Final Project Report

General Information

The information below was submitted through your Grant Application.

If there have been any changes to this information, please contact your NextFifty Initiative Grant Manager.

Organization Name

Colorado Mesa University

Organization Address

1100 North Ave

Project Manager

Dr. Patrick W. Page M.D.

Project Title

Western Colorado Frailty Index: Enhancing Quality of Life though Collaboration and Data

Final Project Report Narrative

The two fields below were submitted through the Grant Application and are for reference when completing the Final Report.

Measurement

The information below was submitted through the application process and cannot be edited.

The following research-based questions will guide the project's measurement and evaluative interests, and are aligned with project objectives, project plans and budget:

1. How do healthcare professionals in clinics and long term rehabilitation and care facilities use frailty data to support care of elderly patients?

2. What are the barriers and opportunities that healthcare professionals in clinics and long-term rehabilitation and care facilities face when implementing a frailty indexing and care plan program for elderly patients?

3. What are the barriers and opportunities when adding frailty data to existing data networks and health related data sets?

4. What kind of model of frailty indexing and associated care plans for elderly can be created through the involvement of primary care physicians, specialty physicians, and long-term care and rehabilitation facilities?

Specific Objectives and Activities, as listed above, will be measured as follows:

Objective One: Structurally, legally and ethically prepare the community for frailty care that is maximized by full collaboration across the spectrum of care, and that meets state, federal and institutional review board standards for patient safety and ethics.

Measurement: Completion and completeness of initial agreements by Western Colorado Physicians Association, Home Care of the Grand Valley, Larchwood PARC/LTC and Quality Health Network.

Objective Two: Establish schedules and processes for communication and reporting to grantor, project participants and advisory groups.

Measurement: Ability to plan for and utilize calendar for pushing out communications; feedback from recipients regarding frequency, clarity and usefulness of communications; acceptance of writings and presentations for broader audience distribution.

Objective Three: Train healthcare workers at participating organizations on use of Patient Pattern software.

Measurement: By month three of use, healthcare workers will be able to provide oversight of software use within their respective organizations and identify optimization features for the software vendor. By month 13, healthcare workers at Phase One participating organizations will be able to mentor counterparts at Phase Two participating organizations in use of the software within their respective organizations.

Objective Four: Institutionalize Patient Pattern software and data into the Quality Health Network information system, efficiently organized with advanced directives and patient-specific care plans to meet (and improve) community standards for frail elderly care.

Measurement: Standardized access to risk-based frailty assessments and care plans for those participating in the project. By Month 13, Patient Pattern data and the Quality Health Network interoperability team will provide access to risk-based frailty assessments and care plans.

Objective Five: Integrate Medicare's Outcome and Assessment Information Set (OASIS) with Patient Pattern software, Quality Health Network and Home Care of the Grand Valley for data sharing.

Measurement: Completion and ongoing operability of integration.

Objective Six: Integrate Patient Pattern with Center for Medicare and Medicaid Services (CMS) to establish the proposed unique code for Advanced Care Planning that then becomes the metric for the step wedge strategy, in preparation for a future innovation grant for measuring the model and impact regionally, state and/or nationwide.

Measurement: Assignment of a CMS modifier code; federal review and validation of frailty data outcomes.

Objective Seven: Conduct a retrospective analysis of OASIS-derived frailty indices of patients at Western Colorado Physicians Group and Home Care of the Grand Valley using data from the 12 months preceding project initiation.

Measurement: Completion of analysis; findings that prove improvement in patient health outcomes.

Objective Eight: Integrate OASIS-based frailty indices and associated patient care plans within workflow at participating user organizations.

Measurement: Home Care of the Grand Valley will integrate OASIS and frailty integration efficiencies and patient outcomes into the workflow by Month 13.

Objective Nine: Work with Primary Care Partners (broader healthcare provider with Western Colorado Physicians Group as a division) to establish interfaces for importing frailty assessments and exporting frailty assessments.

