Team Based Care for Older Adults

John Lassere, M.D.
Disclosures

- Currently I work for and with Intermountain Healthcare at the Southridge Senior Clinic in Riverton, UT.

- This views and opinions expressed in this presentation are those of Dr. John Lassere and do not represent the official position of Intermountain Healthcare and its partners.
Human Life Cycle-Function

Birth
Onset of Functional Decline ~70 yo
Frailty ~80 yo
Terminal Frailty ~85-90 yo
Death ?
Human Life Cycle - Team Based Medical Care

OB
Pediatrician
Internist
Geriatrician
Palliative Care
Hospice

Birth
Youth
~18 yo
~65 yo
Functional Decline
Care, not Cure
Terminal Frailty

FP’s also treat Cradle to Grave Team-based care assumed.
At the **beginning** of each new patient (and subsequent annual wellness exams), I ask the patient, “**What are your goals for your health? What to you want your Health and Life to be like in the decades ahead?**”
Goals for Life and Medical Care

This helps to learn what the patient and family’s (if present—encouraged) definition and expectations for Quality of Life and medical care are. It gives an opportunity to learn, clarify, and adjust to reality—Cure vs Care.
What is Function?

Purposeful doing of tasks needed to live-instrumental and basic.
Functional Inventory

- Mowing the grass
- Removing snow from the driveway
- Taking our the trash
- Paying bills and managing finances
- Driving
- Taking medication
- Using the telephone
- Preparing means
- Doing laundry
- Doing housework
- Shopping
- Managing transportation
- Walking outside, upstairs, or room-to-room

Basic or Self-Care

- Dressing
- Bathing
- Toileting
- Transferring from bed to chair
- Feeding oneself
What sets Geriatric Medicine apart from other specialties is a subtle change in emphasis from disease to function.

The focus and goal of geriatrics is to: preserve and improve the functional status of the individual,
treat disease only as it impairs, or threatens to impair function.
Caring for the patient is more important than curing the disease. When asked, geriatric patients choose an improved quality of life rather than an increased lifespan.
Why does function decline?

- Age related changes and chronic disease burden.
Determinants of Health

Age related changes and the prevalence of disease vary from individual to individual, and within different organ systems within the same individual. Thus the impairment in function varies from individual to individual, and organ system to organ system with the aging process.
One may encounter a healthy and functional 85-year-old or an impaired 65-year-old. Note that only 30% of patients greater than 85 years of age are impaired in any activity required for daily living--only 20% live in nursing homes.

Chronological vs Physiological age.
Small improvements in treating each disease and system can lead to marked overall improvement in function, and thus quality of life. We need to identify all problems (including diseases and risk factors) and initiate interventions--treat all at one time.
Cure versus Care

In geriatric medicine, one must change the way one measures success and quality of life.

**IN MANY WAYS GERIATRICS IS PEDIATRICS IN REVERSE!**
Plan for Functional Decline

Just as older patients plan for end of life issues through living wills/advanced directives, they should plan for functional decline.

We need a similar instrument to give to all of our 65 yo patients/Medicare.

1. *Who* will assist you when you need help with activities of daily living-instrumental and/or basic?
Plan for Functional Decline

- 2. *How* is that help going to be paid for?
- 3. *Who* is going to pay for it
- Guess what #1, #2, and #3 were?
- Studies show that older adults chose their spouse, if they had one.
Teams and Why the Need for Team-Based Care?
Team Based Care

What is it?

**Definition:** An integrated, multidisciplinary approach for addressing the physical, emotional, and social needs of a patient (spiritual, as appropriate).

All in one visit/location?
Team-Based Medical Care

- History in the US
- Modern Era, 20th Century to Present
- Focus on Outpatient
Traditional Model of Practice Management

- A single provider generally sees a patient for only physical health acute problems, and refers to specialty providers and team members (off site @ a different time/date) as needed.
- Limited in-office team.
The Way it Was

In the 1940’s and until recently, physicians in private practice in rural areas, small town and cities, lead office based teams in providing care for their patients.

