

# Staffing Community Based Long Term Care and Health Professions Training

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# The Big Issues

- Practice of the model
- Professional staff
- Communication issues
- Training issues
- Ongoing care differences
- Differences in outcomes

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# What Is Different About Rural Health Care

- The obstacles faced by health care providers and patients in rural areas are vastly different than those in urban areas therefore urban programs cannot be automatically replicated or transformed to fit the rural communities needs.
- Rural Americans face a unique combination of factors that create disparities in health care not found in urban areas.



# What Is Different About Rural Healthcare

- 2,157 health professional shortage areas (HSPA's) in rural and frontier areas of all states and US territories compared to 910 in urban areas.
- Only about 10% of physicians practice in rural America despite the fact that one-fourth of the population lives in those areas.
- Professional shortage areas in the US were in non-metropolitan counties and home to over 30 million people.



# A National Rural Health Snapshot

\*Rural

\*urban

Percentage of USA Population	25%	75%
Percentage of USA Physicians	10%	90%
Medical Specialists per 100,000 population	40.1	134.1
Population > 65	18%	15%
Population below the poverty level	14%	11%
Average per capita income	\$19k	\$26k
Non-Hispanic White population	83%	69%
Adults who describe health as fair/poor	28%	21%

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# Barriers in Rural Areas

- Poverty
- Geographical isolation
- Cultural and ethnic differences
- Lack of/difficulty with transportation
- Lack of knowledge regarding the need for or availability of health services



# Guiding Principles

- Begin with what people and healthcare systems know about diseases and the needs of the community
- Build on what systems and people already have
- Go (frequently) to where people live, work, worship, play and seek healthcare
- Enhance/improve rather than duplicate
- Build trust and collaboration and never violate confidentiality



# More Contracted Staff

- Communication issues
- Alignment of goals
- Who is in charge
- Controlling cost and quality

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# Systems of Care Even More Important

- Build systems of care that don't rely on staff to remember everything they need to do.
- Esp important around big areas of care:
  - Transitions of care
  - Monitoring of complex care issues
  - Relay of information between different groups



# Working With the Teams

## PACE

- Staff model
- Larger numbers of team members
- Site based
- Protocols
- Daily team meetings
- Clear expectations
- Mature infrastructure and model
- Comprehensive geriatric model



# Working With the Teams Partnership

- Smaller number of team members
- External physicians
- Home+site based
- Less meeting time
- Better/More consistent understanding of home and family environment
- Less rigidity of model? more room for innovations?



# Strength's of the Models

## Pace

- Medically complicated cases
- More physician buy-in and support
- More medical continuity
- More available ancillary services
- More NP support
- Advance directives
- Utilization

## Partnership

- More and earlier referrals
- More choices in primary providers and hospital systems
- Ease of more home based care
- NP autonomy
- Quicker start-up
- More facile team structure



# Opportunities

## Pace

- Start-up costs
- More time in initial start-up
- Less choice in providers
- Less understanding of the home environment

## Partnership

- Utilization
- Less overall continuity
- Less control of quality of medical services
- Home care staffing issues



# Practice Changes in the Model

- Less use of day health services (“?None?”)
- More home based care
- Carefully delineating the roles of other staff members
- Use of informal supports even more important
- Telemedicine concepts
- Communication, communication



# Elements of Primary Care

- **Medical director**
- **Primary care development**
- **Primary care physician**
- **Nurse practitioner**

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# Role of the PACE Medical Director

- Oversight of medical care/development
  - Standards
  - QI
  - Professional advisory
  - Ethics committee
- Responsible for medical care of MD's and NP's
- Liaison with physician/hospital community
  - Negotiate contracts/oversee quality: medical specialist, consultants, ancillary
  - Pr
- Develop on-call coverage
- Active member of committees

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# Role of the Partnership Medical Director

- PACE responsibilities
- More oversight of NP's and clinical care of the teams
- Resource and support for the NP's



