A GERIATRIC CARE PLAN: THE COLLABORATIVE ASSESSMENT AND RECOMMENDATION FOR ELDERS PROGRAM

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Background

Older adults are at increased risk for poor outcomes while transitioning from a higher level of care to home due to multiple medical problems, functional deficits, decline in cognition, and/or lack of social support.

Introduction

The C.A.R.E (Collaborative Assessments and Recommendations for Elders) Program utilizes the Coleman Model to build a comprehensive network providing geriatric care across the continuum through a Transition Care Clinic and a Geriatric Consult Clinic.

The Transition Care Clinic is for patients aged 60 or greater, recently hospitalized, frequent emergency room (ED) utilization, and recently discharged from a Skilled Nursing Facility. The goal is to evaluate patients within the first 72 hours of discharge from the ED or hospital if unable to get an appointment with their primary care provider (PCP). Benefit to health plan is increased meaningful engagement with a patient's PCP:

- Comprehensive evaluation provides patient/family education, community resources, communication of patient's condition, and progress to PCP, resulting in seamless follow up care for patient and PCP.
- Assist patients in finding another PCP within the network by discussing this first with the current PCP and obtaining any additional recommendations from the PCP regarding the change.
- Assist the patient with establishing a PCP within network.
- Follow up phone calls: 1) post discharge 1st phone call, 2) follow up phone call (one week after 1st visit), and 3) discharge phone call three weeks from previous.

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The Geriatric Consult Clinic is for Honor Health patients aged ≥ 70, to provide additional support and expertise to all Honor Health PCPs. Benefit to health plan is enhanced outpatient care as detailed below:

- Comprehensive plans for managing older adult conditions, including medication reconciliation and/or medication reduction recommendations, patient-specific health education, information and access to community and private support for patients.
- Assure the PCP will know of the patient's pending evaluation by requiring a referral be placed by the PCP and after the patient's office visit a detailed consult note of findings, recommendations, community support services used and planned further follow up if needed will be sent to the referring PCP.
- Follow up phone call: 1) Follow up phone call (one week after 1st visit), and 2) Discharge phone call three weeks from previous.

Results for Both Transition and Consult Care

71% success rate to link every patient into any community resources he/she may need.
100% success rate to communicate to each patient's PCP with a summary of care including assessments and recommendations for continued geriatric focused care.
100% success in increasing each patient's health literacy regarding recent higher level of care that was needed or of chronic illnesses.

Conclusion

Valuable to the health care organization: Decrease avoidable hospital readmissions or revisits to the ED within 30 days following an acute encounter. Only one patient has been readmitted within 30 days following an acute encounter. Only one patient has revisited the ED within 30 days following an acute encounter