Collaborating in Care of Older Patients under the Geriatrics Workforce Enhancement Program:

What did we do, and did it make a difference?”

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NICHE + Nebraska Methodist Hospital Regional Geriatric Nursing Conference

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Nebraska Geriatrics Workforce Enhancement Program: AFHS work 2019-2024

- Focus entirely on outpatient settings.
- Each site received 4Ms training and designated a site champion
- Interprofessional teams from all sites participated in monthly Case Conferences
  - Cases developed and presented using 4Ms framework
  - 50 conferences over 5 years
- About 2800 professional person hours of training.

Outcomes:

- AFHS level 2
  - All 14 NM PCMH clinics
  - All 3 Immanuel PACE sites.
- AFHS Level 1
  - Seven (7) OneWorld Community Health Center sites
  - NM Specialty Care Clinic (HIV)
- EMR or chart review assessed measures of improvement

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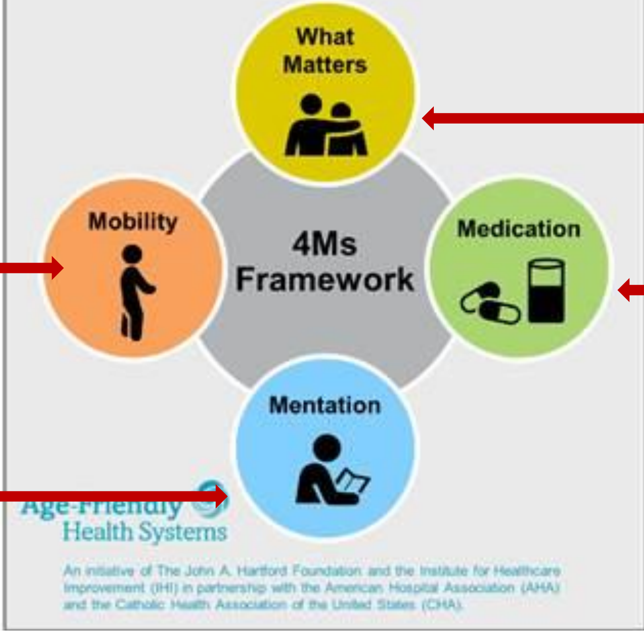
What Did We Try to Teach/Learn?

Can the patient move safely to do what Matters?
Can they get up out of a chair?
Does she need a mobility device?

Dementia (mini-cog, MoCA, Rudas)
Depression (PHQ-2,9)
Anxiety (GAD 7)



What brings you joy?
What makes life worth living?
Who would speak for you if you can't speak for yourself?

Medication review and reconciliation
Why is the patient taking this medication?
Is the med still needed?
The differential diagnosis of every geriatric problem includes a drug side effect.

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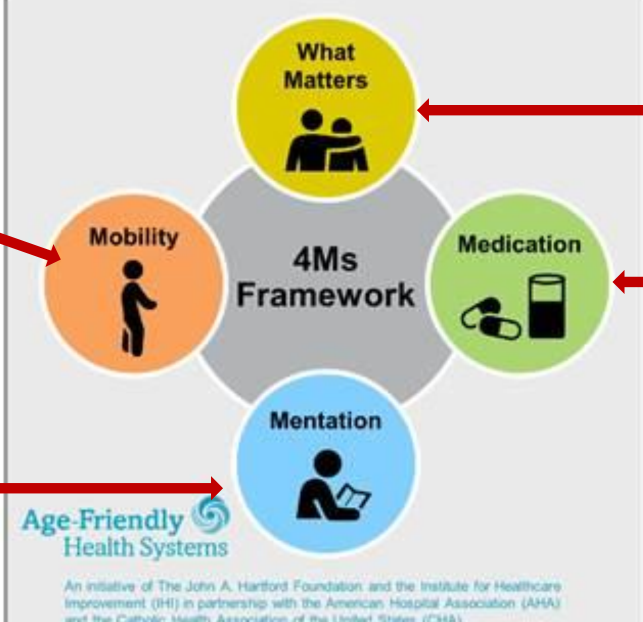
Can We Measure Improvement?

