Moving Primary Care Forward to Meet the Complex Care Needs of Older Adults.

Lynn M. Wilson DO
Lehigh Valley Health Network, lynn_m.wilson@lvhn.org

Nyann Biery MS
Lehigh Valley Health Network, nyann.biery@lvhn.org

Laura J. Benner RN, BSN, ACM-RN, CCCTM
Lehigh Valley Health Network, Laura_J.Benner@lvhn.org

Julie Dostal MD
Lehigh Valley Health Network, Julie.Dostal@lvhn.org

Brenda Frutos MPH
Lehigh Valley Health Network, Brenda.Frutos@lvhn.org

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Moving Primary Care Forward to Meet the Complex Care Needs of Older Adults

Lynn M. Wilson, DO, Nyann Biery, MS, Laura Benner, RN, Julie Dostal, MD, Brenda Frutos, MPH

Objectives

- Describe the underlying model of care supporting the delivery of elderly primary care
- Identify and describe the tools utilized to engage elderly patients and clinicians in shared-decision making
- Identify the benefits of utilizing interdisciplinary teams in caring for older adults in primary care settings

Background

- With a growing older adult population, caring for elderly patients will be one of the greatest challenges for the healthcare field
- By 2025, more than 25% of the U.S. population will be living with multiple chronic conditions, and the cost for managing their care is expected to reach $1.07 trillion
- This demonstration project fosters practice improvement by embedding a team of interdisciplinary professionals into primary care sites to improve care for elderly patients

The Journey….

- Primary Care Development Task Force
  - Developed a Comprehensive Plan for Primary Care at LVHN
- Participation in State-Wide Initiatives
- Learning Collaborative with LVHN owned and aligned practices
  - Resulted in the 2012 Launch of Community Care Teams

Foltz, C., Lawrence, S., Biery, N., Gratz, N., Paxton, H., & Swavely, D. (2014). Supporting Primary Care Patient-Centered Medical Homes with Community Care Teams: Findings from a Pilot Study. Journal of Clinical Outcomes Management, 21(8), 352-361.

Community Care Teams (CCTs)

- CCTs are interdisciplinary teams working collaboratively with primary care and select specialty practices to offer care coordination and management of high risk patient populations.
- CCTs are comprised of the following members:
  - Nurse Care Managers
  - Behavioral Health Specialists
  - Social Worker/Social Service Coordinator
  - Clinical Pharmacists

Geriatrics Workforce Enhancement Program (GWEP) Grant

- $2.5 million dollar grant over 3 years from the Health Resources and Services Administration (HRSA) under U.S. Department of Health and Human Services, started on July 1, 2015
- One of 44 programs across country
- LVHN Locations:
  - 4 practices owned by LVHN network
  - 1 independent practice
  - 1 FQHC
  - All participate in either the Family Medicine or Internal Medicine Residency program

Expansion of CCT

- **Home-based**, team assessments
- Integration of Community Health Workers into patient care team
- Utilization of the Guided Care Model for nursing
- Enhanced partnerships and communication with community resources
- 16 assessments specific to geriatric adults
- Provides in-home and community-based caregiver support and education

Guided Care Model

- The Guided Care model was developed by a team of researchers at Johns Hopkins University.
- Results indicate that Guided Care:
  - Improves the quality of patient care.
  - Improves family caregivers' perception of quality.
  - Improves physicians' satisfaction with chronic care.
  - Produces high job satisfaction among nurses.
  - Increased patient perception of care quality and may reduce the use of expensive services.
  - Reduced the use of services in an Integrated Delivery System

Boult, C., Karm, L., & Groves, C. (2008). Improving Chronic Care: The "Guided Care" Model. The Permanente Journal, 12(1), 50-54.

Guided Care Nurses

- Completion of Guided Care Course through Johns Hopkins
  - Certified in Guided Care
- Population Health's Care Manager orientation for CCT
  - Ambulatory Certification as Certified Care Coordination and Transitions Management
- Negotiated understanding of CHW's role on the team
- Facilitated care planning with clinicians and residents

Community Health Workers (CHWs)

- Education
  - 100 hours through local Area Health Education Center (AHEC)
  - Ongoing staff development and geriatric specific education
- CHW duties
  - Community program linkage
  - Reinforcement of nursing education
  - Social barrier exploration
- Development of documentation process for CHWs.
  - Based on CCT Social Work template and workflow

