Proactive Action
– The Antidote to Reactive Care

Presented by:
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Session Learning Objectives

• Explore and implement methods to involve the entire staff in an early intervention approach.
• Understand how advance care planning can support early intervention.
• Learn to detect and flag high risk “frequent flyers” and intervene early.
• Identify methods to reduce adverse drug events.
• Identify staff educational strategies to promote preventative care.
The PACE Model

The PACE Model of Care is centered on the belief that it is better for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible.
Benefits of Proactive Actions

For Participants and Families

- Improve quality of life for participants and families
  - Slow the decline of chronic diseases and stabilize health
  - Decrease exacerbations of chronic disease symptoms and acute episodes requiring ER/hospitalization
  - Improve daily wellbeing with better symptom management
Benefits of Proactive Actions

For the Providers of Care

➢ Decrease costs of healthcare for frailest population
  • Pay for less costly care (wellness) to save on more costly care (acute)
  • Coordinate care to manage utilization of services/avoid unnecessary care
  • Pay for nontraditional approaches that are more cost effective and with same or better outcomes
Traditional healthcare models

- Traditional health care = Reactive
  - Primary approach is to treat, not prevent
  - When ill, then seek care
  - Requires the patient to figure out when to get help – wait too long
  - Very limited opportunities for regular observation and ongoing education
  - Poor communication with limited ability to coordinate care among multiple providers and disciplines
Wellness approach = Proactive

• Frequent intervention when well/stable
• Observation and early reporting of s/s by all staff
• Identification of high risk for ER, med non-adherence, instability, and more
• Planned interventions through proactive care planning by IDT
• Improved communication with opportunities for multiple disciplines to collaborate and coordinate care
• Access to and coordination of care in all settings
Implementing a Proactive Approach

- Two programs will share their projects and data-based outcomes using multifaceted proactive approaches

Senior Community Care of North Carolina’s Clinic Manager will share her story about a program that was underutilizing its nursing team and paraprofessional staff and how involving them through proactive interventions has decreased unnecessary and preventable ER visits and resulting hospitalizations, improved outcomes, and participant satisfaction while reducing costs.

Inspira LIFE’s Medical Director will share his story of a program facing fiscal instability and what he and his team did to turn it around improving its fiscal stability and resulting improved quality of care.
Proactive Action
Moving Toward a Proactive Care Mindset

Lakesha Bradford, RN, BSN
Clinical Service Manager
Senior Community Care of NC
The Quest

The Mission

Improve Participant Outcomes

Improve Clinic Flow

Provide Same Day Visits

Decrease Hospital Days

Improve Care Coordination

Improve Utilization of Specialists Visits

Cost Containment

Improve Staff Morale

Improve Utilization of Specialists Visits

Improve Staff Morale
SOLUTION?

PROACTIVE CARE
The Process

Evaluation of Current Processes

Relationship Building

Identify Key Players

Empower all involved

Complete follow-up
What Processes Do We Have in Place

• Care planning
• Staff Buddies
• Open Clinic via Stop and Watch Notification Tool
• Weekly disease specific education sessions
• On-call nursing visits
• 24 hour consultation with physician via nurse
• Access to medications at all times
Preparing the Participant

- Pre-Enrollment interview

1. What is being healthy to you?
2. How would you define a perfect life?
3. If you could control your death what would it look like?
4. Inform Participant of clinic role and expectations.

Care Plan based on the Participant and Caregiver views
Be specific and purposeful
Post Enrollment

- Nursing, Social Work, Occupational Therapy, Physical Therapy and/or Staff Buddy to complete 4 weekly post enrollment visits

THE PURPOSE

- MOST Form in the home current
- Provide education on medication administration and refill ordering
- Review upcoming appointments
- Provide disease specific education
- How to call out
- Ordering DME
- How to get medical assistance after hours
Who Are the Key Players

Dietary, OT/PT

Nursing, Providers, Social Workers, Behavior Health and Chaplin

Driver's, Home Health Aides, Certified Nursing Assistants, Medical Assistants Staff Buddies

The Participant
What Process Had the Biggest Impact

Stop and Watch

A written notification tool completed by paraprofessional staff, participants and caregivers that informs the clinic that a participant is experiencing a change in condition.

