

ADOPTION OF GERIATRIC MODELS BY MEDIC PARTICIPATING SITES

AURORA SINAI MEDICAL CENTER

Aurora Health Care Makes Strong Progress with MedIC

December 2010—Through its work with the Medicare Innovations Collaborative (MedIC), Aurora Health Care has been building on its excellent senior service line on several fronts.

The ACE (Acute Care for Elders) program has been in use at Aurora Sinai Medical Center since September 2000 and was expanded to 11 Aurora hospitals. The ACE program works to decrease the risk of functional decline that sometimes occurs during the hospitalization of frail older patients. ACE advisory committees now include nursing leaders from local skilled nursing facilities, and an ACE consult service has been implemented at St. Luke’s Medical Center, helping about fifty patients per month. Aspirus Wausau Hospital is the latest hospital to sign up for the ACE “e-Geriatrician” collaboration which enables Aspirus to serve patients in northern Wisconsin and Michigan with two ACE units, but without any geriatricians on site.

In primary Palliative Care, following a needs assessment, Aurora proposed and received a \$10,000 grant from the Association for Hospital Medical Education. Twice-monthly interactive education conferences for Continuous Professional Development (CPD) have begun and nationally recognized expert David Weissman, MD has joined in palliative care teaching sessions.

Also in palliative care, at a combined Aurora Sinai Medical Center and St. Luke’s Medical Center, Aurora has proposed a new section of geriatrics and palliative care, and has also completed a proposal for the Wisconsin Geriatric Education Center to incorporate principles of palliative care into the ACE Program and ACE Tracker tool at Aurora St. Luke’s Medical Center. The proposal includes a plan to add an indicator for palliative care need on the ACE Tracker (electronic) tool.

Aurora is also expanding other MedIC models of excellent geriatric care, including a proposal to pilot NICHE (Nurses Improving Care for Healthsystem Elders) at four medical centers, three outpatient clinics, three long-term care facilities and one VNA Home Care branch.

The HELP (Hospital Elder Life) program is also growing. Dr. Ellen Danto-Nocton has completed an assessment of the prevalence of delirium among patients at Aurora Sinai Medical Center, and its financial impact, and she and Dr. Michael Malone, Medical Director of Senior Services for Aurora Health Care, have proposed adding a delirium indicator to the ACE Tracker tool. Aurora has posted a HELP coordinator position.

Finally, in Care Transitions, Aurora has developed and piloted several tools to define hospital readmission risks, and developed and implemented a 20-point risk score that is now programmed into the ACE Tracker. Aurora has proposed methodology for home care nurses to view the ACE Tracker, as well as assessing the predictive value of incorporating the risk tool into electronic health records.

CAROLINAS MEDICAL CENTER-MERCY

Three New Models Help CMC-Mercy Advance Healthy Aging and Geriatric Care

December 2010 — As one of the MedIC sites working to demonstrate the effectiveness of a portfolio model of care for seniors, Carolinas HealthCare System/CMC-Mercy has initiated a Healthy Aging Steering Committee and three task forces, Palliative Care, NICHE and Care Transitions.

The Palliative Care Task Force, led by Dr. John Barkley, includes senior leaders from hospital administration and case management, hospitalists, ICU RN executives, members of the community-based hospice and palliative care program, clinical nurse specialists and a pastoral care professional.

The task force has reviewed the multi-year history of Palliative Care at CMC-Mercy and completed a program assessment based on the recent consensus recommendations from the Center to Advance Palliative Care (CAPC) for hospital-based palliative care operational features.

Based on this assessment, an action plan has been developed and the task force is making progress on assignments, identifying key stakeholders and developing plans to transition the Palliative Care program to work in line with a portfolio approach. The team worked with Mercy Leadership and IS to use Cerner as a tool to identify patients as they move through the portfolio model. Work flows are being reviewed and roll-outs are planned for late September.

In CMC-Mercy's work on another model, Nurses Improving Care for Healthsystem Elders, or NICHE, nurse leaders have formed a core team to facilitate the effort to implement NICHE within the hospital. This core team is enrolled in the NICHE Leadership Training Program, engaging staff nurses and hospital stakeholders in the process and creating excitement surrounding the initiative and the benefit it will have on daily operations and patient outcomes. Twelve nurses have formally completed the NICHE training program. CMS is hoping to enroll five more nurses in the NICHE program for the February 2011 course. "One of the best successes in my mind came today when I heard from two different nurses who are involved in NICHE training that they think they want to pursue education as a Geriatric Nurse practitioner. Wonderful!!! Also rare in Charlotte," reports Sindy McCrystle, Director of the Division on Aging.

In addition, Care Transitions is positioning itself to become an important component of CMC-Mercy's Senior Services program. With both an administrative champion and a physician champion, Care Transitions has a working committee building a framework. The foundation of this framework will target adults with admitting diagnoses of CHF, Pneumonia, and acute MI. The committee is currently working on determining methods to identify these patients through various IT (IS) reporting

tools, determining volumes, exploring staffing and funding options among other program essentials.