Pharmacy

- In-home assessments and education for patients and caregivers
- Disease/Drug Management
- Medication Therapy Management
- Promote patient self-management
- Practice-based education

EMR Development

- Creation of geriatric patient registry (60+)
- Identification and build of geriatric assessments into EMR
- CCT Template for documentation
- Creation of standard processes for optimal geriatric care
- Creation of Guided Care Plan and Action Plan

RN Tools

- Fall Risk
- Advanced Directives
- PHQ Depression Scale
- CAGE-AID
- Cognitive Impairment (MMSE)
- Neurocognitive (Adult)
- Geriatric Assessment
  - ADL
  - IADL
  - Hearing
- Social Isolation
- Home Safety Check
  - Safety assessment
  - Home access
- Learning Assessment
- Abuse Risk Screening
- Nutrition
- Pain
- Caregiver Strain Index
- Frailty
- Neurovascular

CHW Tools

- Living Situation
- Support Services Currently Utilized
- Education
- Income/Expenses
- Transportation
- Primary Support Person
- Other Verbalized Concerns

CASE PRESENTATIONS

RC 74 year old Hispanic Gentleman

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Case Presentation

- Patient primary language is Spanish
- Past medical history includes type 2 diabetes, CHF, CAD, right foot osteomyelitis, DVT, hypertension, anemia, colorectal adenocarcinoma and hyperlipidemia.
- PCP prescribes 12 medications not including vitamins, creams, lotions
- Limited health literacy and poor medication adherence
- Using multiple health systems for care

Case Presentation

- GWEP Team engaged with patient in June of 2016
- Patient Goal was to remain independent
- Guided Care Plan initially focused on falls, nutrition and medication adherence
- Found to have:
  - Unstable housing
  - Food insecurity
  - Lacking insurance coverage

Multidisciplinary Collaboration

- Physician Preceptors
- Residents
- PCP Office Staff
- CCT Social Worker
- GWEP Pharmacist
- Community Pharmacist
- Diabetic Educator
- Nursing Home Team
- Outside Health System
- Oncology Team
- Wound Care Team
- Home Care
- Shelter Staff
- Lehigh County Aging and Adult Services

Outcomes

- Patient now has food security and stable housing
- Trust in his medical team
- Increased social engagement
- Increased medication adherence
- Improving health literacy

RESULTS

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Practice Assessments

- ULCA Geriatric Attitudes Scale
  - Social Value
  - Medical Care
  - Compassion
  - Resources Distribution
- Attitudes Toward Health Care Teams Scale (ATHCT)
  - Quality of Care
  - Time Constraints

Curran, V. R., Sharpe, D., Forristall, J., & Flynn, K. (2008). Attitudes of health sciences students towards interprofessional teamwork and education. *Learning in Health and Social Care, 7(3),* 146-156;
Lee, M., Reuben, D. B., & Ferrell, B. A. (2005). Multidimensional attitudes of medical residents and geriatrics fellows toward older people. *The American Geriatrics Society, 53,* 489-494.

Practice Assessments

- Assessment of Inter-professional Team Collaboration Scale (AITCS)
  - Cooperation
  - Coordination
  - Partnership
- Practice assessments disseminated at the GWEP practices
  - Baseline – 2016
  - 1-year follow-up – 2017

Orchard, C. A., King, G. A., Khalili, H., & Bezzina, M. B. (2012). Assessment of Interprofessional Team Collaboration Scale (AITCS): Development and testing of the instrument. *Journal of Continuing Education in the Health Professions, 32(1),* 58-67.

Practice Assessments

	Geriatric Attitudes Scale		ATHCT		AITCS	
	Baseline n = 143	**Follow-up** n = 101	**Baseline** n = 134	**Follow-up** n = 91	**Baseline** n = 114	**Follow-up** n = 78
Clinical	32%	42%	31%	43%	30%	31%
Nursing	21%	23%	22%	23%	23%	21%
Clerical	29%	14%	29%	15%	35%	32%
Other	18%	22%	17%	19%	12%	17%
Score	**3.51**	**3.90**	**3.88**	**3.92**	**4.19**	**4.19**

Note: 5-point rating scale, with 5 denoting positive views.

