

# Senior Health and Wellness Clinic Model

As a central element of the Senior Health and Wellness Clinic model, the interdisciplinary team meets weekly to discuss high-risk, complex patients. At PeaceHealth in Eugene, OR, staff members contribute valuable information that enable the clinic's most frail and vulnerable to continue living in the community. Senior Health and Wellness Center patients had lower average Medicare charges than comparison groups—even though participants were older, more vulnerable and higher risk—driven by same or reduced utilization of outpatient, hospital, and emergency department service



Geriatric Interdisciplinary Teams in Practice Senior Health and Wellness Clinic Model Ronald D. Stock, MD, MA, Principal Investigator, PeaceHealth, Eugene, Oregon http://www.peacehealth.org/oregon/SeniorHealth/ClinicOutcomeStudy/TeamHome.htm Supported by the John A. Hartford Foundation

## Managing Care of Older Patients in the Clinic by Fostering Team Care

ONE APPROACH TO INTERDISCIPLINARY TEAM CARE for older patients with chronic illness involves providing comprehensive specialized geriatric primary care services all in one setting. The PeaceHealth Oregon Region Center for Senior Health set up such a clinic. The Senior Health and Wellness Clinic came to the attention of the Foundation through their work in the Institute for Healthcare Improvement (IHI) Breakthrough Collaborative on Improving Care for People with Chronic Conditions. Their work was subsequently presented at an IHI Congress conference in October 1998. The Foundation was impressed with the Senior Health Wellness Clinic model and in 2000 awarded PeaceHealth a 63-month grant of \$1,407,390 to measure the impact of their interdisciplinary team care approach. The project is led by Ronald D. Stock, Executive Medical Director, the Gerontology Institute, PeaceHealth Oregon Region, Center for Senior Health, Eugene, Oregon.



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23- Stock RD, Reece D, Cesario L. Developing a comprehensive interdisciplinary senior healthcare practice. J Am Ger Soc. 2004;52:2128-2133.

"An interdisciplinary, interdependent team provides the best health outcomes, especially for older patients with complex care needs," says Dr. Stock. However, simply placing a group of health professionals from different disciplines in the same room does not mean that they will function well as a team. Most medical professionals are not trained in team skills. Formalized training and ongoing support of team behaviors is required, as demonstrated by the work of the Hartford Foundation's Geriatric Interdisciplinary Team Training (GITT) initiative.

Because interdisciplinary team care is not routinely practiced, the team care model developed at PeaceHealth focuses on team development. The model was designed to be most applicable for large, multispecialty group practices. It was developed and tested at the PeaceHealth Senior Health and Wellness Center (SHWC).<sup>23</sup> The SHWC is an outpatient fee-for-service clinic affiliated with Sacred Heart Medical Center, PeaceHealth in Eugene, Oregon. The SHWC is staffed by geriatricians, nurse practitioners, a social worker, a dietician, a pharmacist, and other health professionals.

The methods created by the SHWC project team improve health outcomes by fostering productive interactions between a prepared, proactive health care team and informed, activated patients and/or caregivers. To ensure the ongoing benefits of team care, the SHWC developed a tool to continuously measure team development.

#### Senior Health and Wellness Center: Total Care Under One Roof

The SHWC interdisciplinary team is defined more broadly than many health care teams. It includes physicians, nurse practitioners, a social worker, nurses, receptionists, a pharmacist, and a dietician. Ad hoc members include a chaplain, physical therapists, a home health nurse, a behavioral health professional, and a patient information librarian.

Each patient's health status is assessed at the first visit using standardized tools that measure mental status, risk for falls, depression, nutrition, and other health conditions. Medical practice guidelines for chronic pain, falls, diabetes, urinary incontinence, dementia, and osteoarthritis are used.

An electronic medical record houses all of a patient's medical records (from hospitalizations and visits to the clinic) on the same platform. Extension of the electronic medical record into nursing homes and home health/hospice has allowed for improved communication of vital information across care settings. Reports identify patients who go to the emergency room, hospital, or outpatient surgery.

A central element of the SHWC team care approach is hour-long weekly care conferences. The interdisciplinary team, which includes every staff person in the clinic, meets to discuss high-risk, complex patients. "Everybody has their own perspective," says Kathleen Chinn, Nurse Practitioner, Senior Health and Wellness Center, PeaceHealth Medical Group. "The people in the front office know the patients differently than the nurses and the nurses know the patients differently than the physicians. Everyone brings something valuable to the table."

#### Team Care Approach at SHWC

An elderly patient made recurring visits to the emergency room at Sacred Heart Medical Center with minor complaints or questions about his medications. The SHWC was notified through the electronic medical record and the patient was asked to come to the clinic for an appointment with the lead physician, Jeffrey Larkin, MD, to reconcile his medications. Every time the patient came in he either had different medications or forgot to bring his medications. It was apparent to Dr. Larkin that the patient was having memory problems, and tests confirmed the diagnosis of Alzheimer's disease. Dr. Larkin asked the patient's wife to accompany him to the next appointment and then asked her to help manage his medications. "I wanted to make sure I knew what the patient was taking before starting him on medications for Alzheimer's," said Dr. Larkin. "An interdisciplinary, interdependent team provides the best health outcomes, especially for older patients with complex care needs."

