Looking Forward: Imagining New Models of Care

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University of Colorado Health Sciences Center
Frame the Discussion

Focus is on the interface between new models that improve geriatric care and strategies that overcome the aging workforce shortage.
Disclaimer

- Conceptual rather than evidence-based approach
- Illustrative examples will be offered of models under development
Assertions:

- Business as usual will not suffice
- Need a fundamental shift to promote change
- Defenders of the status quo are powerful
- The distinguished IOM platform is needed to chart a course for meaningful change
Pipeline or Funnel?

Good ideas

Resources committed to conduct study

Rigorous evaluation approach

Reached study recruitment goals

Positive results

Results appeal to decision makers

Adopted in “real world”
Looking Into Our Crystal Ball...
Strategic Partnerships...
Model End Adopters: A Moving Target

- Attracted to “cutting edge” technology
- Reliance on evidence-based practice varies
- Expect a short turnaround to achieve ROI
- Recognize benefits do not always accrue to those who make the investment in the model
Partnerships Between Model Developers and End-Adopters

- Too often operate in isolation
- No formal mechanism to foster collaboration
Need for a Collaborative Triad

End Adopters

Funders

Model Developers
Variation On A Theme

End Adopters

Payors

Model Developers
Medicare Chronic Care Practice Research Network

- Led by Cheryl Schraeder, RN, PhD Carle Clinic
- Legislation sponsors: Sen Obama and Sen Derbin
- Fundamental changes to CMS’ research approach
Limitations of the Current CMS Demonstration Mechanism

1) A mismatch between project duration and rate at which benefits accrue to different populations
2) Delayed feedback about program performance makes midstream project adjustments impossible
3) Insufficient means to validate care management best practices to ensure replicability & scalability
Goals of the Network

1) To improve our understanding of which care management interventions achieve the greatest benefit at the lowest possible cost

2) To provide a reproducible, reliable and scalable framework to implement effective standardized care management services nationwide

3) To implement a comprehensive evaluation to assess the impact of care management that has implications for current and future policy
Network Activities

1) Collaboration between CMS and select group of care providers (Medicare Care Coord Demos)
2) To function as “laboratories” to develop, test, adjust, and re-test new approaches
3) To rigorously assess coordinated care management interventions
4) To enable feedback loops between local organizations and policy makers to accelerate practice and policy refinements
The *Anemic* Aging Workforce
The Anemic Aging Workforce

1. Inadequate red blood cells produced in the “factory” (i.e., health professional schools)
2. Loss of red blood cells (i.e., leaving the field or retirement)
3. Sequestration of red blood cells (i.e., workers’ roles leave them unavailable to effectively care for older adults)
Sequestration: The Spleen of Health Care Delivery
‘All Assessed Up and No Where to Go’

- Assessment often over-emphasized relative to need for execution of care plan
- Enormous drain on health professionals’ time and providers’ resources
- Ties into IOM goals for greater efficiency
- Need to decrease both the number of assessments and the length of assessments
Let the Punishment Fit the Crime

Current Division

Assess

Do

Ideal Division

Assess

Do
Process Mapping

- Led by Jane Brock, MD, Medical Director of Colorado Foundation for Medical Care
- CMS Special Study to CFMC and UCHSC
- Applied principles of lean thinking to intake and discharge processes for hospital, skilled nursing facilities, and home health care
Disclaimer: “This material was prepared by CFMC PM-415-076 CO 2007, the Medicare Quality Improvement Organization for Colorado, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.”
TOC CFMC
Thursday, April 05, 2007
Print daily census
Manually compare today's census w/yesterday's census
Manually transfer yesterday's census notes to today's census
New Patient?
Yes
No
Look in Meditech
Check email and voicemail
Make notes on census and/or face sheets
Confirm pt assignments with CMs/SWs
Print face sheets
Prioritize patients:
1) d/c today
2) d/c tomorrow/soon
3) need initial assessment
Based on priority look for pt chart at nurse station
Chart found?
Yes
No
Take chart to CM/Phys Room w/PCs
Chart with nurse?
Yes
No
Chart with Phys?
Yes
No
Look in chart for:
- Progress notes
- Discharge order
- Other
Ready for d/c?
Yes
No
d/c order signed?
Yes
No
Enter CM notes in Meditech and in chart
Place d/c forms (and others?) in chart (if not already in chart) to prepare for d/c
Take chart back to nurse station
Call/page/cell/text/email hospitalist to get signature
svcs required?
Yes
No
svcs arranged?
No
Yes
Previous SNF/HH?
Yes
No
Ask pt and/or family for preference
Talk to liaison if available
Call 1st choice, if not avail, call 2nd choice, if not avail, call 3rd choice
Update pt and family re: SNF/HH
Choice letter signed?
Yes
No
Ask pt to sign choice letter or get verbal agreement
Call family/contract w/ update re: svcs arranged
Arrange transportation
Update pt re: arrangements, transportation time, etc.
Make notes in chart
Print standard info from Meditech (see checklist of 13 elements)
Copy info from chart (see checklist of 13 elements)
Fax M'tech printouts and chart notes copies to facilities or agencies
Put printouts & copies in envelope
Write notes on envelope for charge nurse re: what's missing
CM d/c summary note in Meditech
Finish filling out d/c order (pink sheet)
Call SNF/HH to let them know info has been faxed
Hole-punch fax information & place in chart
Put envelope on charge nurse's desk for nurse to finish
Nurse prints out MARS
Nurse physically prepares pt for d/c
Nurse delivers final d/c instructions
RN d/c note in Meditech
MD medication reconciliation
RN call pt w/in 24 hrs (d/c'd to home)
Home Health Intake  
TOC CFMC  
Thursday, April 05, 2007