Patient Registry & Geriatric Patients At-Risk

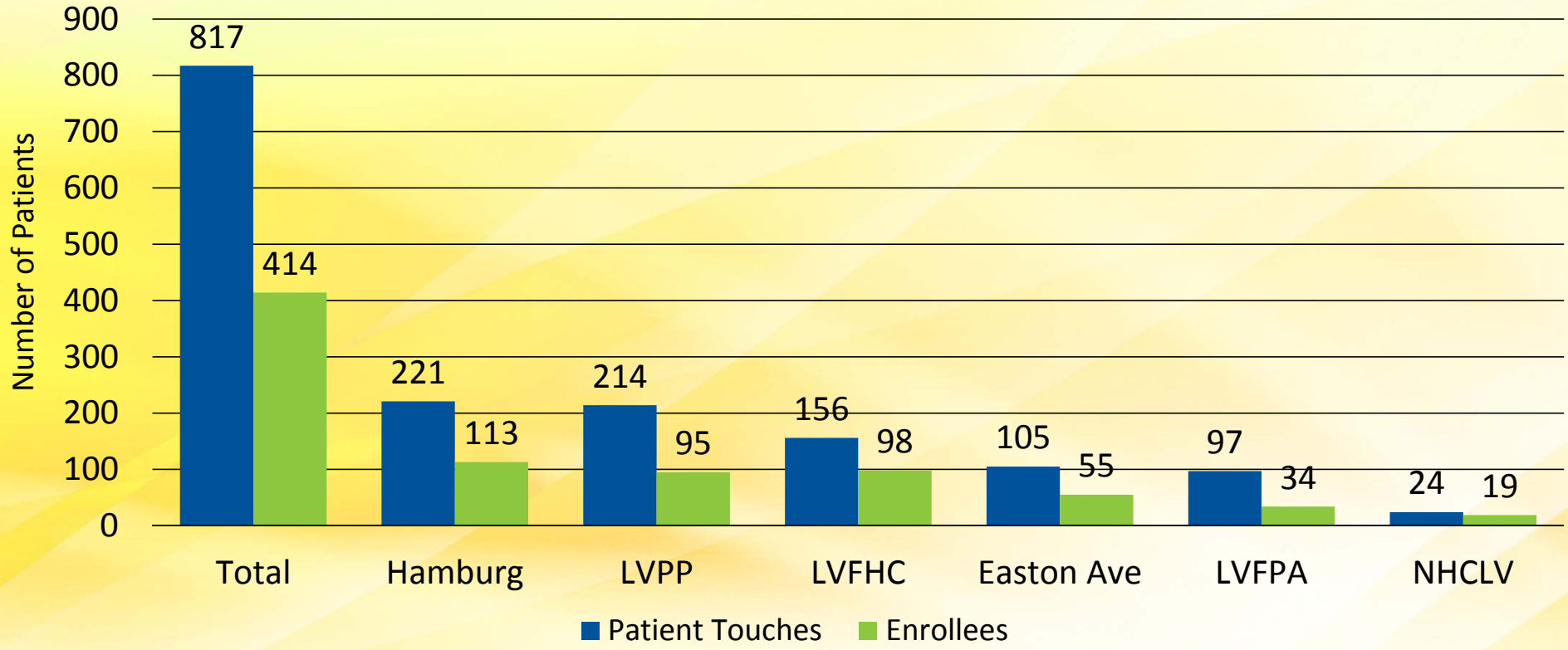
	Patient Registry	High-Risk
Total	7,980	817
Hamburg	2,607	177
LVPP	1,596	266
FHC	1,188	167
Easton	1,068	103
LVFPA*	950	-
NHCLV	571	104

Patients aged 60 or older, as of November 19, 2017.

*Patients aged 60 or older, as of July 27, 2017.

Note: High-risk patients are defined by GWEP risk scores greater than or equal to 3 (score range 0-5).