Measurement: Successful completion of care plan and frailty assessment data import and export by Month 15.

Objective Ten: Integrate and test the inclusion of Patient Pattern data and care plans in the Medicare Minimum Data Set at Larchwood PARC/LTC; conduct retrospective analysis of Minimum Data Sets-derived frailty indices of patients at Western Colorado Physicians Group and Larchwood PARC/LTC using data from the 12 months preceding project initiation.

Measurements: Completed integration with MDS. Completion of past-patient analysis; findings that prove improvement in patient health outcomes, such that by Month 6, Western Colorado Physicians Group and Larchwood PARC/LTC will have a strong basis for collaboration to advise process and future deployments.

Objective Eleven: Initiate and maintain Larchwood PARC/LTC adoption and utilization of Frailty Index-based care plans.

Measurement: The review process will describe outcomes, process assimilation, and opportunities for system improvements and for future evaluation.

Objective Twelve: Hold meetings of clinical leaders at three healthcare provider sites and representatives of Patient Pattern and Quality Health Network to describe path toward true collaboration in work with the elderly frail population.

Measurement: By Month 24, the group will be able to describe a simple path toward true community collaboration in work with the elderly frail population.

Objective Thirteen: Develop plan to and provide education/professional development on Frailty Indexing and care planning for representatives of hospitals, Independent Physicians Association, United Health Care, Rocky Mountain Health Plans, Monument Health, Quality Health Network and Primary Care Physicians.

Measurement: Ability to schedule and provide quality training. Attendance at trainings, interest in project generated as a result of trainings.

Objective Fourteen: Conduct formalized planning and recruiting for future project participating organizations throughout the region.

Measurement: Recruitment and engagement of participating organizations throughout the four-county region.

Objective Fifteen: Create a Care Compact among specialty and primary care physicians

Measurement: Ability to craft and garner agreement/commitment to Care Compact by physicians in the region.

Objectives and Outcomes

The information below was submitted through the application process and cannot be edited.

Objective One: Structurally, legally and ethically prepare the community for frailty care that is maximized by full collaboration across the spectrum of care, and that meets state, federal and institutional review board standards for patient safety and ethics.

a. Timeline: Year one, month one (and ongoing as additional organizations opt in).

b. Steps: Establish due diligence legal commitments with participating organizations, which will review current HIPAA operating agreements and assure alignment with legal and ethical guidelines (for disparate organizations to share information and comply with HIPPA, all must address their information sharing arrangements with each other).

c. Measurement: Completion and completeness of initial agreements by Western Colorado Physicians Association, Home Care of the Grand Valley, Larchwood PARC/LTC and Quality Health Network.

Objective Two: Establish schedules and processes for communication and reporting to grantor, project participants and advisory groups.

a. Timeline: Year one, month one (and ongoing)

b. Steps: Prioritize and organize the project's communications calendar via quarterly refinements of critical reporting elements (based on input from advisory groups), issuing of progress reports to participating organizations, building of fluency in the processes of effective care for the age-related frail and annual (or as otherwise required) technical and financial reporting to funder(s). Year Two: Additional activity to include publications and conference presentations regarding model implementation and evidence of effectiveness. c. Measurement: Ability to plan for and utilize calendar for pushing out communications; feedback from recipients regarding frequency, clarity and usefulness of communications; acceptance of writings and presentations for broader audience distribution.

Objective Three: Train healthcare workers at participating organizations on use of Patient Pattern software.

a. Timeline: Year one, month one (and ongoing, as needed)

b. Steps: Biweekly phone conferences hosted by Patient Pattern representatives with healthcare workers at Western Colorado Physicians Group, Home Care of the Grand Valley, Larchwood PARC/LTC and Quality Health Network to gain understanding of software use and enhancements.

c. Measurement: By month three of use, healthcare workers will be able to provide oversight of software use within their respective organizations and identify optimization features for the software vendor. By month 13, healthcare workers at Phase One participating organizations will be able to mentor counterparts at Phase Two participating organizations in use of the software within their respective organizations.