The teams usually consisted of a nurse (not necessarily formally trained or licensed), and a receptionist. In larger or group practices, their may have been a bookkeeper, xray/lab tech.
These practices performed all of the functions of today’s larger clinics, including preventive care, Instacare, emergencies, hospital care, surgery, OB, nursing home care, case/care management, care coordination through transitions of care, counseling.
The Way it Was

- Medicine was simpler, less complex
- Physicians knew everyone (especially in small towns), treated multiple generations.
- No computers - paper charts, little or no charting.
- Mainly fee for service - insurance
- No hassles with insurance companies - no prior authorizations.
The Way it Was

- Did they do a good job? Have good outcomes?

- Why did healthcare delivery change?
Why Did Health Care Delivery Change?

- Increased complexity
  - more medications, surgical procedures, technologies
  - rules, regulations, and laws.
- Increased demand - more people, higher expectations
- Money - changes in reimbursement from self pay, to private insurance to Medicare/Medicaid, to HMO’s, PPO’s, Managed Care.
- Increased liability
- Overall increased cost to provide healthcare.
Change to Managed Care of the 1980’s, 1990’s and 2000’s

- HMO’s, MCO’s, and PPO’s
- Financially driven - Fee for service, incentive for more procedures/CPT codes.
- Less personal - patient’s felt like a number and not “cared about.”
- Less emphasis of preventive care and keeping patients well.
- Poor Care Coordination
- Not team based
- Poorer outcomes all around.
## Future of VA Health Care

<table>
<thead>
<tr>
<th>What can I fix?</th>
<th>What is the matter with you and how can we help?</th>
<th>What really matters to you and how can we help you live your life fully?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VA Past</strong></td>
<td><strong>VA Current</strong></td>
<td><strong>VA Future</strong></td>
</tr>
<tr>
<td>Physician</td>
<td>Clinical Team</td>
<td>Veteran, Family &amp; Health Care Team</td>
</tr>
<tr>
<td>Paper Medical Record</td>
<td>Disease-Based Electronic Medical Record</td>
<td>Whole-Person Electronic Health Record</td>
</tr>
</tbody>
</table>

- "Thanks for driving 5 hours to get here. Come back if you don’t feel better".
- "You have a medical problem. Please follow this treatment plan to improve by your next visit".
- "Together we design your personalized health plan to meet your goals".
Better Medical Delivery Needed

- Within large, multispecialty clinics to go back to what the GP’s and their small teams were able to do in a bygone era of healthcare.

- Not enough providers, especially in primary care, need help and team to provide quality care to patients.
Projected primary care physician supply vs. demand
The goals are to show patients that they are cared for as a “person,” not just a number-to develop “trust” and thus a “therapeutic alliance” to obtain the best medical outcomes for the patient and improve their quality of life in the provision of medical care.
Patient Centered Medical Home

- Is how primary care will be organized and delivered.
- Most medical organizations are developing and implementing their own versions.
- VA - PACT or Patient Aligned Care Team
- Intermountain - PPC or Personalized Primary Care
- Others
Patient Centered Medical Home - PCMH

- In 1967 the American Academy of Pediatrics (AAP) introduced the concept of medical home. Children were going home from the hospital without a comprehensive plan of care. They ended up being re-hospitalized due to all of their needs not being addressed prior to discharge.

- 2008 Multiple Organizations, including the National Committee for Quality Assurance (NCQA) launch medical home accreditation programs.

- 2010 ACA signed into law with provisions for enhancing primary care and Medical Home
Meaningful Use
MACRA
2014 New NCQA criteria released
PCMH: Functions and Attributes

- Comprehensive Care
- Patient Centered - the Patient is the Center of the Team!
- Coordinated
- Accessible
- Quality Improvement and Safety
- Team based
<table>
<thead>
<tr>
<th>Principle</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Patient-Driven</td>
<td>Patient preferences guide care</td>
</tr>
<tr>
<td>Team-Based</td>
<td>Interdisciplinary &amp; collaborative</td>
</tr>
<tr>
<td>Efficient</td>
<td>Care is timely; each discipline works at the top of their license</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Care addresses Veterans’ range of needs; integrates with VA and community resources</td>
</tr>
<tr>
<td>Continuous</td>
<td>Patients have established, continuous relationships with their care team</td>
</tr>
<tr>
<td>Communication</td>
<td>Communication is honest, respectful, and culturally sensitive</td>
</tr>
<tr>
<td>Coordinated</td>
<td>Care is coordinated across the VA and with the private sector</td>
</tr>
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</table>
Who is on the Care Team?
So who is helping older patients now?