- Nurse led urgent care clinic were skilled nurses provide care based on an approved set of protocols, under direction of the Medical Director
- Medical Assistant and/or RN completes a follow-up call within 24 hours to re-evaluate participant status
- Clinic tracks and evaluates list of call outs daily and provides a skilled home visit if necessary
- One on one education sessions with participants and caregivers with CHF, uncontrolled DM, and uncontrolled chronic pain issues
Center Attendance

+How does it correlate?

Amount of Days Between Last Staff Contact to Hospitalization

Hospital Days

[Charts showing data for 2017, 2018, and 2019 for January, February, March, April, May, and June]
How Do We Empower Staff?

- During orientation
  - Explain the Stop and Watch Process
  - Explain importance of participation in staff buddies
- Monthly during Staff meetings
  - Educate on specific diseases, what’s an emergency
- Daily recognition with PACE Super Hero board
  - Compliment and recognize while they are in act of doing good
- Provide one on one support during supervisory visits
  - Provide participant specific education and encourage relationship building
How Do We Bounce Back When We Get Off Track?

Post Hospital 1-3-7 Visits

Post Hospital Day 0-1
- Nursing performs a home visit and ensures that meds are correct & educates

Post Hospital Day 1-3
- Participants receive follow-up clinic visit with Provider

Post Hospital Day 7
- Nurses perform a follow-up visit to ensure that current plan of care is effective
Proactive Care fosters the PACE model because it promotes shared decision making, optimizes function, comfort and longevity.

Allows the all-inclusive healthcare team to plan care based on preventive and predictive model in participants current setting.

Proactive care supports the constraints of a PACE model budget, all while improving participants quality of life and healthcare literacy.
PROACTIVE ACTION: The Antidote to Reactive Care

Ankur Patel, MD, MBA, FAAFP
Medical Director
Inspira LIFE & Population Health
Can you turn this program around?
How will you do it?
How much time do you need?
QUICK ACTION
Admission Cycle

70%
Know Your Players

Clinic Staff

Providers

Nurses

Quality

Dietician

BH

Transport

Aide

OT / PT / RT

Social Worker

ED, CD, FD, MD, VP

Medical Director

Preventing Hospitalizations

Living Safely in the Community
STRATEGY
Success Strategy: 3P

POLST
Prevention

Poly Pharmacy

STRATEGY
Adverse Drug Events

2/3 ARE PREVENTABLE
• Identified:
  – 20% of participants: 20+ medications
  – 60% of participants: 10-19 medications
• Action Plan:
  – Educate Providers & Nurses
  – Polypharmacy review with Pharmacist
  – Sedative Burden Score (Now Risk Score)
  – ACB Score (Now Risk Score)
• Identified: **Reasons for frequent ER Visits**
  – Shortness of Breath from COPD, CHF, Pneumonia
  – Abdomen Pain from Constipation
  – Falls/Dizziness from Dehydration, Adverse drug event

What can be done to prevent ER visits and Hospital admissions?
Taking Action

1. Vaccinations
2. Educate ALL staff to look for early signs of illness
   – Education sessions: “Think like a Geriatrician”
3. Triage process
4. Same day visit (Home or Clinic)
   – IV Fluids, IV medication, Enemas
5. Hired Transition of care nurse (Discharge care)
6. Post discharge visits:
   – Nurse within 24 hours and Provider within 48 hours
Goals of Care: *Live or Die with Dignity*

- Identified: Only **19%** of participants had POLST forms
- Action Plan: **All** within 6 months.
The Missing Puzzle Piece
Think Outside the Box & Go Beyond Expectations
ER ONLY Visits

