CARING FOR UNREPRESENTED OLDER ADULTS: AN AGE-FRIENDLY PERSPECTIVE

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UTAH GERIATRICS SOCIETY
ANNUAL BUSINESS AND EDUCATION MEETING

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DISCLOSURES

- I have no relevant conflicts of interest to disclose.

OBJECTIVES

- Understand how to apply the 4Ms – What Matters, Medication, Mentation, and Mobility - to every clinical encounter with older adults
- Recognize that social isolation contributes to increased morbidity and mortality among older adults
- Appreciate how the complex needs of unrepresented older adults can be anticipated and addressed by Age-Friendly Health Systems

DR. MARY TINETTI

[What is an Age-Friendly Health System? - YouTube]

ORIGIN OF AGE-FRIENDLY HEALTH SYSTEMS - 1

JOURNAL OF THE AMERICAN GERIATRICS SOCIETY

SPECIAL ARTICLES

The Age-Friendly Health System Imperative

Terry Fulmer, PhD, RN, Kedar S. Mate, MD,†‡ and Amy Berman, BSN**

<u>Age-Friendly Health Systems - Founding Organizations</u>

- Institute for Healthcare Improvement
- The John A. Hartford Foundation
- American Hospital Association
- Catholic Health Association of the United States

Fulmer T, Mate S, Berman A. J Am Geriatr Soc 2018; 66(1): 22 – 24.

ORIGIN OF AGE FRIENDLY HEALTH SYSTEMS - 2

- Many evidence-based geriatric care models exist

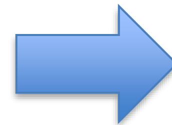
- However, implementation of these geriatric care models across US health systems is uneven

ORIGIN OF AGE-FRIENDLY HEALTH SYSTEMS - 3

Table 1. Seventeen Care Models with Level 1 or 2a Evidence of Impact.

1. ACE Unit
2. CM+
3. Care Transitions Program
4. Center to Advance Palliative Care
5. Geriatric Emergency Department
6. Geriatric Interdisciplinary Team Training
7. GRACE
8. Guided Care
9. HomeMeds
10. Hospital at Home and Mount Sinai's MACT
11. HELP
12. IMPACT
13. NICHE
14. Patient Priority Care
15. PACE
16. TCM
17. University of California at Los Angeles Alzheimer's and Dementia Care Program

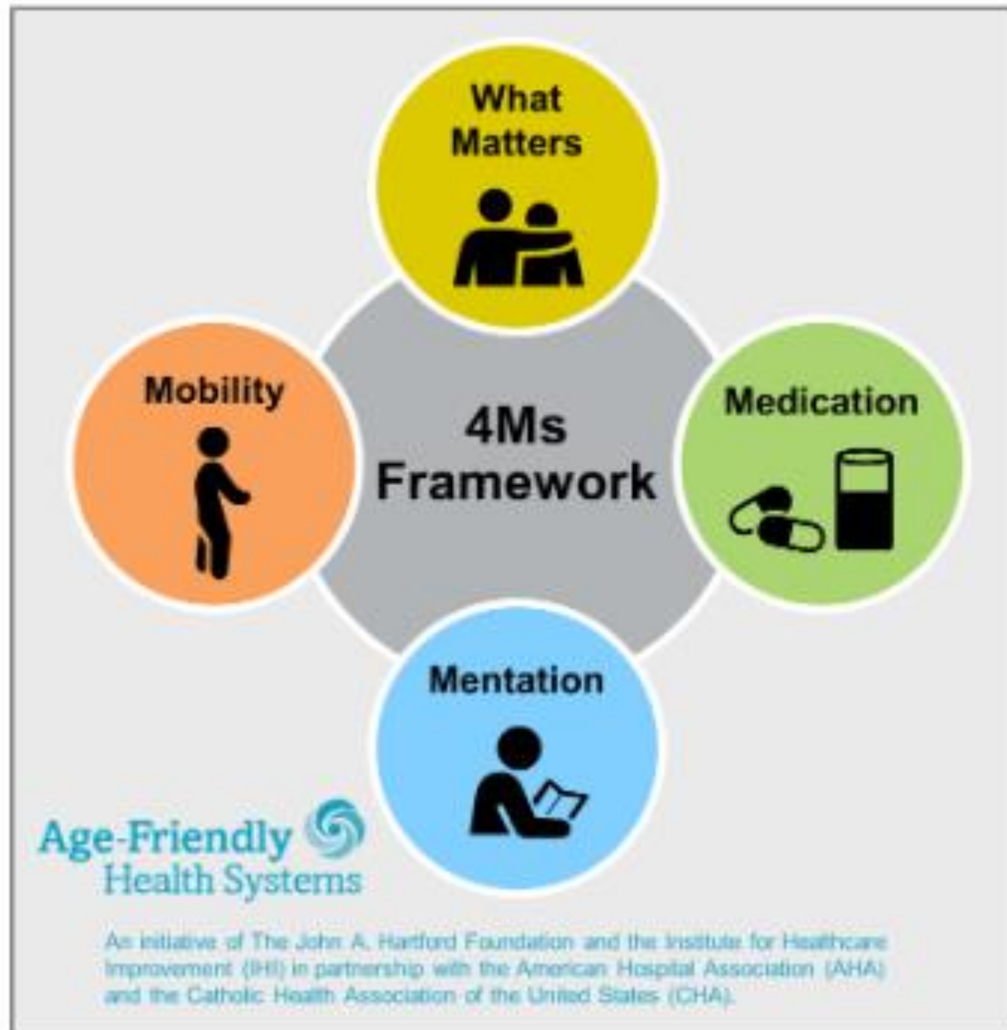
Note. ACE = Acute Care for Elders; CM+ = Care Management Plus; GRACE = Geriatric Resources for Assessment and Care of Elders; MACT = Mobile Acute Care Team; HELP = Hospital Elder Life Program; IMPACT = Improving Mood–Promoting Access to Collaborative Treatment; NICHE = Nurses Improving Care for Health System Elders; PACE = Program for All-Inclusive Care of the Elderly; TCM = Transitional Care Model.



Distilled to 4 elements or "4Ms" that should be reliably provided to all older adults, regardless of the care setting or specialty

Mate K et al. J Aging Health 2021.

THE 4MS OF AGE FRIENDLY HEALTH SYSTEMS



What Matters

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, and across settings of care.

Medication

If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

Mentation

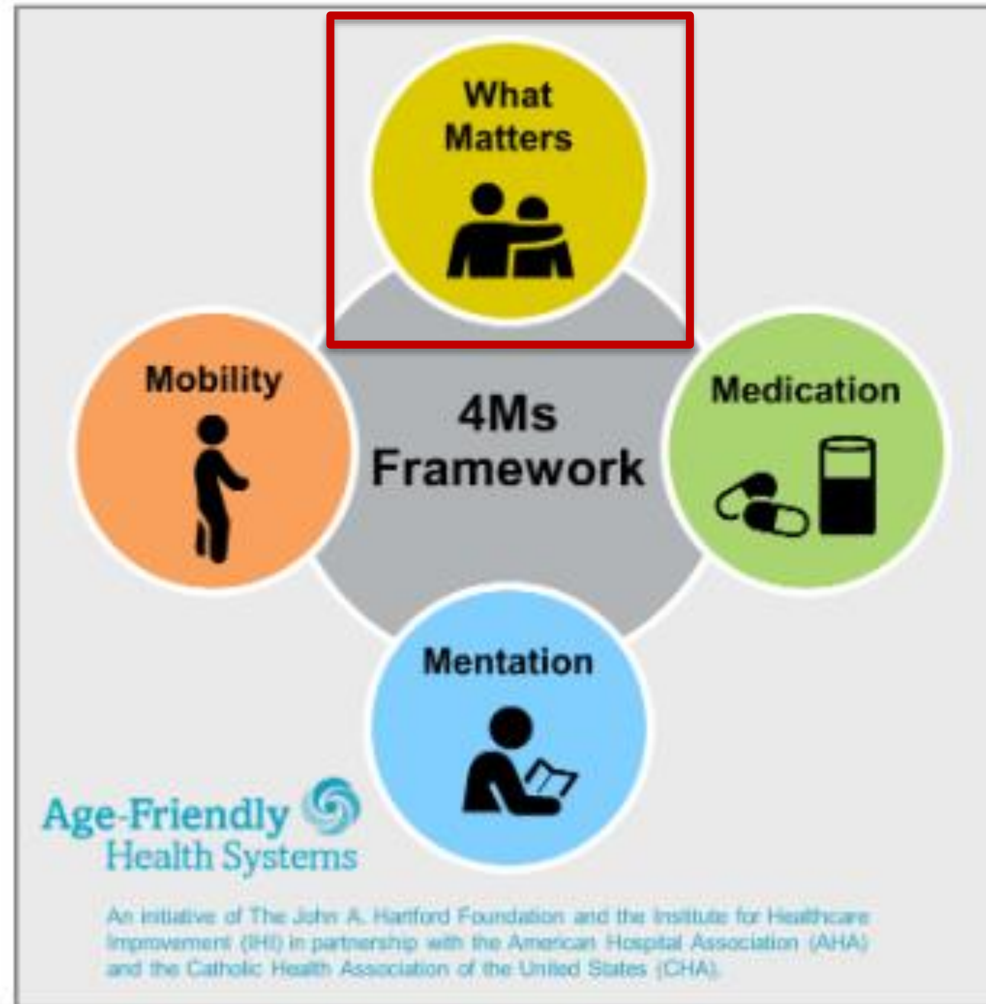
Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Mobility

Ensure that older adults move safely every day in order to maintain function and do What Matters.