Patient Enrollment by Practice

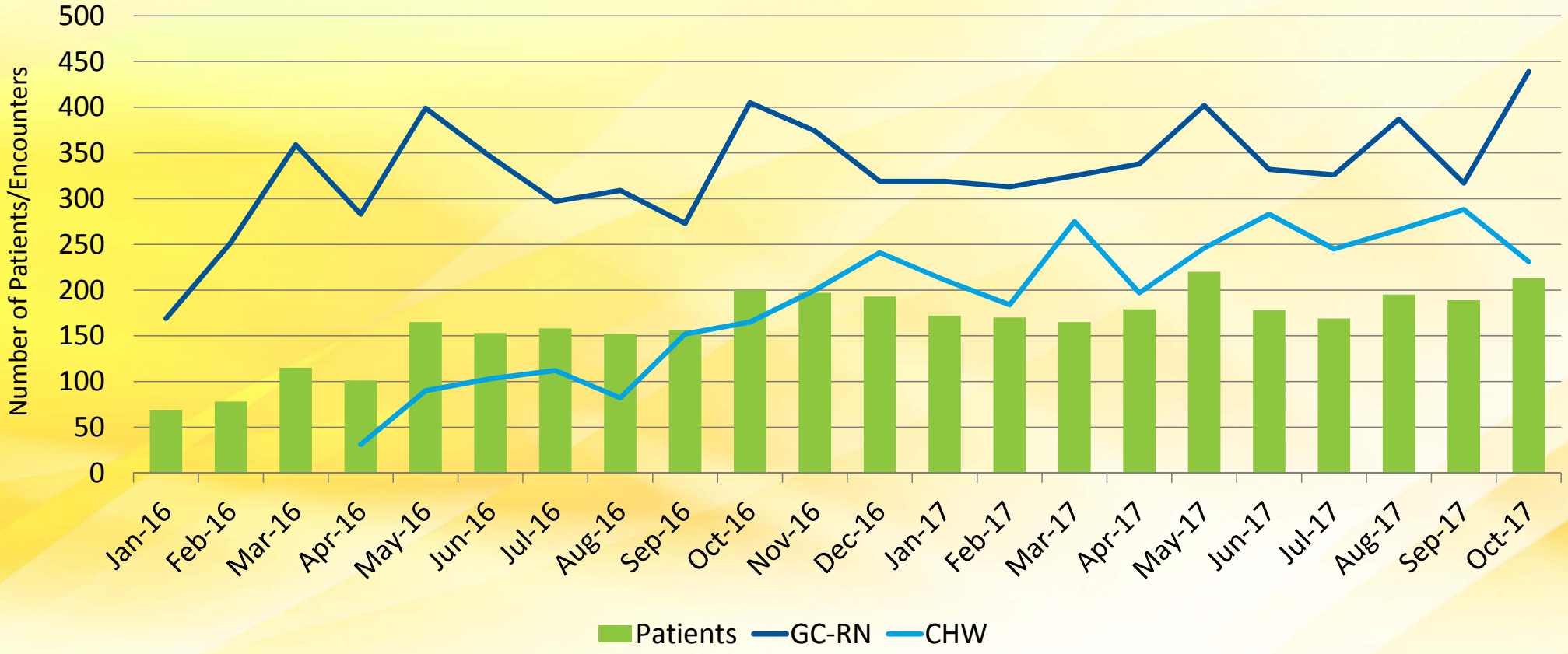


As of October 31, 2017

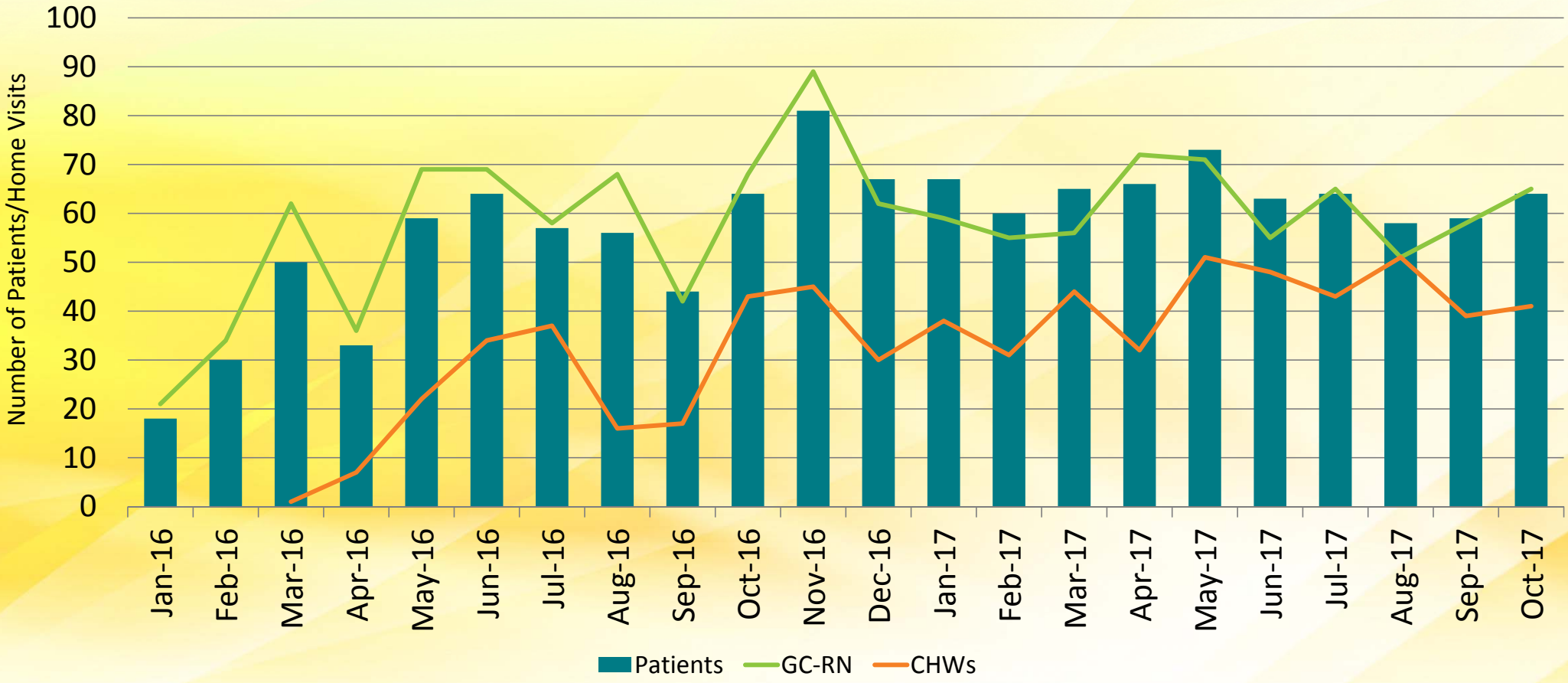
Demographic Variable	n (%) or Median (IQR)
Race	
White	471 (65.51)
Ethnicity	
Hispanic/Latino	256 (35.61)
Preferred Language	
English	476 (66.2)
Spanish	218 (30.32)
Other Language	29 (4.01)
Sex	
Female	454 (63.14)
Male	265 (36.86)
Age (Years)	76 (69-84)
Marital Status	
Married	244 (33.94)
Widowed	203 (28.23)
Single	136 (18.92)
Divorced	82 (11.4)
Separated	31 (4.31)

	n (%)
Chronic Conditions	
Diabetes	326 (45.15)
Depression	230 (31.86)
CAD	193 (26.73)
COPD	137 (18.89)
Obesity	137 (18.89)
Atrial Fibrillation	135 (18.7)
CHF	130 (18.01)
Dementia	114 (15.79)
Asthma	95 (13.16)
Substance Abuse	45 (6.23)
Patient Smoking Status	
Never Smoker	320 (44.32)
Former Smoker	282 (39.06)
Current Smoker	78 (10.81)
Passive Smoke Exposure	5 (0.69)
Never Assessed	3 (0.42)

