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

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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

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

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
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
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

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

# Practice Assessments

<table>
<thead>
<tr>
<th></th>
<th>Geriatric Attitudes Scale</th>
<th>ATHCT</th>
<th>AITCS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline (n = 143)</td>
<td>Follow-up (n = 101)</td>
<td>Baseline (n = 134)</td>
</tr>
<tr>
<td>Clinical</td>
<td>32%</td>
<td>42%</td>
<td>31%</td>
</tr>
<tr>
<td>Nursing</td>
<td>21%</td>
<td>23%</td>
<td>22%</td>
</tr>
<tr>
<td>Clerical</td>
<td>29%</td>
<td>14%</td>
<td>29%</td>
</tr>
<tr>
<td>Other</td>
<td>18%</td>
<td>22%</td>
<td>17%</td>
</tr>
<tr>
<td><strong>Score</strong></td>
<td><strong>3.51</strong></td>
<td><strong>3.90</strong></td>
<td><strong>3.88</strong></td>
</tr>
</tbody>
</table>

*Note: 5-point rating scale, with 5 denoting positive views.*
Patient Registry & Geriatric Patients At-Risk

<table>
<thead>
<tr>
<th></th>
<th>Patient Registry</th>
<th>High-Risk</th>
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</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>7,980</td>
<td>817</td>
</tr>
<tr>
<td>Hamburg</td>
<td>2,607</td>
<td>177</td>
</tr>
<tr>
<td>LVPP</td>
<td>1,596</td>
<td>266</td>
</tr>
<tr>
<td>FHC</td>
<td>1,188</td>
<td>167</td>
</tr>
<tr>
<td>Easton</td>
<td>1,068</td>
<td>103</td>
</tr>
<tr>
<td>LVFPA*</td>
<td>950</td>
<td>-</td>
</tr>
<tr>
<td>NHCLV</td>
<td>571</td>
<td>104</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Practice</th>
<th>Patient Touches</th>
<th>Enrollees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>817</td>
<td>414</td>
</tr>
<tr>
<td>Hamburg</td>
<td>221</td>
<td>113</td>
</tr>
<tr>
<td>LVPP</td>
<td>214</td>
<td>95</td>
</tr>
<tr>
<td>LVFHC</td>
<td>156</td>
<td>98</td>
</tr>
<tr>
<td>Easton Ave</td>
<td>105</td>
<td>55</td>
</tr>
<tr>
<td>LVFPA</td>
<td>97</td>
<td>34</td>
</tr>
<tr>
<td>NHCLV</td>
<td>24</td>
<td>19</td>
</tr>
</tbody>
</table>

As of October 31, 2017
<table>
<thead>
<tr>
<th>Demographic Variable</th>
<th>n (%) or Median (IQR)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Race</strong></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>471 (65.51)</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>256 (35.61)</td>
</tr>
<tr>
<td><strong>Preferred Language</strong></td>
<td></td>
</tr>
<tr>
<td>English</td>
<td>476 (66.2)</td>
</tr>
<tr>
<td>Spanish</td>
<td>218 (30.32)</td>
</tr>
<tr>
<td>Other Language</td>
<td>29 (4.01)</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>454 (63.14)</td>
</tr>
<tr>
<td>Male</td>
<td>265 (36.86)</td>
</tr>
<tr>
<td><strong>Age (Years)</strong></td>
<td>76 (69-84)</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>244 (33.94)</td>
</tr>
<tr>
<td>Widowed</td>
<td>203 (28.23)</td>
</tr>
<tr>
<td>Single</td>
<td>136 (18.92)</td>
</tr>
<tr>
<td>Divorced</td>
<td>82 (11.4)</td>
</tr>
<tr>
<td>Separated</td>
<td>31 (4.31)</td>
</tr>
<tr>
<td>Chronic Conditions</td>
<td>n (%)</td>
</tr>
<tr>
<td>----------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Diabetes</td>
<td>326 (45.15)</td>
</tr>
<tr>
<td>Depression</td>
<td>230 (31.86)</td>
</tr>
<tr>
<td>CAD</td>
<td>193 (26.73)</td>
</tr>
<tr>
<td>COPD</td>
<td>137 (18.89)</td>
</tr>
<tr>
<td>Obesity</td>
<td>137 (18.89)</td>
</tr>
<tr>
<td>Atrial Fibrillation</td>
<td>135 (18.7)</td>
</tr>
<tr>
<td>CHF</td>
<td>130 (18.01)</td>
</tr>
<tr>
<td>Dementia</td>
<td>114 (15.79)</td>
</tr>
<tr>
<td>Asthma</td>
<td>95 (13.16)</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>45 (6.23)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Smoking Status</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never Smoker</td>
<td>320 (44.32)</td>
</tr>
<tr>
<td>Former Smoker</td>
<td>282 (39.06)</td>
</tr>
<tr>
<td>Current Smoker</td>
<td>78 (10.81)</td>
</tr>
<tr>
<td>Passive Smoke Exposure</td>
<td>5 (0.69)</td>
</tr>
<tr>
<td>Never Assessed</td>
<td>3 (0.42)</td>
</tr>
</tbody>
</table>
Patient Outreach

