North Carolina Institute of Medicine Task Force on Alzheimer's Disease: Duke Medicine Geriatrics and ACO Collaborative Efforts

DukeMedicine

Agenda

- Brief overview of Duke Connected Care
  - Mission, Vision
  - Structure of the ACO
  - Overview of services provided to attributed patients
- Geriatric Care Programs
  - Geriatric Rounds
  - Perioperative Optimization of Senior Health (POSH)
  - Health Optimization Program for Elders (HOPE)
  - Geriatric Workforce Enhancement Program (GWEP)

DCC Mission

Improve population health through a focus on excellence in care delivery, care coordination, and analytics

DCC Vision

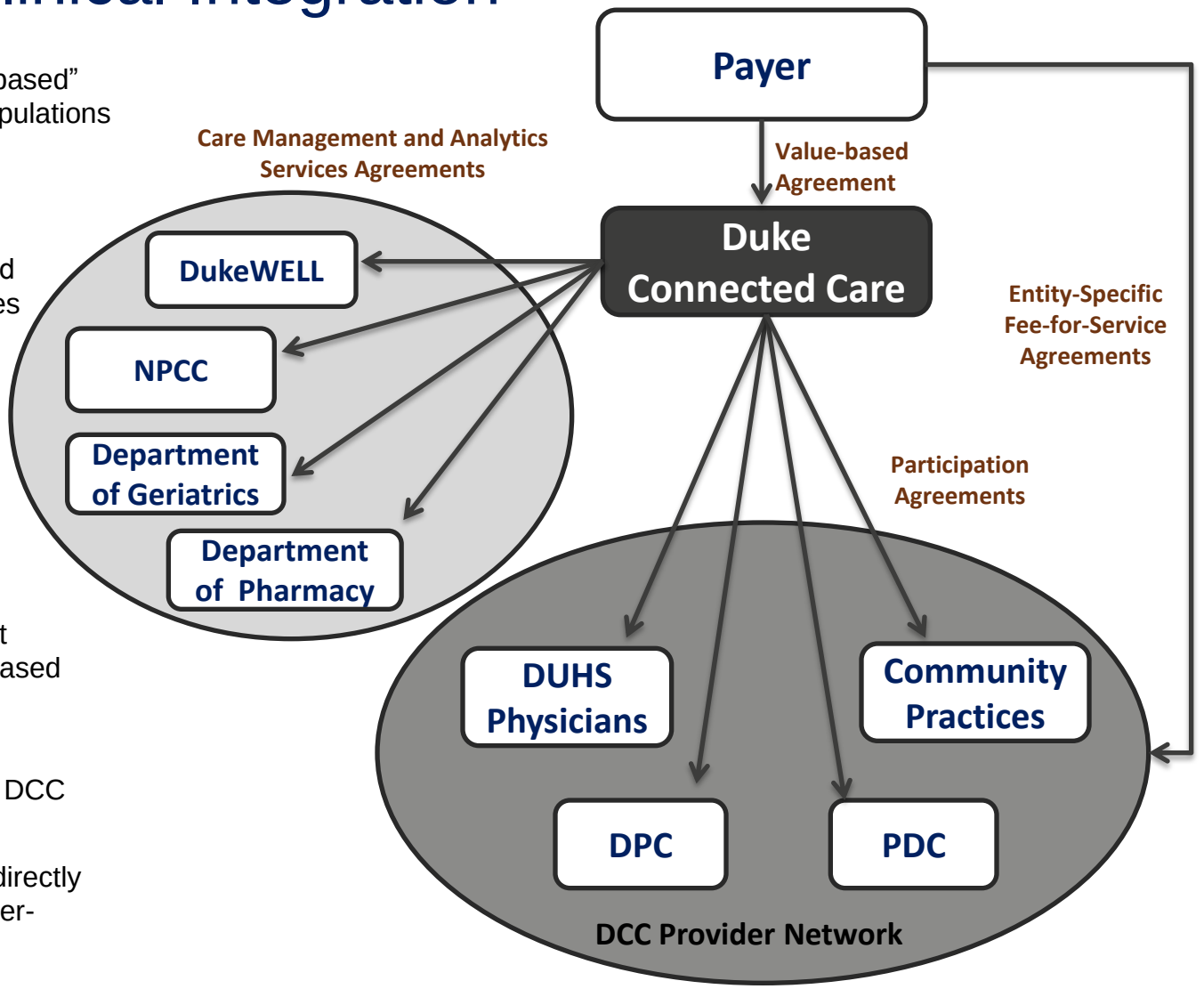
Through its core functions of developing networks of providers, engaging payers in value-based care, and delivering coordinated care services to patients, Duke Connected Care will be the preeminent population health program in the Greater Triangle

