



Eldercare Voices Columns

Perspectives from Leading Geriatrics Health Professionals

February 2019



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Thank you to the dozens of leading national geriatrics experts and advocates who contributed to columns over the years. Generous support for our Geriatrics Provider Collaboration project came from The John A. Hartford Foundation.



Eldercare Voices Columns

Improving the care of older adults is a core part of the Center for Consumer Engagement in Health Innovation's mission. Starting in 2014 with a grant from The John A. Hartford Foundation, we launched our Geriatrics Provider Collaboration project, with one of its goals being to educate key stakeholders about what good care looks like for dually eligible and other vulnerable older adults.

Our e-newsletter, *Health Innovation Highlights* (formerly *The Dual Agenda*), is a key communications and education vehicle for this work, and the Eldercare Voices column has been a successful avenue to promoting geriatrics care practices, policies and timely issues. This feature publishes guest columns written by leading geriatrics and gerontological professionals, highlighting topics within the geriatrics field that have meaningful impact on aging adults, their caregivers and the care they receive. By providing this forum for the sharing of expertise, the Eldercare Voices columns make available field-level perspectives on quality care models and competent-care best practices and policies that assist older adults in navigating their health care.

With the implementation of the Centers for Medicare and Medicaid Services' Financial Alignment Initiative, the quality of care for older adults and people with disabilities dually eligible for Medicare and Medicaid became a key focus of our work. During this time, the Eldercare Voices column focused largely on providing frontline perspectives on how the federal-state dual eligible demonstration projects were progressing. As the work and focus of the Center for Consumer Engagement in Health Innovation expanded beyond the duals demonstrations, so too did the scope of topics presented in this feature. Now with a collection of over 35 guest columns, Eldercare Voices continues to serve as a valuable resource for stakeholders across the health care field.

For the last five years, Eldercare Voices has provided our newsletter with a specialized focus on innovative programs and policies that improve the care of older adults. Given the popularity of these columns, we wanted to compile some of the most-viewed columns for dissemination. The columns fall into three categories of geriatrics topics: Models of Care; Geriatrics Clinical Topics; and Advocating for Better Care. The appendix lists all of the columns by title and author.

The demand for good geriatrics care will continue to grow as 10,000 people in this country are turning 65 every single day, and this is expected to continue into the 2030s. We hope that this information will contribute to addressing this need through the best shared solutions and practices.

Models of Care

Taking Charge! Evidence-Based Self-Management Programs Key to Better Care and Lower Costs

August 20, 2014

Rob Schreiber, MD

The United States is facing unprecedented growth of its over-65 population as more than 10,000 baby boomers are now reaching this age daily. In addition, adults with disabilities are growing in numbers and make up a significant part of this population. With this demographic expansion comes continuing explosive growth in Medicare and Medicaid expenditures needed to provide health care services for this population. In [The State of Aging and Health in America 2013](#), the Centers for Disease Control and Prevention (CDC) reported that two out of three older Americans have multiple chronic conditions such as diabetes, hypertension and heart disease, and over 95 percent of health care spending for older adults is attributed to chronic disease. Among the main precipitating causes of chronic disease are individual behavior patterns, such as poor nutrition habits, lack of physical activity and smoking. Social determinants of health, including environmental and financial issues also come into play. All told, 70 percent of health spending has a non-medical cause.

Engaging the older adult to reach her best quality of life has continued to be a challenge for health care providers. The vital importance of the individual in taking responsibility for her own health is strongly recognized by the US Prevention Services Task Force as key to improving health outcomes. Indeed, according to a [2013 study](#), people actively involved in their health care tend to have both better outcomes and lower costs. However, in the US health care system, there often exists no *formal training or education aimed at activating individuals* struggling with chronic illness to take a strong role in managing their own health.

The Massachusetts [Healthy Living Center of Excellence](#) (HLCE) seeks to address the gap in self-management education by providing community-based health and wellness programs for older adults. Unlike traditional programs, HLCE initiatives emphasize the patient's role in managing his medical illnesses, resulting in better quality of care and better health outcomes. These programs teach self-confidence skills through an evidence-based approach that has been proven effective at improving one's quality of life and health.