Can the patient move safely?
Falls Screening
- Feel unsteady
- Fear of falling
- Any falls

Dementia
- Mini-cog during AWV
- Refer caregivers to resources



Who would speak for you if you can't speak for yourself?
DPOA/ACP

Medication review and reconciliation
During AWV

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Mentation: Dementia

- A big public health problem
- The most common cause of new onset and progressive disability after age 70
- Therapies are of marginal benefit and may cause harm
- What does improve outcomes? : **Caregiver information and support**
- NGWEP Approach
  - Annual outreach to caregivers with resources
  - Referral through EPIC EMR
  - REACH out Primary Care (small group education)

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Measure: % of patients with dementia whose caregivers were provided education on dementia AND referred for support.

Year	# with Dementia	# Referred	Percent	Which clinics
2019	250	0	0	5 PCMH
2023	407	406	99.8	5 PCMH
2024	≊1,082	1,082	≊ 100%	14 PCMH
2019	47	0	0	OneWorld
2023	97	97	100%	OneWorld

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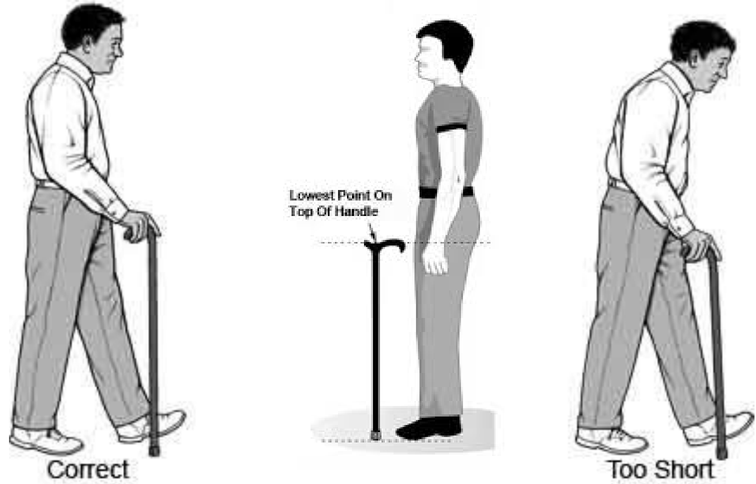
Measure: % of patients ≥65 yrs. screened for future fall risk

- Feel unsteady?
- Fear of falling?
- Any falls?
- Or Up and Go



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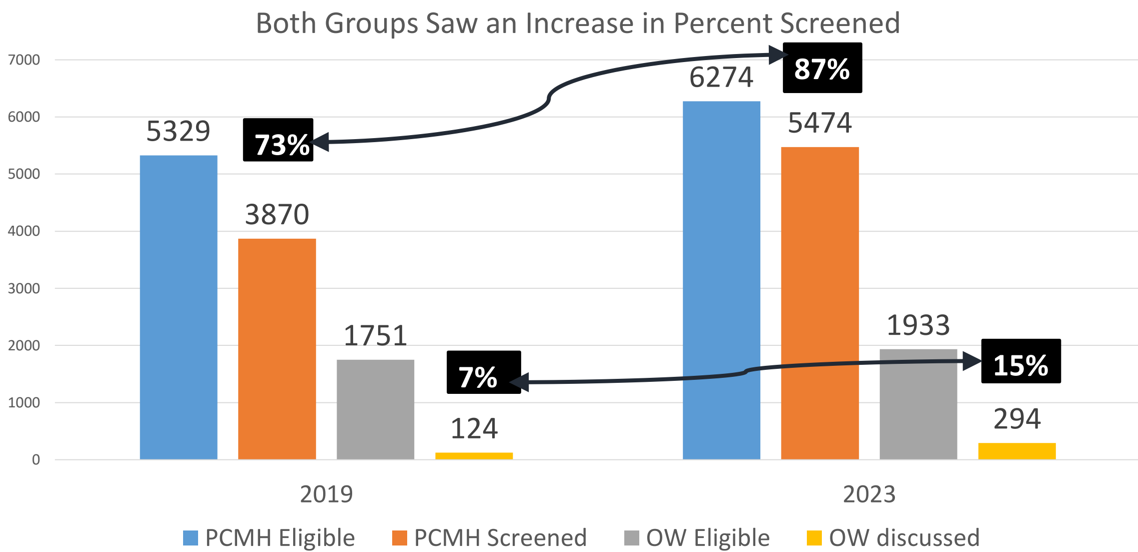
Change in Falls Screening 2019-2023