- Caregiving is attending to another individual’s health and other needs, often including one or more ADL’s, such as bathing or dressing.
- 85% of unpaid help provided to older adults in the US is from family members.
- In 2014, caregivers for people with Dementia provided an estimated 17.9 billion hours of assistance, with an estimated value of $217.7 billion—nearly equal to the cost of direct medical and long-term care.
Family Team

- Spouse, as able to help. First choice by most patients.
- When patients are asked, “Who would you want to help you if needed, if you spouse couldn’t?”
  - #1 Response
  - #2 Response
  - #3 Response
Family Team

- Varies, depending on the age of the patient and age/functioning of family members.
- Parents
- Siblings
- Children
- Grandchildren
- Nieces and nephews
- Cousins
- Who else?
Community Team

- Neighbors
- Friends
- Church
- Government: County AAA’s, Senior Centers, Rec Centers, State Agencies, VA
- Not For Profit: Alzheimer’s Association,
- For Profits: Home Health, Independent and Assisted Living, Nursing Homes
- Who else?
Team members
- Clinical Pharmacy Specialist: ± 3 panels
- Clinical Pharmacy anticoagulation: ± 5 panels
- Social Work: ± 2 panels
- Nutrition: ± 5 panels
- Case Managers
- Trainees
- Integrated Behavioral Health
  - Psychologist ± 3 panels
  - Social Worker ± 5 panels
  - Care Manager ± 5 panels
  - Psychiatrist ± 10 panels

Teamlet: assigned to ±1200 patients (1 panel)
- Provider
- RN Care Manager
- Clinical Associate (LPN, Medical Assistant, or Health Tech)
- Clerk
Engaged and Effective Teams

- Relationships:
  - Cohesiveness
  - Psychological Safety
  - Respect
  - Civility

- Functions:
  - Awareness and responsiveness
  - Communication
  - Role Clarity
  - Purpose and Methods
Roles and Responsibilities of Team Members

- Very Important!
- Clearly Defined.
- Everyone should know theirs and those of the other team members!
How do teams communicate?

- One on one-talk to each other
  - Warm handoffs.
- New architectural office design facilitate communication
  - IM, Skype, email.
- Huddles:
  - Micro or teamlet daily - 3 to 5 minutes-daily.
  - Macro or Team Meeting - Every 2 to 4 weeks, 30 to 60 minutes
- What to we talk about?
- Who leads the huddles?
Does new team based care improve Geriatric patient outcomes?
The Healthy Aging Care Model

- University of Indiana School of Medicine-Center for Aging Research
- Wishard Hospital and Health Centers
- Innovative model of dementia care
- The program began in 2008
- Goal: keep patients healthy and out of the hospital
- A pilot program at 2 university-affiliated healthy systems reduced ED visits by 45% and hospitalizations by 54% for dementia patients receiving a year of care management, versus those not in the group.

Christopher M Callahan, Greg A. Sachs, Michael A. LaMantia, Kathleen T. Unroe, Greg Arling and Malaz A. Boustani

Redesigning Systems Of Care For Older Adults With Alzheimer’s Disease

Boise VA Gold Team-Geri Scholar’s Project
2014
Title: Cognitive Screening For Primary Care Patients  
Owner: Dr. Richard Lasere
Sponsor: Dr. Vilper
Team Members: Dr. Lassere, Jaime Champion, Darcey Perez-cahill, Shawn Neumeyer
Coach: Craig Fagan
Facilitator: Dr. Richard Lasere
Start Date: 09/2014
Updated on: 

1. Reasons for
The U.S. Dept. of Health & Human Services / Agency for Health Research & Quality recommends operation allowing the detection of cognitive impairment during visits in the Primary Care setting. Locally, we recognize that our process is informal and provides opportunity for patients in high risk categories to slip through the cracks.

Our AIM is to implement a process that will enable us to ensure 50% of patients > 85 years old will receive a cognitive screen during their Primary Care appointment by 08/26/14.

Process Start: Review of Patient Appointment List. (Day prior to appointment)
Process End: Patient receives cognitive screen and results are communicated to provider.

In Scope: Patients (Primary Panels) within the Gold PACT team.
Out of Scope: Patients/Panelists outside of the Gold Team.

2. Current State:
A record review was conducted for the six months prior to the project starting. 10/119 (8.5%) of patients 85 and older received a MoCA screen on the Gold Team.

