CARE Program: Older Adult Transition and Consult Clinics

HONOR HEALTH JOHN C LINCOLN MEDICAL CENTER

APRIL 22, 2017
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Honor-health John C Lincoln Medical Center

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- Magnet designated/re-designation
- NICHE Hospital since 2011
- Senior Friendly status
- Part of Honor Health Network, Arizona

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Demographic Trend

As the boomers reach 65, then 75, then 85, the population in each age bracket will swell; the age mix of the old will shift upward.

Population 65+, millions

100
90
80
70
60
50
40
30
20
10
0
12
8
40
6
13
21
89
19
29
40
85+
75-84
65-74
1950
1970
1990
2010
2030
2050

Source: U.S. Census Bureau, 2002b and 2008d.

A-8
Stanford Center on Longevity

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With This Trend Has Come…

- Approximately $130 billion in health care
- Three times as many hospital stays
- Higher medical provider, nursing home, home health, and prescription costs

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Development of **C**ollaborative **A**ssessments and **R**ecommendations for the **E**lderly Program

- **Started:** End of April 2016
- **Target Population:** Vulnerable older adults that could benefit from an interdisciplinary approach
- **Mission**: Provide high quality evaluations, medical care, community referrals, recommendations for older adults that will maximize quality of life and maintain independence

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Criteria for Entry into the Program

- The CARE Program will evaluate patients that meet the following criteria for **Transition Care**:
  - Patient is at least 60 years old
  - Recently discharged from a hospital, skilled nursing facility or ED, ideally patient is seen within the first 72 hours of discharge
  - Identified as an Accountable Care Organization high risk patient

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Criteria for Entry into the Program

- The CARE Program will evaluate patients that meet the following criteria for **Consult Care**:
  - Patient is at least 70 years old
  - Has an established employed or aligned Honor Health primary care physician
  - Not currently being cared for in a Skilled Nursing Facility

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Goals of the Program

- Link every patient to community resources he/she may need
- Communicate with patient's primary care provider with a summary of care including assessments and recommendations for continued geriatric focused care
- Increase each patient's health literacy regarding recent higher level of care needed or chronic illnesses
- Viewed by patients, caregivers and medical community as beneficial
- Valuable to health care organization: Decrease avoidable hospital readmissions or revisits to ED within 30 days following an acute encounter

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Started with REDESIGNING How Care is Delivered within Our Clinic

- <u>Innovative use of team</u>
  - Medical Assistant/Nurse: Structured needs assessments at every visit, implementation, monitoring and revising care plans based on follow up phone calls, knowledge of community resources
  - Physician: Provide clear communication with clinic team members and strengthen co-management of patient with physicians through frequent communication, develop individualized care plans that address patient/family concerns and are mindful of current resources, empower patients/families using Coleman Model principles
  - Patient/Family: active role in their care (based on Coleman Model principles) to ensure needs are met

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Key Components of the CARE Program

- Structured needs assessments of patients and their families
- Creation and implementation of individualized care plans
- Monitoring and revising care plans
- Co-management model that does not assume primary care of patient

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What is Involved with a Needs Assessment

- Questionnaires and instruments are utilized
- In person visits completed in office or home
- Initial 60-minute visit with patient/family member/caregiver including:
  - Patient: Functional Assessment, Cognitive Assessment, Mood Assessment, Medication-Understanding Assessment
  - Patient/Family: Resource Assessment, Advance Care Planning
  - Patient/Family: Concerns Assessment
  - Discussion of various community services/programs

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Senior Centers	Fall Prevention
Area Agency on Aging: Elder Resource Guide	Foundation for Senior Living
SAIL Program	Home Delivered Groceries
Adult Day Care Center	Home Delivered Meals
Duet AZ	Legal Assistance
Retail Prescription Program Drug List	Medical Equipment Loan Closet
Elder Domestic Violence	Insurance Help
Elder Housing Program	Private Duty Home Caregivers
Transportation Services/Resources	Caregiver Support
Medical Equipment Stores	Placement Coordinators
Private Duty Home Caregivers	Crisis Line
Behavioral Health Services	Psychiatric Urgent Care Centers
Healthcare for the Homeless	Church of the Street
Mission of Mercy Mobile Medical Clinic	Shelter Services

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Care Plan: What Do Primary Care Physicians Receive