DCC Goals

- Promote evidence-based medicine, cost efficiency, and patient engagement
- Improve clinical quality and health outcomes by establishing methods and processes to coordinate care throughout an episode of care and during care transitions

Approach to Clinical Integration

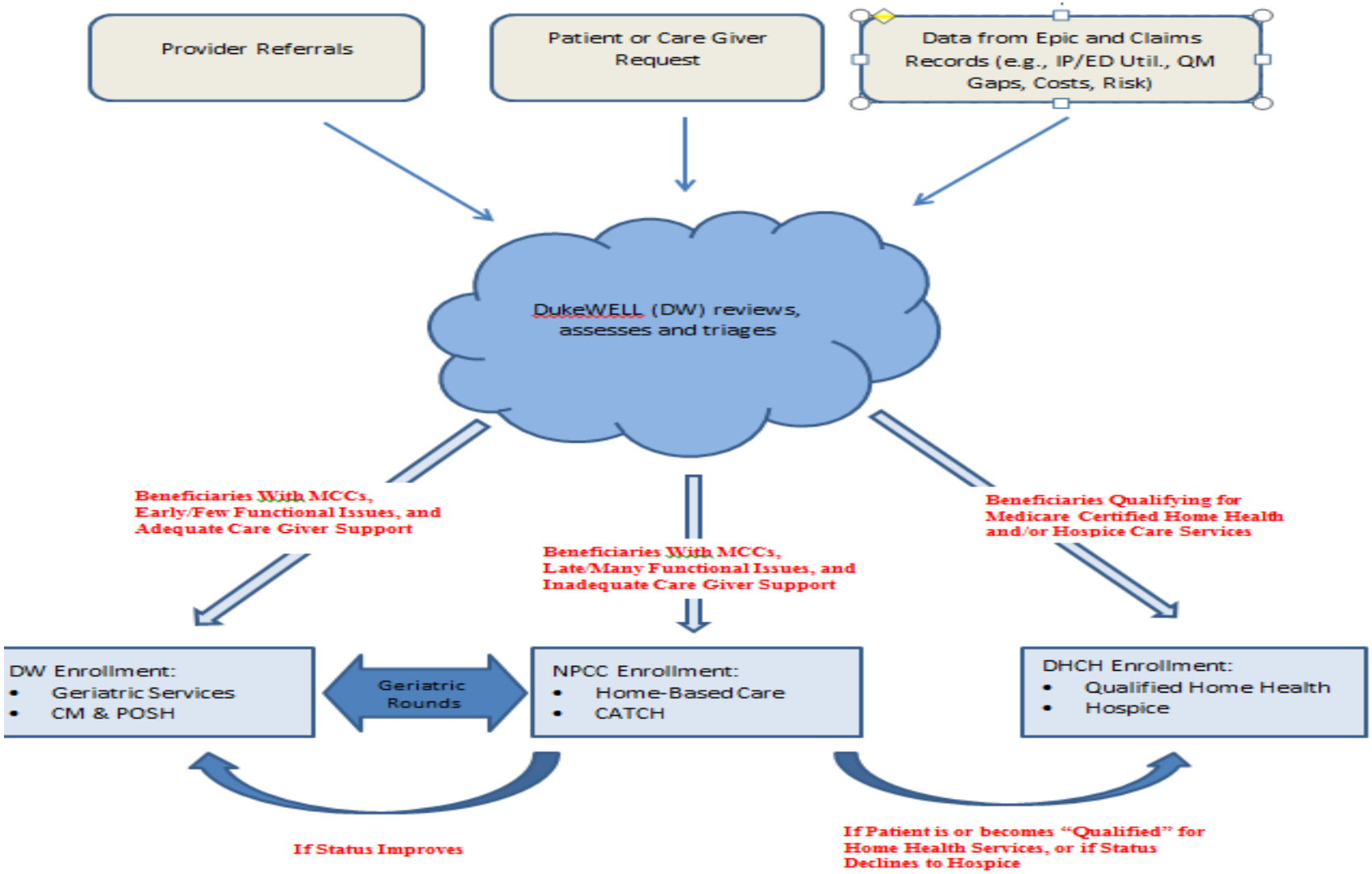
- ✓ Payer and DCC execute a “value-based” agreement for applicable payer populations or products
- ✓ Value-based agreement defines assignment of members to DCC (“attributed population”), quality and cost targets, care management fees and shared-savings methodology
- ✓ DCC provides population health services (e.g., through service contracts and MOUs).
- ✓ DCC providers bound to value-based contracts via participation agreements
- ✓ Payer disburses care management fees and shared savings to DCC based on CIN’s overall quality and cost performance
- ✓ DCC distributes shared savings to DCC Participants
- ✓ Payer reimburses DCC providers directly on a FFS basis via existing, provider-specific FFS contracts