Reception Receives call  
Transfer call to Intake Dept  
Assess ability to take patient  
Take Patient?  
Yes  
Receive fax info from referring facility  
Fill out Intake Form  
Schedule RN staff  
Print map from Mapquest  
Manually write case on Intake Log  
No  
Write on "Referral Triage" Log  
Highlight signature on Intake Office packet copy  
Signal Found?  
Yes  
Verify MD signed order for HH  
Take #2 Copy (face sheet only) to Insurance Dept for verification of insurance*  
Place #1 packet in HH RN Box*  
Make copies of Intake Packet:  
1) Field RN  
2) Insurance Dept (face sheet)  
3) Intake Tracking slot system  
No  
Call referring facility for signature  
Place #3 packet in "Waiting for MD" Orders slot*  
Fax packet to HH RN if necessary (RN can't pick up packet)  
Place #3 packet in "Waiting for Insurance Auth" slot  
Alert HH RN via telex  
Insurance Verified?  
Yes  
Attach verified face sheet to packet  
MD signed order received?  
No  
Yes  
Place #5 packet copy in HomMed to assess for appropriateness of telemonitor*  
No  
No  
No  
Yes  
Attach signed order to packet  
Schedule PT/OT Staff as ordered  
Make additional copies of Intake Packet:  
4) Team Leader  
5) HomMed  
6) MM (med info mgt)  
Take #4 packet to Team Leader for entry into "Active Roster" and notify PCP (if PCP is known)*  
Place #5 packet copy in HomMed to assess for appropriateness of telemonitor*  
* separate processes not represented on this map because they have not yet been observed
What If We Re-Invested the Time and Resources Dedicated to:

- Joint Commission Accreditation
- MDS/OASIS/IRF-PAI
- HIPAA Compliance
Continuity Assessment Record and Evaluation (CARE)

- CMS tasked to create under Deficit Reduction Act
- Cross-setting assessment tool initiated upon hospital discharge to post-acute care
- Three primary purposes:
  - Improve information transfer
  - Longitudinal outcomes assessment
  - Promote payment reform

CMS contracted awarded to RTI to develop
Sequestration Continued...
Adding More Care Managers Won’t Fix It!

Hospital

Skilled Nursing Facility

Home

Ambulatory Care Clinic

Rehabilitation Facility

Disease Manager
Poly-Management Syndrome

- Physicians deal with multiple care managers
  - Health plan
  - Disease category

- Patients deal with multiple care managers
  - Provider-based
  - Disease-based
  - Special programs

Attribution to Cheryl Phillips, MD, CMD
Affect on Older Adults

- Confused by multiple case/disease managers
- Cannot identify their case manager
- Become more passive or disengage
Too Many Cooks….