Through collaborative grants from [The John A. Hartford Foundation](#), the [Tufts Health Plan Foundation](#) and the [Administration on Community Living](#), the HLCE works with a team of community-based organizations to offer programs in every county in Massachusetts. The programs are typically offered in community-based settings such as senior centers, area agencies on aging, community health centers, hospitals, faith-based organizations and medical offices. Among the programs available in Massachusetts are:

- Chronic Disease Self-Management Program (CDSMP)
- Tomando (CDSMP for Spanish-speaking populations)
- Diabetes Self-Management
- A Matter of Balance
- Healthy Eating for Successful Living in Older Adults
- Powerful Tools for Caregivers
- Pain Self-Management Program

CDSMP, the HLCE's principle program offering, based on the Stanford Chronic Disease Self- Management Program, is a 6-week workshop offered to adults living with the challenges of one or more persistent health conditions. Participants meet for 2½ hours, once a week. Workshops, which are led by two certified lay leaders, use a mutually supportive model that encourages individual problem-solving, goal-setting and behavior change. The topics include: dealing with difficult emotions; physical activity and exercise; power of the mind; pain and fatigue management; healthy eating; communication skills; medication usage and making informed treatment decisions.

Studies of CDSMP have shown significant improvements in participants' health and well-being, improved communication with health care providers, decreased pain and fatigue, increased confidence in participating in their health care, and, in some cases, [reduced hospitalizations and associated cost savings](#). Because these evidence-based programs are even more effective when the results are shared with the participant's health care team, the HLCE is working to build stronger linkages between older adults, their community-based organizations and providers. This type of integration is among the goals of the dual eligible demonstration projects and is viewed by many as a key means to improve care and lower costs. Indeed, many of the Massachusetts health care plans serving dually eligible individuals are already successfully implementing these programs.

To learn more about these programs in Massachusetts, visit the [Healthy Living Center of Excellence](#) website. For information on these programs in other states, visit the [Administration on Aging](#) website.

Rob Schreiber, MD



Rob Schreiber, MD is Medical Director of the Healthy Living Center of Excellence, Medical Director of Evidence-based Programs at Hebrew SeniorLife Department of Medicine in Boston, and a Clinical Instructor of Medicine at Harvard Medical School. (As of date of original publication, 2014.)

Goal-Oriented Care Is Person-Centered Care

February 22, 2018

David B. Reuben, MD

Millions of older adults live with chronic conditions – those that last a year or more and require ongoing medical attention. Examples include arthritis, diabetes, asthma and chronic lung disease, heart failure, and dementia. Few chronic conditions are curable. Therefore, the focus turns to prolonging survival and reducing symptoms. With advancing age, the likelihood of having two or more chronic conditions increases substantially, often leading to frailty, disability and advanced illness as treatments begin to lose their efficacy and general health and functioning progressively decline.

The care of chronic conditions has traditionally focused on guideline-based care and condition-specific markers of success (e.g., lower blood glucose or blood pressure readings, cancer remission). These outcomes are what might be considered “universal” goals that would be embraced, in theory, by most people who are free of multiple medical conditions and have a long life expectancy. However, many people with multiple chronic conditions, especially those with advanced illness, may not be able (or want) to attain these goals. For them, the focus must be on maintaining or improving quality of life and preserving dignity.

In response to this need, a new approach of goal-oriented, or priority-directed, care is gaining traction. This approach focuses on identifying a patient’s individual health goals within or across a variety of dimensions (e.g., symptoms; physical functional status, including mobility; social and role functions), creating health care plans to achieve these goals and determining how well these individual goals are being met. The underlying foundation of goal setting is identification of and attention to the person’s values. When trade-offs must be made between competing goals (i.e., not all are achievable) or when a short-term goal may not reflect long-term wishes, ascertainment of the patient’s underlying values is crucial.

The goal-oriented approach to health care decision-making, care and measuring of success has a variety of advantages. First, it frames the discussion in terms of individually desired situations and health states (i.e., what a person states she or he personally wants). It also allows people to focus on outcomes that span across conditions and lets the health care team plan treatment for multiple conditions at the same time with the aim of meeting the stated personal goal rather than controlling each individual disease. Finally, by knowing what states are most desired, patients and clinicians can agree on steps that can be taken to achieve these goals and monitor progress in reaching them. This approach allows for effective shared decision-making with the patient selecting the health outcome of highest priority and the clinician determining which treatment strategies are most likely to achieve the selected outcome.

Several approaches have been taken to implement goal-directed care. For example, at UCLA we held focus groups with persons living with dementia and their caregivers to identify an inventory of goals that are important. Examples include being physically safe (e.g., avoiding household hazards or getting lost), being able to maintain a relationship with a significant other, being able to live at home and not being a burden on his or her family. In the case of dementia, caregivers’ goals, such as being able to deal with stress and minimizing family conflict are also important. For dementia, most of these goals are non-medical.