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Measure % of patients ≥65 yrs. with an ACP or DPOA in the EMR or discussed but the patient declined

- Who can be there for you when you need them?
- Who can you talk to about your wishes?
- Who can you trust to follow your wishes and do what is best for you?

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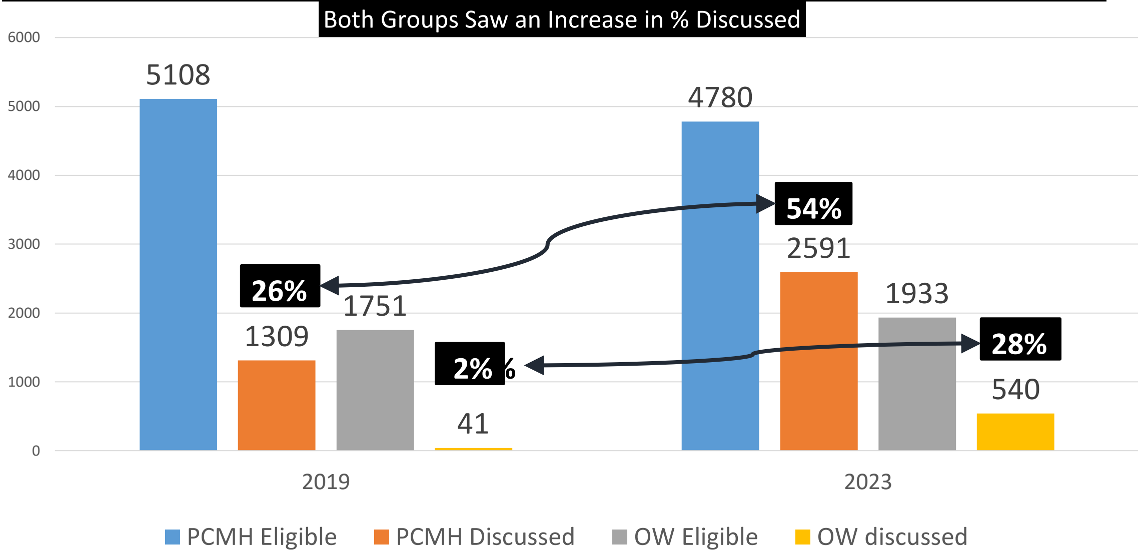
Change in ACP/DPOA 2019-2023



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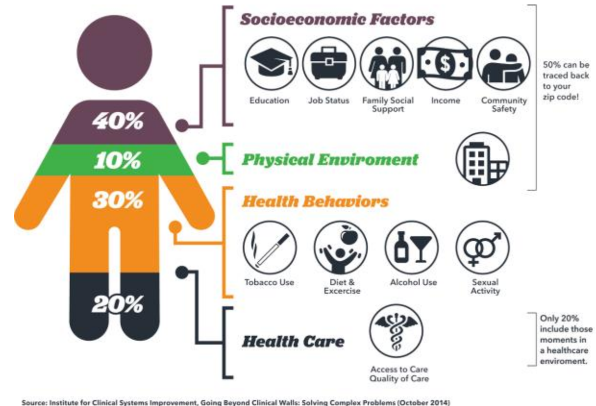
Social Determinants of Health (SDH)



Measure: 30-day All-Cause Hospital Readmission

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SDH: Can we intervene?