Need a care manager for the care managers!
A Solution: Sutter Health System

- Formal mechanism for cross referral between health plan and provider programs
- Designate one care manager (ideally with a continuous relationship) to serve as lead, obtaining input of other managers to create a single plan of care with patient and family

Attribution to Cheryl Phillips, MD, CMD
Returning to Our Analogy
Workforce = Red Blood Cells
Need for Champions…
Geriatric Resource Nurses

- Nurses Improving Care for Health System Elders
- RNs with enhanced skills in care of older adults
- Valuable resource on geriatric best practices
- Improve management of pain, incontinence
- Reduce readmission rates

John A. Hartford Foundation Institute for Geriatric Nursing
One Patient, Many Places:  
Managing Health Care Transitions

A Report from the HMO Care Management Workgroup

Supported by the Robert Wood Johnson Foundation
Practice Change Fellows

- Build leadership capacity among health care professionals with operational responsibility for aging programs & geriatric service lines
- 10 selected each year
- Nurses, Physicians, Social Workers
- Foster national network and platform for change

Supported by Atlantic Philanthropies & John A. Hartford Foundation
eGeriatrician and ACE Tracker

- Cannot build and/or staff enough ACE units
- Incorporate principles into all programs
- Reach seniors in urban and rural settings

Michael L. Malone, MD
Aurora Sinai, Milwaukee WI
ACE Tracker- Purpose

- To identify vulnerable hospitalized seniors
- To provide focus for interdisciplinary rounds
- To promote care planning

Michael L. Malone, MD
ACE Tracker - Description

- **Who?** Team members enter data into EMR
- **What?** Daily reports
- **Where?** 12 hospitals
- **Why?** Focus on reducing complications

Michael L. Malone, MD
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Patients Totals:

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- 4

Legend:
- CXG = Cognitive, MDS EXTEND = MDS Extend, MDS URGENT = MDS Urgent, INCI = Incontinence of Urine, D/C = Discharge, ALLALLOW = Allow, SERVICES = Services.
eGeriatrician

Urban and rural hospitals connect via conference call with the “e-Geriatrician”.

Michael L. Malone, MD
**ACE Cards**

**Check List to Improve the Hospital Care of the Elderly**

**Acute Care for the Elderly (ACE) Program**

Aurora Sinai Medical Center/UCW Medical School

**Prevent Problems:**
Critically review the necessity of all tests/procedures.

**Pressure Ulcers:**
- Ambulate; avoid “bed rest” order.
- Correct nutrition restrictions.
- Turn q 2 hrs. if bedridden.

**Delirium:**
- Assess cognitive function.
- Bring in glasses/hearing aide/items from home.
- Keep hydrated p.o.

**Immobility/Falls:**
- Prescribe assist device; physical therapy.
- Order acute rehab therapy consult.
- Walk with assist.
  (Else, consider DVT prophylaxis.)

**Functional Decline:**
- Define baseline ADLs.
- Increase activity level.
- Avoid restraint and catheters.

**Constipation:**
- Provide prune juice/power pudding.
- Provide stool softener.

**Undernutrition:**
- Review serum albumin.
- Consider nutrition consult; supplement.
- Could medications contribute to anorexia?

**Depersonalization:**
- Music, pictures, food from home.
- Encourage visitors, stuffed animals.
- Chaplain visit (hospice care).

**History:**
- Collaborate data with family; nursing staff.
- Define goals of care.
- Define Advanced Directives.
- Assess for pain.
- Define baseline functional status ADLs.

**Physical Exam:**
- Assess for delirium.
- Assess risk for pressure ulcer.
- Is patient out of bed?
- Can urine catheter, IV line be removed?
- Avoid restraints.

**Data Collection:**
- Review vital signs, intake/output, daily weight, diet intake, bowel movement.
- Review the medication cardex:
  - How does it compare to Rx prior to admit?
  - Could problems be caused by the Rx?
  - Should any Rx be stopped?
- Add multiple vitamins.
- Review therapy notes (PT/OT/speech).
- Review social service note (living situation/support).
- Review dietitian notes; lab data changes.

**Communicate:**
- Talk with the nurse to assess status;
- discuss goals and anticipated discharge.
- Update family of anticipated discharge plans or change in status.

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Michael Malone, MD & Ellen Danser Norton, MD  03-03
X22187 (02/04) ©AHC
Geriatricize Other Disciplines

“Hospitalists are geriatricians in denial”
– Eric Segal, MD Madison Wisconsin

John A. Hartford Foundation is supporting Society for Hospital Medicine to improve care transitions for older adults

Develop toolkits to foster adoption amongst hospitalists across the country
Advanced Care Medical Home

- ACP White Paper: Re-invigorate primary care
- Medicare Medical Home Demonstration
  - 3 years duration
  - Urban/rural/underserved areas
  - Small physician practice encouraged
Components of a Medical Home

- Advocates for and provides ongoing support, oversight, and guidance to implement a care plan
- Uses clinical decision support tools
- Develop a health assessment tool
- Uses health information technology
- Provides support for self-management
- Promote patient access to health information
Will Physician Practices Join the Party?