Ronald D. Stock, MD, MA Principal Investigator, Senior Health and Wellness Clinic



PeaceHealth team with Christa St. George, patient and volunteer. (Left to right) Alison Gregory, RMA, Sandy Sanders, LCSW, Danny Stobaugh, PT, Jeff Larkin, MD, Kari Cox, RD, Ericka Carter, Receptionist, Brad Johnson, RPh, CGP, (Center) Christa St. George

The medications continued to be taken incorrectly. The patient's wife was a patient at the clinic, but she was not Dr. Larkin's patient. Dr. Larkin decided to discuss this case at the weekly care conference. In consultation with the team, which included the wife's physician, it became evident that the patient's wife was also exhibiting memory problems. Because of the care conference, the wife was brought in for testing and was diagnosed with dementia. The social worker was able to work with family members to arrange for proper care of the couple. The pharmacist got involved with a medication review to ensure the patient was on the proper regimen for his multiple health conditions and that it was being followed. "With a team approach, we were able to come up with a solution for this patient that I wasn't able to achieve alone," said Dr. Larkin. "This is a common scenario," he said.

#### Measuring the Success of Senior Health and Wellness Clinic

The SHWC model improves quality of care and reduces the number of medications that older patients take. Supported by the Foundation's grant, Dr. Stock and his colleagues conducted a study in which patients of the SHWC were compared to patients receiving care from primary care providers supported by a care manager and patients cared for in practices without a care manager. And the practice grew with implementation of the model.

#### SENIOR HEALTH AND WELLNESS CLINIC MODEL 5



#### PATIENT CARE IS COORDINATED WITHIN THE SENIOR CLINIC



#### Senior Health and Wellness Clinic Model

The interdisciplinary team consists of every staff member who interacts with patients, including physicians, nurse practitioners, social workers, nurses, receptionists, pharmacists, dieticians, physical therapists, home health nurses, chaplains, and librarians. The entire team meets for hour-long weekly care conferences to discuss high-risk, complex patients.

For all patients seen in the SHWC, health status is assessed using standardized tools for health data such as mental status, risk for falls, depression, nutrition, and others. Medical practice guidelines for pain, falls, diabetes, urinary incontinence, dementia, and osteoarthritis are used. An electronic medical record houses patient's medical records from hospitalizations and visits to the clinic. Weekly reports identify patients who go to the emergency room, hospital, or outpatient surgery.



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Bradley T. Johnson, RPh, CGP, CDM, FASCP Clinical Geriatric Pharmacist, PeaceHealth, Eugene, OR

24- Stock RD, Mahoney E, Reece D, Cesario L. Developing a senior healthcare practice using the chronic care model: effect on physical function and health related quality of life. J Am Ger Soc. 2008. Accepted for publication. Patients treated at the SHWC were more likely to receive vaccinations. They were prescribed fewer medications (thus lowering the risk for dangerous interactions among drugs). Rates of falls were less in the SHWC model compared to the other models, especially for older female patients. Scores on tests for depression improved with the SHWC model, whereas scores worsened in the comparison groups. Physical function declined for more than 80 percent of participants in all the groups given aging over two years. However, the health-related quality of life (HRQL) remained unchanged for those in the SHWC model, while the participants in the other groups experienced a decline in HRQL that paralleled the decline in physical function.<sup>24</sup>

Of note, average Medicare charges per participant were less in the SHWC group than the other two groups for all services. Despite evidence that the patients treated at the SHWC were older, more vulnerable, and at higher health risk than patients in the comparison groups, utilization of outpatient, hospital, and emergency department services were the same or less. Also, while caring for this population, the practice grew, adding staff and patients.

#### **Customizing Team Care to Work Locally**

A team approach to geriatric care must be adapted to the needs and culture at each institution. Dr. Stock and his colleagues invite those who are interested in the SHWC model, or aspects of the model, to a site visit. They provide detailed written materials and often visit the site where the model will be implemented to discuss how it can be efficiently incorporated within the existing structure and to provide technical assistance for implementation. This one-on-one assistance can be particularly helpful for convincing sometimes reluctant administrators of the benefits, both clinical and financial, of the model.

Rosemary Laird, MD, Health First Aging Institute, Cocoa Beach, Florida, found this individualized assistance particularly useful. She had to surmount some common hurdles. Dr. Laird is a geriatrician in a small, community-based, not-for-profit health system, and several years ago she was looking for ideas to improve care for her patients. She met Dr. Stock at a meeting of the American Geriatrics Society and became aware of his work on team care in a geriatric clinic. With advice and counsel from Dr. Stock, she began to implement some of the concepts of the SHWC model in her clinic, and was pleased with the results. When a new administrator was hired, all of these concepts were scrapped. Undaunted, Dr. Laird began calculating the lost revenue resulting from having shut down the SHWC initiatives. A year later, armed with the data she had collected and an article Dr. Stock and his colleagues had published in the *Journal of the American Geriatrics Society*, Dr. Laird convinced the leadership at the Health First Aging Institute to engage in a formal relationship with the group at PeaceHealth and to reinstate aspects of the model. For example, they broadened their pool of providers, increased revenue-generating clinical services (such as adding a foot care clinic), and have regular team meetings in one of their two clinics.