Care Management Capabilities and Competencies

- ***Care Coordinators*** help patients schedule appointments and engage with primary care physicians
- ***Nurse Care Managers*** work directly with patients to counsel and help manage disease
- ***Practice Direct Representatives*** screen & monitor population, work directly with practices and patients to assist in transitions and closing patient health gaps
- ***Pharmacist*** supports care managers and counsels patients about medication access and adherence
- ***Psychiatrist*** support care managers and counsel patients with complex mental diseases
- ***Geriatricians*** advise care managers about patients with complex geriatric conditions
- ***Nephrologist*** advise care managers and patients with (or risk of) chronic kidney disease

Work Flow Overview



Geriatrics Advisory Council

- Interprofessional group focused on:
  - Needs and priorities of older patients
  - Methods of identifying high risk enrollees
  - Development of programs to improve care/services
- Attendees: DCC leadership and staff, geriatric medicine, nursing, pharmacy, psychology
- Meets quarterly
- Recent topics:
  - Fall risk
  - Cognitive screening
  - High risk medications
  - Transitions and readmissions

Geriatrics Rounds

- Weekly meeting of care managers, medical director, pharmacist, geriatrician
- Review 4-5 highly complex patients:
  - Multiple chronic conditions/multiple medications
  - Cognitive impairment or falls
  - Recent change in health status, admission or utilization
  - Difficulty with access to care
- Care manager administers survey: falls, function caregiving
- Discussion of issues and specific recommendations
  - Medical management/ Medication changes
  - Referrals—PT, OT, speech, Geriatrics, Palliative Care
  - Consideration of prognosis and goals of care
  - Communication back with patient, family and PCP