Objective Four: Institutionalize Patient Pattern software and data into the Quality Health Network information system, efficiently organized with advanced directives and patient-specific care plans to meet (and improve) community standards for frail elderly care.

a. Timeline: Monthly throughout the project

b. Steps: Via monthly teleconferences (or as needed) with Patient Pattern technical support, Quality Health Network programmers will ensure incorporation and integrity of, and access to Frailty Index database information.

c. Measurement: Standardized access to risk-based frailty assessments and care plans for those participating in the project. By Month 13, Patient Pattern data and the Quality Health Network interoperability team will provide access to risk-based frailty assessments and care plans.

Objective Five: Integrate Medicare's Outcome and Assessment Information Set (OASIS) with Patient Pattern software, Quality Health Network and Home Care of the Grand Valley for data sharing.

a. Timeline: Year one, month three

b. Steps: Prepare plan for integration of the frailty data using OASIS Medicare standards. Create a comprehensive approach to care plan and risk indexing, to be integrated into the master patient index of Quality Health Network, then routed to treating and primary care physicians at Western Colorado Physicians Group (and future participating primary care groups) as reliably-obtained and applicable information. Report to advisory committee and participating users through communication strategy.

c. Measurement: Completion and ongoing operability of integration.

Objective Six: Integrate Patient Pattern with Center for Medicare and Medicaid Services (CMS) to establish the proposed unique code for Advanced Care Planning that then becomes the metric for the step wedge strategy, in preparation for a future innovation grant for measuring the model and impact regionally, state and/or nationwide.

a. Timeline: Beginning year one, month one and ongoing to completion

b. Steps: Contact CMS to establish relationship with Frailty Index project. Hold phone meetings with Patient Pattern technical support regarding integration with CMS. Working with Patient Pattern, introduce the CMS innovation team to the long-term project goal of regional community-wide use of frailty data. Work with CMS to explore creation of an Advanced Care Planning Modifier Code to convey value added by Frailty Index/data within the health information exchange to provide a patient-specific comprehensive geriatric assessment, and as a marker correlated to outcome measures of frailty data for use at the national level. Report progress to advisory committee and participating users by end of year one.

c. Measurement: Assignment of a CMS modifier code; federal review and validation of frailty data outcomes.

Objective Seven: Conduct a retrospective analysis of OASIS-derived frailty indices of patients at Western Colorado Physicians Group and Home Care of the Grand Valley using data from the 12 months preceding project initiation.

a. Timeline: Beginning year one, month two

b. Steps: Review previous OASIS reports to conduct clinical review of demographics, outcomes and opportunities for altered care plans for Western Colorado Physicians Group patients who were in the care of Home Care of Grand Valley in past 12 months. Compare patient outcomes with prior approaches and outcomes based on no frailty data. Use analysis/findings to inform the project team and healthcare

workers at participating organizations regarding effective use of frailty data and associated care plans compared with prior approaches and outcomes without frailty data. Report findings to advisory committee and participating users.

c. Measurement: Completion of analysis; findings that prove improvement in patient health outcomes.

Objective Eight: Integrate OASIS-based frailty indices and associated patient care plans within workflow at participating user organizations.

a. Timeline: Ongoing from year one, month two through year two

b. Steps: Assimilate Frailty Index and care plans in the work and collaboration between Western Colorado Physicians Group and Home Care of Grand Valley. Report to other practices working with elderly patients through Quality Health Network. Conduct ongoing review of process, outcomes and opportunities for future evaluation. Conduct ongoing review of potential for collaboration with acute care facilities. Report quarterly report to advisory committee and participating users group.

c. Measurement: Home Care of the Grand Valley will integrate OASIS and frailty integration efficiencies and patient outcomes into the workflow by Month 13.

