



AGE-FRIENDLY HEALTH CARE AND A FOCUS ON 4MS TO IMPROVE CARE OF OLDER ADULTS

- A CME CONFERENCE SERIES

DEVELOPED AND PRESENTED BY:
THE SAN DIEGO /IMPERIAL GERIATRIC EDUCATION CENTER (SDIGEC)

The SDIGEC is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services under grant number U1QHP28717, Geriatric Workforce Enhancement Project award.

Aligning Care with ‘What Matters’ Most for Older Adults

October 21, 2021

Presented by:

Khai Nguyen, MD, MPH and Cari Jones, FNP

Request in the Chat: Type Name, Clinic Location, and Type of Provider (MD, DO, NP, MSW...)

Want CME credit? Please sign-in and complete an evaluation to receive CME credit for your participation using the link or QR code below:

https://ucsd.co1.qualtrics.com/jfe/form/SV_0ClbG8VGR5UHqAK

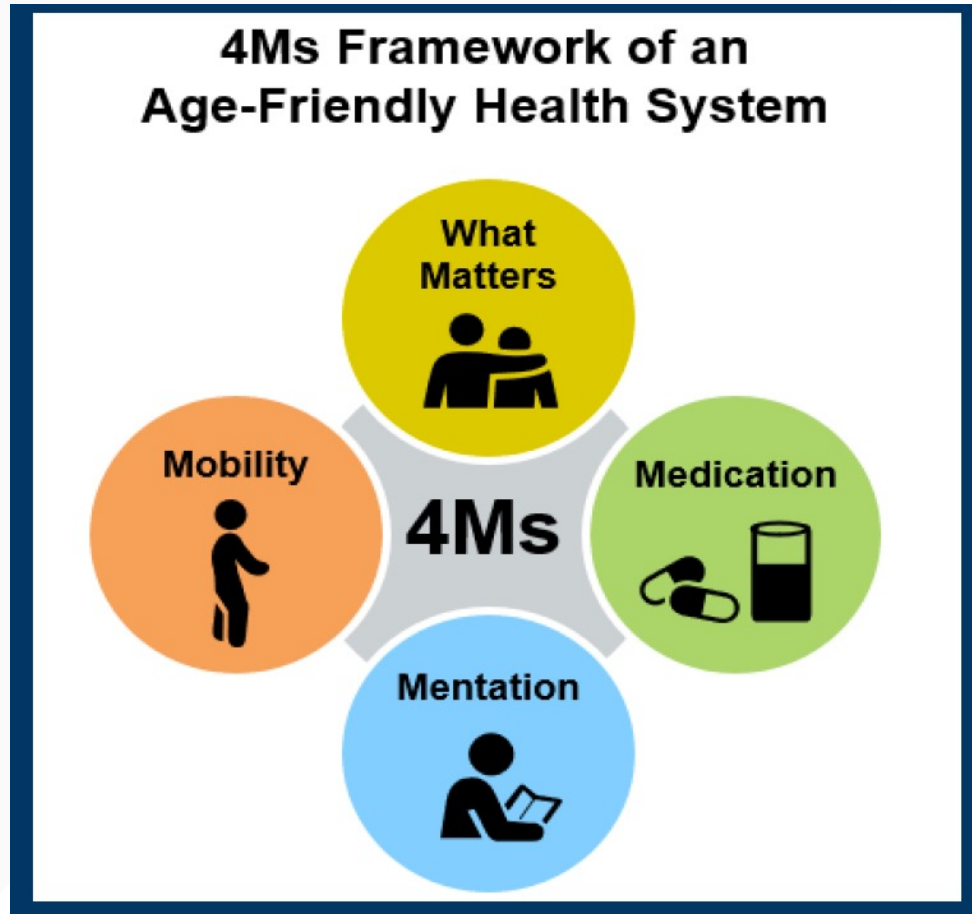


Please refer to the calendar invite for the syllabus for this series.

