Population Health: Rated G (for Geriatric)
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Session A26 & B26
December 12, 2017
No Disclosures

Session A26 & B26

The presenters have no actual or potential conflict of interest in relation to this program/presentation.
1. Identify the importance of targeting seniors to meet their individualized needs to improve access to wellness resources

2. Identify the value of having a community-based population health management model for seniors housed in an acute care and community settings

3. Identify how to develop a center for healthy aging for your organization
<table>
<thead>
<tr>
<th>Service</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employees</td>
<td>17,800</td>
</tr>
<tr>
<td>5 Acute Care Hospitals</td>
<td>1,830 licensed beds</td>
</tr>
<tr>
<td>Transitions from Inpatient Care</td>
<td>80,609/year</td>
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</tbody>
</table>
| Behavioral Health Inpatient & Outpatient Services | Transitions from inpatient 5,713/year  
Outpatient Visits 146,866/year             |
| Primary Care Visits                         | 379,438/year                                 |
| Homecare Admissions                         | 19,425/year                                  |
| Outpatient Rehab Visits                     | 838,125/year                                 |
| Senior Services Skilled Nursing Beds        | 354                                          |
| Assisted Living/Residential Care Apartments  | 332                                          |
| Towns in HHC Service Area                   | 101 (169 CT towns)                          |

Non-profit organization
The Genesis: A Need for A “Roadmap for Care”

B.C. (before Center)
- “A boat without a rudder (or captain)”

Creative solution to value-based care

Established in 2004
- Seed funded by a small grant from the United Way

Expansion in 2006 and 2013

Continued growth
- 2014 state of Connecticut diversification grant allowed significant expansion in the Center’s service lines and geographic reach
What is the Center for Healthy Aging?

- The Center is a starting point for people seeking help and/or information.
- A **free resource** and **assessment** center for individuals and their families.
- **Our goal** is to provide the **right** level of care at the **right** time in the **right** place to maximize an individual’s quality of life.
Services Provided by the Center for Healthy Aging

- Education and Prevention
- My Healthy Advantage magazine (senior affinity program)
- Wellness programming and articles (community centers and across various media platforms)
- Assessments
- Resources and Referrals
- Case Management
Video Clip

https://youtu.be/mXvRZEYshnE
Typical Client(s)

Dementia

Safety
- Falls
- Medication management

Care needs
- Medical
- Activities of daily living

Socio-economic
- Care funding
- CHOICES-Medicare options
- Long-term planning
Multi-Generational Impact
Meeting Basic to Advanced Individual Needs

- **Self Actualization**: Healthy living
- **Esteem**: Disease specific education, payer understanding, Alzheimer/dementia coaching
- **Social**: Support groups, lunch and learn, family forums
- **Safety**: Eligibility for homecare, home safety evals, lifeline, homecare for elders, funding for homecare, medication support
- **Physiological**: Food, shelter, financial, utilities, Medicaid, Medicare, VA benefits
Center for Healthy Aging
Service Lines

- Resource Coordinators
- Transitional Care Nurses
- Dementia Specialists
- Geriatric Care Management
Resource Coordinator

Provide home, telephonic, or office assessments
  • Strong focus on socioeconomic and psychosocial needs

Work collaboratively with community agencies to assist with resource allocation
  • Food, Housing, Transportation
  • Care Funding
  • Medication Support
  • Benefits (VA, CHOICES)
  • Eligibility for state programs

Ongoing telephonic follow-up
https://www.youtube.com/watch?v=RHRHt5YvgfI
Transitional Care Nurse

Provides home assessment for high-risk individuals who are not currently receiving homecare services

- Includes validated risk assessment tools
  - BOOST, MACH 10, Braden, PHQ4

- Medication management, safety, nutrition and disease specific education, fall assessment

- Communicate concerns to care providers

- Assessment for certified homecare services (if homebound)

- Telephonic weekly follow-up for 30 days.

Operate weekly Wellness Clinics
Dementia Specialist

Assist families and clients with new or ongoing diagnosis of Dementia

- Support to overwhelmed family/caregiver
- Strategies to manage challenging behaviors, improve communication, and learn new approaches for care
- Long range planning
- Address safety & wandering concerns
- Ongoing follow-up

Curriculum education to:

- Clinical staff
- First responders
- Organizations
- Informal caregivers
- Public
Geriatric Care Management*

Additional Help & Guidance
Advocate, Communicate, Coordinate

A high level of assistance for coordination of care for those who have family living in another area or are unable to be involved “surrogate daughter”

Escort, Communicate and Coordinate at Physician appointments

Coordination with family and medical providers to develop an individualized plan of care

*Fee for Service
**The Who and How of Referrals**

Formal and Informal Referral Sources

**Referral Sources:**
- Acute care hospital
  - Case management
  - Physicians, physical therapy, clergy, RNs, etc.
- Community providers
- Community-base organizations
- Family & friends
- Self (Dorothy)