[What Is an Age-Friendly Health System? | IHI - Institute for Healthcare Improvement]

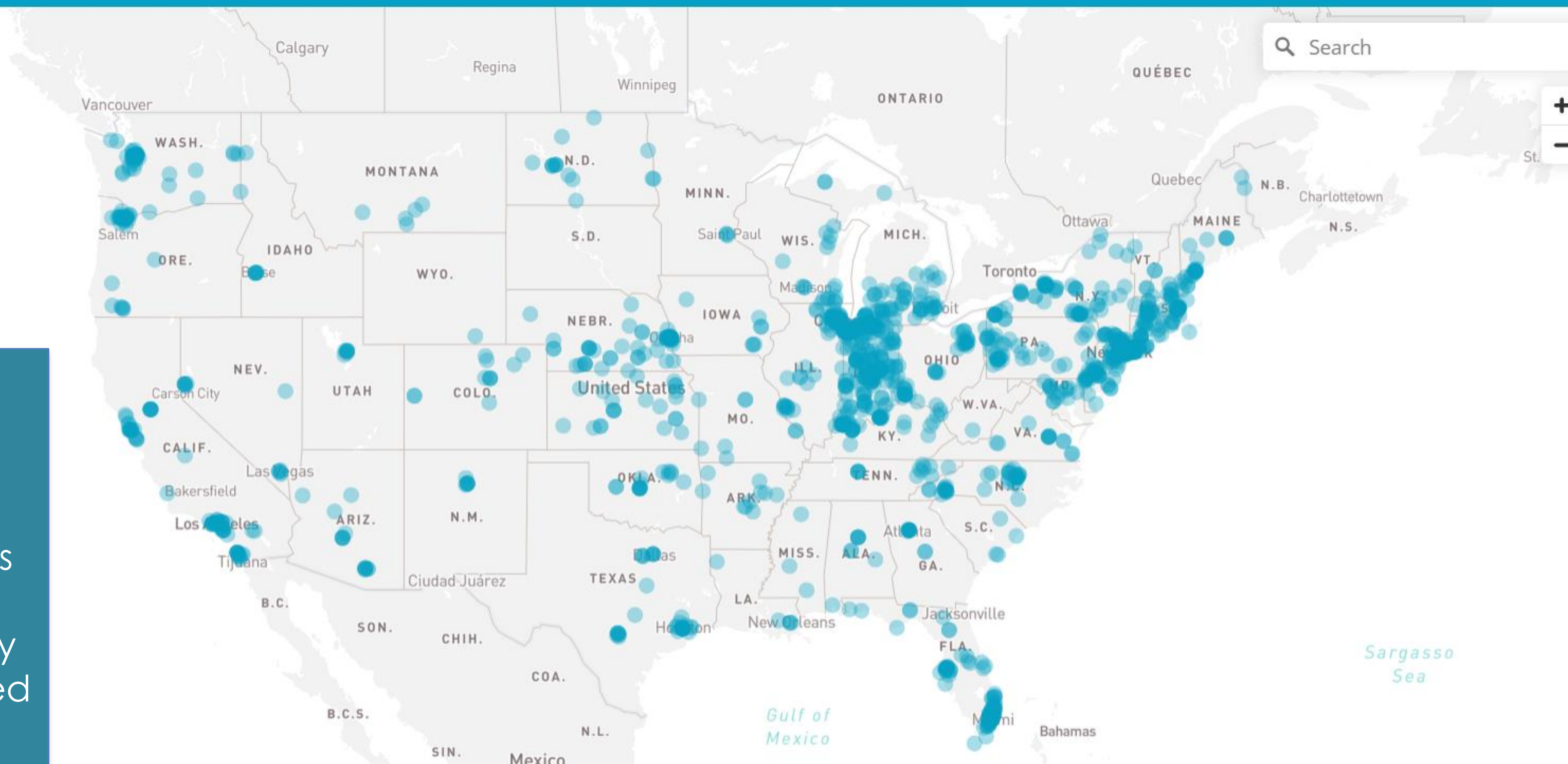
WHAT MATTERS MOST TO YOU?



Age-Friendly Health Systems

Participant Sites

learn more



As of July 2022:

~2800 participating hospitals and practices

813, including University of Utah Health, achieved “Committed to Care Excellence” designation

Age-Friendly Health Systems sites (johnahartford.org)

DOES IT MATTER TO ASK "WHAT MATTERS MOST TO YOU"?

JAMA Internal Medicine | Original Investigation

Association of Patient Priorities–Aligned Decision-Making With Patient Outcomes and Ambulatory Health Care Burden Among Older Adults With Multiple Chronic Conditions

A Nonrandomized Clinical Trial

Mary E. Tinetti, MD; Aanand D. Naik, MD; Lilian Dindo, PhD; Darce M. Costello, EdD, MPH, MBA; Jessica Esterson, MPH; Mary Geda, BN, MSN, RN; Jonathan Rosen, MD; Kizzy Hernandez-Bigos, BA; Cynthia Daisy Smith, MD; Gregory M. Ouellet, MD; Gina Kang, MD; Yungah Lee, MD; Caroline Blaum, MD

Question Is care for older adults with multiple chronic conditions that is aligned with their health priorities associated with improved patient-reported outcomes and reduced unwanted care?

Tinettii et al. JAMA Intern Med 2019 Dec; 179(12): 1688–1697.

STUDY BACKGROUND: MULTIPLE CHRONIC CONDITIONS (MCCS)

- Older adults with MCCs receive much care with unclear benefit
- Clinical trials often exclude older adults with MCCs
- Focus on disease-specific outcomes can lead to treatment burden
  - People with MCCs spend an average of 2 hours per day on health care-related activities

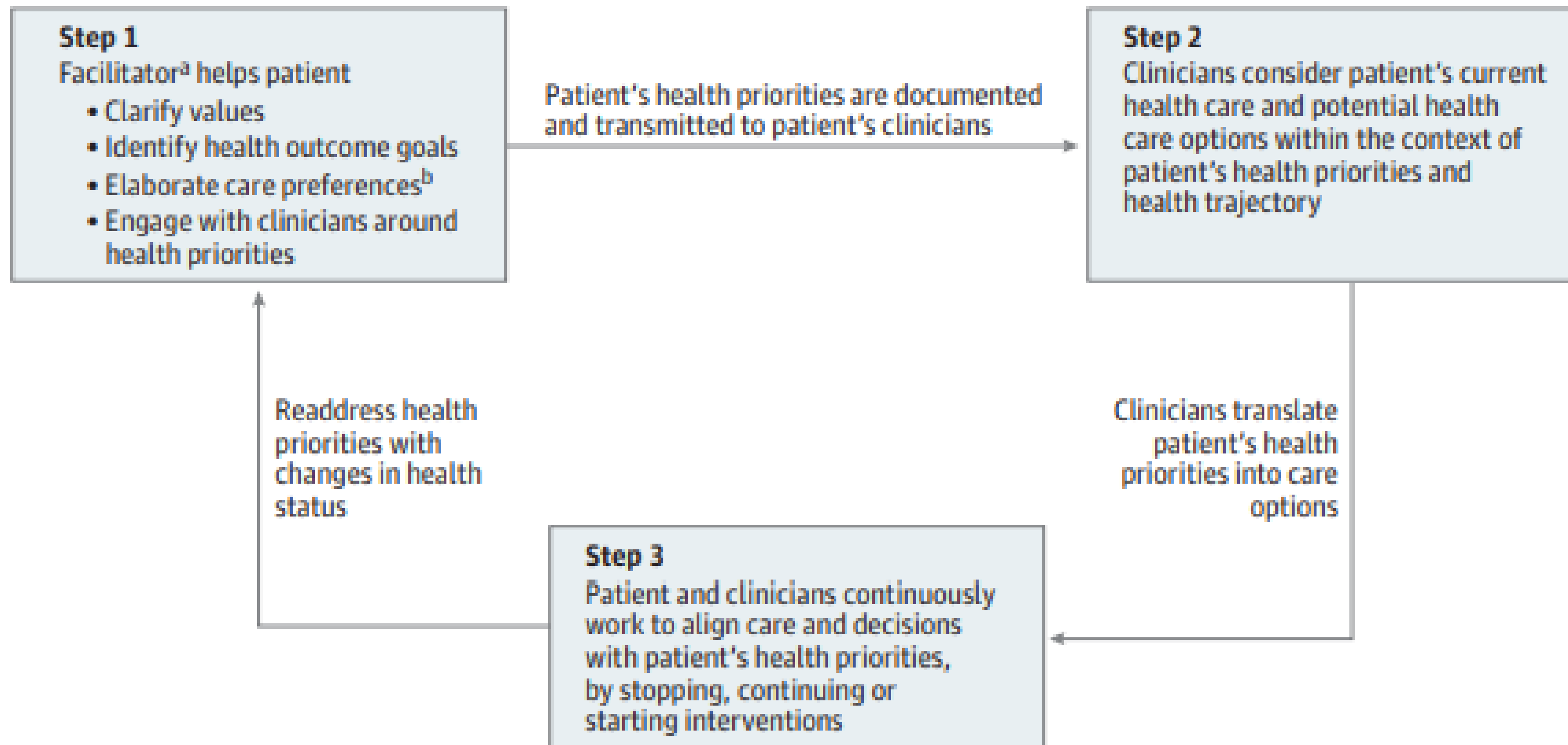
Tinetti et al. JAMA Intern Med 2019 Dec; 179(12): 1688–1697.