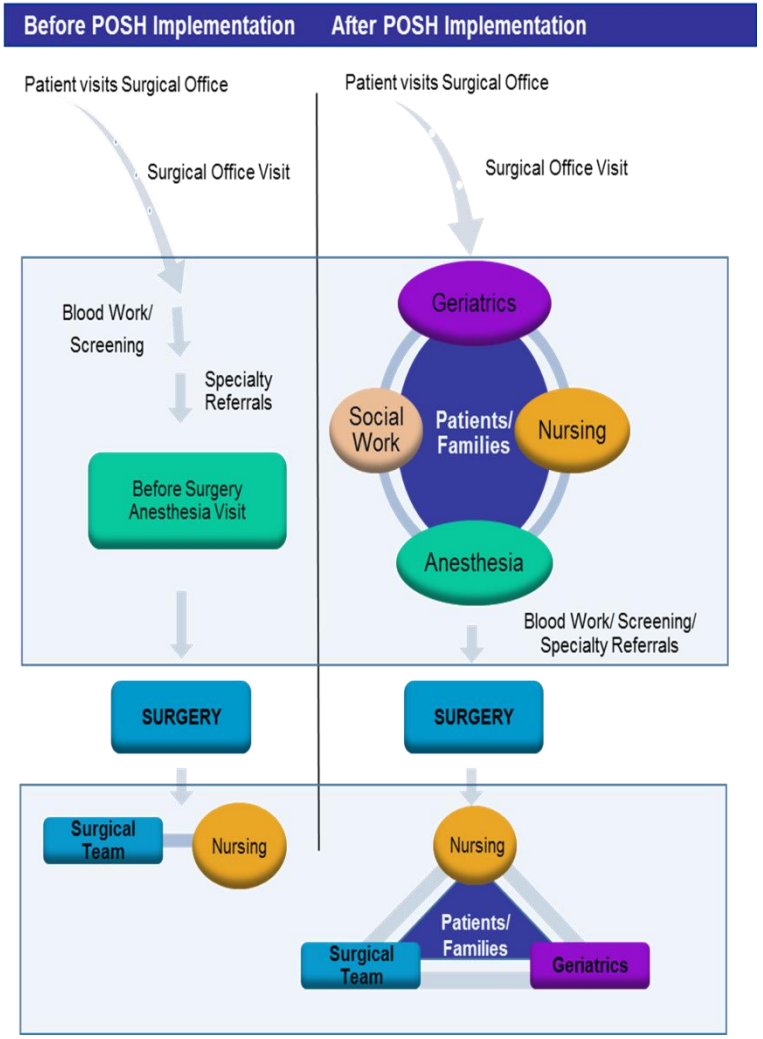
Perioperative Optimization of Senior Health (POSH)

Step 1: Identify high risk DCC patients scheduled for surgery

Criteria: **cognitive impairment**, poor nutrition, multiple chronic conditions, impaired vision/hearing, age > 85

Step 2: Single visit, multidisciplinary, interprofessional evaluation focused on identifying and mitigating risk factors for post-operative complications

Step 3: Post-operative geriatrics consult for management of medical conditions, medications, pain, complications (including delirium), and planning for post-hospital care