We then implemented goal-oriented care by following a series of steps. Prior to a clinical visit, the list of goals was provided to the patient or caregiver to prioritize them. Then a nurse practitioner with specialized training as a Dementia Care Manager met with the patient or caregiver and facilitated the identification of the top goal, determined what success (e.g., living at home with a 24-hour caregiver) or failure (e.g., living in a nursing home) in meeting the goal would look like and developed a plan to attain the former. At six months, we measured how well

the goals were met and people were given the opportunity to set new goals or revise the previously set goals. Most were able to meet their goals and the vast majority of patients and their caregivers felt that the approach was helpful in planning future care and that the goals set were meaningful. They also felt that this process was capturing something different from usual care.

David B. Reuben, MD



David B. Reuben, MD is Director, Multicampus Program in Geriatrics Medicine and Gerontology and Chief, Division of Geriatrics at the University of California, Los Angeles (UCLA) Center for Health Sciences. He is the Archstone Foundation Chair and Professor at the David Geffen School of Medicine at UCLA and Director of the UCLA Alzheimer's and Dementia Care program. Dr. Reuben is a past President of the American Geriatrics Society and former Board Chair, American Board of Internal Medicine.

Geriatrics Clinical Topics

Medication Management Issues in Caring for Older Adults

April 4, 2014

Joseph T. Hanlon, PharmD, MS, BCP

Many older adults have multiple medical conditions, so it is not surprising that over 40 percent use four or more prescription medications. Of potential concern, is that as more medications are added to a person's regimen, there is greater potential for unexpected new interactions. The result is that adverse effects may start to manifest, decreasing rather than adding to overall well-being. In addition, a growing list of medications can make adherence difficult, due both to the overall costs and the complexity of managing them. Good geriatrics practice includes a frequent, careful review of all prescribed and over-the-counter medications. This review may identify medications no longer indicated, important drug-drug or drug-disease interactions, and newly-indicated medications that are not yet prescribed. Medication reviews are particularly important for the frail, older adult on multiple medications and for adults with advanced illness. Careful consideration needs to be given to side-effects that become more relevant with advancing age, such as any medication that may affect alertness or balance, as the risk of falls becomes more significant over time.

In the past decade, the concept of de-prescribing for older adults has emerged due to a greater emphasis on trying to optimize quality of life, especially when the accrual over time of numerous chronic conditions increases the complexity of medication management. De-prescribing can be defined as the process of tapering, withdrawing, discontinuing or stopping medications to reduce multiple medication use. While each prescription was medically indicated, and made sense when originally prescribed, each needs to be reevaluated continually with advancing age, and/or the addition of subsequent prescriptions. In caring for patients who are in very advanced stages of serious illness, and planning for end-of-life treatment, it is essential to identify unnecessary drugs that were once helpful, but that do not help make the dying patient feel better or more comfortable, in keeping with principles of palliative care.

To start this process, older patients, sometimes with the help of their family or friends, need to visit their primary care physician and bring with them all the prescription and nonprescription medications they are taking, in their original bottles and packages. He or she can ask the physician to review the medications to see if some can have the dosage reduced, or be discontinued entirely. Typically, the physician, sometimes in concert with a nurse or pharmacist, will consider the risks versus the benefits of continuing on the existing regimen. Experts have begun to agree that some medications such as blood thinners, anti-dementia medications, drugs to reduce cholesterol and medications to prevent bone fractures can be discontinued with very advanced age and frailty. The benefit is that these patients no longer have to be burdened by taking multiple medications that can expose them to unnecessary harms, in the form of understood risks – such as increased risk of internal bleeding, in the case of blood thinners, for example – that taking medications may entail.

Health professionals should always develop a de-prescribing plan in concert with the patient and, when appropriate, his or her caregiver. For many medications, one will be able to just stop taking the medication. However some others (e.g., medications to help mood or treat high blood pressure), it is necessary to slowly withdraw the medication to prevent known adverse reactions that can occur with sudden cessation. In either case, it will be important for the older adult, his or her caregiver and health professionals to monitor together certain signs and symptoms to avoid the small chance of adverse effects from stopping or decreasing a given medication. Patients and caregivers who are tapering medications should get specific written information about when to decrease the dosage and can benefit from the use of an aid, such as a daily pill box, with compartments for administering pills several times in a day. Many pharmacies that are attuned to the needs of older adults and people with complex conditions are able to package prescription and non-prescription pills together on “blister”

or bubble-packed weekly organizer cards, with several distinct times clearly marked for administering medications each day, to make the regimen as simple as possible for both patients and caregivers.

If swallowing medications becomes difficult due to advanced illness, many medications can be crushed and given with apple sauce or ice cream to make them easier to take. A pharmacist should always be consulted first, since some drugs should never be crushed, such as those with a special coating to protect the stomach or time-release the drug slowly. As alternatives to swallowing pills, many medications come in a skin patch form or can be given rectally.