- Health systems and community-based organizations (CBOs) exist in separate silos in most parts of the US
- CBOs are access points for services that address deficits in SDH

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Our Approach: Primary Care Liaison (PCL)

- PCL worked from the offices of the Eastern Nebraska Office on Aging with access to all CBO services (Aging and Disabilities Network, etc.)
- Fontenelle clinic (for one) added PCL services to the **Transitional Care** services of patients discharged from NM hospitals.
- PCL calls **discharged patients** within 72 hrs. and **screens for SDH** and educates and **connects patients to services**, with f/u calls to assist and encourage service use.

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Hypothesis: addressing SDH will reduce risk of hospital readmission

Sample and Methods:

- Pre/post, quasi-experimental design with longitudinal data analysis for quality improvement
- 754 patients with hospital discharge; PCL worked with 145; 609 comparison
- Outcome **30,60,90**-day readmission rate measured every 6 months
- Data for the year before the intervention were extracted for comparison.

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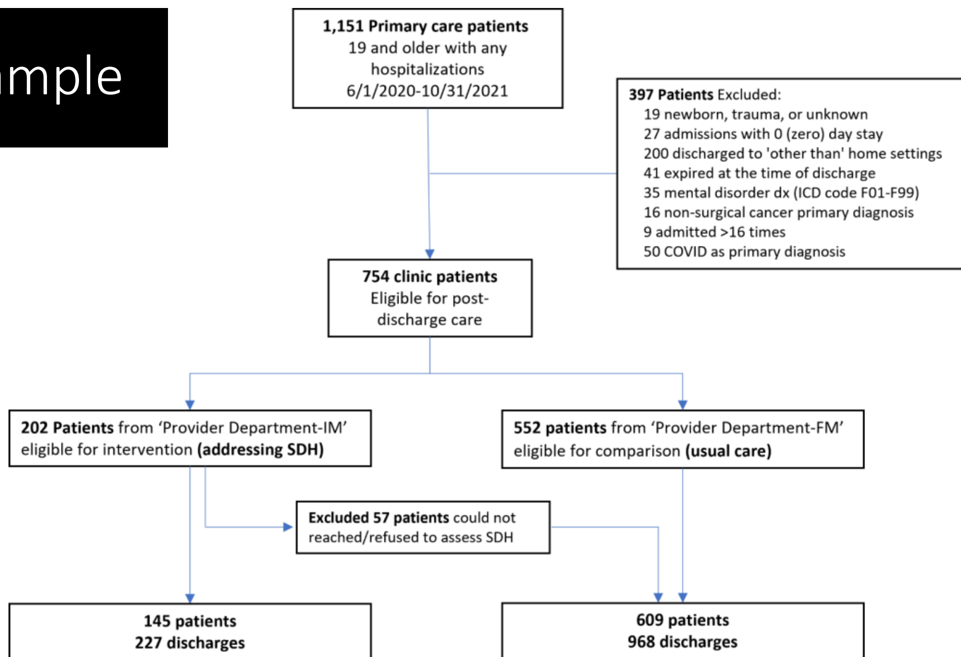
Sample



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Readmission Model: confounding factors

What predicts being readmitted?

- **HCC/chronic illness scores**
- **Length of stay** in the hospital
- **Patient age**
- **Type of insurance**
- **Diagnosis (**Clinical Classification group)