POSH Initial Results

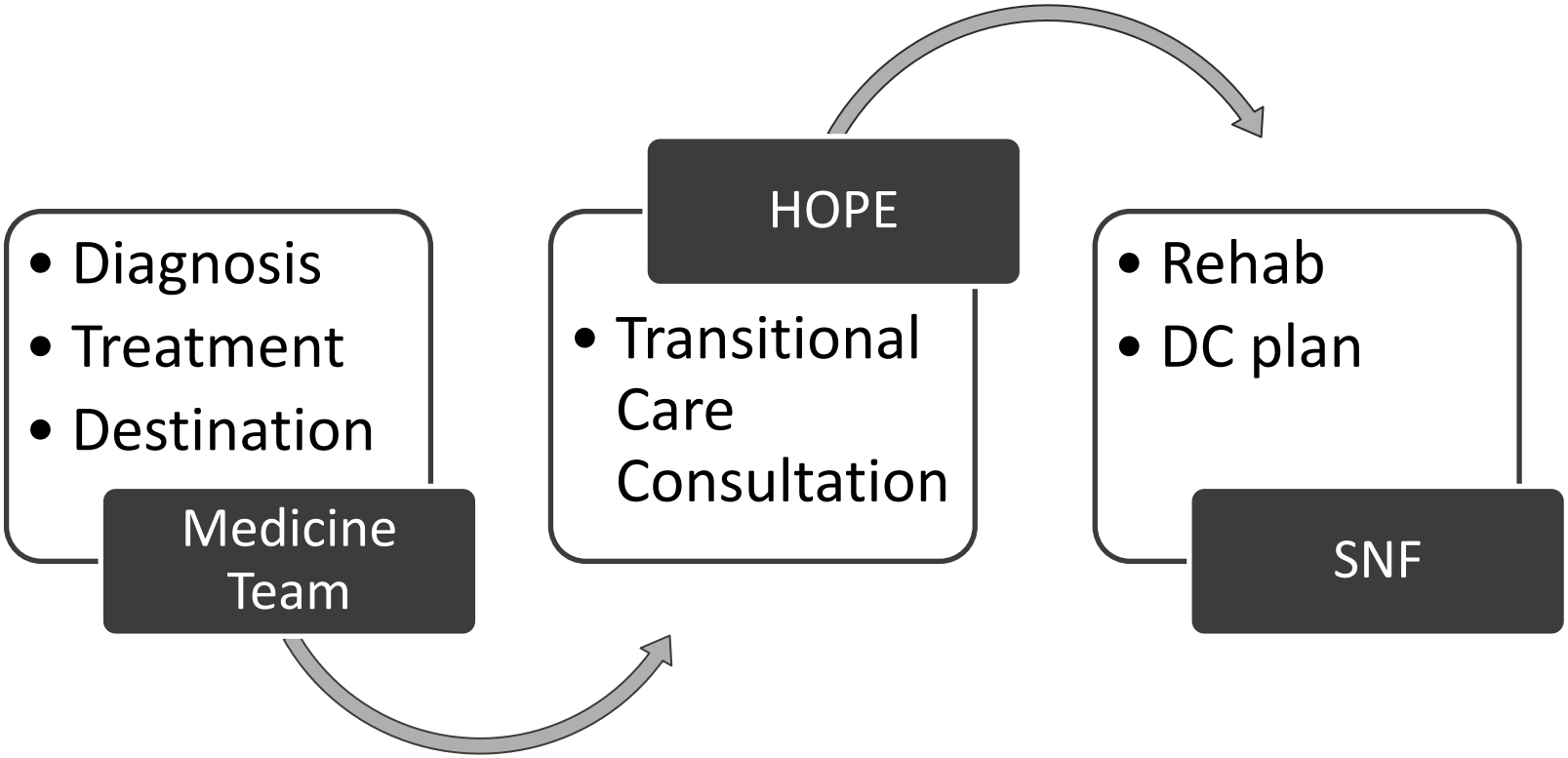
Outcomes	Historical Comparison - Control Group (n=146)	POSH - Referred Patients (n=69)
Age	71.8 ± 6.24 yrs	75.0 ± 6.82 yrs
Assessment Period	January 2010 – May 2011	June 2011 – May 2013
Median LOS (days)*	5.9	4.3
Percent Discharged to SNF	19.0%	14.5%
30-day readmissions rate	10.7%	3.6%

*p=0.004

- Same 4 primary surgeons
- All elective cases, all underwent ERAS protocol
- Laparoscopic: POSH 33% v. Comparison 34%

Lessons to Date

- Provides model for care bundles that integrate technical expertise across different disciplines and settings
- Evaluate resource needs for expanding capacity to other surgical and medical specialties
- Streamline process through better integration of customized documentation and order entry in electronic medical record



Optimization for rehabilitation
Anticipate issues to address while in SNF
Discuss rehab prognosis, contingencies, advance care planning
Detailed medicine review
Communication—Physician and Nurse

HOPE Process Improvements

- Nurse Telephone report (PRMs facilitate)
- Transitional Care Assessment (PRMs complete)
- Discharge to Outside Facility Form
  - Enhanced Medicine Reconciliation
  - More complete instructions for topical creams
  - Reporting of last doses given
  - Inclusion of nursing report *within* DOF form

Health Resources and Services (HRSA) funded Duke Geriatric Workforce Enhancement Program (GWEP)