Objective Nine: Work with Primary Care Partners (broader healthcare provider with Western Colorado Physicians Group as a division) to establish interfaces for importing frailty assessments and exporting frailty assessments.

a. Timeline: Years one and two, months 3-15

b. Steps: Flow care plans and frailty indices derived from other facilities into Primary Care Partners' record, thus enabling patients of Western Colorado Physicians Group and all other Primary Care Partners' divisions to have their data viewed by their primary care provider. Flow care plans and frailty indices derived from Primary Care Partners into Quality Health Network.

c. Measurement: Successful completion of care plan and frailty assessment data import and export by Month 15.

Objective Ten: Integrate and test the inclusion of Patient Pattern data and care plans in the Medicare Minimum Data Set at Larchwood PARC/LTC; conduct retrospective analysis of Minimum Data Sets-derived frailty indices of patients at Western Colorado Physicians Group and Larchwood PARC/LTC using data from the 12 months preceding project initiation.

a. Timeline: Year one, months 4-6

b. Steps: Larchwood PARC/LTC will submit Minimum Data Sets (MDS) to be capture at Quality Health Network. Quality Health Network submits MDS to Patient Pattern and Medicare; MDS routed back to Quality Health Network and Larchwood PACR/LTC with precision to match the Master Patient Index, such that the exchange of information is reliable for downloading into the patient electronic health

record to be addressed within Larchwood PACR/LTC's normal workflow. Review previous MDS reports to conduct clinical review of demographics, outcomes and opportunities for altered care plans for Western Colorado Physicians Group patients who were in the care of Larchwood PARC/LTC in past 12 months. Compare patient outcomes with prior approaches and outcomes based on no frailty data. Use analysis/findings to inform the project team and healthcare workers at participating organizations regarding effective use of frailty data and associated care plans compared with prior approaches and outcomes without frailty data. Report findings to advisory committee and participating users.

c. Measurements: Completed integration with MDS. Completion of past-patient analysis; findings that prove improvement in patient health outcomes, such that by Month 6, Western Colorado Physicians Group and Larchwood PARC/LTC will have a strong basis for collaboration to advise process and future deployments.

Objective Eleven: Initiate and maintain Larchwood PARC/LTC adoption and utilization of Frailty Index-based care plans.

a. Timeline: Ongoing from year one, month six to end of year two

b. Steps: Frailty Indexing and care plan development will be integral to workflow and patient outcomes via routine Minimum Data Set database use.

c. Measurement: The review process will describe outcomes, process assimilation, and opportunities for system improvements and for future evaluation.

Objective Twelve: Hold meetings of clinical leaders at three healthcare provider sites and representatives of Patient Pattern and Quality Health Network to describe path toward true collaboration in work with the elderly frail population.

a. Timeline: Ongoing throughout 24-month project

b. Steps: Meet monthly to report outcomes and share opportunities.

c. Measurement: By Month 24, the group will be able to describe a simple path toward true community collaboration in work with the elderly frail population.

Objective Thirteen: Develop plan to and provide education/professional development on Frailty Indexing and care planning for representatives of hospitals, Independent Physicians Association, United Health Care, Rocky Mountain Health Plans, Monument Health, Quality Health Network and Primary Care Physicians.

a. Timeline: Ongoing from year one, month three to end of year two

b. Steps: Create and implement a process for providing professional development on use of Patient Pattern for frailty indexing and developing care plans. Project Director and Project Manager to meet with an education committee member of each organization prior to Month 6. Schedule of educational

opportunities for Year Two announced by end of Year One. Include education/outreach as standing agenda items for advisory committee.

c. Measurement: Ability to schedule and provide quality training. Attendance at trainings, interest in project generated as a result of trainings.

Objective Fourteen: Conduct formalized planning and recruiting for future project participating organizations throughout the region.

a. Timeline: Starting in year one and accelerating in year two.

b. Steps: Work with project advisory committee members to identify and recruit organizations to engage in planning for integration of Frailty Indexing and care plans. Meet with representatives of potential participants, invite to trainings, etc. to engage interest and commitment. By month 6, introduce the Phase Two process to select participating organizations to begin planning for region-wide deployment of project.

c. Measurement: Recruitment and engagement of participating organizations throughout the four-county region.

