

# Designing and Implementing Pragmatic Interventions for Older Adults in the Health System Context

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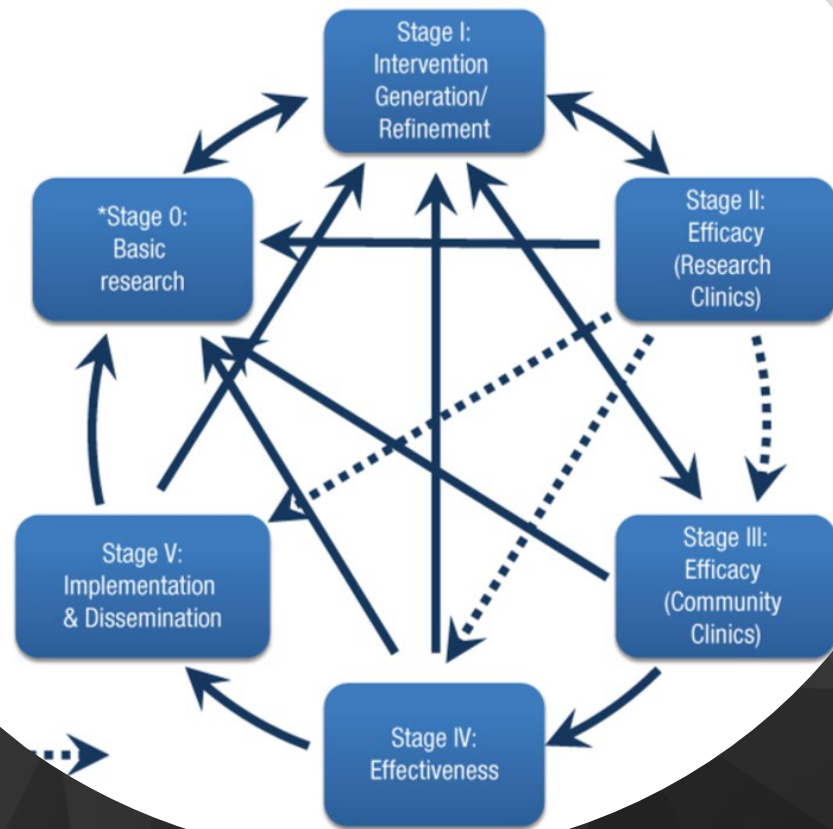


Division of Geriatric Medicine

SCHOOL OF MEDICINE

UNIVERSITY OF COLORADO **ANSCHUTZ MEDICAL CAMPUS**

# NIH Stage Model



# Pragmatic Considerations

Stakeholder Experiences

Real-World Interventions

Data Collection

Adaptations

Public Goods

# Advance Care Planning Meets Group Medical Visits: The Feasibility of Promoting Conversations

Session 1

1 Month Apart

Session 2



8-10 Participants

Physician +  
Social Worker

## CONTENT



Check in, vital signs, medication review (30 min)



Introductions, rapport building (15 min)



Facilitated ACP discussion (60 min)



Individualized goal setting (15 min)