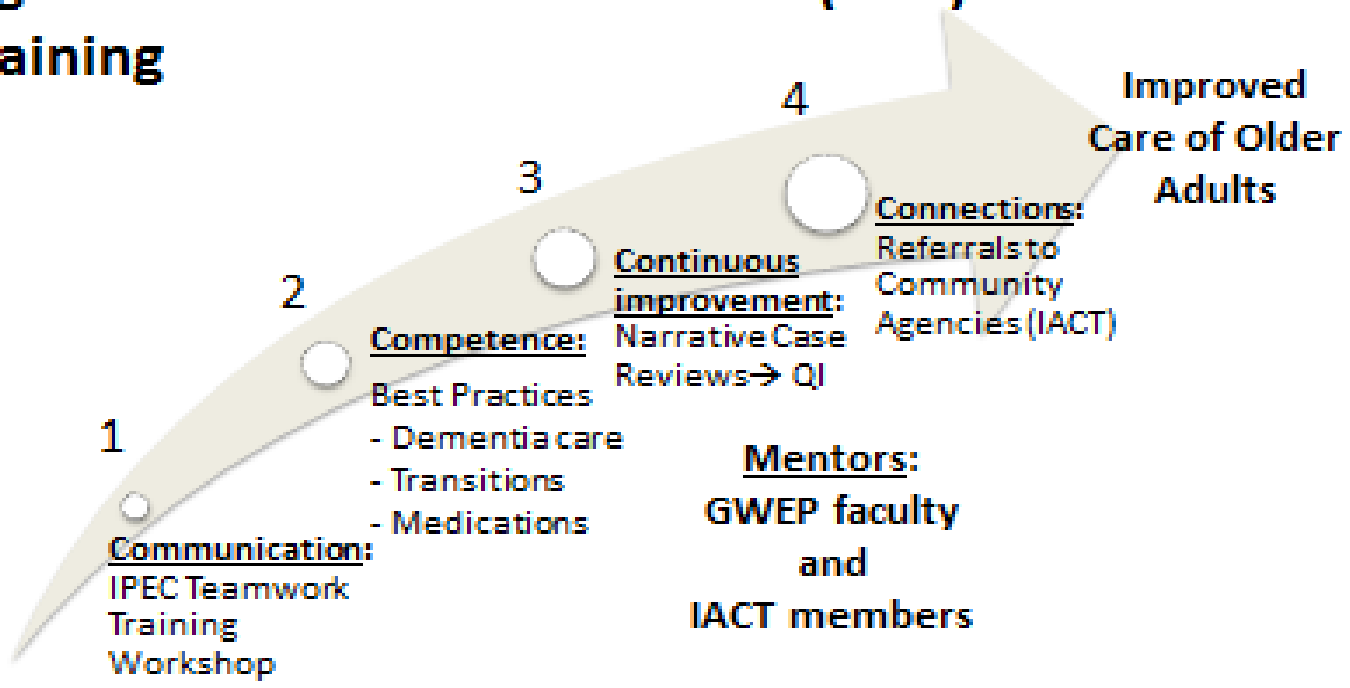
Aim: Strengthen capacity to provide patient-centered coordinated healthcare for seniors locally, regionally, and nationally.