Objective Fifteen: Create a Care Compact among specialty and primary care physicians

a. Timeline: Year two, with completion by month 18

b. Steps: Advisory committee to facilitate creation of a written commitment, to be adopted among specialty and primary care physician members of the Mesa County Independent Practice Association, to assimilate frailty-advised care as a community and practice standard. (Agreement based on narrative reporting to the advisory committee by Phase One participating organizations, and as informed by the implementation and proof of concept through Phase One of the project.)

c. Measurement: Ability to craft and garner agreement/commitment to Care Compact by physicians in the region.

Please complete the following questions. The answers must relate directly to the funded Project.

Progress and Results

Describe the progress made toward the goals and objectives as stated in the funded grant application. Summarize the key evaluation results related to the funded Project.

Thank you Next 50 for this opportunity.

I feel that the project has successfully completed the objectives initially proposed, with a few minor exceptions.

A supplemental document will annotate the measured success of each objective.

We were able to successfully capture live clinical data, and OASIS and MDS data sets, route the data to the software vendor, where a frailty index was calculated, and return the discrete data of the index, with an attached PDF of the clinical consultation and care recommendation, precisely back to the patient's primary care physician, as well as to a filed within the health information exchange. The data filled fields in the health information exchange allowing workflow cohesion. Likewise, the discrete data and PDF were designed to precisely flow into the daily workflow in the electronic health record of the primary care physician.

Primary care physicians, who never had geriatric training, were piqued toward a transformation of their concept of aging, toward the emerging field of risked based care management.

A subgroup of providers experienced the point of care comprehensive geriatric assessment first hand and were able to realize the gradual nature of the emergence of frailty and the need for adjusting care planning on a patient specific fashion.

The principle investigator was able to address a vast array of clinical providers from specialty, surgical, oncologic, long term care, hospice disciplines, over a vast array of national and international audiences. An interest group of innovative family physicians, who collaborate on best practices and practice based research is prepared to adopt the frailty project for 2023. The Principle investigator has been invited to participate in a panel of clinicians to address the future of frailty based care, augmented by data systems, for future research or care improvement, as convened by invitation from Medicare's innovation center, at the annual Academy Health conference on aging.

The frailty workgroup has penned a white paper to guide other regional or systems approach to consideration of lessons learned (see supplemental documents).

Challenges experienced

Describe the challenges the organization experienced related to the funded Project.

The Pilot's principle investigator's spouse of thirty years became ill with ampullary cancer, underwent a Whipple Pancreatectomy, chemotherapy, immunotherapy, hospice care and ultimate death, all while she continued to work, and insisted that the PI continue his work on the pilot. She was a force of nature.

Her celebration of life can be viewed at :

www.ronnacapra.com

The COVID epidemic distracted all of the clinical partners of the grant.

Its call to action both affirmed the high stakes of the vulnerable state of frailty from any insult, and the need for prompt and personal commitment of all who aspire to meet the needs of those who are frail.

Other pay for performance mandates interfered with the natural tendency of the grant partners to adopt this innovation eagerly. The PI did not initially budget appropriately for the type of engagement necessary. None the less, the passive receipt of frailty reports within the workflow of busy family physicians did pique their natural curiosity toward solving the complex problems of those supporting or experiencing aging afflictions.

While Medicare did away with the three day qualifying acute care stay prior to skilled nursing and it did allow telehealth visits, many bureaucratic obstacles to safe, simple and respectful care of the frail elderly continue.

When frail patients need ambulatory devices, the urgent need is excessively onerous which results in acute injury awaiting a simple accessible remedy.

This outcome was not unique.

Successes experienced

Describe the successes the organization experienced related to the funded Project.

Despite the distractions, the pilot was able to meet the objectives.

