Family Caregiving Advisory Council Meeting

February 11 – 12, 2020
The Agenda

February 12, 2020

1:00 – 1:15  Welcome, Roll Call, Re-Cap Day 1
1:15 – 1:45  Overview of the Driver Diagram Process
1:45 – 3:30  Establishing a Framework to Achieve Goals
3:30 – 3:45  Outlining Technical Assistance Needs and Future Planning
3:45 – 4:00  Wrap-up and Charge to Sub-committees
Welcome and Roll Call

Greg Link, Director
Officer of Supportive and Caregiver Services
Administration for Community Living

Wendy Fox-Grage
Project Director
National Academy for State Health Policy (NASHP)
Preliminary Revised Goals

• Expand access to services to optimize the health and wellness of caregivers and care receivers
• Empower family caregivers and care recipients to be at the center of all healthcare and LTSS settings.
• Protect financial and workplace security of family caregivers
• Promote research and the adoption of evidence-based practices
• Strengthen program administration, governance and collaboration
Overview of the Driver Diagram

Bruce Finke, MD
Director (acting)
Nashville Area Indian Health Service
NAPA Driver Diagram

Bruce Finke
Laura Gitlin
Rohini Khillan
A Driver Diagram...
- Is a logic model that provides a visual display of a team's theory of action.
- Posits the actions necessary to achieve the shared aim.
- Shows the relationship between the overall aim of the project, the primary drivers that contribute directly to achieving the aim, the secondary drivers that are components of the primary drivers, and specific change ideas to test for each secondary driver.*
- Is a useful tool for communicating across a range of stakeholders and a team that is working toward a shared aim.

A Driver Diagram is not...
- A hard and fast, set in concrete, plan

*Institute for Healthcare Improvement’s Definition
Driver Diagrams

Basic format:

1. Start with a clearly defined aim
2. Identify “drivers” necessary to achieve that aim.
3. Capture drivers – and set these out in the diagram format.
4. Identify actions or interventions for each driver.
5. Identify measures for drivers and actions – that help you understand progress toward the aim.
Example: Driver Diagram

Aim: Reduce by 50% colonization and infection with MRSA by August 1.

Primary Drivers:
- Reduce transmission of infection and colonization

Secondary Drivers:
- Decolonization
- Screening patients
- Good hygiene
- Reliable precaution routines
- Bundles

Change Ideas:
- Try chlorhexidine washcloths
- Test standing order for screening
- Feedback hand hygiene adherence rates
- Ensure ideal placement of sanitizer
- Incorporate adherence check on rounds

QI Essentials Toolkit: Driver Diagrams
Institute for Healthcare Improvement (IHI)
What Can a Driver Diagram Do?

- Communicate the "theory of the case"
  - What we hope to accomplish.
  - How we will accomplish it.

- Make explicit the actions we believe are necessary to achieve our aims
  - Avoids "magical thinking"

- Facilitate measurement of progress toward our goals
  - Measure the work in the drivers as interim outcomes well and key processes.
The intent was to lay out clearly how the various aspects of NAPA work and tie together:

- National Plan, Council recommendations, Summit work, federal and non-federal activities to address recommendations

Provides a broad overview of where things fit together and affect each other.

Intended to be very flexible, but will hopefully allow us to see the progress made over time.
<table>
<thead>
<tr>
<th>Aim</th>
<th>Primary Driver</th>
<th>Secondary Driver</th>
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<tbody>
<tr>
<td>Eliminate the burden of Alzheimer’s</td>
<td>Prevent and Effectively Treat Alzheimer’s Disease by 2025</td>
<td>Identify Research Priorities and Milestones</td>
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<tr>
<td>Disease and Related Dementias</td>
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<td>Expand Research Aimed at Preventing and Treating</td>
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<td>Accelerate Efforts to Identify Early and Pre-symptomatic Stages</td>
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<td>Coordinate research with International Public and Private Entities</td>
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<td>Facilitate Translation of Findings into Medical Practice and Public Health Programs</td>
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<td>Enhance Care Quality and Efficacy</td>
<td>Build Workforce</td>
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<td>Ensure Timely and Accurate Diagnosis</td>
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<td>Educate and Support People with Dementia and their Families</td>
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<td>Identify High-Quality Dementia Care Guidelines and Measures Across Care Settings</td>
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<td>Explore the Effectiveness of New Models of Care</td>
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<td>Ensure Safe and Effective Transitions between Care Settings and Systems</td>
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<td>Advance Coordinated and Integrated Health and Long-Term Services and Supports</td>
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<td>Improve Care for Populations Disproportionately Affected by Alzheimer’s Disease</td>
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<td>and for Populations Facing Care Challenges</td>
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<td>Expand Supports for People with Alzheimer’s Disease and Related Dementias and their Families</td>
<td>Ensure Receipt of Culturally Sensitive Education, Training, and Support Materials</td>
<td>Enable Family Caregivers to Continue to Provide Care while Maintaining Their Own Health and Well-Being</td>
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<td>Assist Families in Planning for Future Care Needs</td>
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<td>Maintain the Dignity, Safety and Rights of Persons with ADRD</td>
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<td>Assess and Address the Housing Needs</td>
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<td>Enhance Public Awareness and Engagement</td>
<td>Educate the Public</td>
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<td>Work with State, Tribal, and Local Governments to Improve Coordination and Identify Model Initiatives to Advance Awareness and Readiness across the Government</td>
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<td>Coordinate United States Efforts with Those of the Global Community</td>
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<td>Track Progress and Drive Improvement</td>
<td>Enhance the Federal Government’s Ability to Track Progress</td>
<td>Monitor Progress on the National Plan</td>
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<tr>
<td>Aim</td>
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<td>Secondary Driver</td>
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<tr>
<td>Eliminate Burden of ADRD</td>
<td>Prevent and Effectively Treat ADRD by 2025</td>
<td>Identify Research Priorities and Milestones</td>
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Support from Multi-stakeholder Environment