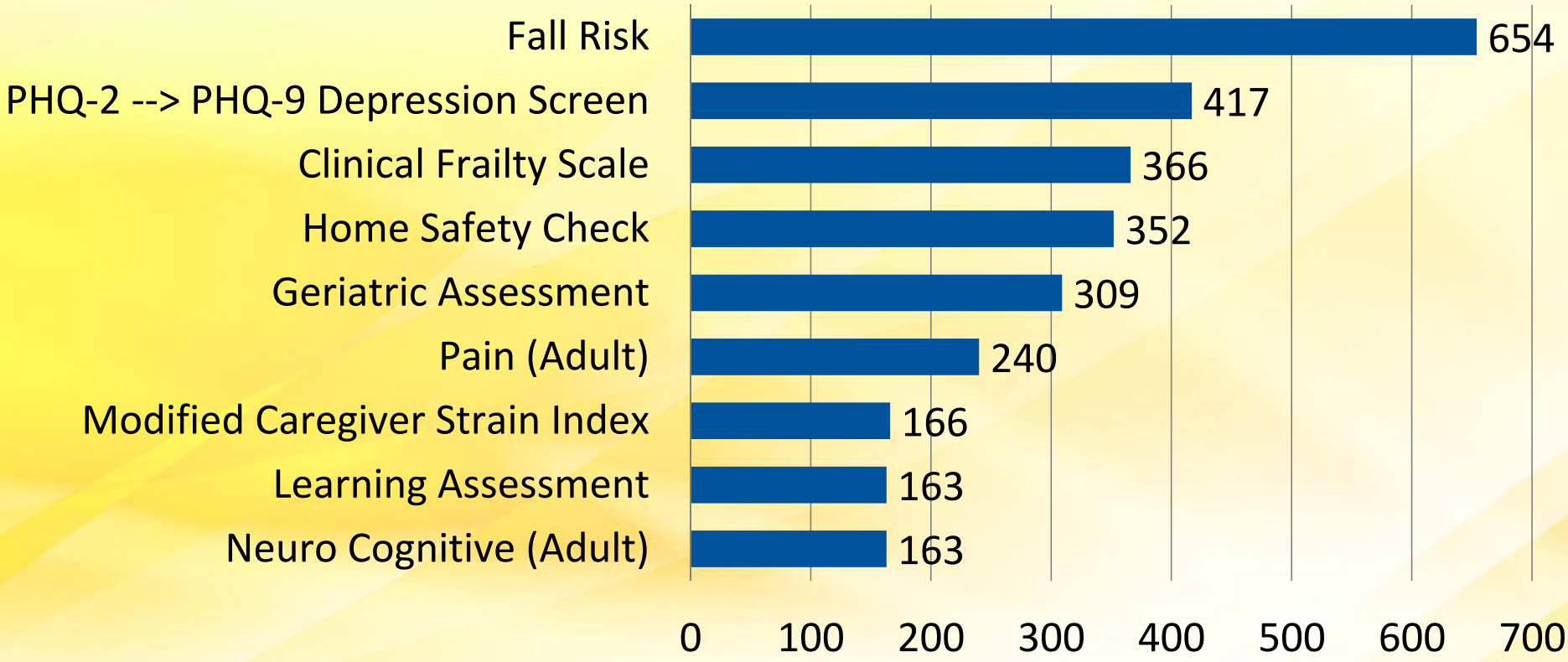
Patient Outreach



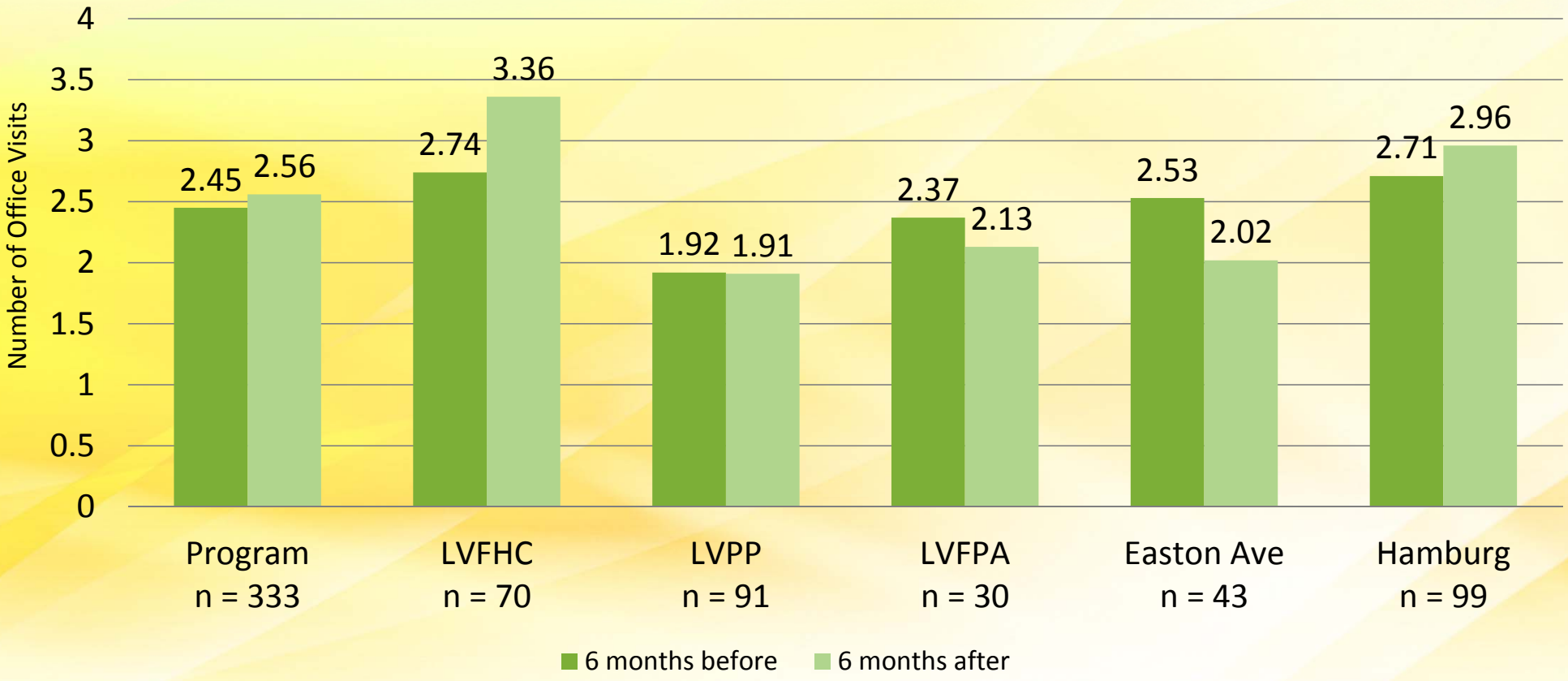
Home Visits


Number of Patients/Home Visits
100
90
80
70
60
50
40
30
20