METHODS

- 366 adults aged ≥65 with >3 chronic conditions <u>and</u> either 10 medications or visits to >2 specialists over the past year
- Exclusion criteria: Advanced dementia, hospice-eligible, receiving dialysis, or residing in a nursing home
- Patient Priorities Care intervention group
  - Included a primary care practice and a cardiology practice
  - Included discussion of health priorities by a facilitator and by clinicians
  - Identified **"the one thing"** that is the most important health outcome goal

Tinetti et al. JAMA Intern Med 2019 Dec; 179(12): 1688–1697.

PATIENT PRIORITIES CARE INTERVENTION



Tinetti et al. JAMA Intern Med 2019 Dec; 179(12): 1688–1697.

PATIENT-REPORTED OUTCOMES

Table 2. Baseline Follow-up Differences in Patient-Reported Outcomes Among Older Adults With MCCs Receiving PPC or UC

	Least Squares Mean (SE)[a]		Baseline − Follow-up[b]	
Patient-Reported Outcome	Patient Priorities Care	Usual Care	Difference (SE)	P Value
Treatment Burden Questionnaire	−12.4 (4.0)	−7.4 (4.0)	−5.0 (2.0)	.01
O-PACIC	−0.2 (0.2)	0.1 (0.2)	−0.06 (0.1)	.60
CollaboRATE	−1.2 (5.3)	2.9 (5.2)	−4.1 (2.8)	.14

Abbreviations: MCCs, multiple chronic conditions; O-PACIC, Older Patient Assessment of Chronic Illness Care; PPC, patient priorities care; SE, standard error; UC, usual care.

[a] Treatment Burden Questionnaire (score range, 0-150; higher score indicates greater perceived burden of treatment); O-PACIC (score range, 1-5; higher score indicates better perceived experience of chronic disease care); and CollaboRATE (score range, 0-100; higher score indicates greater perceived shared decision-making and goal ascertainment).

[b] Parameter estimates from the propensity score–weighted, doubly robust linear regression analysis for the patient-reported outcome difference scores were adjusted for sex, age, race, educational level, marital status, living situation, insurance type, physical and mental health functioning, cognitive functioning, chronic conditions, number of medications, and duration of follow-up.

Tinetti et al. JAMA Intern Med 2019 Dec; 179(12): 1688–1697.

DOCUMENTATION OF PATIENT PRIORITIES

"Documentation by the PCPs or cardiologists of discussion or decision-making concerning patients' heath priorities were noted in 108 of 163 (66.3%) of the PPC participants versus none of the UC participants."

Tinetti et al. JAMA Intern Med 2019 Dec; 179(12): 1688–1697.

Table 3. Changes in Ambulatory Health Care Use in Older Adults With MCCs Receiving PPC or UC

Health Care Use Category	Bivariate Analysis: Weighted %[a] PPC (n = 163)	Bivariate Analysis: Weighted %[a] Usual Care (n = 203)	Bivariate Analysis: Odds Ratio (95% CI)[b]	Multivariable Analysis, Odds Ratio (95% CI)[c]
Weighted No.	357	362		
Medications				
Any medication				
Added	65.0	58.9	1.15 (0.83-1.58)	0.93 (0.63-1.39)
Stopped	52.0	33.8	2.00 (1.47-2.72)	2.05 (1.43-2.95)
Cardiovascular medication[d]				
Added	20.8	15.7	1.33 (0.90-1.96)	1.07 (0.69-1.67)
Stopped	25.9	8.9	3.42 (2.20-5.30)	3.43 (2.10-5.60)
Psychotropic medication[e]				
Added	18.7	11.2	1.73 (1.13-2.65)	1.67 (1.02-2.72)
Stopped	11.0	7.0	1.57 (0.92-2.65)	1.66 (0.92-3.01)
Diagnostic/laboratory tests[f]				
Any ordered	80.8	86.4	0.33 (0.20-0.57)	0.22 (0.12-0.40)
Any avoided[g]	5.0	3.6	1.37 (0.66-2.86)	1.33 (0.62-2.85)
Referrals/consults[h]				
Any ordered	48.9	44.4	1.09 (0.81-1.49)	1.02 (0.72-1.43)
Any avoided[g]	5.5	2.6	2.08 (0.94-4.62)	1.87 (0.80-4.36)
Procedures[i]				
Any scheduled	29.2	21.5	1.41 (1.00-2.00)	1.37 (0.95-1.98)
Any avoided[g]	12.3	7.1	1.75 (1.04-2.93)	1.49 (0.86-2.57)
Self-management tasks[j]				
Any added	57.5	62.1	0.71 (0.52-0.97)	0.59 (0.41-0.84)
Any stopped	6.4	8.6	0.69 (0.39-1.22)	0.58 (0.31-1.11)

Abbreviations: MCCs, multiple chronic conditions; PPC, patient priorities care; UC, usual care.

Tinetti et al. JAMA Intern Med 2019 Dec; 179(12): 1688–1697.

STUDY LIMITATIONS

- Not randomized
  - Clinicians were not blinded to group assignment
  - Outcome assessors were blinded
- Single practice with relatively homogenous population (White, female)
- Involvement of only 2 specialties may underestimate effect
- Impact on clinic revenue is unclear

STUDY STRENGTHS

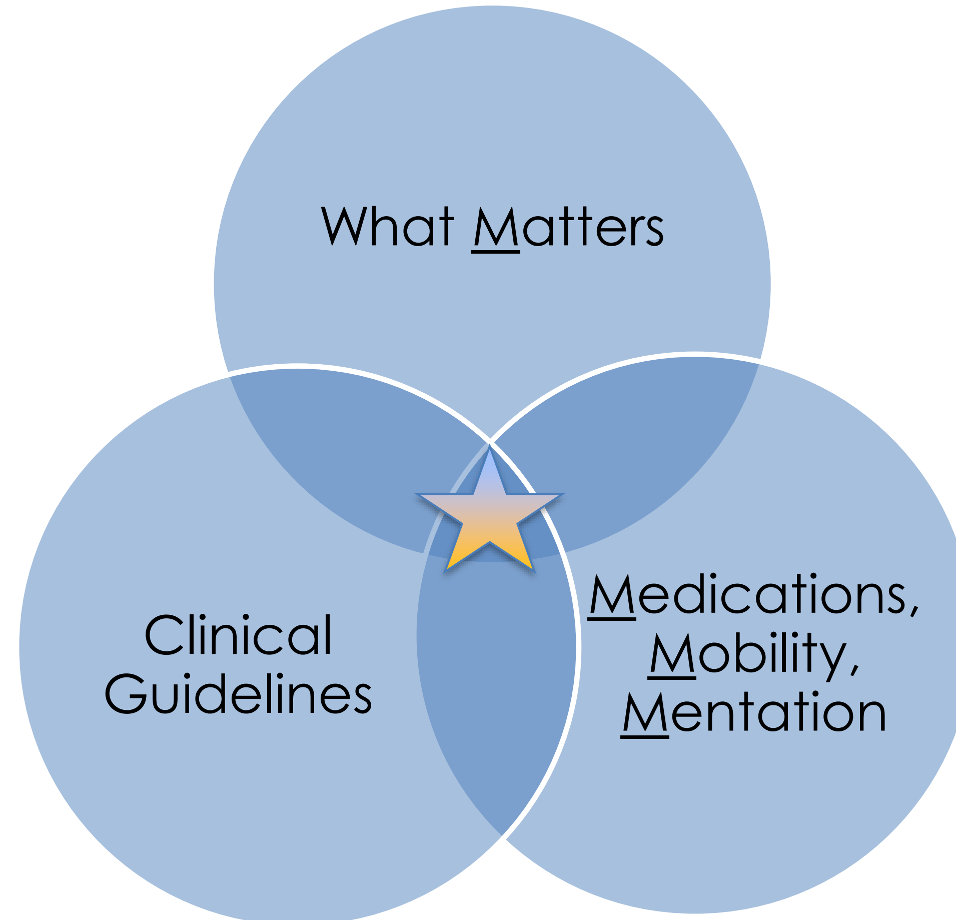
- Feasible for patients
- Readily incorporated into clinic workflow
- Modest time required for Patient Priorities Care
  - Training: 8 hours over 15 months
  - Clinical practice: 30 min distributed across 3 office visits