OBJECTIVES

- Identify how your health system addresses what matters most to each older patient for:
 - Current care planning (e.g., Plan for a patient at a clinic visit)
 - Advanced care planning (e.g., Advanced directive)
- Provide examples for how to assess what matters most to each older patient
- Discuss ways to act upon what matters most using patient care examples

Refresher on 4Ms of Age-Friendly Care



what **M**atters

Know and align care with what Matters to each older adult

Medications

Deprescribe or do not prescribe high- risk meds considering what matters most

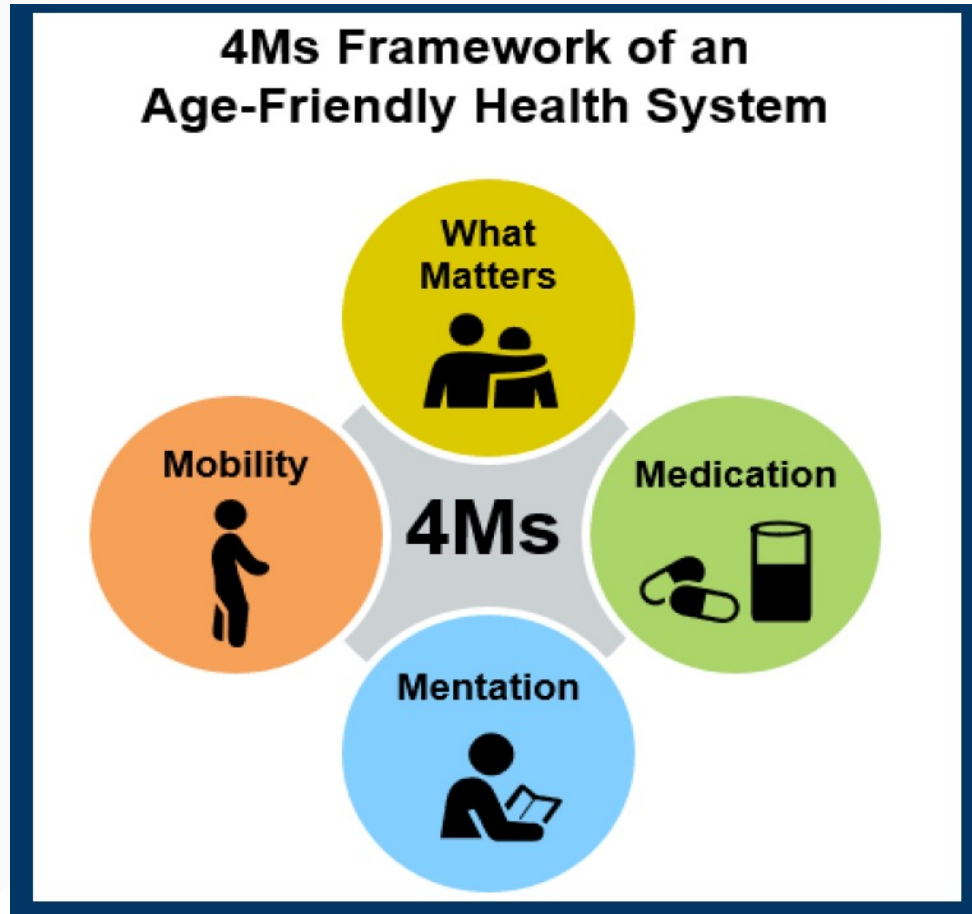
Mobility

Promote safe mobility to maintain function and do what matters most

Mind

Prevent, diagnosis, and manage delirium, depression, and dementia to enjoy what matters most

Refresher on 4Ms of Age-Friendly Care - *Continued*



Age-Friendly Healthcare aims to:

- Follow essential set of **evidence-based practices**
- Cause **no harm**
- Align care with **what Matters** to each older adult and their family

Why what MATTERS Most Matters Most

- For older adults:
 - Vary in What Matters most
 - Feel more engaged, listened to
 - Avoid unwanted care and receive wanted care
- For clinicians:
 - Connect with and understand your patient
 - Motivate adherence to their plan of care
- For health systems:
 - Better patient experience scores and retention
 - Avoid unnecessary utilization



Aim of What Matters Most

- Reframes question from “**What is the matter with you?**” to “**What Matters to you?**”
- **Know** and **align care** with each older adult’s specific health outcome goals and care preferences, including, but not limited to, end-of-life care

Reflection on What Matters Most

Chat Function

Do you have older patients where you felt a disconnect between what mattered most to them and their healthcare?