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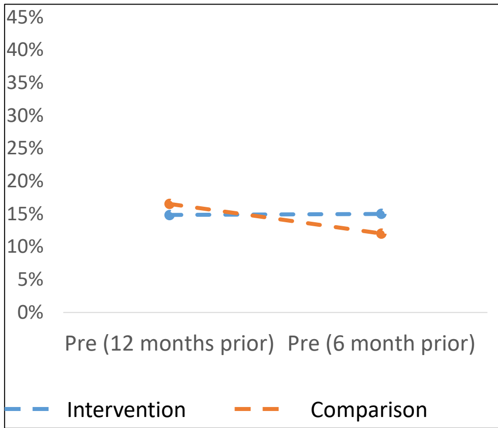
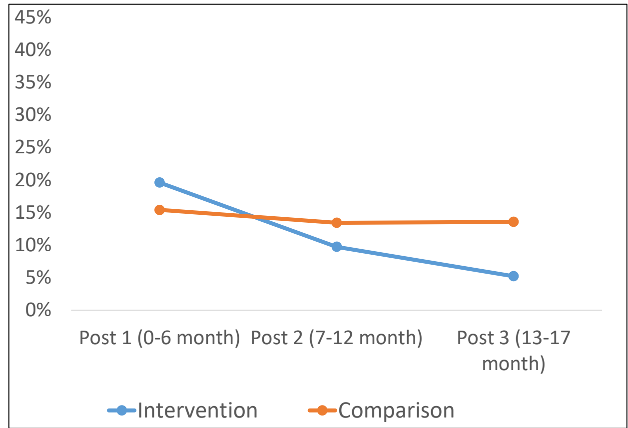
30-Day Readmission (Pre)



30-Day Readmission (Post)



Note: group definition is different
Pre: intervention group is patients who had PCL intervention at least one time in any time points during the intervention
Post: intervention group is patient encounters who have received PCL intervention by each time period

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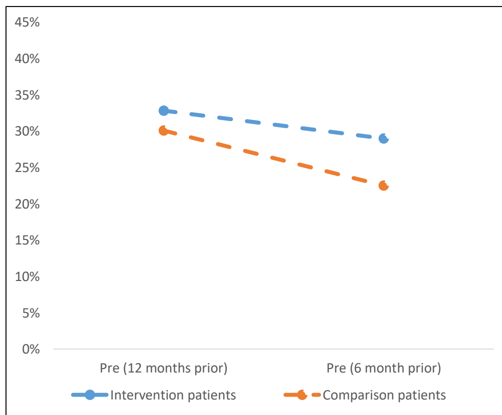
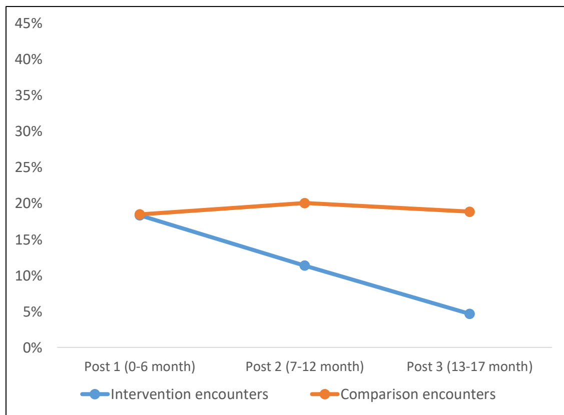
60-Day Readmission (Pre)



60-Day Readmission (Post)