## RESOURCES



ACP Handouts



PREPARE video  
stories




Easy-to-use advance  
directive forms

In Outpatient Clinic

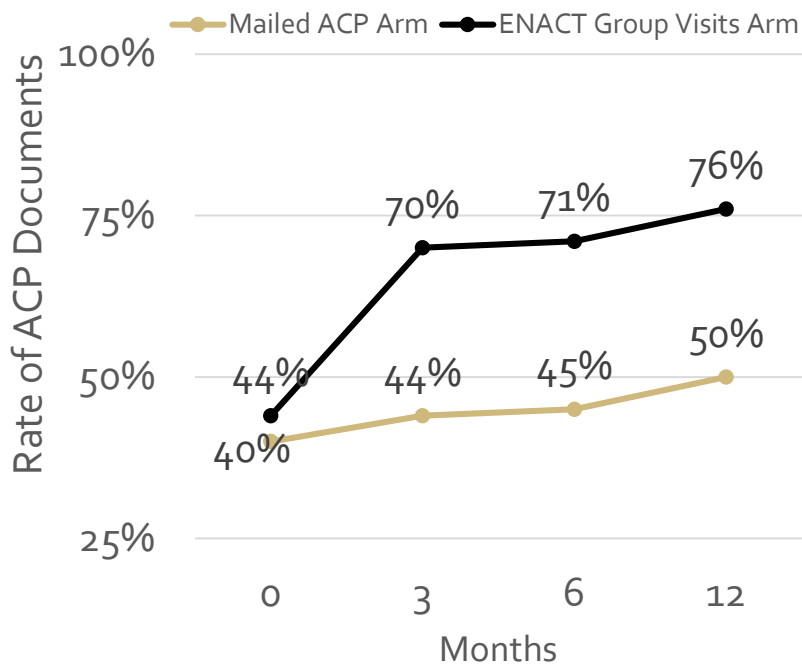
# Effectiveness of Advance Care Planning Group Visits Among Older Adults in Primary Care

J Am Geriatr Soc. 2020  
Oct;68(10):2382-2389

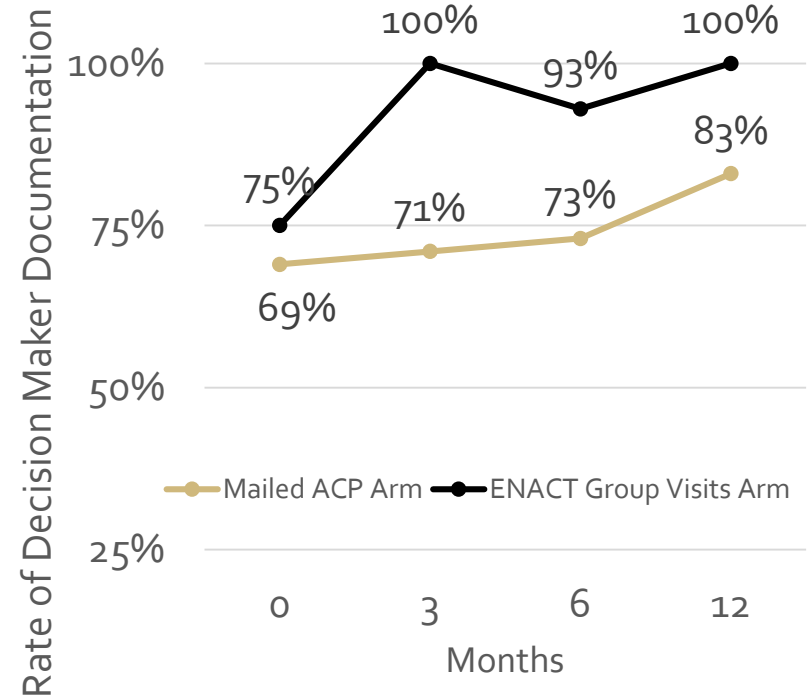
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Elizabeth Juarez-Colunga, PhD,¶ Prajakta Shanbhag, MS,\* Jean S. Kutner, MD, MSPH,||  
Cari R. Levy, MD, PhD,\*†† and Rebecca L. Sudore, MD\*‡‡

## ACP DOCUMENTS

$p < 0.01$  at 3, 6 and 12 months



## DECISION MAKER DOCUMENTATION



Next step: Five Clinic RCT (R01 AG066804)

# Public Goods: Patient Awareness



Module Title	% Complete	Progress	Completed
Engaging in Advance Care Planning Talks (ENACT) Module 1	88 %		
Preparing for the ENACT Group Visit: Module 2	87 %	Continue	
ENACT Session A Group Visit: Module 3	100 %	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
ENACT Session B Group Visit: Module 4	100 %	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
ENACT Group Visit - Facilitator Tips & Tricks: Module 5	0 %	Get Started	