PRACTICAL IMPLICATIONS: MANAGING COMPLEXITY

- What is the most common chronic condition experienced by older adults? ***Having > 1 chronic condition (i.e. multimorbidity)****
- The 4Ms provide a useful framework to focus what can be an overwhelming visit for the patient and clinician
- Conversations about What Matters can be relatively brief
- Addressing What Matters may reduce treatment burden for older adults and improve communication among clinicians about What Matters to patients

*Weiss CO, Boyd CM, Yu Q, Wolff JL, Leff B. Patterns of prevalent major chronic disease among older adults in the United States. JAMA. 2007;298(10):1160–1162

THE 4MS OF AGE-FRIENDLY CARE: FINDING THE SWEET SPOT



UNREPRESENTED OLDER ADULTS AND THE 4MS

UNREPRESENTED OLDER ADULTS AND THE 4MS

What happens when it is difficult – or impossible – to find out What Matters most to an older adult?

CASE STUDY: PATIENT R.G.

- 67 year old gentleman with type 2 diabetes, hypertension, macular degeneration, frequent falls, and cognitive impairment thought related to TBI
- Inconsistent medication adherence leading to uncontrolled blood pressure and A1c
- Accompanied to some visits by an aide from Volunteers of America

CASE STUDY: PATIENT R.G. (CONTINUED)

- R.G.'s capacity to make his own medical decisions is in question
  - Montreal Cognitive Assessment (MOCA) score is 5/30 (normal ≥ 26/30)
- The aide is not his guardian and is therefore is unable to make health care decisions on his behalf
- He lacks an advance health care directive
- He has no known family or friends

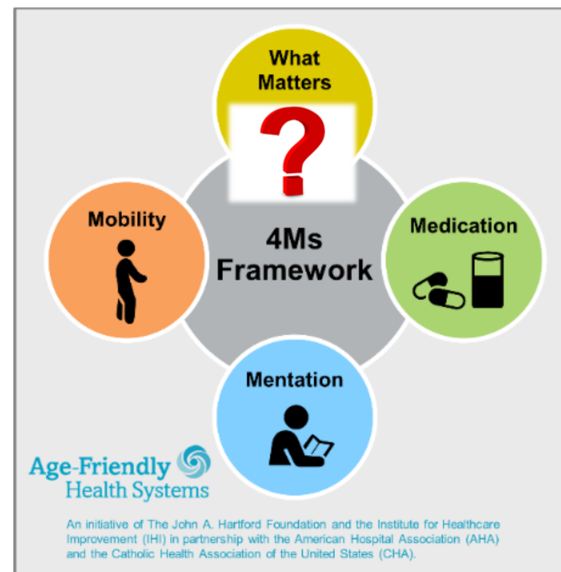
A TYPICAL OFFICE VISIT WITH R.G.

- He has only a vague idea of what medications he takes and why he takes them
- He leaves medication bottles on the transit bus
- Social worker states that "little can be done to provide him with more resources until a crisis occurs"

VIEWING R.G. THROUGH THE 4MS LENS

What Matters: Unclear given cognitive deficits and lack of family, friends, or a surrogate decision maker

Mobility: Several ED visits related to falls



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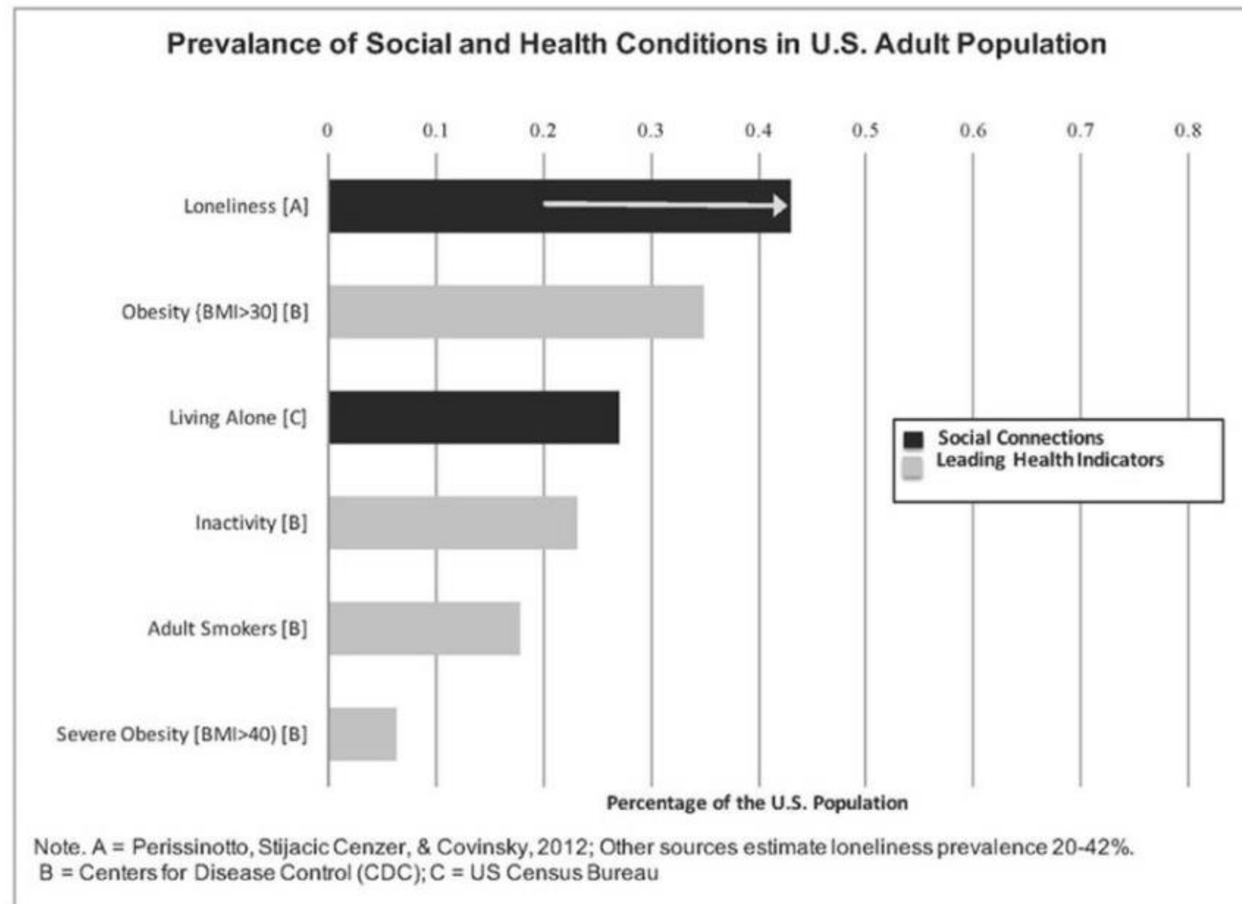
Graphic files and guidance at ihi.org/AgeFriendly

Medications: High risk for an adverse medication event

Mentation: History of traumatic brain injury and MOCA score <10 suggests that he may lack medical decision-making capacity

LONELINESS & SOCIAL ISOLATION: A PUBLIC HEALTH CRISIS



Holt-Lunstad J, Robles TF, Sbarra DA. Am Psychol 2017.

ADVERSE HEALTH IMPACTS OF LONELINESS & SOCIAL ISOLATION

- Loneliness is a more powerful predictor of adverse health outcomes than obesity, sedentary lifestyle, and air pollution*
- Adverse health impact of social isolation is equivalent to smoking 15 cigarettes per day**
- Loneliness and social isolation are independent predictors of ASCVD risk***
- ↑morbidity and mortality from social isolation is found across all age groups¶

*Holt-Lunstad J et al. Am Psychol 2017.
**Holt-Lunstad J et al. PLoS Med 2010.
***Valtorta et al. Heart 2016.
¶Donovan and Blazer, Am J Geriat Psych 2020.