Comprehensive Primary Care Functions

Comprehensive Primary Care for:
Patient & Family
Better Health
Better Care • Lower Cost

Continuous Improvement Driven By Data

Optimal Use of Health IT

Access and Continuity
Planned Care for Chronic Conditions and Preventative Care
Risk-Stratified Care Management
Patient and Caregiver Engagement
Coordination of Care
Coordination of Care
Data Exchange
Continuous Improvement of HIT
Culture of Improvement
Allocation of Resources
Accountable Payment
Enhanced Practices

August 2012
“Empanelling” is the process of associating individual patients with individual primary care providers (PCPs) within a primary care practice. This organizational activity within a primary care practice is key to patient-centered care. The PCP is the leader of an established care team; this team is responsible for the ongoing comprehensive and coordinated care of its empanelled patients. The team works together to provide high-quality care through patient-centered processes with lead responsibility for their identified, empanelled patients. Empanelment does not in any way limit a Medicare beneficiary’s freedom to choose their own primary care provider.

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**Change Concept**

A. Optimize timely access to care guided by the medical record.
B. Empanel all patients to a care team or provider.
C. Optimize continuity with provider and care team.
Change Concept

A. Use a personalized plan of care for each patient.
B. Manage medications to maximize therapeutic benefit and patient safety at lowest cost.
C. Proactively manage chronic and preventive care for empanelled patients.
D. Use team-based care to meet patient needs efficiently.
Comprehensive Primary Care for: Patient & Family

Better Health
Better Care • Lower Cost

Continuous Improvement Driven By Data

Allocation of Resources

Culture of Improvement

Change Concept

A. Allocate resources to support continuous improvement driven by data.
B. Use available data to guide improvement.
Change Concept

A. Adopt a formal model for quality improvement.
B. Create a culture in which everyone actively participates in improvement activities.
C. Active participation in transformation collaborative.
Discussion
Establishing a Framework to Achieve Goals

Nancy Murray, M.S.
President
The Arc of Greater Pittsburgh at Achieva
Exercise
Outlining Technical Assistance Needs and Future Planning

Pamela Nadash, Ph.D.
Associate Professor
Department of Gerontology
McCormack Graduate School
University of Massachusetts
Learning from Family Caregivers

Workplan for Conducting Listening Sessions for the RAISE Family Caregiving Advisory Council

2-12-2020
Research Objectives

• Reach out to family caregivers and other stakeholders to provide multiple forums for expressing needs and challenges;

• Help identify the specific services, supports, or policy initiatives that might better meet their caregiving needs; and

• Inform the development of federal, state, and community blueprints for programs and services that can enhance the resilience of a diversity of family caregivers.
Three Unique Forums

- Detailed analysis of comments from the Request for Information (RFI)
- Web-based focus groups
- In-person listening sessions
RFI Response Analysis

- Roughly 1800 responses
- Two questions: issues and recommendations
- Analysis will identify key themes across responses
- Council feedback on the results will help areas of exploration in the subsequent stages of the research
Web-based Focus Groups

- Allow us to explore priority issues in more depth
- Advantages of web-based approach:
  - Caregivers whose circumstances might not permit travel to an in-person meeting can participate
  - Can gather input nationally
- Will convene 12 sessions, working with project team to develop and evolve discussion guide
In-Person Listening Sessions

- Convened at community-based settings involving key stakeholders within a given community
- Two in English and one in Spanish
- One in the DC area
Project Team Expertise

• **Community Catalyst** – National non-profit consumer advocacy organization. Works with state and federal policymakers to make systems more responsive to consumer needs through research and policy development;

• **LTSS Center at UMass Boston** – Subject matter experts and research expertise with consumers, family caregivers and LTSS stakeholders, including states and federal government. Skilled at qualitative research;

• **ET Consulting** – Expertise in consumer focus group design on a broad range of LTSS topics, including several projects in collaboration with U Mass Boston.
## Project Timeline

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<th>Time Period</th>
<th>Activities</th>
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<tr>
<td><strong>1st Quarter</strong></td>
<td>Analysis of Federal Register comments</td>
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<td><strong>2nd Quarter</strong></td>
<td>Research design and kick off for web-based focus groups</td>
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<tr>
<td><strong>3rd Quarter</strong></td>
<td>Continue focus groups and begin In-Person Listening Sessions</td>
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<tr>
<td><strong>4th Quarter</strong></td>
<td>Complete Listening Sessions, analysis of findings, Project Presentation</td>
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Thank you.
Wrap-up and Charge to Sub-committee

Greg Link, Director
Office of Supportive and Caregiver Services
Administration for Community Living

Wendy Fox-Grage, Project Director
National Academy for State Health Policy (NASHP)