Reflection on What Matters Most

Chat Function

How do you find out or ask about what matters most to your patients in their daily lives (eg. current care planning)?

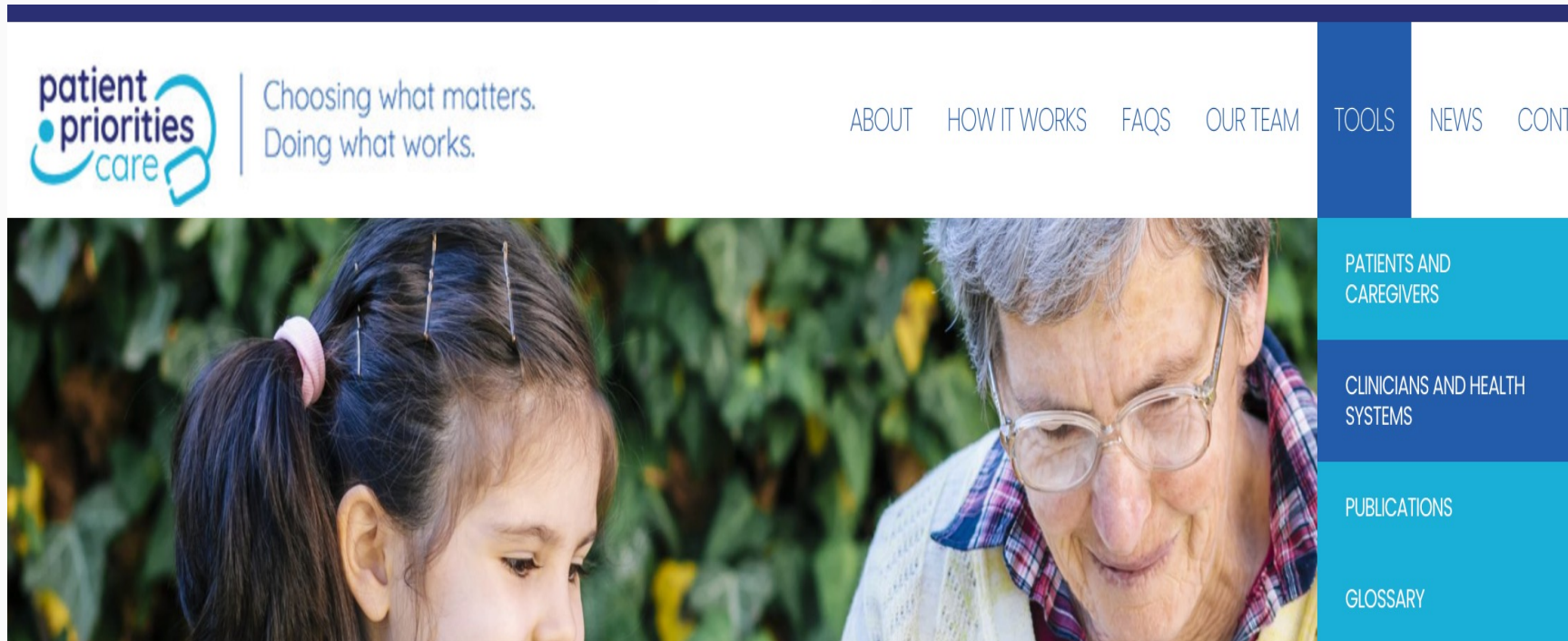
Questions you can ask - choose one to try!

Current Care Planning:

- What is important to you today?
- What would make tomorrow a really great day to you?
- What brings you joy? What makes you happy? What makes life worth living?
- What are some goals you hope to achieve in the next 6 months or before your next birthday?