For late-in-life care situations, when the focus may be shifting strongly towards pain management and comfort care, the prescribing health professional can focus on carefully adding in new medications to manage pain and non-pain symptoms such as constipation, nausea and vomiting, difficulty breathing, anxiety and depression, to make the patient's comfort the highest goal. Probably the safest and most effective medication for treating pain is acetaminophen (e.g., Tylenol®). One should use medications known as nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen, or naproxen with great caution as they can hurt the stomach, kidneys and heart. Their use should be primarily for inflammation pain and given for the shortest time possible. For nerve pain, there are some specific medications that can be used.

A very sensitive subject is the introduction of a narcotic/opioid such as morphine for pain and comfort management. Even in hospice situations, many older adults and their family members may be understandably afraid of, or concerned about suggestions from health professionals about starting such medications, even when death is anticipated in days or weeks, and such drugs can provide great palliative benefit. Concerns about addiction with these medications in such a situation can be sensitively put into perspective through honest communication from health professionals.

Managing medications for older adults regardless of what stage of life they are in is an important part of geriatric care management and quality of life for them and their families.

Joseph T. Hanlon, PharmD, MS, BCP



Joseph T. Hanlon, PharmD, MS, BCPS, is a Professor of Medicine in the Division of Geriatrics and Department of Pharmacy and Therapeutics at the University of Pittsburgh and a Health Scientist in the Center for Health Equity Research and Promotion and Geriatric Research Education and Clinical Center at the VA Pittsburgh Healthcare System. Dr. Hanlon is a practicing clinical pharmacist who has been working with older adults to improve their medications for over 30 years, and frequently speaks to health professional meetings and groups of older adults.

Managing Dementia in the Primary Care Setting

April 30, 2015

Angela Hanson, MD

There are currently 5.3 million Americans living with dementia, and this number will go up to 18.5 million by 2050. Alzheimer's disease is the most common form, and other types include vascular dementia (from strokes), Lewy Body Dementia (related to Parkinson's disease), and Frontotemporal Dementia. Age is the biggest risk factor for developing dementia, but some types can be seen in younger and middle-aged persons.

How is dementia different from normal aging? As we age, changes occur in our brains that affect how we learn and remember information. Mild troubles with short-term memory can increase with age; we all occasionally forget where we put our keys or why we walked into a room. Also, it can sometimes take longer for an older person to learn new information. Dementia, though, is different from normal aging, and is caused by progressive loss of brain tissue, also called atrophy. It is diagnosed when memory troubles become more common or serious. People with Alzheimer's disease will ask the same questions over and over, will frequently misplace items, and have trouble remembering the month or year.

What if you suspect dementia in yourself or a loved one? The first step is to visit your primary care provider. Not all memory loss is dementia, and your doctor may order blood tests to rule out medical conditions that can cause cognitive symptoms. Insomnia and mood disorders like depression can affect memory and thinking. A great many medications can cause confusion, so you should review all the medications you take, including over-the-counter medications, with your provider. He or she may then administer memory tests, order brain scans, and if needed, refer you to a dementia specialist. For any memory problem, it is good to bring a trusted friend or family member to the appointment to provide collateral information about how you are doing and to take notes on useful information your provider may share.

When it comes to a diagnosis, it can be complicated. I tell my patients that diagnosing dementia is like prosecuting a criminal; you build a case based on evidence, but it's not usually just one test that makes or breaks the diagnosis. One reason for this is that neurodegenerative diseases like Alzheimer's take many years to develop. Therefore, brain images like CAT scans (CT scans) or MRIs can sometimes look normal, especially in early stages of the illness. Other special scans, such as PET scans, that look at how well brain cells are functioning, can be more accurate but they are not always available. Detailed cognitive testing by a neuropsychologist can be helpful in sorting out whether memory concerns are due to normal aging or something more serious, and can often identify distinctive patterns of cognitive impairment that go along with certain diagnoses.

As a geriatrician, I think of managing dementia like a “syndrome” that has a lot of moving parts. First, do no harm. I make sure the person's medications are appropriate, and that other medical conditions like diabetes are being managed properly. Each patient should have a good assessment of their mood: are they sleeping reasonably well? Is there any sign of depression or anxiety? And finally, we discuss dementia medications. There are no cures for the most common forms of dementia, but treatments can help improve memory and mood in some people.

Another important part of dementia care is providing support for caregivers. In our memory clinic, I continue to be amazed at the strength and resolve of caregivers, who are often older themselves and may have their own health problems. Caring for dementia involves caring for the entire family. The Alzheimer's Association is a great resource for families and caregivers dealing with a dementia diagnosis – even if the type is another form of dementia.