See supplemental material

During COVID, the three day qualifying stay was suspended, which was one of the meta aims of the grant.

COVID made explicit, the apparent risks of frailty, as nursing home residents died preferentially, confirming the construct of the concept of frailty.

The Principle investigator was able to perform direct patient assessments of frail patients in all clinical settings: ambulatory, in patient, at home, in hospice, in facilities, in governmental housing settings.

Surgeons were eager to implement objective measures to assist in counselling patients of the real risks of procedures more likely to harm patients.

Primary care physicians gain a new appreciation of the gradual and subtle nature of emerging frailty and its risk.

A British clinician published a book (Shibley Rahman: Living With Frailty) which augmented and summarized the vast and growing use cases, pitfalls and opportunities which the pilot aimed to provide.

The executive director (Julie Riesken) of the Cross Disabilities Coalition for Colorado was able to create disability awareness education programs, certified by the American Academy of Family Physicians. This effort also illuminated the urgent need for simplification of prescribing ambulatory assistance to acutely frail patients. She is currently leading an effort to provide ambulatory assistance to Ute Indian tribal members. The PI is the medical partner of this team effort.

In the principle investigator's practice, an already efficient and comprehensive group, continued improvements occurred during the pilot, using a proactive approach.

High risk patients were readily identified by the workflow of the pilot.

Acute complications, emergent evaluations and futile procedures were minimized.

Provider, patient and family satisfaction was enhanced.

Home visits and telehealth visits increased.

The approach to support caregivers allowed for the delight of resilience to be celebrated and nurtured.

Where futility threatened to overtake hope, reminiscence therapy allows affirmation and the emotional connection which allows the avoidance of regret and guilt.

Lessons Learned

Describe what the Organization learned based upon the results, successes, and challenges throughout the Project.

Frailty is a demographic and ethical imperative requiring a retooling of the health care system.

It is a community concern and requires a cohesive community approach of teamwork and shared data to achieve what the principle investigator has proposed:

Care of the elderly should be safe, simple and respectful.

This mantra has not been challenged as an ethical imperative, when frailty is emerging, and serves as a redirect toward resetting goals.

Only by retooling can this be achieved.

The new order will require primary care physicians to acquire some of the skills of geriatricians. They will need to work in consort...a team approach..... involving geriatric nurse practitioners, physician assistants, physical and occupational therapists, geriatricians when available, engaged family members, case managers and community health workers in housing settings, who will need to learn frailty concepts.

These team members will need to learn to utilize the right syntax that avoids stigmatizing persons experiencing aging crises.

Providers will need to not only screen for frailty, but loneliness, and unique family and community assets that allow for patient and family self direction of their goals of care.

A trend toward aging at home is highly valued and highlighted during COVID.

Providers will need to reach outside the usual information streams of the medical literature to understand the social science literature to learn the language to abide patients' desire to allow their natural resilience.

Examples of a required reading list:

Atul Guwande's 'Being Mortal'

Shibley Rhahman's 'Living with Frailty, from deficits to assets and resilience'

George Bonanno's ' The end of Trauma, How the Science of Resilience is changing how we think about PTSD'

The software partner in this pilot, Patient Pattern, has been collaborating with Pathway Health, and have a ready frailty training program toward this effort, focusing on eldercare facilities as well as medical directors and care managers.

Full assimilation of frailty sensitive care will require aligning incentives and avoidance of stigma.

Incentives are needed to build teams around families faced with frail family members.

Communication and family process skills need to be rewarded.

No doubt for profit health plans will attempt to capture available shared savings rewards.

The principle investigator maintains a bias that is not siloed, that plows shared savings back into the workflow that benefits the populace rather than shareholders and executives, especially when the innovation needed is among the team and family support members.

Sharing of Information, Scalability, and Replicability

Now that your NFI grant is complete, how will your organization share information learned from the Project to advance the field of aging? How do you anticipate that the information shared from your Project will lead to scalability and/or replicability?