Resources: Current Care Planning for what Matters Most

www.patientprioritiescare.org



- Paper Template
- Myhealthpriorities.org
- Documentation in EHR
- Billing

Patient Priorities Care



Choosing what matters.
Doing what works.

Patient Priorities Care Health Priorities Template (facilitated version)

What Matters Most (Values):

Most Important Health Goals: Health goals are specific and realistic activities or outcomes that show you are doing what matters most in your life. These health goals are what you want to achieve with your healthcare.

- 1.
- 2.

Most Bothersome Symptoms or Problems interfering with your health goals:

- 1.
- 2.

Health care preferences (Helpful and burdensome care and medications)

Helpful care: self-management tasks, clinical visits, tests, or procedures, that you think are helping most with your health goals and you can do them without too much difficulty

- 1.
- 2.

Helpful medications: Medications you think are helping most with your health goals and you can take without too much difficulty

- 1.
- 2.

Burdensome care: self-management tasks, clinical visits, tests, or procedures that don't think are helping your goals and are burdensome or too difficult. You should talk with your doctor about whether these are helping your goals. If not, can you stop them or cut back? If they are helping, is there a way to make them less burdensome or less difficult?

- 1.
- 2.

Burdensome medications: Medications you don't think are helping your goals and are too burdensome. You should talk with your doctor about whether these are helping your goals. If not, can you stop or decrease? If they are helping, is there a way to make them less burdensome?

- 1.
- 2.

One Thing: Your most important health goal is *(insert most important health goal)*. From among the *symptoms or health problems, burdensome health tasks or medications, fill in the ONE THING you most want to focus on so that you can do (insert most important health goal) more often or more easily*"

Values:

What comes to mind when you think about who or what matters most to you in your daily life?

Healthcare Goals:

What are the values and activities that matter most to you and are impacted by your health (eg. ability to play on floor with grandchildren)?

Healthcare preferences:

What parts of your healthcare (self-management tasks, clinical visits, tests, procedures) seem to help with your healthcare goals?

What parts don't seem to help or are too burdensome?

One thing:

What is the one thing you want to focus on most in your healthcare in order to achieve your healthcare goals?

Reflection on What Matters Most

Chat Function

How do you find out what would matter most to your patients if they were too ill to make decisions for themselves (e.g., Advance care planning)?

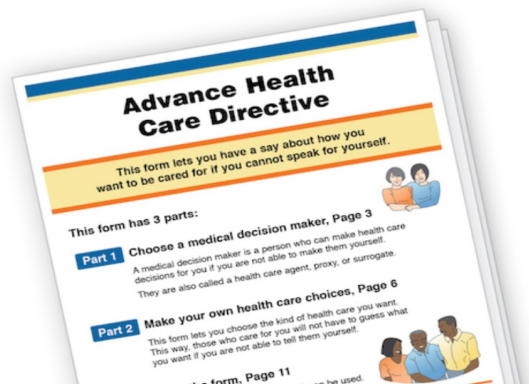
Questions you can ask - choose one to try!

Advance Care Planning:

- Who would you want to make medical decisions for you?
- What are your most important goals if your health situation worsens?

Resources: Advance Care Planning for what Matters Most

www.prepareforyourcare.org



PREPARE Easy-to-Read Advance Directives:

Free to fill out and print for all states.

[Get the PREPARE Advance Directive](#)

Advance Directive is a form that lets patients have a say in how they want to be cared for if they cannot speak for themselves

- Medical decision-maker
- Healthcare preferences

Low Health Literacy, Easy to Read

Multiple languages

Resources such as **videos** to help patients fill out the advance directive

California Advance Health Care Directive

This form lets you have a say about how you want to be cared for if you cannot speak for yourself.

This form has 3 parts:

Part 1 Choose a medical decision maker, Page 3

A medical decision maker is a person who can make health care decisions for you if you are not able to make them yourself.

This person will be your advocate.

They are also called a health care agent, proxy, or surrogate.