Patient  
Recruitment  
Video

Colorado  
Advance  
Care  
Planning  
Website

eLearning  
Module for  
Facilitator  
Training

# Design and Implementation of Patient Portal–Based Advance Care Planning Tools

Hillary D. Lum, MD, PhD, Adreanne Brungardt, MM, MT-BC, Sarah R. Jordan, MA, Phoutdavone Phimphasone-Brady, PhD, Lisa M. Schilling, MD, MSPH, Chen-Tan Lin, MD, Jean S. Kutner, MD, MSPH

J Pain Symptom Manage. 2019 Jan;57(1):112-117.e2

## Three Implementation Phases

### Phase 1 (May 2017)

- New Webpage
- Online Message for ACP questions to centralized team

### Phase 2 (July 2017)

- Electronic Medical Durable Power of Attorney  
(includes messages to provider and patient)

### Phase 3 (Oct 2017)

- Display advance directives to patient via patient portal

# Patient Use of My Health Connection ACP Tools



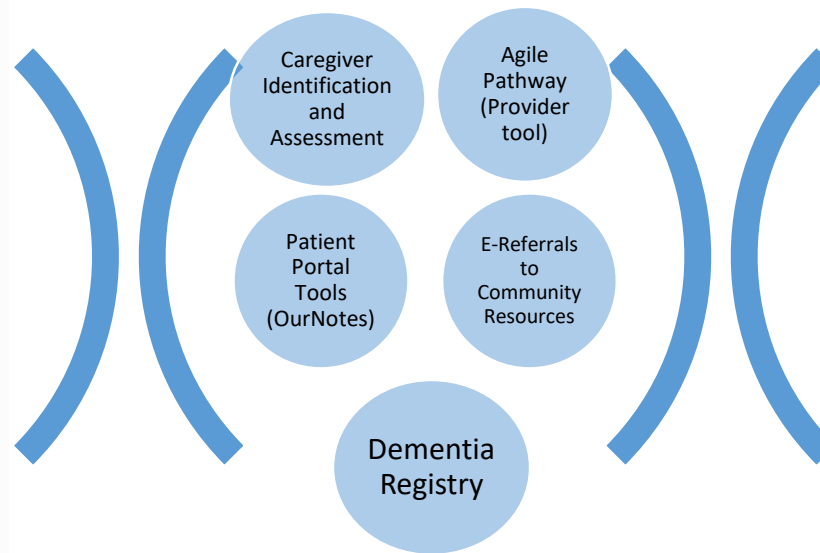
# NIA IMPACT Collaboratory Health Care Systems Scholar Emerging Results: Stakeholder Priorities & Opportunities

What needs to be true about communication?

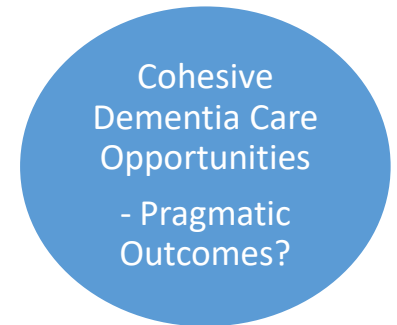


Patient/Care Partners:  
Desire simple transparent communication in a caring manner

What are opportunities for EHR-based dementia/caregiver specific tools?



What is important, feasible, and fundable (pragmatic clinical trials)?



Health Care Teams,  
System Leaders, and  
Fundurs





# Reflections

<b>Be creative</b>	Create things that people can and want to use
<b>Partner</b>	Collaborate with different people, especially patients, care partners, and community members
<b>Listen</b>	Seek to understand what others need, incorporate their input
<b>Persist</b>	Highlight important things - sometimes funders, health care systems, payors and policy makers will agree

# Thank you!

## Teamwork makes the dream work



### ■ Mentors

Jean Kutner  
Cari Levy  
Rebecca Sudore  
Dan Matlock  
Brienne Bettcher  
David Reuben  
Leah Hanson

### ■ Clinical Partners

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