# On-site Primary Care Development

- **Recruit MD/NP/nursing staff**
- **Work with RN sup/admin to put together clinic**
  - Staffing
  - Operation
  - Primary care triangle
- **Home care development**

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# The PACE MD

- Getting the “right” MD
- Integrating primary care into the multidisciplinary team
- Gait-keeper of medical services
- Provides primary care across all settings
- Good communicator
- Participates in the entire program
- On-site enough time
- Excellent clinician
- Facilitator/educator

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# Physician Extenders and So Much More: NP's and Pa's

- Key to successful implementation to a rural model or any model using community physicians
- Primary care representative on the team
- Practices primary care not just case management



# Community Physicians

- Need to work with who is there and who is available
- Less time available
- Geriatric knowledge base
- Fitting their part of the model without sacrificing quality and cost effectiveness



# Clinic Set- up and Layout

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# Utilization Comparison

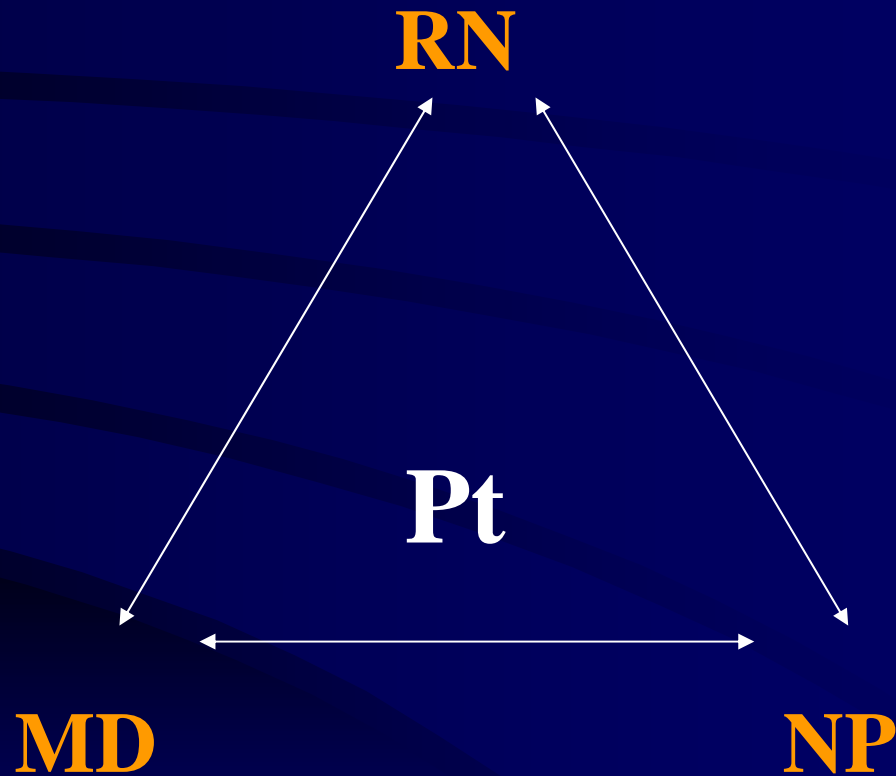
	PACE	Partnership
Hospital Days	↓	↑
Medication Costs	↓	↑
Team/staffing costs	↑	↓
Advance Directives	↑	↓

# Utilization Comparison

	PACE	Partnership
NH/CBRF Days	Slope of increase in the use of alternative housing equal in both programs expect in 1-2 years utilization will be similar	
Overall Costs	<p>??</p> <p>Difficult to look at the programs separately within the same Organization</p>	



# Medical Triad



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# Transitions in Care

- What is a transition?
- Why are they important in this population?
- **Steps to ensure improved care across transitions**

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# Transitions of Care

- Home → acute care → SNF
- New illness
- New provider/specialist



# Key Components:

## Maintaining Continuity Across Patient Transitions

- Primary medical triad maintains control of medical decisions across all settings
- Interdisciplinary team remains involved and informed

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# Why Is This Important?

