiver identification, as above, recognize caregiver stress, introduced, social worker/integrated behavioral health to caregiver and patient during visit, and they scheduled follow up appointment.

**Barriers/successes**

Barriers: availability of external community resources within the ALF setting
Successes: patients and families accept referrals when they address specific needs and concerns.

**What strikes you as most interesting about this project?**

It is important to focus on the needs of the patients we are serving

# Milestone Document & Resource Guide

| Milestone Document | Resource Guide |
| --- | --- |
| View here | View Here |

# Discussion, Questions & Next Steps

ADVANCING INTEGRATED HEALTHCARE

**Learning Collaboratives**:
Wrap up: **February 21st, 2024, 7:30 - 8:30 AM**

**Practice Facilitator Meetings** scheduled monthly individually with PF and practices
**(Sept 2023-Feb-2024)**

**Next PDSA Due Date:**
February 1st, 2024

**Process-Walkthrough Post Assessment Due:**
February 7th, 2024

**IHI Level 1 Plan Due**: February 29th, 2024

**Please complete the following evaluation via survey monkey**