10
0
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Patients
GC-RN
CHWs

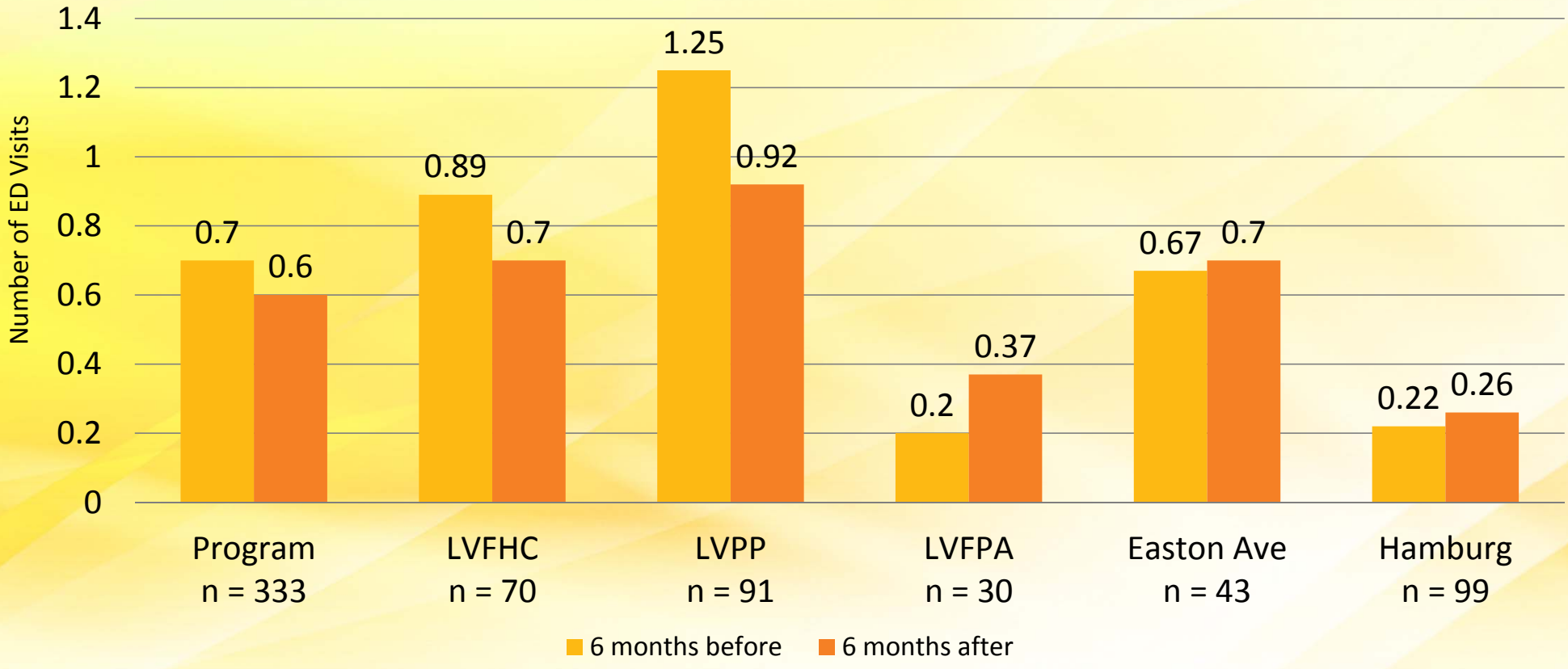
Most Frequently Used Screening & Assessment Tools