At a system level, CMC-Mercy is rolling out senior friendly sensitivity training for clinicians interacting routinely with seniors. This baseline training will be provided for all Mercy clinical and non-clinical staff.

CROUSE HOSPITAL

Crouse Hospital Moves Forward with Five MedIC Initiatives

December 2010—At Crouse Hospital in Syracuse, New York, one of the six MedIC sites, the focus is on care planning for adults with chronic care needs and finding ways to integrate five different models into a coordinated service— NICHE (Nurses Improving Care for Healthsystem Elders), ACE (Acute Care for Elders), HELP (the Hospital Elder Life Program), the Care Transition Intervention and Palliative Medicine.

NICHE and ACE are providing the foundation for Crouse’s central care planning process, which includes in-person and virtual rounding. In 2010, Crouse established an interdisciplinary ACE team and is piloting it on the adult general-surgical unit. Crouse hopes to expand this approach to all adult patient care units. Christy Pavetto Bond, MS, FACHE, Director of the Complex and Aging Care service continually thanked Aurora and Summa for their generosity of time and advice in her effort to incorporate ACE into their integrated geriatric service.

Through HELP, the interdisciplinary team gains the services of a nurse mentor who will work with bedside nurses and nursing assistants to implement the HELP protocols and act as a liaison between the bedside staff and the interdisciplinary team.

The interdisciplinary team is facilitated by an APN and includes a geriatrician. The APN, following the Care Transitions Intervention, coaches patients in self-management strategies as they transition home. Crouse utilizes the Patient Activation Measure to assess patients’ readiness for self-management and plan coaching strategies.

The Palliative Medicine service is participating in the interdisciplinary team in order to engage with patients to proactively plan for advanced care.

Crouse is looking for additional regional funding to continue partnering with MedIC to demonstrate successful adoption of innovations from the collaborative.

Concurrently Crouse will document the adoption process and serve as a base for implementation tool development and case study that can be used for subsequent replication. The funding will support the following activities:

1. Take a team to Akron, Ohio for formalized training on the ACE model through Summa Healthsystem.
2. Implement the ACE tracker developed at Aurora Health System.
3. Serve as a pilot site for the implementation of patient screening, assessment and outcomes.
4. Support recruitment efforts to hire a geriatrician to serve as the consulting physician for this array of services.

GEISINGER HEALTH SYSTEM**Adoption of NICHE Continues to Improve Geriatric Care at Geisinger**

December 2010—Geisinger Health System in Danville, Pennsylvania, as part of the Medicare Innovations Collaborative, has advanced its aging care delivery systems through the adoption of NICHE (Nurses Improving Care for Healthsystem Elders). A steering committee of nursing leaders has formally completed the NICHE Leadership curriculum and participated in an awards celebration during the annual NICHE conference in Baltimore in April 2010. The enthusiasm from nursing staff for the NICHE program has precipitated the rollout to other units within Geisinger.

Other innovation models operating throughout the health system include palliative medicine and an active transitions of care program. Both have produced positive clinical outcomes for patients and families by providing meaningful interventions for improved quality of life.

Pennsylvania ranks third in the number of seniors over the age of sixty-five and Geisinger is committed to expanding and creating programming specific to the unique needs of their community. The Medicare Innovations Collaborative has created a forum to share best practice at a national level.

Geisinger is also vested in contributing political insights and recommendations as health care reform unfolds, through hosted visits by legislative officials, congressional testimony, and advocacy for quality care. Geisinger again expresses its appreciation to The Atlantic Philanthropies for funding the Collaborative project and the work it will contribute to improving geriatric practice and legislation for older adults.

After a year of collaboration with the five other MedIC sites, Amy Minnich, Director for Life expressed her gratitude and said, "It's hard to believe it's only been a year! The work accomplished would take a lifetime in organizations independently. Thank you for letting us be a part of it. It has been an exciting project and I hope we were able to contribute to the greater good."

LEHIGH VALLEY HEALTH NETWORK

New Care Models Improve Lehigh Valley Health Network’s Inpatient Experience and Care Transitions

December 2010—At Lehigh Valley Health Network (LVHN), our care for older adults sets us apart, prompting U.S. News & World Report to recognize us as one of America's Best Hospitals for geriatrics. Our geriatricians receive special education to understand the aging process and how it affects health. We are the region's largest Level I Trauma Center for adults, and the only one that specializes in care for older adults.

Our Center for Healthy Aging is a one-stop resource for information, activities and social events. And Our Vitality PLUS program helps older adults stay healthy and active.

According to Dr. Deb Salas-Lopez, Chair of Medicine at Lehigh Valley Health Network (LVHN), “our involvement with MEDIC is very exciting and timely given the growth and ongoing needs of our elder population.”

MED-IC prompted LVHN to focus on the development of two programs. In the outpatient setting, LVHN is focusing on improving quality and safety as older patient’s transition from acute hospitalization back into their homes with the implementation of the Care Transitions Program (CTI). This dovetails with the ongoing collaboration with IHI sponsored efforts to improve the discharge process. LVHN was able to hire a new full-time Care Transitions coach funded through a one-year grant (\$100,000) from the Physician Hospital Organization (PHO). The CTI program is complemented not only by a newly designed discharge process, but also by expanded home health services and a growing outpatient palliative care service that provides in-home care to patients with advanced complex illness.