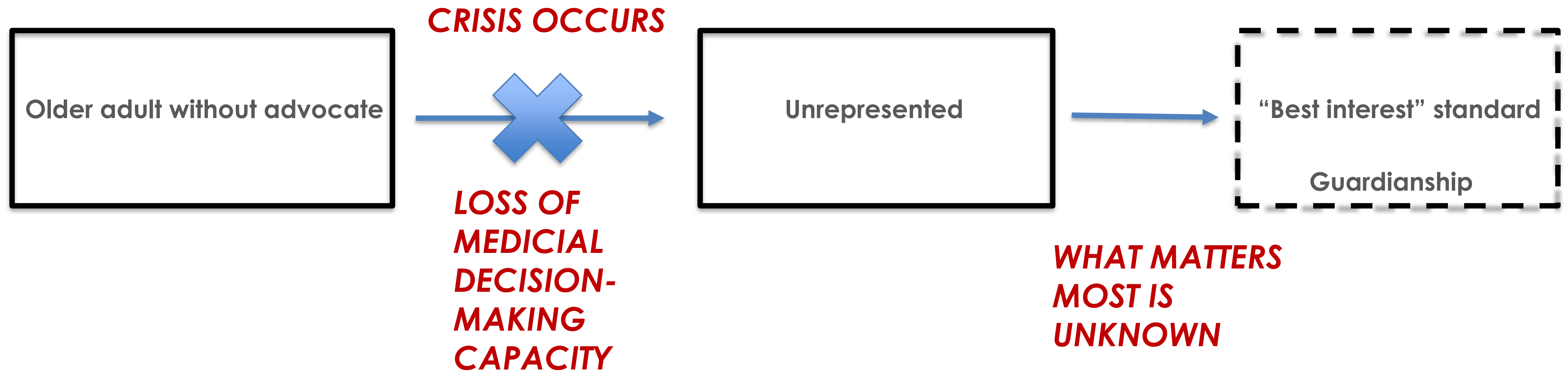
TERMINOLOGY THAT MAY DESCRIBE PATIENT R.G.

- “**Adult without advocate**” or “adult orphan”
- “**Unrepresented**” or “unbefriended”

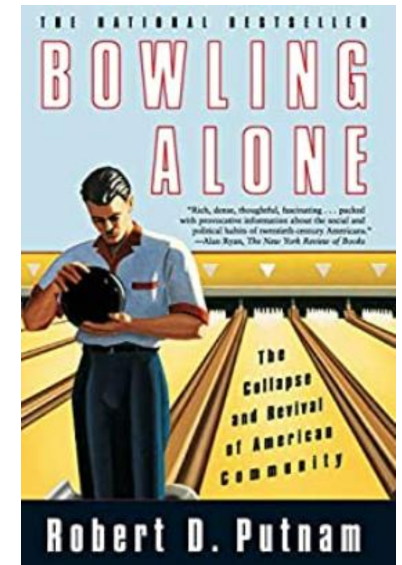
DEFINITIONS

	Has medical decision-making capacity?	Has a completed advance health care directive?	Has family, friends, or a legally authorized surrogate who is willing and able to assist with medical decisions?
Adult without advocate or adult orphan	**Yes**	No	No
Unrepresented or unbefriended	**No**	No	No

CONTINUUM OF VULNERABILITY



PREVALENCE OF ADULTS WITHOUT ADVOCATES IN HEALTH CARE SETTINGS



*But, we do know that Baby Boomers are at high risk of becoming unrepresented since >10 million live alone, and 20% are childless.**

*AARP, 2016.

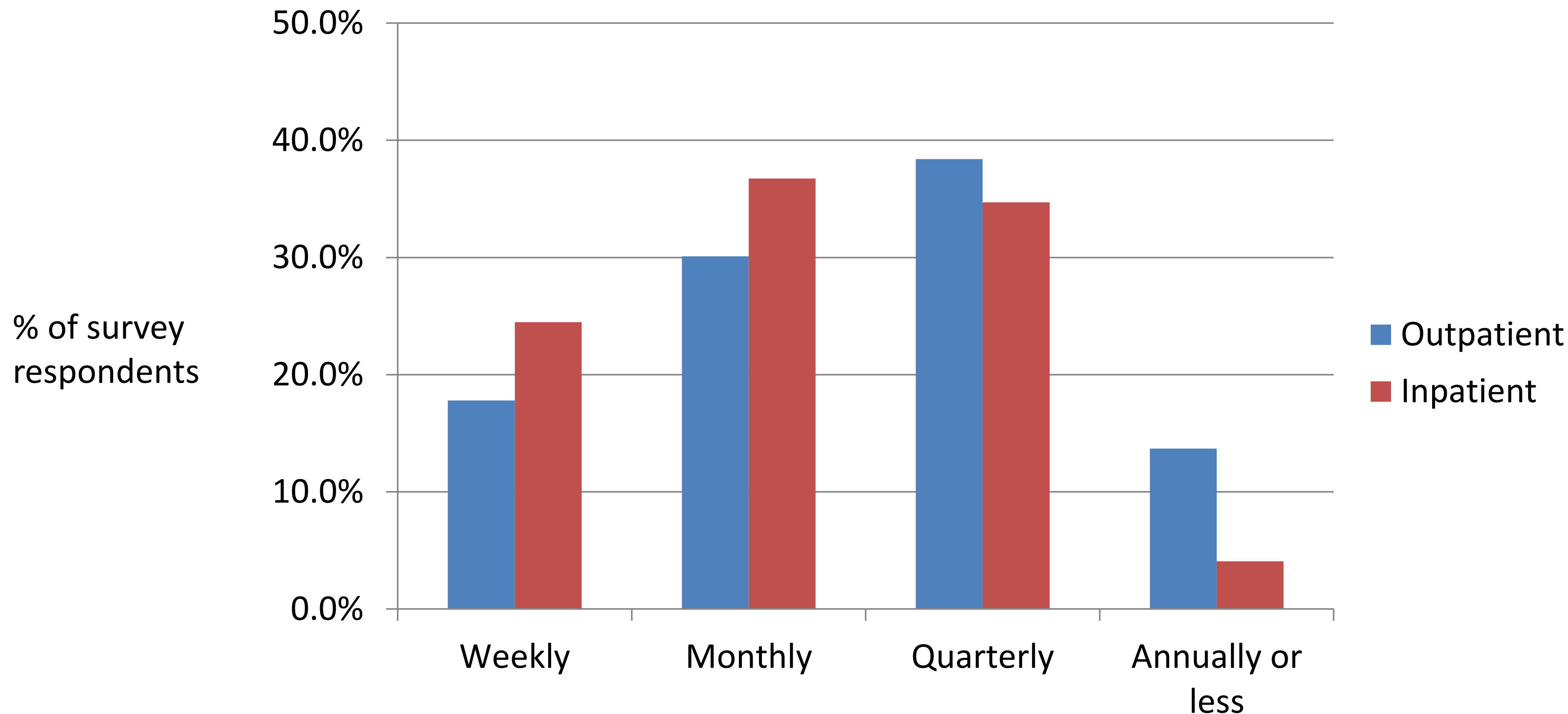
PREVALENCE OF UNREPRESENTED PATIENTS IN HEALTHCARE SETTINGS

- 16% in the intensive care unit*
- 4% in long term care†
- Unknown in primary care

It is estimated that there are 70,000 to 330,000 unrepresented older adults in the US.¶

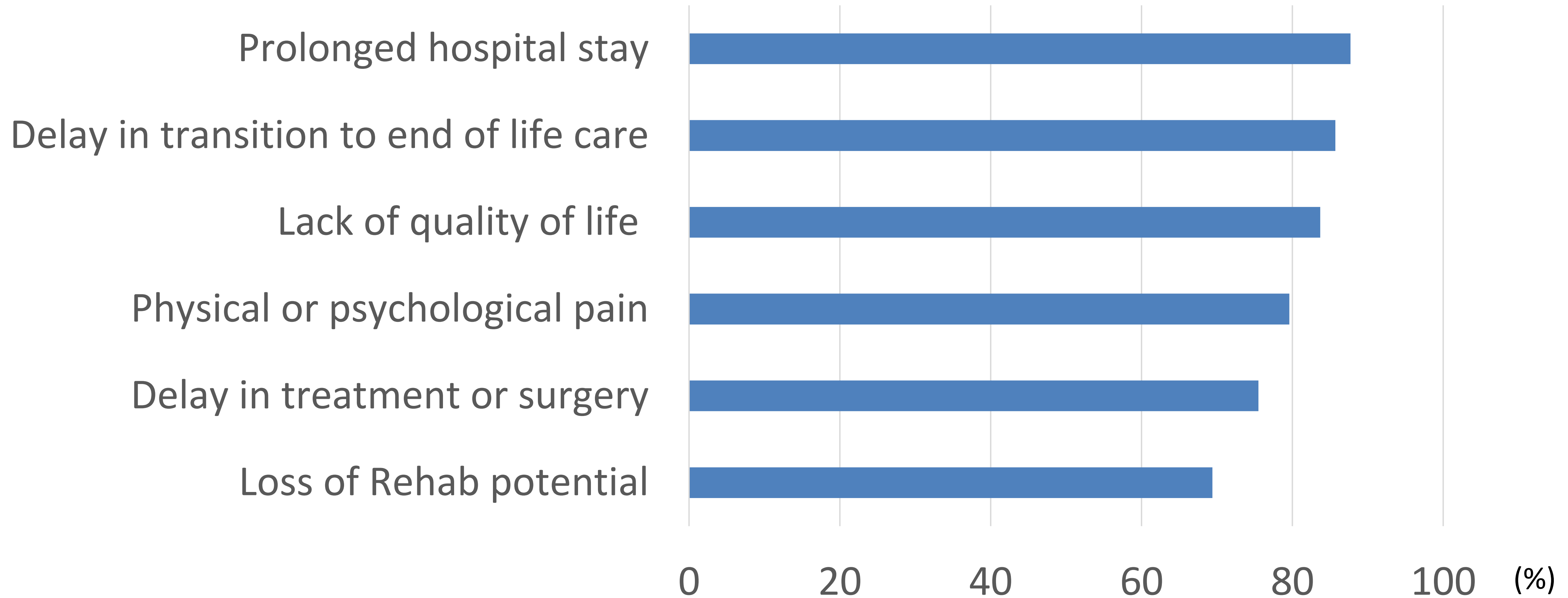
*White DB. Crit Care Med 2006.
†American Bar Association 2004.
¶Schweikart, AMA J Ethics 2019.