3. Target State:
AIM - to implement a process that will enable us to ensure 50% of patients > 85 years old will receive a cognitive screen during their Primary Care appointment by 08/26/14. (Quality/Success)

We will train members of the PACT team to utilize the Mini-Cog. This will help increase the number of clinically appropriate patients being screened and build a foundation for awareness of cognitive impairments. [Human Development]

4. Gap Analysis:

5. Countermeasures / Solution Approach:
If We:  
Review Appointment List To Identify: Patients Who May Need To Be Screened.
Change Screening Tool To Identify: Patients With Cognitive Function.
Formalize A Process:

Then we expect:  
An Increase in awareness and screens being conducted. Also: TEAM BUILDING
An increase in awareness and screen being conducted. Should systematically more practical: achievable.
An increase in awareness and screens being conducted. Should help people work to the top of their ability: scope.

6. Rapid Experiments:

7. Implementation / Completion Plans:

8. Confirmed:
Exceeded AIM - 30% of Patients > 85 Will Receive A Cognitive Screen During Primary Care Visit. First PDSA Cycle Yielded 10% Rate. Second PDSA Cycle Yielded 10% Screening Rate. (Improved 88% Over Baseline)

9. Insights:
What Went Well:
- We learned that it can be done utilizing current resources.
- It’s possible to screen a provider’s panel for high risk patients (over time).
- Patient’s willingness to participate in screening process.

What Didn’t Go Well:
- Privacy - Mini-Cog should be conducted in a quiet setting. Current clinic structure doesn’t always allow for that to happen.
- Mini-Cog may not be ideal for patients who are hearing/visually impaired.
- Initially, the MoCA was too cumbersome/time consuming.

Lessons Learned:
- We may need a separate screen to accommodate patients who are hearing/visually impaired.
- We may need a reminder/tool for structured prompting that a cognitive screen should be administered.
“Providing integrated mental health and primary care is the right thing to do for the sake of the patient, but the resultant financial benefits of reduced resource utilization accrue to someone else — the employer who pays for health insurance, the insurance company itself, or a large health system — and not to the practice that bears the expense and reduced reimbursement.”

JAMA Editorial: Integrated Behavioral and Primary Care, “What Is the Real Cost?” Thomas L. Schwenk, MD
RESEARCH IMPACT — Study shows that integrating mental and physical health through primary care teams results in better clinical outcomes and lower costs.

**10-YEAR STUDY 2003-2013**
- **Participants:** 113,452
  - 113 Primary care providers
  - 27 Team-based care (TBC) medical practices
  - 75 Traditional practice management (TPM) medical practices

**Screened for Depression**
- 46.1% TBC
- 24.1% TPM

**Documented Self Care Plan**
- 48.4% TBC
- 8.7% TPM

**Adhered to Diabetes Protocol**
- 24.6% TBC
- 19.5% TPM

**Emergency Room Visits**
- Reduced 23%

**Hospital Admissions**
- Reduced 10.6%

**Primary Care Encounters**
- Reduced 7%

**Payments to Providers**
- Reduced 3.3%

($3,401 for TBC vs. $3,516 for TPM)

* Savings of $115.00 Per patient per year (PPYR)
* Savings of over $13 Million per year

Brenda Reiss-Brennan, PhD, APRN, et al. 2016
Mental Health Integration in Primary Care Practices

- **Emergency Room Visits**: Reduced 23%
- **Hospital Admissions**: Reduced 10.6%
- **Primary Care Encounters**: Reduced 7%
- **Payments to Providers**: Reduced 3.3%
2010 – Cost and Quality Impact of Intermountain’s Mental Health Integration Program

Brenda Reiss-Brennan, Pascal C. Briot, Lucy A. Savitz, Wayne Cannon, and Russ Staheli
Resources

Create Information Hub-Inventory of ALL resources- available to all for Care/Case Managers to share. Most start from scratch, inventing their own. We need to know who we are and talk/communicate with each other.
Resources

- 55+ Senior Resource Directory 2017

- Senior Bluebook
  - SeniorBluebook.com

- We all need to know who we are and coordinate care in our geographic area

- Population Medicine for our Older Adults!
Conclusion

I would like to acknowledge and thank the VA, American Geriatric Society, the University of Utah, Intermountain Healthcare for material for this lecture.

Thank you all for coming and participating!