On the inpatient side, LVHN launched a NICHE Task Force to bring together nurse leaders from the three hospital sites, physician champions, allied health professionals and administrators and is began introducing the NICHE (Nurses Improving the Care of Health System Elders) program to some of its units. Twelve nurse leaders completed the NICHE leadership training in the spring and summer of 2010. Since then, thirteen nurses completed the Geriatric Resource Nurse (GRN) training on the pilot unit. Rollout of the program has begun on a second unit, with an implementation plan to spread NICHE across the network to all adult units. Lehigh Valley Hospital Cedar Crest and Lehigh Valley Hospital Muhlenberg have become NICHE certified.

UNIVERSITY HOSPITALS CASE MEDICAL CENTER

Five Model Programs Advance Care of the Older Adult at University Hospitals Case Medical Center

December, 2010—As one of six medical centers participating in the Medicare Innovations Collaborative (Med-IC), University Hospitals Case Medical Center (UHCMC) is developing its senior service program by working with the Med-IC to implement five model programs that promote improved quality of care and service to older adults. “We are working to identify opportunities to introduce model programs of senior care and integrate these programs into coordinated senior care services across the community continuum of care within our health system,” said Peter DeGolia, MD, CMD, and Director of the Center for Geriatric Medicine at UHCMC. Med-IC provides a forum to examine these model programs and develop measures to track their impact. After a year of participating in the Med-IC program, UHCMC is starting to see impressive results.

From the outset, UHCMC recognized the importance of Nurses Improving Care for Healthsystem Elders (NICHE) as a foundation program upon which other model senior care programs could be established. This program develops nursing knowledge and skill in working with frail elders, as well as changes attitudes about caring for older adults. “What is especially unique about the UH program is that we are reaching out to community nursing homes and taking NICHE to a clinical setting where it has not gone before” observed Catherine Roscoe-Herbert, DNP, CNS and Coordinator of Senior Services at UH. Dr. Roscoe-Herbert developed a complete training program called “Teach Me Tuesdays” that includes nurses from our Academic Medical Center, community hospitals, home care, and community nursing homes. She recounts a story about a nurse who attended the NICHE training: “I’m excited to be a champion. I am embarrassed to say that I was not prepared to help the elderly before this training”. Over the past year, the UH Center for Geriatric Medicine has assisted four community hospitals to become NICHE designated and trained two classes of nurses resulting in 75 Geriatric Resource Nurses. Four NH’s and UH Home Care Services have achieved NICHE affiliation this year as well.

Palliative Care is a Med-IC model program developed in collaboration with the Department of Nursing and the Center for Geriatric Medicine at UHCMC. The Med-IC helped UH identify appropriate measures to assess the impact of our work in Palliative Care. Our data to date shows we are having a significant impact in supportive care for our patients: improved pain control, increased goals of care discussions with advance directive designation, shortened ICU stays, avoidance of undesired interventions such as intubations, PEG tubes, and dialysis, and increased admission into Hospice for appropriate patients.

UHCMC was the site of the first Acute Care for the Elderly (ACE) unit in the USA. Today the ACE program takes place on both a medical floor and surgical floor. Now we have expanded this program to UH Bedford Medical Center, a community

hospital. Nurses on each ACE unit discuss their older patients with an interdisciplinary team of geriatrician, Gerontological Clinical Nurse Specialist (GCNS), therapist, social worker, discharge planner, and pharmacist. The team recommends interventions that can lead to better health outcomes. “Through our new ACE program we are identifying opportunities to improve care for our frail elders. Early referral to rehabilitation therapy services, removing Foley Catheters, and identifying potentially inappropriate medications that could result in iatrogenic problems are just a few of the outcomes we have recorded,” stated Joyce Restifo, RN, Gerontological CNS at UH Bedford Medical Center.

Transitional Care focuses on an interdisciplinary approach to managing the care of older persons as they transfer from hospital to home or skilled nursing facility. “Information and plans of care can get lost or disrupted when a person leaves one care setting and transfers to another,” stated Peter DeGolia, MD, CMD. The UH Transitional Care program is working with two community hospitals and eleven area nursing homes (NH’s) to improve communication and collaboration for more rapid response to patient needs.

The House Calls Program at University Hospitals brings physicians and nurse practitioners into the home to provide primary medical care to homebound seniors. We are linking up with several of the other Med-IC model programs to provide care to seniors that may otherwise have been lost to follow-up. Referrals are made by Transitional care, ACE, and Palliative Care teams for hospitalized homebound patients to be seen by the House Calls staff after discharge if they cannot get to their primary doctor’s office. “As staff learn about our programs and see how they connect, the impact we have on the care of our patients grows,” observed Dr. Karen Parker, MD, Medical Director of the UH/Case House Calls Program.