Number of Patients/Encounters

- Patients
- GC-RN
- CHW

Date Range:
- 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
Most Frequently Used Screening & Assessment Tools

- Fall Risk: 654
- PHQ-2 --> PHQ-9 Depression Screen: 417
- Clinical Frailty Scale: 366
- Home Safety Check: 352
- Geriatric Assessment: 309
- Pain (Adult): 240
- Modified Caregiver Strain Index: 166
- Learning Assessment: 163
- Neuro Cognitive (Adult): 163
PCP Visits

<table>
<thead>
<tr>
<th>Program</th>
<th>n = 333</th>
<th>LVFHC</th>
<th>n = 70</th>
<th>LVPP</th>
<th>n = 91</th>
<th>LVFPA</th>
<th>n = 30</th>
<th>Easton Ave</th>
<th>n = 43</th>
<th>Hamburg</th>
<th>n = 99</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 months before</td>
<td>2.45</td>
<td>2.74</td>
<td>1.92</td>
<td>2.37</td>
<td>2.53</td>
<td>2.71</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 months after</td>
<td>2.56</td>
<td>3.36</td>
<td>1.91</td>
<td>2.13</td>
<td>2.02</td>
<td>2.96</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Emergency Department Visits

<table>
<thead>
<tr>
<th>Program</th>
<th>LVFHC</th>
<th>LVPP</th>
<th>LVFPA</th>
<th>Easton Ave</th>
<th>Hamburg</th>
</tr>
</thead>
<tbody>
<tr>
<td>n = 333</td>
<td>n = 70</td>
<td>n = 91</td>
<td>n = 30</td>
<td>n = 43</td>
<td>n = 99</td>
</tr>
<tr>
<td>0.7</td>
<td>0.89</td>
<td>1.25</td>
<td>0.2</td>
<td>0.67</td>
<td>0.22</td>
</tr>
<tr>
<td>0.6</td>
<td>0.7</td>
<td>0.92</td>
<td>0.37</td>
<td>0.7</td>
<td>0.26</td>
</tr>
</tbody>
</table>

Number of ED Visits 6 months before and 6 months after.
Hospital Admissions

- Program: n = 333
  - 6 months before: 0.3
  - 6 months after: 0.27

- LVFHC: n = 70
  - 6 months before: 0.21
  - 6 months after: 0.31

- LVPP: n = 91
  - 6 months before: 0.6
  - 6 months after: 0.36

- LVFPA: n = 30
  - 6 months before: 0.07
  - 6 months after: 0.17

- Easton Ave: n = 43
  - 6 months before: 0.28
  - 6 months after: 0.26

- Hamburg: n = 99
  - 6 months before: 0.16
  - 6 months after: 0.19

Legend:
- Green: 6 months before
- Orange: 6 months after
Questions?

Contact Information:

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