Improving Care for Frail Elders: The Role of the Healthcare System

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Objectives

- Explain why frailty associated with old age is a priority area for national action to improve healthcare quality

- Describe drivers of healthcare quality at the level of the system, the organization, and the individual provider

- Identify barriers to translating evidence into practice within organizations

- Incorporate effective organizational change strategies to ensure your organization’s management of frailty is consistent with current evidence
What do we know about quality?

- 44,000 – 98,000 people die each year due to medical errors in hospitals (IOM, 2000)
- A hospital patient experiences one medication error/day (IOM, 2007)
- Just 15% of those 65+ who report falls are assessed for modifiable risk factors within 3 months (McGlynn et al., 2003)
- 50% of heart failure patients are readmitted within 6 months (van der Wal et al., 2008)
- Average Medicare beneficiary with 1+ chronic conditions seen by 8 different physicians in a year (Anderson & Knickman, 2001)
What are the challenges? (IOM, 2003a)

- Consistently deliver known best practices
- Avoid preventable harm
- Care for an aging population
- Manage high prevalence of chronic conditions
- Staggering Costs (Projected 2009) (Sisko et al., 2009)
  - $2.5 trillion total healthcare spending
  - $8,160 per capita annual spending
  - Healthcare spending is 17.6% GDP
How do we cross the chasm?

- System Redesign
- Professional Competencies
- Focus on common chronic conditions
Six Aims of System Redesign to Cross the Quality Chasm

- Equitable
- Efficient
- Timely
- Patient-Centered
- Effective
- Safe

If we know better...
Why don’t we do better?

“Health services research can save more lives in the next decade then can bench science, work on the human genome, stem cell therapy and cancer research.”

Atul Gawande, MD
Better: A Surgeon’s Notes on Performance
External Drivers of Quality

Domains of Quality
- Safe
- Consistent with Knowledge
- Customized

Funding to Study System Redesign

NIH and AHRQ FY 2009 Budgets

- NIH Budget FY 2009: $30,395,098,000.00
- AHRQ Budget FY 2009: $372,000,000.00

http://officeofbudget.od.nih.gov/pdfs/FY09/Final%20Conference.pdf
Figure 3-1  Relationship among core competencies for health professionals.
Focus on Chronic Conditions (IOM, 2003a)

- ...for which patients often receive substandard care
- ...first step in improving quality
- Account for majority of health burden
- Account for 78% of total health spending
- Transfer learning about system approach to other areas
- Cross the continuum of care
Initial Framework for Determining Priority Areas (IOM, 2003a)

Impact
Improvability
Inclusiveness
Final Priority Areas (IOM, 2003a)

- Care coordination (cross-cutting)
- Self-management/health literacy
- Asthma
- Cancer
- Children with special needs
- Diabetes
- End of life
- Frailty associated with old age—preventing falls and pressure ulcers, maximizing function, developing advanced care plans.
- Hypertension
- Immunization
- Ischemic heart disease
- Major depression
- Medication management
- Nosocomial infections
- Pain control in advanced cancer
- Pregnancy and childbirth
- Severe and persistent mental illness
- Stroke—early intervention and rehabilitation.
- Tobacco dependence
- Obesity (emerging area)
Aim of Frailty as a National Priority Area
(IOM, 2003a)

- Provide optimally safe environment
- Provide necessary assistance with ADLs
- Maintain/improve function
- Prevent and treat secondary complications
- Use advanced care plans that reflect patient/family preferences
Impact of Frailty as a National Priority Area (IOM, 2003a)

- Patient with Three of Five Components of Frailty
  - Unintentional weight loss
  - Self-reported reduced energy
  - Decreased grip strength
  - Slow walking speed
  - Low level of physical activity

- Prevalence of frailty: 7% of community dwelling elders 65+
  - Nebraska 65+ population = 234,007
  - 16,380 Frail Elders in Nebraska!

- Services typically poorly coordinated; NOT continuously coordinated across a continuum of settings
Impact of Poor Coordination

- Frustration
- Confusion
- Unmet Needs
- Harm
Impact of Coordinated Multidisciplinary Team Care

Planned
Proactive
Preventive
What is the Improvability of Care for Frail Elders in your Community?

• Can organizations…
  • Prevent skin break down
  • Improve advanced care planning
  • Help to avoid preventable injuries
  • Increase physical activity, strength, and function
  • Support family caregivers

(IOM, 2003a)
Barriers to Organizational Change

- Structural
  - Financial disincentives
  - Lack of skills, facilities, equipment
- Peer group practice patterns
- Professional
  - Knowledge, skills, attitudes, beliefs
- Patient Factors
  - Preferences based on advertisement, not science
  - Values

(Shojania & Grimshaw, 2005)
What is the most effective way to translate the best available evidence into routine practice?