- Omission problems
- Transcription problems
- Duplicative problems
- Slow down in service delivery
- Creativity/risk taking of new providers
- Wariness of patient



# Build Internal Organizational Systems That Meet These Goals

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# Functional Integration Model

- Care providers know patient/family intimately
- Pt/family trust care providers
- Team trusts each other



# Functional Model in Action:

- More care occurs in the community setting:
  - Less iatrogenic institutional effects
- Maintains functional status of patients
- More cost effective



# Key Components of a Working Model

- Trust and effective communication between all care providers
- Effective case management team
  - Interdisciplinary
  - Integrated interdisciplinary plan of care
  - Fluid plan of care
  - Patient/family access to appropriate 24/7 coverage of medical and long-term care needs



# Key Components of a Working Model

- Decision making at the level of the provider
  - Case management = provider as much as possible
- Effective communication system between all providers
- All care providers provided with/have access to information needed for good decisions



# Key Components of a Working Model

- Direct and personal communication between providers when a transition occurs
- Program has excellent and complete medical and case management records
  - Complete detailed problem list
  - Up to date medication record
  - Allergies and adverse reactions to medications
  - Health care wishes



# Key Components of a Working Model

- Continuous/daily personal contact with provider during duration of there care if returning to old provider
- Attendance at a specific number of team meetings and all family meetings



# Communication

- Team-community PCP communication
  - Face to face
  - Telephonic
  - Fax items
  - PACE to PCP office staff
- Between team members
  - Scheduled mtg time
- Electronic communication



# Written Protocols

- Diagnosis
- Medications
- Advance directives
- Special needs

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# Other Needs During Transition

- Telephonic contact
- In person contact

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# Health Professional Training

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# Health Professional Training

- PACE staff
- Contracted staff
- Students in training

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# PACE Staff

- Don't short change yourself. As important when you start and on-going.
- Intensive training- even though you may have heard when you have seen one PACE site you have seen one PACE site when it gets down to how care is delivered it is quite similar and can be adapted to your situation.



# PACE Staff

- Not just the professional staff- since there is less face to face mtg time may need to schedule more training and development.
- Facilitation becomes even more important.
- Informal supports and paid family caregivers.



# Contracted Staff

- Primary care physicians.
- Specialists.
- Contracted facilities: ER's, acute care, sniff's, group homes etc.
- PCP office staff.



# Contracted Staff

- Initial training and assessment of their skills and needs.
- Ongoing identification of areas for improvement.
- PACE systems that do not expect them to remember what to do.



# If You Build It They Will Come

Most PACE organizations are involved in a variety of training programs. The issue is how many can you handle adequately and assure quality of care and not a distraction to the program.

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# Types of Trainees at CCE

- Medical students
- Medical residents and fellows
- NP students
- RN and LPN students
- Paw's
- SW students
- Rehab students
- Health administration students
- Clinic assistants
- Etc



# Health Professionals In-training

- Excellent lab for training: participants, longitudinal experience, skilled clinical staff.
- Types of professionals to train: MD's, NP's, RN's and LPN's, rehab and Rec staff, administrative staff.



# Issues

- Identify strategic reasons to do training:
  - Staffing and recruitment
  - Educational mission of your program
  - PACE staff opportunities



# Questions:

- Takes more time: build in adequate time for PACE staff to oversee. Make sure “school” does their part in overseeing.
- Strategic decisions on level of student- 1<sup>st</sup> year nursing student vs. Graduate nursing student. Reflect on your strategic reasons for doing this.

# Questions:

- Make sure the PACE staff person has the appropriate credentials and is the right person to take on this responsibility.
- What if the student isn't a good fit.
- HIPPA and regulatory compliance.



# What You Can Offer:

- Geriatric care training
- Long term care training.

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