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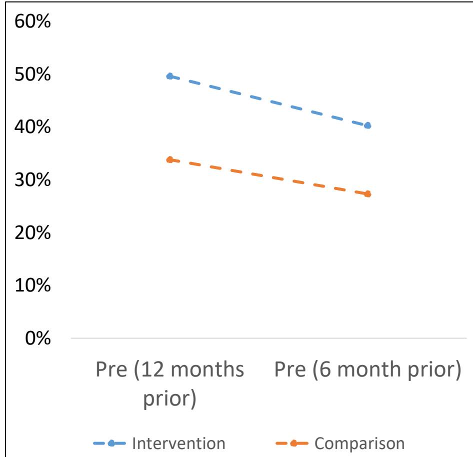
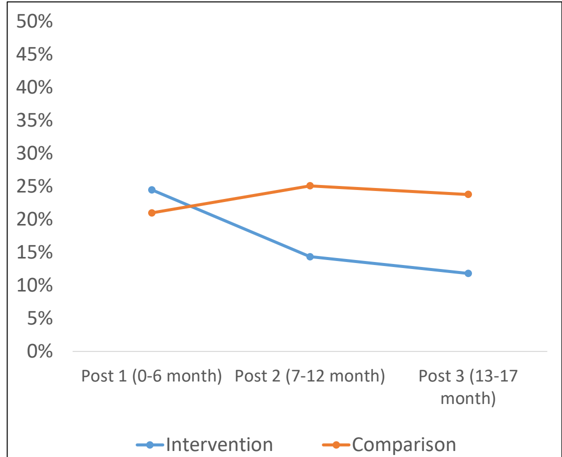
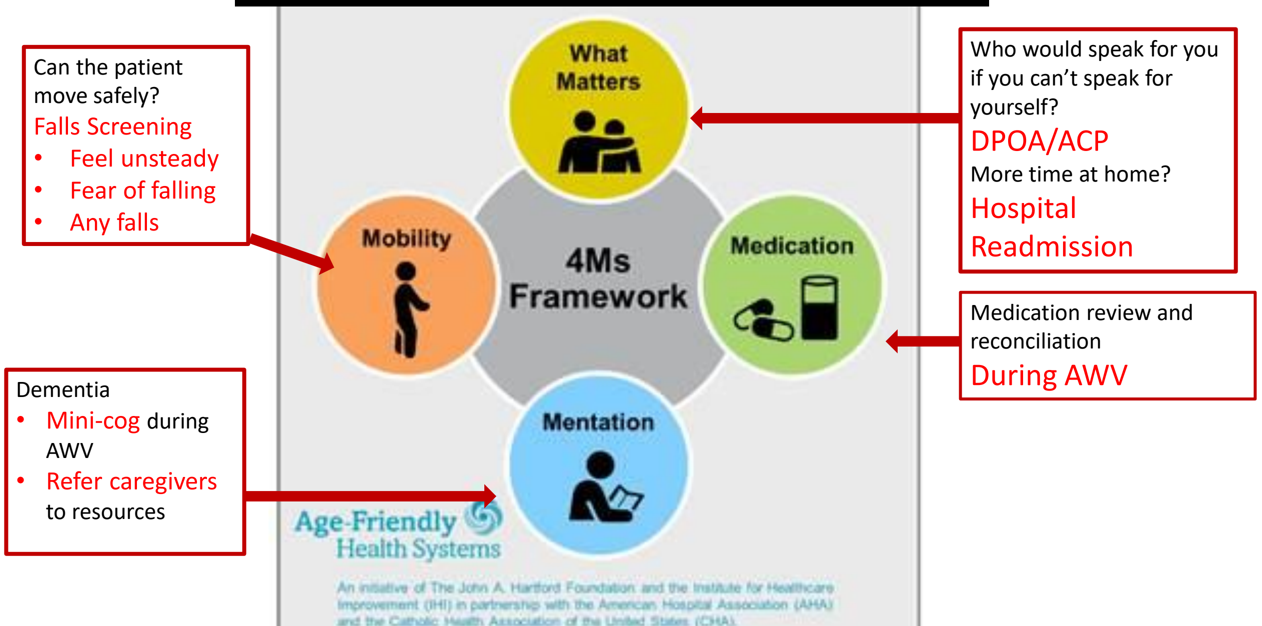
90-Day Readmission (Pre)



90-Day Readmission (Post)



Can We Measure Improvement?



Summary

- Age friendly Care within primary care clinics:
  - Engages teams of providers with community partners
  - Delivers dementia resources and education to care partners
  - Improves the likelihood that patients discuss goals of care (what Matters)
  - Improves falls screening and medication review
- Other lessons learned
  - Case based conferences that address all of the 4Ms in every case is effective in:
    - Deepening knowledge of how to manage complexity
    - Growing understanding of SDH and CBOs

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Thanks to

All of the geriatrics' champions

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Patients who taught us through their voice on what Matters

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