HOW OFTEN DO GERIATRICS HEALTH CARE PROVIDERS ENCOUNTER THE UNBEFRIENDED?



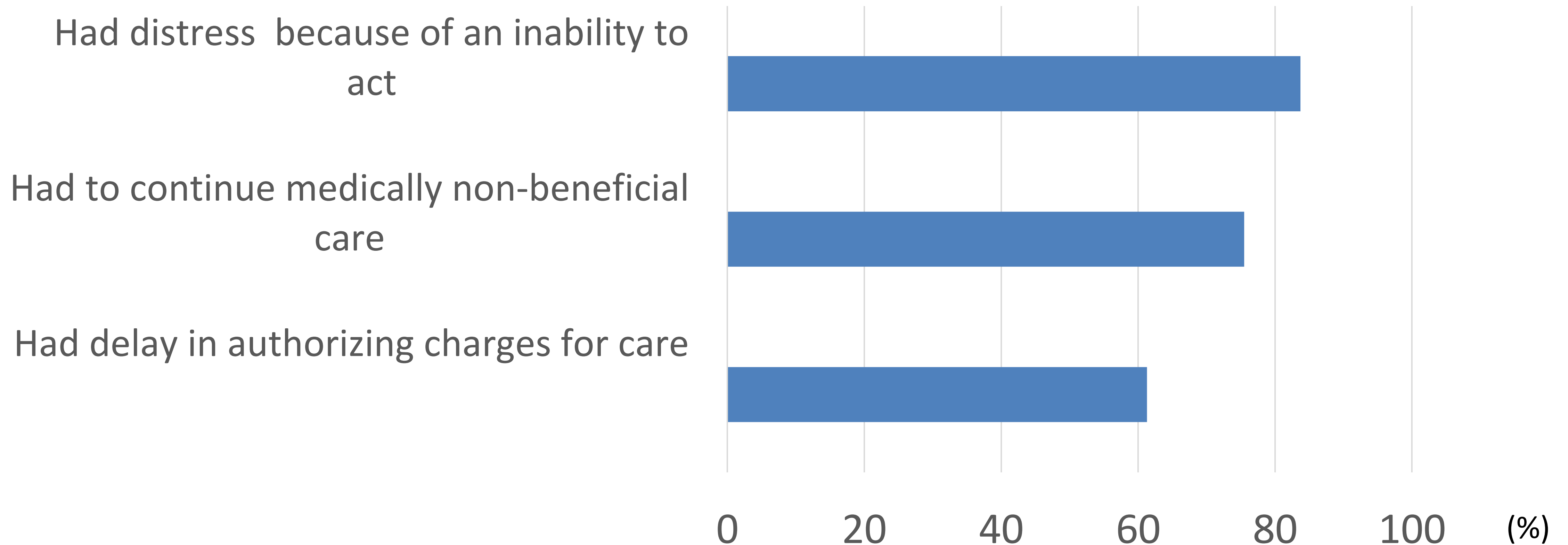
Farrell TW, Catlin C, Chodos AH, Naik AD, Widera E, Moye J. Clin Gerontol 2019

CLINICAL CONCERNS REGARDING THE UNBEFRIENDED



Farrell TW, Catlin C, Chodos AH, Naik AD, Widera E, Moye J. Clin Gerontol 2019

CLINICIAN-SPECIFIC CONCERNS



Farrell TW, Catlin C, Chodos AH, Naik AD, Widera E, Moye J. Clin Gerontol 2019

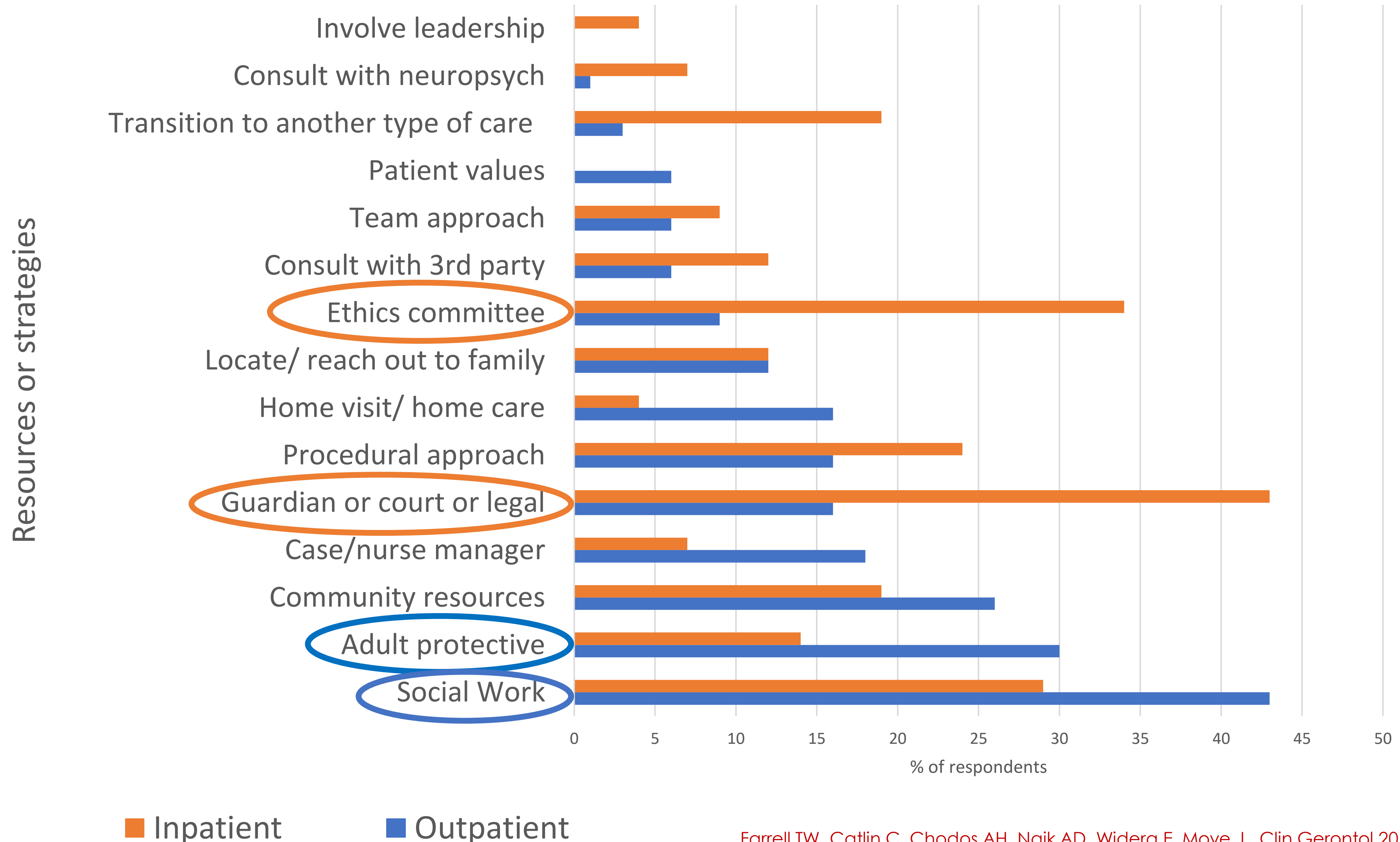
QUALITATIVE COMMENTS: DELAY

- *"We could not find an appropriate place to transfer an adult with frontotemporal dementia who had no family or friends. No psychiatric facility would take him due to his wandering behavior and due to lack of staff for 1:1 supervision. He remained several months in the hospital."*

- *"I also think that there is a gray category where somebody is essentially unbefriended because it is nearly impossible to get ahold of the designated decision maker."*

Farrell TW et al. Unpublished data (2019).

