Addressing Challenges of Health Care Transitions for the Older Adult Patient: A Primary Care Team Approach

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UMHS Geriatric Center Includes:

- Primary Care
- Neurology
- Geriatric Psychiatry
- Rheumatology
- Endocrinology
- Gastroenterology
- Mobility Clinic
Additional assistance………..

- Diabetes Care
- Hypertension Clinic
- Foot Care
It all started........
Twenty percent of all Medicare hospitalizations are rapid readmissions (readmitted within 30 days after discharge; Jencks, Williams & Coleman, 2009). The majority are potentially preventable and estimated to cost Medicare at least 12 billion dollars annually (Goldfield et al., 2008; Jiang, Russo & Barrett, 2009; Medicare Payment Advisory Commission (MEDPAC), 2008).
Preventable re-hospitalizations may result in the functional decline of chronically ill older adults and may increase the need for institutional long term care (Creditor, 1993; Wakefield & Holman, 2007). Such repeated hospitalizations expose vulnerable older adults to medical complications, such as adverse drug events, delirium and infections (Falangas & Karageorgopoulou, 2009; Inouye, 2006; Institute of Medicine (IOM), 1999.
Some History

CMS Demonstration Project

- UMHS Geriatrician; Dr. Caroline Blaum
- Nine Health Care Systems Across the U.S.A.
- It’s the Right Thing to Do
- Reduces Health Care Spending
- Makes Room in the Hospital for Innovative Procedures
Medicare Declares Major Success in Project Treating Costly Chronic Disease

July 12, 2007 – One out of four senior citizens in Medicare suffers with five or more chronic conditions and they account for 68 percent of Medicare spending. Medicare declared yesterday that all participating physician groups participating in a demonstration project aimed at better managing the health care of those with these chronic conditions have improved the clinical management of diabetes patients in the first year of the three-year Medicare Physician Group Practice (PGP) Demonstration. Diabetes is a major chronic disease among seniors.
As one of 10 health care groups in national demonstration project, U-M Faculty Group Practice shows the power of innovation for second year

ANN ARBOR, Mich. — Older patients are getting better treatment than ever at the University of Michigan Health System – even while U-M’s care for Medicare patients is costing less, a new report shows.
The data come from the second year of a national project undertaken by 10 large physician groups, including the U-M Faculty Group Practice. The results were announced today in Washington, D.C., by the Centers for Medicare and Medicaid Services. U-M was one of only two participating groups that achieved both of the project’s aims: to provide the highest-quality care on all 27 of the project’s heart and diabetes measures, and to contain health care spending growth for all traditional Medicare patients, including those with costly chronic illnesses.
Concerns for the Older Adult Patient

- ED Rarely Staffed by a Geriatrician
- ED Visits Nearly Always Result in Inpatient Admission
- Inpatient Stays Cause Functional Decline
- Long Waits in the ED;
- dehydration, exhaustion, missed doses of medication, exposure to illness
- Inpatient Stays Cause Confusion/Delirium;
- Inpatient Stay Focuses on the Acute Medical Concern
- Changes in Medications*
- Patient and Family Don’t Understand the Discharge Plan* (Particularly medications)
- Patient is Weakened/Fatigued
Transitional Care Clinic

- Coordinates With the Geriatric Inpatient Consult Team and Discharge Planning Staff
- Offers an Outpatient Geriatric Consult Within 10 Days of Discharge from ED or Inpatient
- Patient’s Medications Reviewed by a Geriatric Pharmacist
- Review/Repeat Lab Work
- Social Worker Facilitates Follow Up and Provides Coordination of Care
Role of the Transitional Care SWer

- Educate
- Provide Resources and Assistance
- Caregiver Support
- Co-ordination With Other Health Care Providers
- Advanced Directives
- Long Term Care Planning
Part Two

- Affordable Care Act
- Accountable Care Organization
- Michigan Medical Home
Different Goals
• Disease Management Programs:
  - Diabetes
  - Hypertension
  - Heart Failure
  - Pulmonary
  - Depression
  - Stroke
  - Chronic Back Pain
Complex Care Management

- Provide centralized transitional care call back and complex care management services for our BlueCaid, Washtenaw Health Plan, and selected Medicare Patients.

- Promote primary care relationships consistent with the Michigan Medical Home.

- Proactively identify patients’ needs across dimensions, including medical conditions, mental and behavioral health issues, and access to health-related resources.
• Fostering patients’ capacities to improve their physical, mental and emotional health, centering on effective communication with health care providers who know them.

• Collaborate with community case managers to coordinate care and reduce duplication of services.
Nurse Care Navigators

- Primary care outpatient clinics will have a Care Navigator support (full, partial or shared FTE) dedicated to care management

Multifaceted training program comprised of:

- Self-management support training
- MiPCT training (week long state wide training)
- Shadowing opportunities
- Chronic disease specific training (e.g., diabetes, depression, asthma/COPD, geriatrics, etc.)
The role of the Care Navigator is to:

– Closely monitor patients who have been discharged from the hospital to provide them with the support needed to avoid unplanned readmission

– Manage high risk patients referred by the PCPs and patient’s identified via the MiPCT High cost/high utilization patient list and the Daily Transition of Care Report

– Coordinate care across various care team members, including but not limited to PharmDs, dieticians, social workers, moderate risk managers (RNs), etc.
Specific care navigation functions include:

– Completing patient assessments (telephone or face-to-face)
– Communicating with the providers
– Providing self-management support
– Implementing chronic disease protocols
– Maintaining collaborative individualized care plans and implementing Care navigators aspects of the plan
Forward Planning

- Advanced Directives
- Long Term Plan of Care
- Defining Patient’s Life Goals
- Helping Patient and Family Develop a Plan of Care that Supports Patient’s Goals
- Relationship Building
- Palliative Care and Hospice
Case Example

- 89 yr old married male; medical history significant for prostate cancer, CHF, COPD, pulmonary embolism, DVT and frequent falls
- 87 yr old wife with Alzheimer’s dementia, CAD, and depression
- Moved from Arizona after son’s death
- Moved to Michigan to be near their daughter
- Husband seen in ED after a fall at home
- Living in Senior Apartment with assistance
- Daughter recovering from spinal meningitis
Case Example Continued

- Both seen in the transitional care clinic
- Arranged for immediate in-home care
- Secured a walker, shower bench and bedside commode for husband
- Enrolled wife in memory care adult day program
- Educated daughter about the effects of alcohol on the older adult patient
- Tapered alcohol intake
More Services

- Referred both to Housecalls program
- Visiting SWer provided in-home alcohol education and treatment
- Helped move the couple to assisted living
- Husband is now 92
- Wife is 90