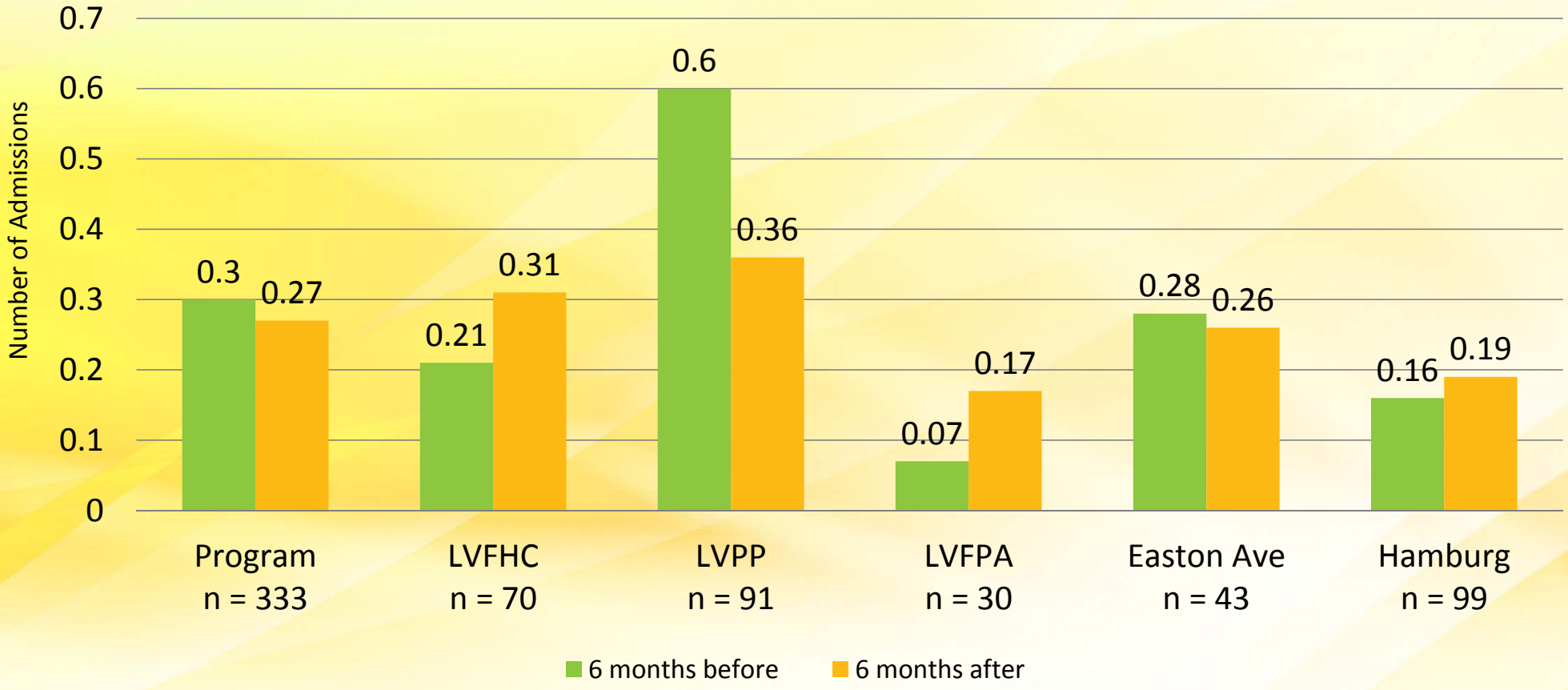
PCP Visits


Number of Office Visits
4
3.5
3
2.5
2
1.5
1
0.5
0
2.45
2.56
2.74
3.36
1.92
1.91
2.37
2.13
2.53
2.02
2.71
2.96
Program
n = 333
LVFHC
n = 70
LVPP
n = 91
LVFPA
n = 30
Easton Ave
n = 43
Hamburg
n = 99
6 months before
6 months after

Emergency Department Visits



Hospital Admissions



Questions?

Contact Information:

Lynn M. Wilson, DO
Division Chief of Geriatrics, Department of Family Medicine
Geriatrics Workforce Enhancement Program, Geriatric Content Expert
Clinical Associate Professor, USF Morsani College of Medicine
Lynn_M.Wilson@lvhn.org