The frailty workgroup website will be maintained for five years.

It is the intent of the workgroup to evolve into an interest group.

Perhaps that interest group will attempt an innovation pilot of broader reach.

The PI plans to continue to work with potential partners such as :

Primary Care Partners in Grand Junction. Other providers within the catchment area of Quality Health Network and especially Gary Knaus MD and Glenn Kotz MD, in the Roaring Fork Valley, as well as other members of the Aspen Renaissance Transformation Team and its 501c3 entity, Colorado Collaboration for Primary Care Innovation.

The PI will continue to discuss collaboration with members of the Academy of Family Medicine in Colorado and Nebraska.

The principle investigator will continue to perform frailty assessments for perioperative patients.

He will also engage interested regional team leaders toward regional adoption involving saturated shared data and pilots that allow for capture of a percentage of shared savings toward improved outcomes for patients and providers and their narrative and relational, rather than a merely transactional approach, siloed to parties not involved personally in providing or receiving care.

Sustainability of Project

Describe any plans you have for sustaining the activities of this project.

The PI has a relationship with both the Colorado Mesa University Foundation as well as the Colorado Collaboration for Primary Care Innovation and intends to work with those entities to explore funding for a wider pilot.

The PI feels that the white paper process, once community partners are engaged, will serve to provoke interested parties toward framing a second phase innovation of larger scope and scale.

Project Impact on Aging

Describe the impact your Project had on Aging.

I have yet to meet someone who has not been touched by the challenges of aging.

If I have 15 minutes to describe the complex aspects of this pilot, I have yet to find someone who disagrees with the moral, personal, ethical, or financial imperative which this pilot proposed to solve.

Number of people 50+ impacted by Project

How many people age 50 and up were impacted by your Project? Enter 0 if not applicable.

2000

Project Budget Final Report

Upload the Budget Project Progress Report here. Please use the same Project Progress Report as the mid-project report(s) and update with final expenditures.

NFI-project-progress-template all - WITH THIRD YEAR CO Mesa - FINAL - Copy.xlsx

Project Budget Narrative

Explain variances or special circumstances in your Final Project Budget Report.

I have been advised by Tracy Mundy, at Colorado Mesa Universities' Sponsored Program office that we fully completed the spend of the grant.

The main variance was that we moved dollars initially targeted for Kathleen Hall to assist in the narrative assessment of the grant outcomes to extending licenses for a third year and thus extend the opportunity of a family physician to receive a frailty report or for the grant partners to continue to consider the software's utility.

I will edit this narrative as the final budget is prepared.

Success Story

Do you have a story to share that speaks to the progress/success of your Project?

These stories have been sprinkled throughout the previous reports.

Jessica Griffiths RN (and DNP candidate at CMU) plans to make a retrospective review of these cases for her capstone research project for her DNP.

She has been hired by Patient Pattern as to succeed Margaret Sayers RN, as national nursing director of Patient Pattern.

The PI plans to write up several of these cases in his planned book on the History of Quality Improvement in Primary Care in Mesa County from World War II to COVID 19.

The video (funded by the Next 50 Foundation for the Cross Disabilities Coalition for Colorado), on assessing durable equipment needs, demonstrates the ultimate positive outcome for a family, during COVID.

Family caregivers were able to adapt to the challenges of frailty, avoid COVID, receive vaccines at home, and avoid loneliness, isolation, institutionalization and stigma.

This video has been approved by the American Academy of Family Physicians for Continuing Medical Education.

Additional Information

Is there anything else you would like to share with NextFifty Initiative that relates to the Project?

Thank you for allowing the opportunity to pursue this project.

Supporting Documentation

Please upload supporting documentation that you would like to share with NextFifty Initiative about your completed Project.

Supporting Documentation

NextFifty final objective supplemental summary.docx

Supporting Documentation

AcademyHealth Roundtable Frailty 1-7-2022 final.docx

Supporting Documentation

Frailty white paper final.docx

Supporting Documentation