How can we prevent dementia? There are no guaranteed preventative measures. However, we have learned a lot about healthy brain aging over the last few years. All things that keep the heart and blood vessels healthy also benefit the brain: treating high blood pressure, high cholesterol, and diabetes. Eating a healthy diet, which includes avoiding high amounts of saturated fat and processed sugars, and eating more fruits, vegetables, and nuts – like a Mediterranean diet – helps prevent dementia. Regular exercise can keep the parts of our brain involved in memory from shrinking as much with age. Continuing to be active socially and keeping an active mind is also protective: playing card games, doing puzzles and reading. There are a lot of 'brain training' games out there, but none of them have been proven to be the 'best' one, and I tell my patients to do things that they already enjoy. Finally, avoiding head trauma by wearing bike helmets and preventing falls is important, as well.

As a community, we all can play a role in helping prevent, diagnose and treat dementia. Making communities safe and 'dementia friendly' takes knowledge and insight from a lot of different people and groups. Public health policies that keep kids and young adults active will reduce the amount of dementia in the next generation. Advocating for persons with cognitive impairment and their families at the local, state and federal level is something we can all do to improve the quality of life for persons living with dementia, and their loved ones.

Angela Hanson, MD



Angela Hanson, MD, is a geriatrician who specializes in the care of older adults with dementia. She completed her training in Internal Medicine and Geriatrics at the University of Washington. Currently she is a member of the Memory and Brain Wellness Center care team at Harborview Medical Center. Her research interests include understanding how dietary factors can affect cognition and Alzheimer's disease progression.

Advocating for Better Care

Medicare's Advance Care Planning Payment Is a Game-Changer

November 19, 2015

Amy J. Berman, BS, RN

Note: This column first appeared in The John A. Hartford Foundation's [HealthAGenda](#) blog on November 12, 2015.

The end of October marked five years since I was diagnosed with stage IV inflammatory breast cancer, a life-limiting disease. A small fraction of people (11-20 percent) in my situation survive to five years.

Clearly, I have survived. But I have done so much more than survive. I have thrived. I still work and enjoy a great life. I feel good. And unlike most people with my medical condition, I've never been hospitalized—no surgery and none of the combination infusions. I take medication to hold back the cancer but, with my team, I choose treatments with the least burden and side effects. And this has helped me thrive!

The secret sauce is the communication I have with my health care team. They told me clearly about the likely course of my disease and laid out options. I chose to focus on the best life possible for my remaining time. However, conversations about the goals and values of the seriously ill, known as advance care planning, don't happen routinely. One reason is that they take time and, for the majority of those with serious illnesses—older adults — Medicare did not pay for these critical conversations — until now.

The Centers for Medicare and Medicaid Services (CMS) recently announced that, beginning in 2016, Medicare will pay for advance care planning. If done well, this will give people the chance to talk about their care as they go through serious illness and at the end of life. This has been lifesaving to me. I believe it is game-changing for us all. CMS' decision follows the recommendation of the American Medical Association (AMA), a wide range of stakeholders, and the overwhelming majority of the American people. According to the Kaiser Health Tracking Poll in September, 89 percent of the public favors having doctors discuss end-of-life care issues with their patients. And 81 percent say Medicare should cover the cost of those discussions.

Now, it will. The coverage, which takes effect with the new Medicare Physician Fee Schedule on January 1, 2016, establishes a separate payment for advance care planning services provided to Medicare beneficiaries. If the discussion happens as part of the annual wellness visit, physicians or other health professionals, such as nurse practitioners, can bill Medicare separately for it, and there is no cost-sharing liability for the patient. For advance care planning discussions that happen outside the annual wellness visit, providers can bill for it and Medicare beneficiaries will be subject to cost sharing, as they are for other physician services. And yes, the decision whether to have the discussion is entirely up to the patient. It's voluntary, not required.

The new payment acknowledges what should be obvious: The time that patients spend talking about their wishes for end-of-life care with physicians is valuable. And as I noted earlier, there's another thing that's obvious: Those discussions are not currently happening for most people. That same Kaiser poll found that only 17 percent of people reported having had a discussion about end-of-life care with their doctor.

The gap between what people want (89 percent think doctors should discuss end-of-life care with patients) and what they get (17 percent have actually had that discussion) is like the Grand Canyon.

And the percentages of those having advance care planning discussions are only somewhat higher among people who need them the most: older adults (27 percent) and those who report having a debilitating disability or chronic condition (31 percent). Meanwhile, only a third of the public (33 percent) say they have participated in a conversation with a doctor about a relative's wishes concerning end-of-life care.