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>2015</td>
<td>8.22%</td>
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<tr>
<td>2016</td>
<td>4.94%</td>
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<tr>
<td>2017</td>
<td>4.87%</td>
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<tr>
<td>2018</td>
<td>3.96%</td>
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52% Decrease
Hospital Admissions

- 2015: 11%
- 2016: 6%
- 2017: 5.10%
- 2018: 4.97%

55% Decrease

Year: 2015, 2016, 2017, 2018
Readmission Rate - 30 Days

<table>
<thead>
<tr>
<th>Year</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
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<tbody>
<tr>
<td>Rate</td>
<td>23%</td>
<td>18%</td>
<td>13%</td>
<td>12%</td>
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47% Decrease
Inpatient Cost - PMPM

<table>
<thead>
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<th>Year</th>
<th>Cost</th>
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<tbody>
<tr>
<td>2015</td>
<td>$1150</td>
</tr>
<tr>
<td>2016</td>
<td>$687</td>
</tr>
<tr>
<td>2017</td>
<td>$587</td>
</tr>
<tr>
<td>2018</td>
<td>$539</td>
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53% Decrease
Location of Death

<table>
<thead>
<tr>
<th>Year</th>
<th>Home</th>
<th>Hospital</th>
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<tbody>
<tr>
<td>2014</td>
<td>37%</td>
<td>63%</td>
</tr>
<tr>
<td>2015</td>
<td>36%</td>
<td>64%</td>
</tr>
<tr>
<td>2016</td>
<td>66%</td>
<td>34%</td>
</tr>
<tr>
<td>2017</td>
<td>78%</td>
<td>22%</td>
</tr>
<tr>
<td>2018</td>
<td>75%</td>
<td>25%</td>
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WHAT’S NEXT?
Expansion!

PACE Gloucester County
References- Poly Pharmacy Statistics


6. Deprescribing.org
Thank you!
What is the PACE Logic?

More Community-Based Care

Less Hospital & NH Care

Saving $$ for Long Term Support and Services

Requires Proactive Action!!
Proactive Planning

Anticipate

Prognosticate

Advance Care Planning

Avoid Surprises
Anticipate

If PPT has been in the hospital/ER, it could happen again

If disease causes SOB, then how might SOB be treated

If falling, plan for fall recovery (other than calling 911)

If you send them to a specialist, what will happen?

Catch changes early- why did the PPT call out?
Why Prognosticate?

- Recognize end of life
- Helpful in advance care planning
- Better match of interventions with likelihood of benefit
- Avoid surprise/crises
Trajectories of Death

Organ System Failure Trajectory

- (mostly heart and lung failure)
- Begin to use hospital often, self-care becomes difficult
- Time - 2-5 years, but death usually seems "sudden"
- Death

Frailty / Dementia Trajectory

- Onset could be deficits in ADL, speech, ambulation
- Time - quite variable - up to 6-8 years
- Death
Would you be surprised if this patient died in the next 12 months?
Most PACE participants have a Limited Life Expectancy

https://www.ssa.gov/OACT/population/longevity.html
Risk calculators cannot predict the future for any one individual. Risk calculators give an estimate of how many people with similar risk factors will live and die, but they cannot identify who will live and who will die.
Some Conditions limiting life expectancy

- Functional dependency
- Weight loss
- Hospitalizations
- Cancer
- COPD
- CKD Stages 3-4-5
- CHF NYHA class 3-4
- Dementia
- Atrial fibrillation
- Parkinson’s
- Stroke
- ALS
- Falls
- Slow Gait Speed
- Dysphagia
- Hip Fracture
Advance Care Planning

Not just Health Care Proxy

What are the participants values?

What makes life worth living?

Present vs Advance Directive

It’s a process, not a one time discussion!

Builds Trust
Proactive Action

Think ahead
Recognize decline
Build Trust
Involve other team members
Don’t wait
Remember the three Ps-
Polypharmacy, POLST, Prevention
Contact Information

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