**Avenues to referrals:**
- Electronic Medical Record (EMR)
- Email
- Telephonic
- Web
- Fax
- Walk-in
A Shared Vision Allows for an Integrated Approach

Acute care setting

- Case management

Community

- Integrated Care Partners (ICP)
- Connecticut Home Care Program for Elders
- Senior Centers
91 y/o with multiple health problems including dementia referred by the ED staff for safety and health concerns

Linked to primary care physician

Transitional care nurse resulting in referral to certified homecare

Additional community resources, wander guard, elderlaw attorney

Home Visit

Discuss long-term care facility options and waitlist

Referral to CT Homecare Program for Elders (future planning)

Private Pay caregiver 2 hours for every morning

Adult Day Center 5 days a week
Top 20 Outgoing Referrals From the Center

1. Dementia Services
2. Health Promotion Services
3. State Programs
4. Homecare/Hospice
5. Community Based Resources
6. Private Duty Services
7. Elder Law/Finance/Advance Directive
8. Assisted Living/Residential Care/Housing
9. Physician
10. Safety (Lifeline, Wander guard)
11. Case Management
12. Benefits Counseling (Veterans/CHOICES)
13. Skilled Nursing Facility
14. Transportation
15. Grants
16. Outpatient Rehab
17. Behavioral Health
18. DME/Home Modification
19. Adult Daycare
20. Pharmacist/Medication Support
Geriatric Pharmacist Home Visits
Aging is a “one-way street”

Our first conversation is rarely our last

- Never leave our watch

Our person-centered, relationship-based approach is rooted in mutual trust and respect

Just say yes
Carolina on His Mind-An Employee Story

• The Story
• Referrals
  • PCP
  • Referral to Transitional Care Nurse for medical assessment
  • Connected to home care services
  • CHOICES and benefit counseling
  • Senior-appropriate exercise facility
  • Eventual transition to an assisted living community
• Planning for the future
  • Establishing advance directive documents
  • Waitlist applications for skilled nursing facilities
• Outcomes:
  • Father- improved wellness and quality of life
  • Son-peace of mind, decreased absenteeism and increased presenteeism
Community Outreach

- Health Screenings/Health & Wellness Fairs
  - Blood Pressure, Cholesterol, Glucose, Memory
- Lunch & Learn
- My Healthy Advantage Magazine
- Live Well– Chronic Disease Self-Management Program
- CHOICES Counseling
- Healthy Brain Series
- Dementia Caregiver Series
- Southington Senior Coalition
- Dementia Library
- Weekly Wellness Clinics
- Annual Dementia Symposium for healthcare professionals

https://www.youtube.com/watch?v=wxrmZngMf-E
Teach A Person To Fish...

- Dementia Caregiver Series (5 part)
- Healthy Brain Series (5 part)
- Memory Loss: When to Worry
- How to Make the Most of Your Doctor’s Appointments
- Screenings for Seniors
- Staying Hydrated
- Strategies and Resources for Health Aging
- What if…In Your Golden Years
Coming together is a beginning; keeping together is progress; working together is success.

Henry Ford
# Eclectic Team

<table>
<thead>
<tr>
<th>Resource Coordinators</th>
<th>Transitional Care Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance &amp; Masters in Exercise Physiology</td>
<td>Bachelors and Masters Degree in Nursing</td>
</tr>
<tr>
<td>Health and Human Services</td>
<td>Certified Dementia Specialist</td>
</tr>
<tr>
<td>Masters in Gerontology</td>
<td>Clinical Nurse Leader</td>
</tr>
<tr>
<td>Certified Dementia Specialist</td>
<td>Certified Case Manager</td>
</tr>
<tr>
<td>Certified Care Manager</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Dementia Specialist</th>
<th>Geriatric Care Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Work</td>
<td>Bachelors in Nursing</td>
</tr>
<tr>
<td>Recreational Therapy</td>
<td>Certified Dementia \ Practitioner/Specialist</td>
</tr>
<tr>
<td>Certified Dementia Practitioners/Specialists</td>
<td>Certified Care Manager</td>
</tr>
</tbody>
</table>

*We have a passion for finding solutions to problems. We’re not know it alls but we want to know it all.*
Welcome Aboard

Structured Process
• 6 week orientation

Designated Trainers
• Orientation Binder
• Checklist

Classroom Content
• Housing options
• State Programs
• System offerings
• Veteran’s Benefits
• Legal Resources
Specialized Education/Trainings

- CHOICES Counselors
- Habilitation Therapy
- Support Group Leaders
- Live Well Facilitators
- Motivational Interviewing
- Senior Medicare Senior Patrol Counselor

- Certified Nursing Clinical Leader
- Care Management Certified
- Certified Dementia Specialists
- Certified Dementia Practitioners
- Case Management Certified
The Science Behind HHC’s Lean

Respect, value and trust for all people
• Encourage exchange of ideas, respect and value backgrounds, be curious vs judgmental, maximize engagement, live the leadership behaviors