HELPFUL APPROACHES TO CARING FOR THE UNBEFRIENDED



Farrell TW, Catlin C, Chodos AH, Naik AD, Widera E, Moye J. Clin Gerontol 2019

MY PATIENT LACKS MEDICAL DECISION-MAKING CAPACITY…NOW WHAT?

- Search for any existing advance directives
- Refer to your state's priority order of surrogate decision makers
- Consider initiating guardianship proceedings in the absence of an advance directive, available surrogate, or patient objection to finding of incapacity

IF THERE ARE NO AVAILABLE SURROGATES: LEGAL GUARDIANSHIP

- **Pros:**
  - Court oversight
  - Appropriate for permanent incapacity

- **Cons:**
  - Slow and expensive
  - Removal of some or all constitutional rights
  - Difficult to reverse
  - “Stranger” guardians

AMERICAN GERIATRICS SOCIETY POSITION STATEMENT

ORIGINAL ARTICLE

AGS Position Statement: Making Medical Treatment Decisions for Unbefriended Older Adults

Timothy W. Farrell, MD, AGSF,[1,2] Eric Widera, MD,[3,4] Lisa Rosenberg, MD,[5] Craig D. Rubin, MD, AGSF,[6] Aanand D. Naik, MD,[7,8] Ursula Braun, MD, MPH,[7,8] Alexia Torke, MD, MS,[9] Ina Li, MD,[10] Caroline Vitale, MD, AGSF,[11,12] Joseph Shega, MD,[13,14] for the Ethics, Clinical Practice and Models of Care, and Public Policy Committees of the American Geriatrics Society

SELECTED AGS CLINICAL RECOMMENDATION

- **Assess medical decision-making capacity in a systematic fashion**
  - RATIONALE: *Evidence suggests that unstructured capacity assessments are often performed poorly. Cognitively impaired patients may still retain capacity to make some or all decisions.*

Farrell et al. J Am Geriatr Soc 2017

SELECTED AGS POLICY RECOMMENDATION

- **Proactively prevent older adult orphans from becoming unbefriended**
  - RATIONALE: *Adult orphans are one crisis away from becoming unbefriended.*

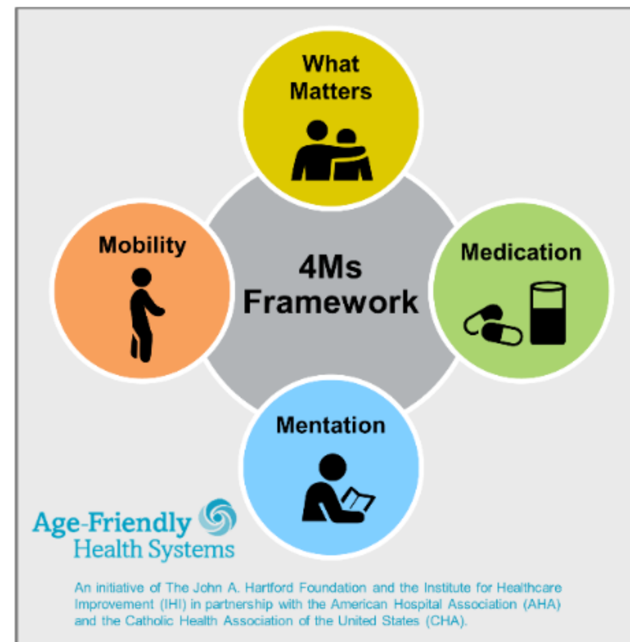
Farrell et al. J Am Geriatr Soc 2017

COULD THE 4MS HELP PREVENT PATIENTS FROM BECOMING UNREPRESENTED?

4MS APPROACHES TO PREVENT PATIENTS FROM BECOMING UNREPRESENTED

What Matters: Identify adults without advocates, conduct proactive advance care planning, engage in court/stakeholder partnerships

Mobility: Assess gait speed (correlates with life expectancy)



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Medications: Arrange for medication blister packs, electronic medication dispensers, or supervised medication administration

Mentation: Assess medical decision-making capacity

COULD THE EHR HELP IDENTIFY ADULTS WITHOUT ADVOCATES ?

Chart Review

Encounters | Notes | Labs/Path/Micro | Surgery | Imaging | CV | Procedures | Anesthesia

OP Snapshot | Open Orders | AMB SBARQ Handoff | Plan of Care | Off

Chart Review
RL6
Rooming
Order Review
Notes
Flowsheets
Plan
Wrap-Up
Graphs
Communicatio...
Demographics
New OB
History

Endoscopy
4 weeks ago
University Hospital OB/GYN Clinic 4 — Lori M Gawron, MD
1 month ago
Sugarhouse Clinic — Rachel Anne Weir, MD

Recent ED Visits and Hospitalizations
None

Social Determinants of Health

Stress
Stress Concern Present

Stress
6/2016 — Today

JUN 26 2019 Stress Concern Present

Do you feel stress - tense, restless, nervous, or anxious, or unable to sleep at night because your mind is troubled all the time - these days?

Rather much

Specialty
No commer
Edit
Show All

Care/Risk Sc
General Risk Sco — 0
Preventive Care — 2
Risk of Admissio — 10%

Advance

EHR: DEMOGRAPHICS AND FINANCES

Demographics

Marital Status:

Other | Single | Married | Divorced | Widowed | Legally Separated | Unknown | Life Partner/Domestic Partner

Spouse Name:

Number of Children:

Years of Education:

What is the highest level of school you have completed or the highest degree you have received?

Primary Language:

Ethnicity:

Race:

Financial Resource Strain

How hard is it for you to pay for the very basics like food, housing, medical care, and heating?

Not hard at all | Not very hard | Somewhat hard | Hard | Very hard | Patient refused

EHR: SOCIAL CONNECTIONS

History

GENERAL
Medical
Surgical
Family

SOCIAL DETERMINANTS
Substance & Sex...
Socioeconomic
Lifestyle
Relationships
Social Documenta...

SPECIALTY
Birth

Relationships

Social Connections

Patient refused all

In a typical week, how many times do you talk on the phone with family, friends, or neighbors?
Never | Once a week | Twice a week | Three times a week | More than three times a week | Patient refused

How often do you get together with friends or relatives?
Never | Once a week | Twice a week | Three times a week | More than three times a week | Patient refused

How often do you attend church or religious services?
Never | 1 to 4 times per year | More than 4 times per year | Patient refused

Do you belong to any clubs or organizations such as church groups, unions, fraternal or athletic groups, or school groups?
Yes | No | Patient refused

How often do you attend meetings of the clubs or organizations you belong to?
Never | 1 to 4 times per year | More than 4 times per year | Patient refused

Are you now married, widowed, divorced, separated, never married or living with a partner?
Married | Widowed | Divorced | Separated | Never married | Living with partner | Patient refused

When a patient is socially isolated, think not only of depression, but also consider whether she could be unrepresented or at risk of becoming unrepresented.

PROACTIVE ADVANCE CARE PLANNING

Utah Advance Health Care Directive

(Pursuant to Utah Code Section 75-2a-117, effective 2009)

Part I: *Allows you to name another person to make health care decisions for you when you cannot make decisions or speak for yourself.*
Part II: *Allows you to record your wishes about health care in writing.*
Part III: *Tells you how to revoke or change this directive.*
Part IV: *Makes your directive legal.*

My Personal Information

Name: ______
Street Address: ______
City, State, Zip Code: ______
Telephone: (____) ______ Cell Phone: (____) ______
Birth Date: ______

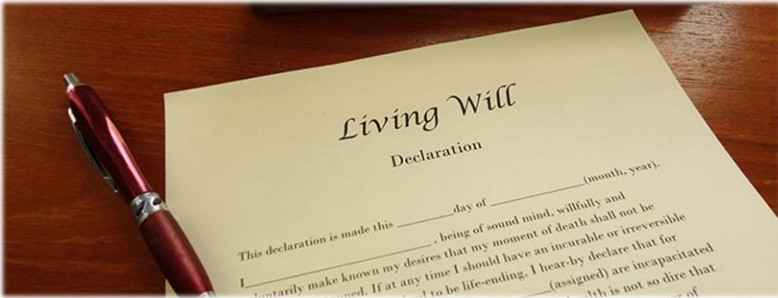
Part I: My Agent *(Health Care Power of Attorney)*

A. No Agent
If you do not want to name an agent, initial the box below, then go to Part II; do not name an agent in B or C below. No one can force you to name an agent.
☐ I do not want to choose an agent.