The new Medicare payment does not mean that advance care planning discussions between physicians and patients will magically become the norm at the stroke of midnight on New Year's Eve. While establishing a separate payment for the services removes one major obstacle, it doesn't address the discomfort many patients and their families feel about discussing end-of-life issues with their doctor. And it doesn't address the discomfort among some physicians and other health care providers who do not feel they have the proper training to engage in such a sensitive and emotional conversation.

The most recent [Kaiser survey](#) finds that only slightly more than half of people (57 percent) say they would be very comfortable talking about end-of-life care with their doctor or other health care provider. That's roughly the same percentage who would be very comfortable discussing the issue with their children (55 percent); close friends (51 percent); their parents (51 percent); or a minister, priest or other religious or spiritual advisor (50 percent). So who are people most comfortable with when it comes to talking about end-of-life care? Their spouse or partner (83 percent).

While I understand the hesitancy some may feel about discussing something so personal and emotional with their health care team, as [I wrote recently](#), I have found the advance care planning discussions I have had with my own team to be nothing less than lifesaving. From a personal as well as a professional perspective (as a nurse, a nationally recognized expert in the care of older adults, and a senior program officer at The [John A. Hartford Foundation](#)), I understand how empowering these conversations can be when done right, and how crucial they are to ensuring that people's wishes are carried out regarding the care they receive at the end of life.

When the CMS decision was announced, the *CBS Evening News* interviewed me about my experiences, and also talked with longtime John A. Hartford Foundation grantee and partner, [Diane Meier](#), MD, director of the [Center to Advance Palliative Care](#). I recounted my decision to choose palliative care, saying: "I really wanted to focus on living the best possible quality of life."

Others in different circumstances may choose different care. That's the whole point in having the discussion: to ensure that you are the one making the decisions, not someone else.

Now that Medicare will pay for advance care planning, I have three hopes:

My first is that people understand the value of advance care planning and demand time with their clinical team to discuss their wishes. As I mentioned before, this encounter is voluntary. There must be greater public education in order to drive demand. The John A. Hartford Foundation recognizes the work of [Ellen Goodman](#) and the [Conversation Project](#) as a leader in this area.

My second hope is for better clinician training around these conversations. The John A Hartford Foundation recognizes the work of the [Center to Advance Palliative Care](#), [Vital Talk](#), [Respecting Choices](#), and [POLST](#).

Finally, I hope that this lifesaving conversation continues to benefit me, and soon will benefit so many others. My cancer continues to spread. But I live well, largely as a result of the conversation.

Thank you to the leadership at CMS.

For more information, read the Advance Care Planning section in the CMS Fact Sheet: [Proposed policy, payment, and quality provisions changes to the Medicare Physician Fee Schedule for Calendar Year 2016](#). Also, the Henry J. Kaiser Family Foundation offers an excellent FAQ on [Medicare's Role in End-of-Life Care](#).

Amy J. Berman, BS, RN



Amy J. Berman, BS, RN, is a Senior Program Officer at The John A. Hartford Foundation, and heads the Integrating and Improving Services program, focusing on developing innovative, cost-effective models of care for older adults. She also directs a number of collaborations with the U.S. Administration on Aging and AARP that address the needs of family caregivers. Prior to joining Hartford, Ms. Berman served as Nursing Education Initiatives Director at the Hartford Institute for Geriatric Nursing at New York University's College of Nursing, and before that she worked in home health care administration.

Moving Toward Age-Friendly Health Care

March 21, 2018

Steven M. Stein, MD, MHS

It's been almost 30 years since I completed my Geriatrics fellowship in Boston. I would love to say that the care of older adults has advanced to a point where all older adults receive "age-friendly" care, but we are still far from such a point. That's why The John A. Hartford Foundation has committed its expertise and resources to achieving the goal of having 20 percent of all health systems be reliably "age-friendly" by 2020. But what is an age-friendly health system? It is a health care system in which:

- Older adults get the best care possible;
- Health care-related harms to older adults are dramatically reduced and approaching zero;
- Older adults are satisfied with their care; and
- Value is optimized for all – patients, families, caregivers, health care providers and health systems.

As a geriatrician at Trinity Health, I wish that I could say that Trinity Health professionals (or professionals from any of the other four premier health systems in the country chosen by the Hartford Foundation to participate in the prototype stage of this initiative) came to this purely as teachers and not at all as learners – but that would not be true. As Terry Fulmer and Amy Berman of The John A. Hartford Foundation wrote in a special [article](#) in the *Journal of American Geriatrics Society* earlier this year, "Although excellence exists today, it is not evenly distributed, and not all older adults have the benefit of an age-friendly health system that delivers on the promise of high-quality, reliable care across the continuum of care." Our systems all agree with this premise. What the five health systems have in common is a desire to inventory what we are doing well and spread it to others, all while identifying where there are opportunities for improvement and commit to filling those gaps. Older adults and their loved ones depend on us for that and deserve no less.

