Senior Care Coordination:
Geriatric Nursing in an HMO Primary Care Clinic

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Objectives

- List 3 Key Elements used by a Senior Care Coordinator (SCC) to safely transition patients from hospital or SNF to home to decrease the likelihood of readmission
- Identify 2 assessment tools used by SCC when a patient is referred for memory issues
- Give 3 examples of interventions in a plan of care for a member identified with dementia
- Describe 2 tools that SCC use to identify frailty in order to enter diagnosis on the problem list

Senior Care Coordination at Kaiser Permanente Colorado (KPCO)

Service Statement

We are specialized registered nurses with expertise in geriatric assessment and care to meet the needs of frail seniors with complex medical and psychosocial concerns. Our goal is to foster and promote independence while maintaining a safe environment. Our service embraces patients, families, caregivers, and other health care providers within the community and Kaiser Permanente.
The Senior Care Coordination Team

Kaiser Permanente Colorado

- Colorado Kaiser Permanente serves a Medicare population of more than 50,000
- 29,000 members over 75 years old
- 23 primary care medical offices
- Supported by 14 Senior Care Coordinators
- SCC physically located in primary care clinics

Who we are

- Registered Nurses with geriatric expertise
- Support primary care physicians in the care of their older patients
- Promote advocacy and support the high risk older member
- Unique role evolved over past 14 yrs
How we got here
The Evolution of Senior Care Coordination

- Began 1997 pilot under Ingrid Venohr, PhD RN Director of Senior Programs
- Response to HSQ (health status questionnaire)
- Vision of nurses with geriatric expertise as care coordinators assessing the needs of the elderly

Our Focus:
Three “buckets” that define Senior Care Coordination

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<td>Primary care collaboration</td>
<td>Reducing risk of falls</td>
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<td>Reducing readmissions</td>
<td>Support caregivers and family</td>
<td>Patient education</td>
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A Comprehensive Care Team
Partnering for improved care

- Supports PCMH by being an active member of patient care team
- Collaborate with primary care physician (PCP)
- Support family and caregivers
- Support the older patient
- Reduce hospitalizations and rehospitalizations
- Address quality of life
What we do:

- Telephone assessments
- In person comprehensive geriatric assessments
- Collaborate with PCP for diagnosis of dementia and frailty
- Assist with plan of care
- Coordinate with home care and community resources
- Facilitate referrals to palliative care and hospice

Communicating with Providers

Benefits of a Shared Electronic Medical Record (EMR)

- Entire Care team (hospitalist, lab, primary care, SCC) share same EMR; all users can access:
  - Labs, meds, progress notes, hospitalizations, rehab, “real time”, notification of hospital discharges
  - Referrals
  - Hospital notes

Transitions of Care: Managing Change
Transitions of Care

Focus:
• Transition from Hospital to Home
• Transition from Skilled Nursing Facility (SNF) to Home

Goals:
• Reduce hospital readmissions
• Actively engage member (patient centered care)

Building a Process around Transition Care

Key Elements

• Receive immediate notification of hospital discharge
• Complete medication reconciliation
• Schedule hospital follow up appt with PCP
• Ensure home care/DME in place
• Answer patient/caregiver questions
• Conduit in care team
• Patient advocate in a complex system

Successful Outcomes

• Collaboration across care settings
• Reduced Hospital readmission rate
• Medication reconciliation
• Satisfied members
The Future

- Further partnerships with area hospitals
- NP home visits to patients at higher risk
- Collaboration with Specialty Departments

Dementia Care: Caring for the Cognitively Impaired

Dementia

- An increasingly large and vulnerable population
- Up to 20% of people 65 years and older have a diagnosis of dementia
- 22% of people 65 years and older have mild cognitive impairment (MCI) and 18% of those patients convert to dementia every year
- Dementia is the 6th leading cause of death in the United States in 2007
- In 2010, Colorado had the 2nd largest increase of Dementia in the nation

References:
Facing the Challenge
Behavioral and Psychological Symptoms of Dementia

- Patients with dementia often experience at least one of the following:
  - Hallucinations
  - Depression
  - Delusions
  - Anxiety
  - Agitation
  - Aggression
  - Depression
  - Anxiety
  - Aggression

Evolution of Dementia Care
Building processes to improve patient support

Evolution:
- Training/Education (weekly):
  - Geriatricians
  - Case reviews
  - Alzheimer’s Association
  - Care Management Institute
  - MMSE and Clock drawing, GDS
  - Dementia vs delirium vs depression
  - Comprehensive Geriatric Assessment

Expansion:
- Gaining expertise:
  - Neuro-psychiatrist
  - Types of dementia and diagnostic process
  - Behavior education and treatments
  - Additional screenings: Trails B, animal naming, alternating triangles and squares, reverse arrow, 7 min screen
  - Telephone and “in person” assessment

Today, Comprehensive Dementia Processes:
- Geriatrician education
- Expand knowledge
- Comprehensive Geriatric Assessment
- More Tools: SLUMS, PHQ-9
- Memory clinic
- Virtual Geriatric consults