- External entity would certify medical homes
- Amount of compensation to practice unclear
- Specialists could qualify to be medical home
- Patients choose their medical home
Models That Elicit and Honor Patient Preferences
Advanced Illness Coordinated Care (AICC) Program

- Developed by Dan Tobin MD (Albany VA) and Dale Larson PhD (UC Santa Clara)
- Approach used for people with advanced illness in all settings
- Continuity across hospital, home based and office based care

Conducted in partnership with SUNY Albany and the Life Institute in Albany with support from the Garfield Memorial Trust
Methodology

- Targeted people with heart failure, renal failure, or chronic obstructive lung disease
- Patients identified with “surprise question”
- Referred to AICC social worker or RN
AICC Program Description

- Social worker guides patients with advanced illness as they transition into end-of-life
- AICC program evaluates the patient's ability to confront diagnosis and fears
- Focuses on practical issues such as legal planning and completion of advance directives
AICC: 6 Sessions

1. Understand perspective in terms of curative, uncertain, or palliative
2. Assess understanding of condition and prognosis
3. Inquire about fears, worries, concerns
4. Elicit values, goals and preferences
5. Planning for the future
6. Coordinate and support per care plan
Preliminary Outcomes

- Psycho-social outcomes positive
- Cost and utilization will be complete by Fall 2007
  - Fewer ICU days
  - Less intensive care
Green House founded as a social model
HSL recognize a subgroup whose move was prompted by a change in health status and need for more support with chronic illness care
Weave in elements of a medical model but try to make invisible or at the very least, non intrusive

Attributed to Robert Schreiber, MD
HSL Green House

- Integrated medical model into environment in non-obtrusive manner—“behind the scenes”
- CNA driven model with less visible RN & MD
- Home visits using cart with wireless EMR

Attributed to Robert Schreiber, MD
HSL Green House: Preliminary Findings:

- Weight gain among persons losing weight
- Reduced number of medications taken
- Fewer falls
- Improved depression scores
- Escaped nosocomial Norwalk virus epidemic
- High satisfaction among residents

Attributed to Robert Schreiber, MD
HSL Green House: Impact on Workforce

- Higher satisfaction and retention
- Career ladder for CNA’s
  - Support to obtain English equivalency
  - Paid during pursuit of LPN degree
  - Nurse mentor program
- New campus opens 2009--all units will adopt approach
- Rigorous measurement strategy to capture outcomes

Attributed to Robert Schreiber, MD
Aliens Did **Not** Build The Pyramids...
And Case Managers Do **Not** Perform The Majority of Care Coordination...
Family Caregivers As Formal Members of the Interdisciplinary Team

- Silent partners/care coordinators
- Tremendous financial offset on health care costs
- Role not recognized (i.e., not part of JCAHO hospital surveys)
Expanding Evidence

- Coordination between formal providers and caregivers improves caregiver preparation to provide care.
- Positively associated with patients’ pain control, functional status, and mental health.

United Health Care Caregiver College

- Six 2.5 hour seminars led by professionals
- Held at community based organizations
- Respite dollars available

Attribution to Danielle Butin, OTR and Kathy Alsgaard, RN
UHC Caregiver College:
Objectives

1. To increase caregiver efficacy
2. To increase services and community support
3. To increase understanding of benefit plans
4. Decrease caregiver burden
5. Decrease unnecessary healthcare utilization

Attribution to Danielle Butin, OTR and Kathy Alsgaard, RN
UHC Caregiver College: Core Topics

- Symptom management
- Self-care management
- Medication management
- Emergency management
- Emotional coping
- End of life planning

Attribution to Danielle Butin, OTR and Kathy Alsgaard, RN
One Final Look at Sequestration
Interoperability is a worthy goal
Adoption of HIT particularly low among nursing homes and home health care agencies
Lack of data standards for physical and cognitive function, roles of family caregivers
Health Information Exchange Across Acute, Post-Acute, & Long-Term Care

- Business case needs to be more compelling
- Workflow concerns as challenging as technology
- Use of national data standards not a high priority

Supported by the Office of the Assistant Secretary of Planning and Evaluation, Department of Health and Human Services
State of Indiana: Docs4Docs

Facilitators:
- Unique patient identifier
- Statewide e-prescribing
- Leadership and financing of hospitals

Information available:
- Laboratory and radiology reports
- Pharmacy data
- Discharge summaries
# Standardize Communication For Family Caregiver Role (s)

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