Each system has tapped passionate professionals charged with spreading evidence-based models at their own site while also building a "real-world approach" that can be systematically replicated in other settings with other providers and in other communities.

But where does one begin? Thankfully, a group of leading geriatricians and gerontologists reviewed 17 evidence-based geriatric models of care and developed a framing that helped us narrow our focus. We have all rallied around centering our work around attaining meaningful and measurable improvement in the areas that have come to be known as the "4Ms":

- *What Matters* (e.g., truly gaining understanding of what matters most to the individual so that the treatment and overall care are aligned with the values and goals of *that* unique older adult);
- *Medications* (e.g., reducing poly-pharmacy through evidence-based de-prescribing);
- *Mobility* (e.g., reducing fall risk through promoting ambulation and lower extremity strengthening, when needed); and
- *Mentation* (e.g., assessing for depression, delirium and dementia and treating optimally with both pharmacological and non-pharmacological approaches).

The development of this important framing has enabled the five health systems to hit the ground running. All the systems shared that while many sites are implementing these models of care or have established programs that support these aims (e.g., Acute Care for Elders units, NICHE hospitals, Green House nursing homes, geriatric assessment clinics, PACE organizations, etc.), none of the systems could honestly say that the 4Ms were systematically being implemented across all communities and across all settings of care. So we have begun our journey here at Trinity Health with the support of The John A. Hartford Foundation, the Institute for Healthcare Improvement (IHI) and some of the leading aging experts in the country.

The age-friendly prototype is being built from the FDR philosophy on action: "Do something! If it works, do more of it. If it doesn't, do something else." It's not getting overwhelmed by the big challenges ahead to create reliable and sustainable change across our entire health system. We know the change will not happen overnight. We will not allow "paralysis from analysis" but have committed to utilize the PDSA approach: [Plan, Do, Study, Act](#).

Though our different teams have begun their journey, working on each of the 4Ms, I must admit that the one "M" that resonated most with me was to make sure that we stop doing well-intentioned things to an older adult before we truly learn what matters most to that individual. What a simple concept, but how often are we too busy working *on* a person's heart before we know what's *in* their heart?

How often do we begin chemotherapy just weeks before the patient's grandson's wedding, when, if we asked, the older adult would have taken the minor risk of starting treatment a few weeks later so that she wasn't so exhausted that she couldn't dance with her grandchild.

How often do we discharge an older adult to a skilled nursing facility because we are concerned that the person may fall at home yet that older adult is able to understand the risk-benefit of the choice ahead and still wants to go home?

So, yes, what matters most to *me* right now is that we at Trinity Health understand what matters most to each older adult we serve and that we ensure that our treatment goals and our overall approach to care align with each individual's wishes; that we take this approach in every setting and in every community; and that the goals of the individual are what drive the behaviors and actions of every one of our providers.

Steven M. Stein, MD, MHS



Steven M. Stein, MD, MHS is the Senior Vice President and Chief Medical Officer for Trinity Health Continuing Care. He has oversight for Trinity Health's home care agencies, hospices, nursing homes, PACE organizations and senior housing complexes. Dr. Stein received his Bachelors in Computer Science at Columbia, his medical degree at Cornell and did his residency at Montefiore Medical Center. He did his geriatrics fellowship at Harvard where he also received a Masters in Health Services Administration at the School of Public Health and subsequently served on the faculty of the Medical School as a member of the Division on Aging. His career has placed him in leadership positions in both managed care and on the provider side – consistently advocating for our most vulnerable citizens receiving high quality, cost-effective health care that is targeted to what matters most to the specific individual served.

APPENDIX

Eldercare Voices Columns 2014-2018

February 20, 2014	Gregg Warshaw, MD	<i>Overview of Geriatric Care</i>
March 26, 2014	Steven Counsell, MD	<i>GRACE Model of Interdisciplinary Care</i>
April 16, 2014	Diane Meier, MD	<i>A Different Kind of Caring</i>
May 14, 2014	Joanne Lynn, MD; and Janice Shuster	<i>MediCaring Communities: Let's Build Medicare 2030</i>
June 12, 2014	John Wasson, MD	<i>Health Confidence</i>
July 23, 2014	Nancy Lundebjerg, MPA, Michelle Saunders, DMD, MS, MPH	<i>Dually Eligible Older Adults Deserve a Well-Trained Workforce</i>
August 20, 2014	Rob Schreiber, MD	<i>Taking Charge! Evidence-Based Self-Management Programs Key to Better Care and Lower Costs</i>
September 17, 2014	Tara Cortes, PhD, RN, FAAN	<i>Expanding the PACE Program to Adults with Disabilities Under Age 55</i>
November 5, 2014	Denise Brown, MSN	<i>Medical House Calls Program and the Value of Team Care</i>
December 4, 2014	Maureen Mickus, PhD	<i>Loneliness and Threats to Health and Wellbeing</i>
February 4, 2015	Lynn Friss-Feinberg, MSW	<i>Moving Toward Person and Family Centered Care</i>
April 2, 2015	Joseph Hanlon, PharmD, MS, BCPS	<i>Medication Management Issues in Caring for Older Adults</i>
April 30, 2015	Angela Hanson, MD	<i>Managing Dementia in the Primary Care Setting</i>
May 28, 2015	Voices for Better Health staff, state partners, & Geriatric Provider Advocates	<i>Geriatric Providers and Consumer Advocates AGS Session Report (content not retrievable)</i>