Connecting to Our Patients
What we do

- Ongoing Support
- Member Centered Care Plan
- Comprehensive Geriatric Assessment
- Primary Care
- Partnership
- Comprehensive Plan
The Comprehensive Geriatric Assessment

- Chart review
- Social history and support
- Functional status
- Medical history and medication review
- Nutritional/weight status
- Depression/mood status
- Cognitive/memory assessment
- Advanced directives
- Assessment tools
- Member Centered Care Plan

Other Assessment Tools

- Activities of daily living (ADL’s)
- Instrumental activities of daily living (IADL’s)
- Functional Activities Questionnaire (FAQ)
- Geriatric Depression Screen (GDS)
- PHQ-9 Depression Screen

Cognitive Assessment

- SLUMS (Saint Louis University Mental Status) Examination
- Cognitive/memory issues and history:
  - short term memory issues
  - difficulty with orientation
  - impaired visuospatial
  - difficulty with language skills
  - difficulty with word finding
  - repeating self
  - caregiver reporting personality changes, hallucinations, delusional thoughts, paranoid ideations, behavioral changes
The Member Centered Care Plan

Outcomes

- Empowerment of Members/Caregivers living with dementia
  - Decrease caregiver stress
  - Improved quality of life
- Creation of coordinated care team around the dementia patient
- Provider, Member, Caregiver satisfaction

Making Strides
Continuing to make a difference in the lives of dementia patients

- Case conference at ED discharge
- Memory Clinic
- Collaborate with Alzheimer’s Association to offer classes
- Advocate the use of MiniCog in Primary Care
- Quantify the outcomes
Frailty: Balancing Care and Compassion

What is Frailty?

“Weakness, fragility, lack of balance or endurance, sarcopenia, immobility, wasting”

-Tabers Medical dictionary, 21st edition

What is Frailty?

“Persons with a high probability of dependency on others within the next 12 months”

-Nicole Hill, Kaiser Permanente Center for Health Research, January 2002
What is Frailty?

“State of vulnerability that carries an increased risk of poor outcomes in older adults”

-Cleveland Clinic Journal of Medicine, December 2005

The Frail Population

- Most frail older adults are women*
- The incidence of frailty increases over 80 years of age*
- The number of frail older adults is increasing every year*

*source: JAMA 2006;296(18);2280.doi10.1001/jama296.18.2280

Potential Trajectory of Frailty

Causes and Outcomes of Frailty

Defining the Challenge

Frailty is difficult to define as it is not a disease, but rather, a condition reflected by the combination of the aging process and a variety of medical problems. As geriatric nurses, we may not always agree on exactly what it is, but we know frailty when we see it.

Working from a Common Ground

Characteristics of the Frail

- Weakness
- Complex medical conditions
- Less able to tolerate the stress of illness, hospitalization and immobility
- Impaired cognitive function
- Need assistance with activities of daily living (dressing, eating, toileting and mobility).
Clinical Challenges

- Malnutrition
- Social Isolation
- Fall Risk due to Impaired Balance

Risks to Frail Population

- Disability
- Hospital admission
- Chronic illness
- Increased likelihood of infection with serious complications
- Loss of independence

Facing the Challenge:
How KPCO Senior Care Coordinators work with the frail population

- Identify: All patients contacted are assessed for frailty
- Screen: Standardized screening tools used by staff
- Document: Use of diagnosis code (D797)
- Plan: Increase awareness of frailty across entire Care Team
- Care Plan: Awareness of frailty across entire Care Team
Frailty Assessment
Using the telephone to accurately identify the frail

- Three standardized questions asked during all telephone assessments and documented in the electronic medical record:
  1. In the past year, have you had weight loss of 5% or more?
  2. Are you unable to rise from a chair 5 times without using arms?
  3. Over the last week, have you not felt full of energy?
- A positive response to at least two of these questions indicates a diagnosis of frailty.

Frailty Wheel

- Developed by the Kaiser Permanente Center for Health Research in 2001*.
- Based on the validated methodology from the Health Status Questionnaire (HSQ) to identify persons with a high probability of dependency on others for daily care.
- The Frailty Wheel addresses three questions:
  1. Because of a disability or health problem, do you need or receive help from another person for taking your MEDICATIONS?
  2. Do you need or receive BATHING ASSISTANCE including sponge baths?
  3. Do any of your HEALTH CONDITIONS interfere with your daily activities?


Case Studies
The Frailty Wheel in practice

- Elizabeth---77 years old, states that she does need assistance with her medications, but does not need help with bathing. Her health conditions do not interfere with her daily activities. Elizabeth is not frail.
- George---80 years old, states that he does need medication assistance and requires standby assistance with bathing. His health conditions interfere with his daily activities. George is frail.
Preventing the onset of frailty in older persons

Food intake maintained
Resistance exercises
Theranostics prevention
Isolation avoidance
Pain
Tai Chi or other balance exercises
Early check for testosterone deficiency


The focus of a gerontological nurse is to promote advocacy and support for the high risk elder member in an integrated primary care model.

1. Care transition after hospital or skilled nursing home discharge to home
2. Dementia identification and management
3. Frailty/falls with proactive assessment and intervention

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Questions