- Note in electronic health record (EHR). If not in same EHR, note is faxed
  Plan has specific recommendations:
  - Medical (PCP may accept or decline)
  - Education and social services (Provided to patient/family that day)
- Phone call or EHR in-basket message to PCP if there is a safety concern
- Periodic follow-up correspondence through EHR in-basket
- Completion of forms (i.e. DMV, moving to higher level of care, electricity discount forms)

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Care Plan: What Do Patients/Families Receive

- Medical Care: treatments for geriatric syndromes, understanding medications, medication adjustments, lab work, imaging
- Education on aging, chronic, and acute medical issues
- Family meetings if needed
- Linkage into community-based services
- Completion of any needed paperwork
- Ongoing follow-up at intervals determined by the care plan

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Community-Based Organizations

- Desert Mission
- Area Agency on Aging
- Adult Day Healthcare
- Local Senior Centers
- Longevity Institute

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Patients Involved in the Program

Breakdown	Transition Care Clinic	Consult Care Clinic
Number enrolled	25	32
Mean Age	77	81
% of patients with 5 or more active medical problems	52%	75%
% of patients with cognitive impairment (i.e. due to mild neurocognitive disorder, delirium, dementia, chronic alcohol use, depression)	40%	84%
% of patients with polypharmacy (4 or more prescription medications)	48%	71%

Services Provided

Breakdown	Transition Care Clinic	Consult Care Clinic
% of visits where older adult care education was provided to patient and family/caregivers	100%	100%
% in need of social services that were provided using community resources	70%	78%
% who achieved a successful polypharmacy reduction	32%	46%
# of patients that required a home visit	7	4

Outcome Measures: Review program goals…

- Link every patient into any community resources he/she may need

Total (includes both transition/consult care clinics) 71% success rate

- Communication to each patient's primary care provider with a summary of care that will include assessments and recommendations for continued geriatric focused care

Total (includes both transition/consult care clinics) 100% success rate

- Increase each patient's health literacy regarding recent higher level of care that was needed or of chronic illnesses

Total (includes both transition/consult care clinics) 100% success rate

Outcome Measures: Review program goals…

- Valuable to the health care organization: Decrease avoidable hospital readmissions or revisits to the ED within 30 days following an acute encounter

One patient has been readmitted within 30 days following an acute encounter

One patient has revisited the ED within 30 days following an acute encounter

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Reviewing program goal: Viewed by patients, caregivers and medical community to be beneficial ….

Patient/Family Satisfaction

- Our Connect Scorecard maintains top performance in all areas
- Direct quote from a patient…

"Do you have a survey on you right now that I can fill out about the excellent attention I've received"

- Direct quote from a patient's family…

"To everyone in the office…your thoughtfulness has touched my heart"

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Are Other Physicians Satisfied with Our Care…

- 100% felt valuable medical recommendations given
- 100% felt valuable social recommendations given
- 100% would recommend our services for other identified patients
- 75% felt our services enhanced his/her relationship with the patient
- 75% felt our services saved them time

Anonymous survey results from 8 primary care physicians who regularly use our services

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Co-Management Challenges

- Defining scope of responsibility
  - Range of clinical problems
  - Acute clinical problems
- Communication
  - With primary care providers
  - With other health providers (specialists, therapists)
- Staffing
  - Change from geriatric trained nurse to social worker
- Awareness
  - How to use us, how to access us

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Future Program Enhancement Projects

- SNF: Better identification of vulnerable patients from SNF to home that would benefit from our care
- Caregiving: Work with HonorHealth Volunteer Services to develop outpatient program to pair volunteers with HonorHealth older adult patients for companionship and assistance
- Genomics: Refine polypharmacy reduction through exploring pharma-cogenetic profiling with a clinical decision support tool to decrease healthcare resource utilization

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Future Directions of Measurement

- Better alignment with nationally recognized ACOVE-3 measurement set, used to evaluate care provided to vulnerable older persons at health system level, health plan or medical group.
- Specifically targeting areas to build into EHR addressing…
- Caregiving counseling: Dx/prognosis/behavioral symptoms, safety, community resources
- Screen for behavioral symptoms beyond depression
- Interventions for symptoms associated with dementia: behavioral, psychological, sleep
- Drive counseling for all older adults

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Summary: Geriatric Co-Management Program

- Has a place in post-discharge care and primary care practice design
- Can bridge clinical care silos
- Facilitate communication among providers, services and community based organizations
- Potential to improve clinical performance metrics and lower costs

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