(Shojania & Grimshaw, 2005)
Conclusion: A Strategy for Leading Change

- Engage: How do I make the world a better place?
- Educate: What do I need to do?
- Execute: How do we ensure that we do it?
- Evaluate: How will I know I made a difference?
- Expand: How does everyone do the right thing?
- Endure: How do we make sure the change sticks?

(Pronovost et al., 2006)
Engage at Multiple Levels

• **Executive Leaders:** How does this innovation fit our mission?

• **Team Leaders:** How do I touch the hearts of my staff?

• **Staff:** Can I make a difference in the lives of others?
Educate at Multiple Levels

• **Executive Leaders:** How do I educate the board and medical staff?

• **Team Leaders:** What is the evidence? Are executive and medical staff aware of the evidence, agree with it, able to implement it? Are there tools to help me develop a plan?

• **Staff:** Why is this change important? How are patient outcomes likely to improve? How does my daily work need to change? Where do I go for support?
Execute at Multiple Levels

- **Executive Leaders:** Do the medical staff and board support the plan? Do we have the skills and vision to implement the plan? Do teams have resources, incentives and organizational support?

- **Team Leaders:** Do staff know the plan? Do they have the skills and commitment? Have we tailored this change to our environment?

- **Staff:** Can I be a better team member? Am I learning from my mistakes?
Evaluate at Multiple Levels

- **Executive Leaders:** Have resources been allocated to collect and use data to monitor the change? Is care better? Are patients safer? How will we know?

- **Team Leaders:** Have I created a system for reporting, collecting and using data? Is care better? Are patients safer? How will we know?

- **Staff:** Is this a better place to work? Do I know if care is better? Is teamwork better? Are patients safer? How will we know?
Engage: Rural Geriatric Assessment Clinic

- Sample County Nebraska
  - Population 9,747
  - 1,764 (18.1%) are 65 years of age and older
  - 123 (7% of elderly) are likely to be frail
  - 587 (1/3 of community dwelling elderly) are likely to fall each year
  - 60 (10% - 12%) falls will result in injury

- The Vision: Cut injurious falls in half...screen all those 65+ who report falls for modifiable risk factors
Educate: Rural Geriatric Assessment Clinic

- Frailty is a syndrome
- Intrinsic and extrinsic risk factors for falls
- What screening instruments are available
- Who needs to be on the team
- Observe others who are doing what you want to do

- The Vision: Screen all older adults who report a fall for modifiable risk factors and frailty
Execute: Rural Geriatric Assessment Clinic

- Implement structures and processes
  - Instruments
  - Roles and responsibilities
  - Team processes
  - Identify community resources
- Make a small test of change to begin, learn, adapt

- The Vision: Screen all older adults who report a fall for modifiable risk factors and frailty
Evaluate: Rural Geriatric Assessment Clinic

- How do we know we made a difference?
  - Patient/family satisfaction
  - Staff satisfaction
  - Decreased rate of injurious falls
  - Decreased rate of institutionalizations
  - Maintain function and quality of life

- The Vision: Screen all older adults who report a fall for modifiable risk factors and frailty
Eight Steps of Change
Kotter & Rathgeber. (2005). Our Iceberg is Melting

Engage
Educate
Execute
Evaluate

Create a new culture
Don’t let up—Be relentless
Short-term wins
Empower others
Understanding & buy-in
Develop a change vision & strategy
Build the guiding team
Create sense of urgency
It will take a committed team to overcome barriers to organizational change and improve care for frail elders in your community.

“Team learning is vital because teams, not individuals, are the fundamental learning unit in modern organizations.” — (Senge, 1990, p.10)
Tools

10 Step Action Plan to Implement Change
Checklist for Implementing Change
Trouble Shooting Graphic
Checklist for Implementation Success

• Clearly define the change
  • The change is a clear advantage over the “old way” (WIIFM)
  • The change is compatible with the existing mission and values of the organization
  • The change is easily understood (it is not overly complex)
  • The change is “trialable”; employees can try it out on a limited basis and “learn by doing”
  • The change is “observable”; employees see others engaged in the change and receive positive feedback

(Helfrich, 2007; Rogers, 2003)
Checklist for Implementation Success

- Management is supportive of the change (WIIFM)
- Implementation “champion”
- Change is a major priority—will be supported, rewarded
- Resources are available
- Policies/procedures changed to sustain the change
- Job descriptions changed to sustain
- Effectiveness of change is evaluated
- New processes continually improved based on evaluation results

(Helfrich, 2007; Rogers, 2003)
### SUCCESS FACTORS FOR CHANGE

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