Part 2 Make your own health care choices, Page 7

This form lets you choose the kind of health care you want. This way, those who care for you will not have to guess what you want if you are not able to tell them yourself.

Part 3 Sign the form, Page 13

The form must be signed before it can be used.



You can fill out Part 1, Part 2, or both.

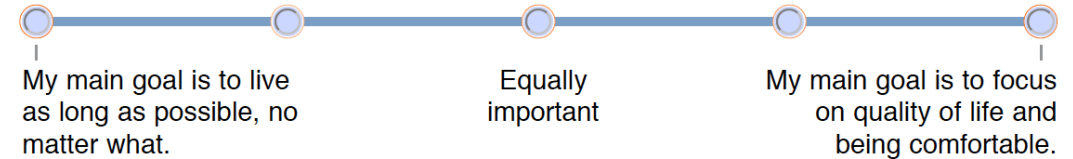
Fill out **only** the parts you want. Always sign the form in Part 3.

2 witnesses need to sign on Page 14, or a notary on Page 15.

Example: page 8

TODAY, IN YOUR CURRENT HEALTH

Check one choice along this line to show how you feel today, in your current health.

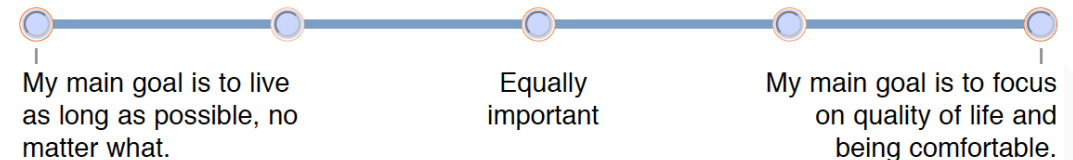


If you want, you can write why you feel this way.

Blank light blue box for writing reasons.

AT THE END OF LIFE

Check one choice along this line to show how you would feel if you were so sick that you may die soon.



How do you introduce topic of Advance Directives?

- Many ways

- The way I like to do it:

”It is my practice to encourage **all of my patients** to do an Advance Directive because I want them to have a say about how they want to be cared for IF they couldn’t speak for themselves. **I’ve done my own Advance Directive** and have made sure that my family has and would like to encourage you to do one, too!”

- Encourage discussion with family

Case Discussions

- Current Care Planning
- Advanced Care Planning
- **Share your stories!**
 - A situation where healthcare (self-management tasks, clinical visits, tests, procedures) may have been interfering with What Matters Most to your patient
 - A time where you needed to find a creative way to address advance care planning with the patient and/or family members

Current Care Planning: Case Discussion

1.

Meet Mr. K & Mrs. K



Mr. K has multiple health conditions



Mr. K's Conditions

- Diabetes
- Heart failure
- Depression
- High blood pressure
- High cholesterol
- Arthritis
- Enlarged prostate
- Blurry vision

Treatment Recommendations

- Check blood sugar 4 times a day
- Take 15 meds each day
- Check feet daily
- Check weight daily
- HgbA1c and other lab tests quarterly
- Echo and EKG annually
- DASH diet



Patientprioritiescare.org. (2019). Retrieved from <https://patientprioritiescare.org/how-it-works/infographic/>

Patient Priorities Care

2.

Mr. K's healthcare team wants him to:



Psychiatric Nurse Practitioner

Stop beta-blocker



Increase beta-blocker



Cardiologist

No need to start insulin



Primary Care Doctor

Start insulin



Endocrinologist



Each clinician is focused on treating his individual conditions.

Is this what Mr. K wants?



Patientprioritiescare.org. (2019). Retrieved from <https://patientprioritiescare.org/how-it-works/infographic/>

3.

Mr. K's healthcare is:



Complicated and burdensome for Mr. K

Fragmented and frustrating for Mr. K's care team



Mr. K. wants his healthcare to help him:



Feel well enough to spend time playing with his grandchildren



Be able to help Mrs. K with housework



Have the energy to go out and visit with friends



4. A member of the healthcare team meets with Mr. K to help him identify his health outcome goals and what he's willing and not willing to do to achieve his goals.