B. My Agent
Agent's Name: ______
Street Address: ______
City, State, Zip Code: ______
Home Phone: (____) ______ Cell Phone: (____) ______
Work Phone: (____) ______

C. My Alternate Agent
This person will serve as your agent if your agent, named above, is unable or unwilling to serve.
Alternate Agent's Name: ______
Street Address: ______
City, State, Zip Code: ______
Home Phone: (____) ______ Cell Phone: (____) ______
Work Phone: (____) ______

Advan Dir 50000 Page 1 of 4



Provider Order for Life-Sustaining Treatment (POLST)

Utah Life with Dignity Order

Bureau of Health Facility Licensing and Certification, Utah Department of Health
State of Utah Rule R432-31 v3.0 December 2014 (http://health.utah.gov/hflcra/forms.php)

Patient's Last Name | First Name/Middle Initial | Effective Date of this Order
Date of Birth | Last 4 of SS# | Address (street/city/state/zip)
Medical Provider's Name (MD/DO/PA/APRN) | Medical Provider's Phone
Brief description of patient's medical condition
Patient's stated goals for medical care

A. CARDIOPULMONARY RESUSCITATION (CPR) Treatment options when the patient does not have a pulse and is not breathing (CHECK ONE)

☐ Attempt to resuscitate (selecting attempt to resuscitate requires selecting full treatment in Section B) ☐ Do not attempt or continue any resuscitation (DNR) (Allow Natural Death) ☐ I do not wish to express a preference (selecting this may lead to attempt to resuscitate)

B. MEDICAL INTERVENTIONS Treatment options when the patient has a pulse and is breathing (CHECK ONE)

☐ FULL TREATMENT: *Prolonging life by all medically effective means.* Medical care may include endotracheal intubation, mechanical ventilation, defibrillation/cardioversion, vasopressors, and any other life-sustaining care that is required. Also includes medical care described below.

☐ LIMITED ADDITIONAL INTERVENTIONS: Treating medical conditions while avoiding burdensome measures. Medical care may include treatment of airway obstruction, bag/valve/mask ventilation, monitoring of cardiac rhythm, IV fluids, IV antibiotics and other medications as indicated. Also includes medical care described below. No endotracheal intubation or mechanical ventilation. Generally avoid the Intensive Care Unit.

☐ COMFORT MEASURES: MAXIMIZING comfort and dignity. Medical care may include oral and body hygiene, reasonable efforts to offer food and fluids orally, medication, oxygen, positioning, warmth and other measures to relieve pain and suffering. Transfer to the hospital only if comfort measures can no longer be managed at the current setting.

☐ NO PREFERENCE: I do not wish to express a preference (selecting this may lead to full treatment).

Other instructions or clarification; Describe goals and/or time period if a trial intervention is desired:

C. ARTIFICIAL NUTRITION

☐ Long term artificial nutrition with feeding tube ☐ Trial period of artificial nutrition with feeding tube ☐ No artificial nutrition ☐ I do not wish to express a preference

Describe goals and/or time period if a trial is desired:

D. ADVANCE DIRECTIVE AND PATIENT PREFERENCES

☐ Advance Directive available, reviewed and confirmed without conflicts ☐ No Advance Directive available

Health care agent named in Advance Directive | Phone Number

☐ I, the patient, want this order to serve as a general guide. I understand in some situations, the person making decisions for me may decide something different if they think it is consistent with my preferences. ☐ I, the patient, want this order to be followed strictly.

Discussed with:

REQUIRED SIGNATURES

Print Name | Relationship: (write self if patient) | Signature

Signature of Medical Provider (MD/DO/PA/APRN) Two signatures required for minors	Print Name	License Number	Date

Signature of licensed professional preparing form	Print Name	Title	Date

UTAH POLST

HEALTH UNIVERSITY OF UTAH

PROACTIVE ADVANCE CARE PLANNING (ACP)

- **Do not wait for a crisis to conduct ACP**
- ACP is a reimbursable service under Medicare*
  - ICD-10 code 99497 (first 30 minutes)
  - ICD-10 code 99498 (each additional 30 minutes)
- ACP can be implemented flexibly
  - Not limited by location or specialty

*https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf

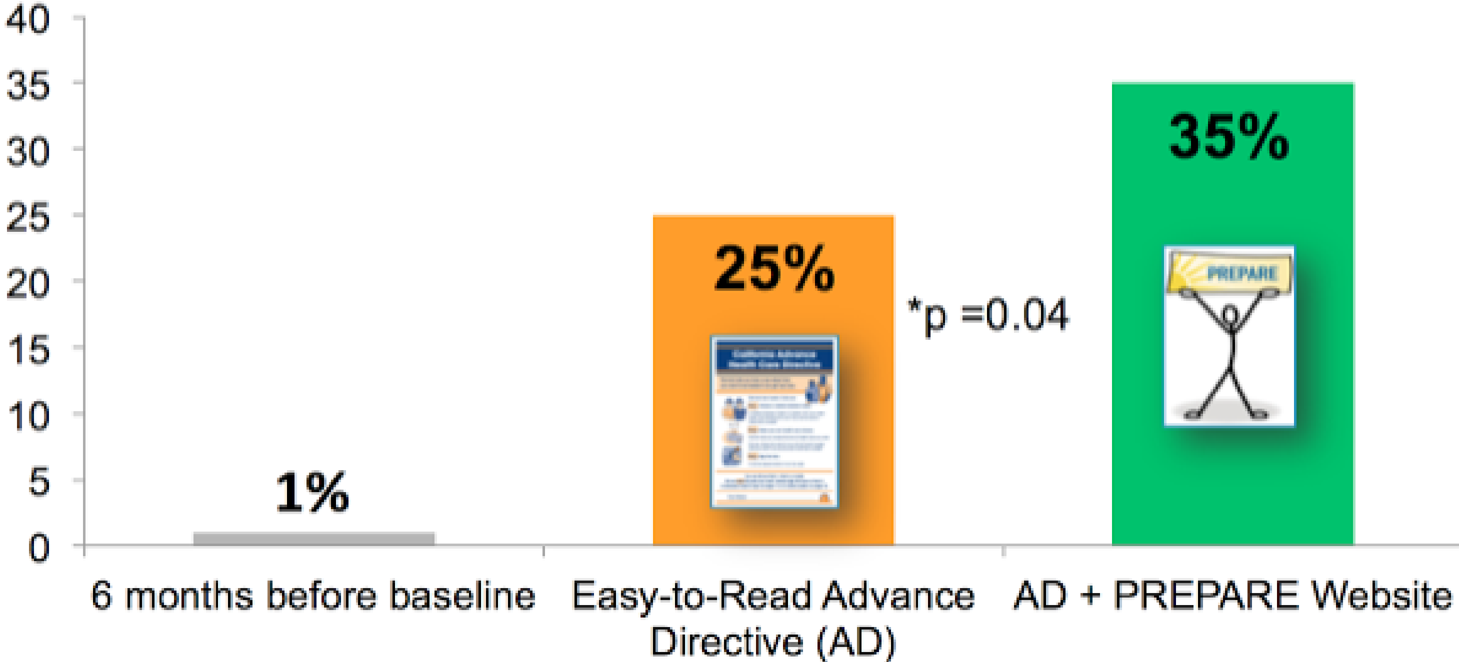
PREPARE™ FOR YOUR CARE

A program to help you make medical decisions for yourself and others

- Step 1 Choose a medical decision maker.
- Step 2 Decide what matters most in life.
- Step 3 Choose flexibility for your decision maker.
- Step 4 Tell others about your medical wishes.
- Step 5 Ask doctors the right questions.

https://www.prepareforyourcare.org

EVIDENCE SUPPORTING PREPARE™



http://www.geripal.org/2017/05/rebecca-sudore-on-advance-care-planning.html

WINGS PROGRAMS

- About half of states have WINGS or similar programs
- Stakeholders include courts, AAAs, APS, bar associations, social services programs, and guardians
- Functions include educating the public, supporting guardians, and advocating for strong court oversight

final-wings-brochure.pdf (americanbar.org)

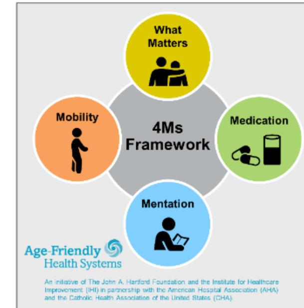
PATIENT R.G.: THE REST OF THE STORY

- ED visit after an unexplained fall
- Discharge from ED at 4 AM without a plan for transportation home
- He wandered and was nearly hit by a car
- This was the crisis that led to action - placement in a long term care facility and initiation of guardianship proceedings

FUTURE DIRECTIONS: ADULTS WITHOUT ADVOCATES AND THE UNREPRESENTED

- Determine the prevalence of older adults without advocates in outpatient primary care settings
- Assess the effectiveness of proactive interventions to prevent older adults without advocates from becoming unrepresented
- Quantify health outcomes and costs when unrepresented older adults have prolonged hospitalizations

FULFILLING THE PROMISE OF AGE-FRIENDLY HEALTH SYSTEMS



- Health systems are only as good as the care they provide for the most vulnerable patients, such as R.G.

- Everyone – patients, caregivers, staff, and clinicians from virtually all specialties – can and should adopt a 4Ms approach to caring for older adults.

Q&A

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