Continuous improvement & innovation
• Use a scientific method for problem-solving, eliminate waste, reduce variation, implement solutions that are data-driven and evidence based

Focus, alignment and two-way communication
• Align goals with balance scorecard, provide authentic and humanistic feedback, provide data, create two-way feedback loops

Creating and supporting high performing teams
• Lead by example, build skills, share expertise, recognize and celebrate achievements
Lean Daily Huddle

Virtual Huddle

Brings 9 satellite offices together

• Engage staff in supportive environment
• Enhance communication
• Large focus on standard work
• Recognize one another for the work we do
• Review yesterday's performance & today’s deliverables
• Improve performance using team’s collective knowledge and ideas
• Report on process improvement activity
• Use visual boards to facilitate communication and ensure understanding
### “Show Me The Data”

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-4%</td>
<td>Decrease in transitions to SNF</td>
</tr>
<tr>
<td>83%</td>
<td>In-network referral rate</td>
</tr>
<tr>
<td>23%</td>
<td>New system consumers</td>
</tr>
<tr>
<td>16,538</td>
<td>Outgoing phone calls</td>
</tr>
<tr>
<td>2,873</td>
<td>Referrals from the ED/Hospital</td>
</tr>
<tr>
<td>7,921</td>
<td>Attendees at educational and support group events</td>
</tr>
<tr>
<td>1,414</td>
<td>Health Screens</td>
</tr>
<tr>
<td>1,457</td>
<td>Wellness Clinic visits</td>
</tr>
</tbody>
</table>
Quality Data for Transitional Care Nursing (TCN) Service Line

- Readmission rate: 8.3%*
- Hospitalization 12.6%

TCN Identified:
85% Medication discrepancies
92% High risk for readmission/hospitalization
82% Fall risk
52% of patients were hospitalized within 12 months prior to seeing TCN
40% of patients live alone

Link to Community Services
- 55% referred to certified homecare services
- 27% connected to provider
- 28% linked to caregiver services
- 57% required referral to social work/resource coordination
- 17% connected to dementia specialists
- 10% linked to behavioral health services
- 7% required referral to elderly protective services

*Medicare Compare readmission rate for homecare 16.4%
Hospital Compare 15.3%
Dementia Caregiver Series Results

**Figure 1. Caregiver Self-Efficacy:**
Can understand dementia and its symptoms*

**Figure 2. Caregiver Self-Efficacy:**
Can handle your loved one’s memory loss*

**Figure 3. Caregiver Self-Efficacy:**
Can handle your loved one’s behavioral symptoms*

*Hartford HealthCare*
Benefits of Dementia Education

Training for caregivers of people with dementia improves:

• Caregiver confidence
• Ability to manage daily care challenges
• Supports caregivers in their role and relationship

*Caregiver education and support has delayed Skilled Nursing Facility (SNF) placement by approx. 1.5 years

• Average cost of CT SNF $144,000/year or $216,000/1.5 years
• 198 people completed the Center for Healthy Aging Dementia Caregiver Series
• Possible healthcare cost savings $42,768,000

Center for Healthy Aging Client Satisfaction Survey Results

- **Strongly Agree**: CHA Staff friendly and professional
- **Agree**: CHA helped with concerns
- **Neither**: I feel better after meeting/speaking with CHA staff
- **Disagree**
- **Strongly Disagree**: I will use CHA again
Provider Satisfaction Survey Results

Provider Satisfaction Survey Results

- Easy to refer
- Staff friendly and professional
- Follow-up was a great help
- Great resource for my patients
- Recommend use of Program

Graph showing satisfaction results for different responses:
- Strongly Agree
- Agree
- Neither
- Disagree
- Strongly Disagree
Anecdotal Comments

Client
Excellent...Professional and yet thoughtful and kind. I feel that I am not alone and they will help me all the way. I did not know about this program but now I will share this information with my peers. Thank you

Nicholas put together many pieces of the puzzle regarding my condition/health concerns. A lot of info was given to me while in the hospital and although I understand it, going over from step one to my going home slowly and patiently; everything made much more sense! I truly appreciated the time he spent with me explaining so much!

Provider
I think this program is excellent. The evaluation is very thorough and the follow-up documentation is excellent.

I feel the program works well and is of great benefit to patients and MD practice.
• Community Benefit
• Quality
• Value Based Care
• Cost Avoidance
• System Health
  • ROI
  • Keepage
  • Growth
Chutes and Ladders

Challenges

• Non-integrated electronic medical record
• State and federal uncertainties
  • Healthcare model and funding
  • Economies
• Geographic disparity in resources

Opportunities

• Improved integration with case management
• Increased integration with clinical resources
  • Geriatricians, pharmacy and behavioral health
• Expanded use of technology/tele-health
• More robust dementia care services
• Asset-mapping with reallocation of funds from redundant resources
Center for Healthy Aging is...
Contact Information

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Center for Healthy Aging
Connect to healthier.

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