July 9, 2015	Robyn Stone, PhD	<i>Affordable Senior Housing & Services: A Coordinated Approach to Serving Vulnerable Older Adults</i>
August 5, 2015	Robyn Golden, MSW	<i>Bridging the Gap: Social Work Driven Care Coordination as a Priority for Improving Health</i>
November 19, 2015	Amy Berman, BS, RN	<i>Medicare's Advance Care Planning Payment Is a Game-Changer</i>
January 14, 2016	Victoria Walker, MD	<i>Building Platforms for America's Family Caregivers</i>
February 24, 2016	Martha Watson, MS, RN-BC, GCNS-BC	<i>Sharing Geriatrics Best Practices with Nurses and Community Providers</i>
March 23, 2016	Jeffrey D. Schlaudecker, MD and Rachel Hart, MD	<i>Strategies to Ensure a Safe & Successful Hospitalization for the Older Adult</i>
April 20, 2016	Todd Semla, MS, PharmD, BCPS, FCCP, AGS	<i>Preventing Adverse Drug Events in Older Adults</i>
May 18, 2016	Rosa Palacios	<i>A Person-Centered Diabetes Prevention Model</i>
June 2, 2016	Julie Schoen, JD	<i>Reflections on World Elder Abuse Awareness Day 2016</i>
July 13, 2016	Christine Fordyce, MD	<i>Hilde's Story: Overcoming a Setback Through Person-Centered Care (content not retrievable)</i>
August 11, 2016	Elizabeth Bragg, PhD, RN	<i>A New Initiative to Diffuse Geriatric Expertise Throughout the Health Care Workforce</i>
October 26, 2016	Carol Rodat	<i>It's Time to Implement a National Family Caregiver Strategy</i>
January 12, 2017	Gregg Warshaw, MD	<i>Vulnerable Older Americans and Their Families Depend on the ACA and Medicaid</i>

March 23, 2017	Terry Fulmer, PhD, RN, FAAN	<i>Let's Work Together To Improve Care For Older Adults With Complex Needs</i>
April 19, 2017	Corrine Eldridge	<i>Home Care Workers on the Interdisciplinary Care Team: A Win for Consumers and Clinicians</i>
May 31, 2017	Sharon Hall, Family Caregiver	<i>Raising Family Caregivers Voices in Older Americans Month and Beyond</i>
June 15, 2017	Katie Smith Sloan	<i>The Assault on Medicaid Funding Puts Long-Term Services and Supports of Millions at Risk</i>
June 30, 2017	David Griffith	<i>Understanding the Unique Health Needs and Vulnerabilities of LGBT Older Adults</i>
August 10, 2017	Deborah Jacobi, RDH, MA	<i>Championing Oral Health for Older Adults</i>
October 12, 2017	Steven M. Stein, MD, MHS	<i>Whatever It Takes: Building a Healthcare System like "Cheers" (Where Everyone Knows Your Name)</i>
November 8, 2017	Lynn Friss Feinberg, MSW	<i>Moving Toward Person- and Family-Centered Care</i>
February 22, 2018	David B. Reuben, MD	<i>Goal-Oriented Care Is Person-Centered Care</i>
March 21, 2018	Steven M. Stein, MD, MHS	<i>Moving Toward Age-Friendly Health Care</i>
November 15, 2018	Gregg Warshaw, MD	<i>Learning to Appreciate Integrated Care to Address Mental Health Needs</i>
December 20, 2018	Lori Simon-Rusinowitz, MPH, PhD	<i>When Person-Centered Services Stop at My Mother's Nursing Home Door: Views from a Daughter and Champion of Person-Centered Care</i>



@CCEHI
healthinnovation.org

COMMUNITY CATALYST
ONE FEDERAL STREET, 5TH FLOOR
BOSTON, MA 02110
617.338.6035