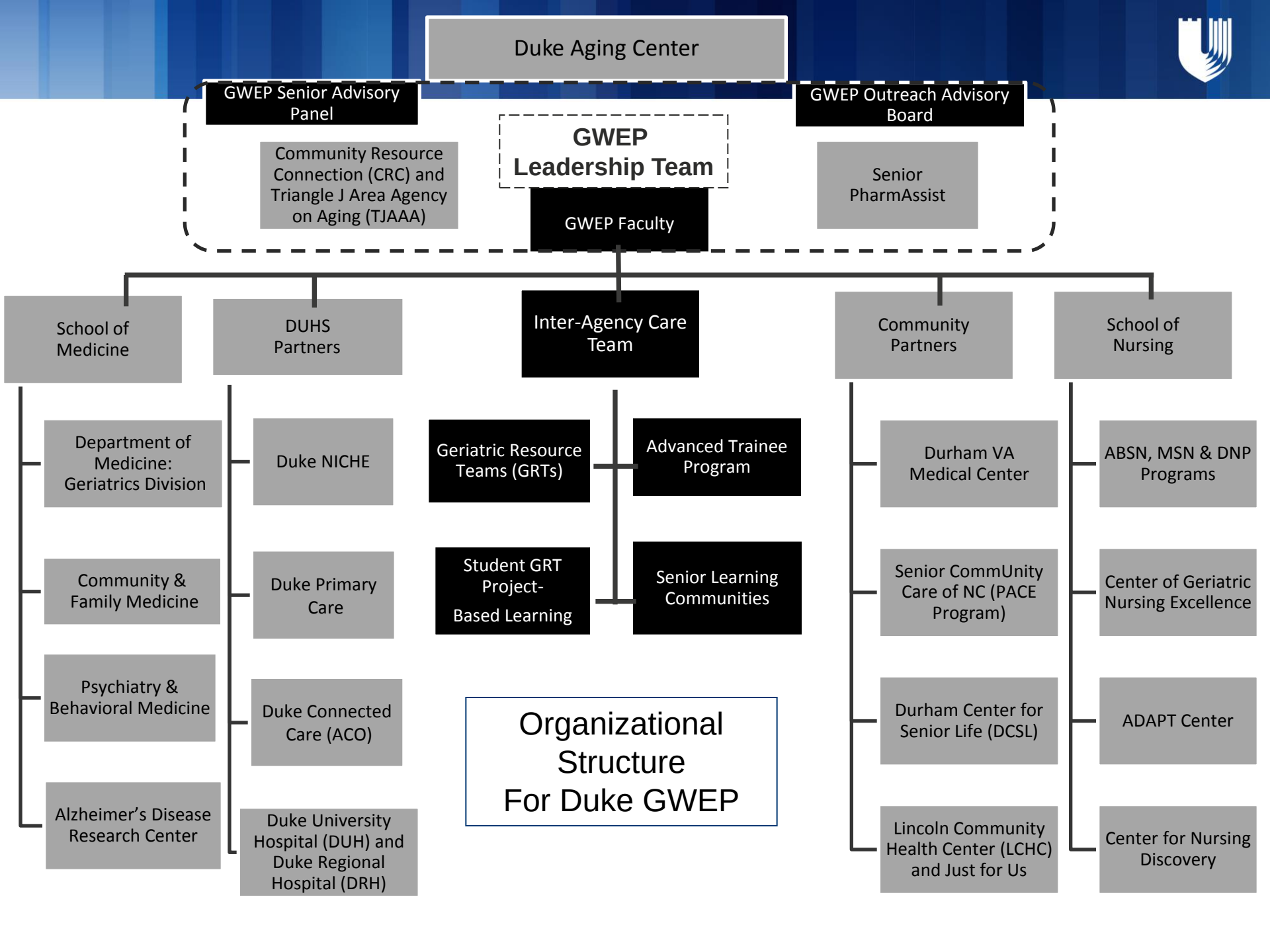
The GWEP will bring together geriatrics training programs, primary care practices, community agencies and healthcare organizations to implement a new model of workforce development that strives to improve outcomes for older adults.

GWEP Programs

- **Geriatric Advanced Trainees** Provide support for trainees in geriatric medicine, geriatric psychiatry and advanced practice nursing by providing specific mentoring, clinical experiences and IP project work.
- **Geriatric Resource Teams (GRTs)** Provide IP teams from area primary care practices training in use of best practices compendium and access to priority referrals for seniors with complex care needs to the interagency care team (IACT) for comprehensive review and care coordination. (See figure)
- **Seniors, their families and caregivers.** Share best practices with seniors, families and caregivers via established venues and networks such as caregiver support groups, faith communities, and community education events. The Duke Early Dementia Support Group will serve as a model for engagement of seniors and caregivers in the community.

Figure: Geriatric Resource Team (GRT) Training




Duke Aging Center
GWEP Senior Advisory Panel
GWEP Outreach Advisory Board
Community Resource Connection (CRC) and Triangle J Area Agency on Aging (TJAAA)
GWEP Leadership Team
Senior PharmAssist
GWEP Faculty
School of Medicine
DUHS Partners
Inter-Agency Care Team
Community Partners
School of Nursing
Department of Medicine: Geriatrics Division
Community & Family Medicine
Psychiatry & Behavioral Medicine
Alzheimer's Disease Research Center
Duke NICHE
Duke Primary Care
Duke Connected Care (ACO)
Duke University Hospital (DUH) and Duke Regional Hospital (DRH)
Geriatric Resource Teams (GRTs)
Advanced Trainee Program
Student GRT Project-Based Learning
Senior Learning Communities
Durham VA Medical Center
Senior CommUnity Care of NC (PACE Program)
Durham Center for Senior Life (DCSL)
Lincoln Community Health Center (LCHC) and Just for Us
ABSN, MSN & DNP Programs
Center of Geriatric Nursing Excellence
ADAPT Center
Center for Nursing Discovery
Organizational Structure For Duke GWEP

Discussion