The Post Acute Continuum Within an ACO or Integrated Delivery System:

*The Geriatrics Perspective*

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Established Models Of Acute Geriatric Care/Transitions

- Acute Care for Elders (ACE) Units
- Hospital Elder Life Program (HELP)
- Comprehensive (interdisciplinary ) Discharge Planning (Naylor)
- Transitional Care Intervention (Coleman)

These models:
- reduce costs
- increase hospital capacity
- improve patient outcomes
Acute Care for Elders (ACE)

- Prepared environment
- Nursing guidelines to maintain ADL
- Medical care review
- Interdisciplinary team care, comprehensive discharge planning

--Palmer RM et al. JAGS 1994;42:545
--Landefeld CS et al. NEJM 1995; 332:1338
--Counsell SR et al. JAGS 2000; 48:1572
ACE Unit: Functional Trajectory: Goal=Optimize Physical Functioning

“Site follows function”

Hospital Elder Life Program (HELP)

- Patients age 70 years and older
- One or more risk factor for incident delirium: cognitive impairment, vision/hearing impairment, dehydration (↑BUN/creatinine)
- Protocols for 6 risk factors
- Nursing coordinator
- Volunteers provide most of intervention

Inouye SK et al. NEJM 1999; 340:669
Hospital Elder Life Program

Inouye SK et al. NEJM 1999; 340:669

[Bar chart showing a comparison between intervention and control groups. The chart indicates a 9.9% decrease in the intervention group and a 15% decrease in the control group. The difference is statistically significant (p<0.05) with a 40% reduction.]

Inouye SK et al. NEJM 1999; 340:669
Comprehensive Discharge Planning: APN

Discharge Planning In Hospital

Home care Up to 4 weeks

Collaboration With physician

Telephone availability

Advanced Practice Nurse

Naylor ME et al. JAMA 1999;281:613
http://www-transitionalcare.info
Reduces Readmissions to Hospital

**Intervention:**
Comprehensive discharge planning (APN)
Home follow-up (APN)

24 Week Results

(Naylor ME et al. JAMA 1999;281:613)
Care Transitions Intervention: Four Pillars

- Assistance with medication self-management
- Patient-centered record owned and maintained by patient to facilitate cross-site information transfer
- Timely follow-up with primary or specialty care
- List of "red flags" indicative of a worsening condition and instructions on how to respond

http://www.caretransitions.org/
Care Transitions: Rehospitalizations

**Intervention**

**Control**

Coleman EA et al. Arch Intern Med 2006; 166:1822

* = Significant
Models of Care: Cost Reductions Compared to Usual Care

<table>
<thead>
<tr>
<th>Model</th>
<th>Cost Reduction (%)</th>
</tr>
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<tbody>
<tr>
<td>ACE Unit</td>
<td>9</td>
</tr>
<tr>
<td>HELP (Intermed risk)</td>
<td>9</td>
</tr>
<tr>
<td>CDP (24 weeks)</td>
<td>46</td>
</tr>
<tr>
<td>TCI (30 days)</td>
<td>17</td>
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</tbody>
</table>

1. Landefeld CS et al. NEJM 1995; 332:1338
2. Rizzo JA et al. Med Care 2001;39:740
3. Naylor MD et al. JAMA 1999;281:613
Reengineered Discharge (RED)

- RCT to reduce ED and hospital return (30 days) after discharge
- General med service
- Urban, academic safety-net hospital
- 749 patients (mean age=50 years)
- Nurse discharge advocate
- After Hospital Care Plan
- Clinical pharmacist call (2-4 days after)

http://www.bu.edu/fammed/projectred/

Reengineered Discharge (RED)

P=0.009
P=0.014
P=0.09

33.9% lower cost for intervention

Hosp Use | ED visit | Readmits

Usual Care | Intervention

Jack BW et al. AIM 2009;150:178
Models of Community Based Care

- **Geriatric Resources for Assessment and Care of Elders (GRACE)**
  - Interdisciplinary care team works with PCP
  - Reduces hospital days in high risk patients
  - Improves quality of life

- **Guided Care**
  - Nurse coordinates 8 services for at risk patients
  - Reduces home care costs

- **Geriatric Evaluation & Management (GEM)**
Models of Quality Improvement

- **Better Outcomes for Older adults through Safe Transitions (BOOST)**
- INTERACT II
- Hospital at Home
- Palliative care/hospice
- Program of All-inclusive Care of Elderly (PACE)

- Reduces Hospital Admits
- Reduces costs
- Better Handoff
INTEGRATED GERIATRIC SYSTEM

Geriatric Evaluation & Management

ACE Units/HELP

Chronic Care
  INTERACT II

Community-Based Primary Care
  (PACE, GRACE)

Palliative Care/
Hospice

Home Care
(Hospital At Home)
Care Transition Record
(24 hours)

- Reconciled medication list received by discharged patient
- Transition record with specified elements received by discharged patients
- Timely transmission of transition record
- Transition record with specified elements received by discharged patients (ED)

--AMA-PCPI Care Transitions Work Group, 2009
Specified Elements

- Reason for admission
- Major procedures/tests/summary
- Principal diagnosis at discharge
- Current medication list
- Studies pending at discharge
- Patient instructions
- Advance directives or surrogate documented
- 24 hour/7 day contact info
- Plan for f/u care
- PCP or other site

AMA-PCPI 2009