Mr. K's Health Goal

I want to: be less weak

so I can: help with chores and play with my grandchildren twice a week



What Mr. K is willing and not willing to do to achieve his goals:

Care Preferences:

- ✓ Stop medications that make me weak and shaky
- ✓ Take medications and do other things that make me feel stronger

Health Tradeoffs:

- ✓ Remove health tasks that might make me live longer, if they don't improve how I feel now



5.

Mr. K's goals and preferences are communicated to his healthcare team.



They align Mr. K's healthcare to treat his **goals**, not just his **diseases**.



Mr. K and his healthcare team now all agree to:



Focus on medications that help him feel stronger, and less shaky
(keep beta blocker and not start insulin)



Start physical therapy to improve his strength



Decrease frequency of lab tests



Patient Priorities Care

6. At each appointment, Mr. K reports progress or challenges in meeting his goals.



I'm feeling better, but still too tired to play with my grandchildren

Ok, let's cut back your blood pressure medication a little and see how that works

Mr. K's care is adjusted accordingly.



Care aligned with Mr. K's priorities results in:

-  Less burden for Mr. and Mrs. K
-  Less frustration for his healthcare team
-  Clear priorities understood by the entire care team
-  Care consistent with what matters **most** to Mr. K



Patientprioritiescare.org. (2019). Retrieved from <https://patientprioritiescare.org/how-it-works/infographic/>

Share your Story

- A situation where healthcare (self-management tasks, clinical visits, tests, procedures) may have been interfering with What Matters Most to your patient?
- A time where you needed to find a creative way to address advance care planning with the patient and/or family members?

Advance Care Planning: Case Discussion



Without Advance Care Planning



With Advance Care Planning



Share your Story

- A situation where healthcare (self-management tasks, clinical visits, tests, procedures) may have been interfering with What Matters Most to your patient?
- A time where you needed to find a creative way to address advance care planning with the patient and/or family members?

Summary

- **Asking and aligning care with what matters most to your older patients** can improve the quality of their care, adherence to the care plan, and is fun
- **Current care planning:** Pick a way to ask what matters that suits your style and try it on your next patient! Decide as a clinic where you'd like to document!
- **Advance care planning:** best way to learn how to do this for your patients is to do an advance directive for yourself and family!

Resources Available

CURRENT CARE PLANNING (Additional Resources)		
Organization	Name	Link
Institute for Healthcare Improvement	What Matters to Older Adults Toolkit	http://www.ihl.org/Engage/Initiatives/Age-Friendly-Health-Systems/Documents/IHI_Age_Friendly_What_Matters_to_Older_Adults_Toolkit.pdf
Institute for Healthcare Improvement	Age-Friendly Health Systems: Guide to Using the 4Ms in the Care of Older Adults	http://www.ihl.org/Engage/Initiatives/Age-Friendly-Health-Systems/Documents/IHI/AgeFriendlyHealthSystems_GuidetoUsing4MsCare.pdf
MyHealthPriorities.org	Identifying My Health Priorities	https://myhealthpriorities.org/
National Committee for Quality Assurance (NCQA)	Person-Centered Care Planning: Identifying Goals and Developing Care Plans	https://www.ncqa.org/news/person-centered-care-planning-identifying-goals-and-developing-care-plans/
ADVANCED CARE PLANNING (Additional Resources)		
Organization	Name	Link
National Institute on Aging	Advance Care Planning: Health Care Directives	https://www.nia.nih.gov/health/advance-care-planning-health-care-directives

❖ Current Care Planning: www.patientprioritiescare.org

❖ Advance Care Planning: www.prepareforyourcare.org



THANK YOU!

Reminder: Please sign in and complete an evaluation to receive CME credit for your participation using the link or QR code below:

https://ucsd.co1.qualtrics.com/jfe/form/SV_0ClbG8VGR5UHqAK



Questions? Contact us at:

Roopali Gupta, MD: rog007@health.ucsd.edu

Jennifer Reichstadt, MSG: jreichst@health.ucsd.edu