"Administrators assume that you can't take care of older people cost effectively," said Dr. Laird. "The group at PeaceHealth were really effective in helping me to communicate with administrators and convince them that it is possible." Individualized assistance from Lorelei Cesario, Director of Senior Business Development, The Gerontology Institute, PeaceHealth Oregon Region, on the financial aspects of the model was instrumental in persuading administrators that it made good business sense.

"If you can't convince an administrator and make the business case, everything just stops," says Dr. Laird.

The PeaceHealth SHWC model has found converts in a variety of health care systems. For example, when Karol Attaway, Vice President of Operations, Healthcare Partners Medical Group, in Southern California, was designing a home care program for older patients with chronic illness who were not able to travel to the clinic, she looked for models of interdisciplinary team approaches. A site visit to the PeaceHealth SHWC provided valuable insights on managing chronically ill patients. Ms. Attaway was especially impressed with the care collaboration meetings that include everyone in the clinic, including the front office staff, and she has incorporated this into the home care program. She was also interested in the written materials the SHWC had created for patients, which include photographs and bios of the physician. "We're going out to patients' homes, so we thought it was a great idea to mail these materials, with the physician's photograph, ahead of the visit," says Ms. Attaway.

Interest in the SHWC model is generated from a variety of sources, including professional networks and visibility at relevant meetings. Dr. Stock and the group at PeaceHealth have been invited to give 25 presentations over the past five years to approximately 1,000 clinicians in venues such as the American Geriatrics Society, National Patient Safety Forum, Institute for Healthcare Improvement, American Medical Association, National Council on Aging-American Society on Aging, Gerontological Society of America, Agency for Healthcare











Senior Health and Wellness Clinic team members meet with patient Christa St. George. Patients treated at the SWHC were more likely to receive vaccinations, were prescribed fewer medications, and were less likely to fall.

### From Clinic Volunteer to Clinic Patient, But Always a Member of the Team

Every new patient treated at the Senior Health and Wellness Clinic (SHWC) begins with an orientation given by volunteer Christa St. George. Christa explains the team concept to patients, informs them about the different types of health providers available at the clinic and what each one does, and gives them a tour of the facility. "I tell them what we have, what we can do for them, and what we expect from them," says Christa.

The patients are attentive and extremely grateful for the information. "People tell me this has never happened anywhere else they've been to for health care," says Christa, who has a friendly, welcoming personality and thoroughly enjoys her work.



(Above) Christa St.George provides a tour of the clinic to Darold Alexander. Having successfully recovered from spinal surgery, Ms. George tells every new patient on orientation what team care did for her, and what it can do for them.

(Right) St. George with Senior Health and Wellness Clinic physician, Jeffrey K. Larkin, MD. When Christa, who is 75, began to feel some tingling in her fingertips, she shrugged it off and continued giving patient orientations. But the morning she wasn't able to button her blouse, she decided to consult with the clinic's lead physician, Dr. Jeffrey Larkin. Dr. Larkin discovered numbness in both hands and some neck pain. An MRI of the neck showed a cancerous tumor in Christa's upper spinal column.

"Two days later, I was in surgery for seven hours, followed by four days in the intensive care unit and more than a month in an inpatient rehabilitation facility," says Christa. With the help and support of different members of the interdisciplinary team, of which Christa, now as a patient, is a vital member, she has gotten through her ordeal, although she remains impaired.

Dr. Larkin credits, in part, the longer appointment times given to clinic patients for his ability to quickly get Christa the treatment she needed. "Spending more time with patients leads to more accurate diagnoses," he says. "Christa's case could easily have been written off as carpal tunnel syndrome, but I had the time to spend with her and get it right."

Even though Christa continues to have difficulty with walking and with hand coordination she has come back to the clinic as a volunteer to give patient orientations, now with a new perspective on the resources of the clinic to share with incoming patients.



Research and Quality, National Institute for Case Management Clinical Case Management Conference, and Society for Social Work Leadership in Health Care. PeaceHealth has consulted with or hosted site visits for 35 health care organizations from the United States and Canada.

In addition to written materials that aid in the implementation of the SHWC team care concepts, the SHWC team also developed an assessment tool called the Team Development Measure (TDM). The TDM (available on the SHWC Web site www.teammeasure.org) measures the degree to which a team has in place the components needed for highly effective teamwork and how firmly these components are in place.

"This survey tool can be used as a measure of quality and it can also be used to provide feedback in order to improve 'teamness,' so it can be a quality improvement measure," says Dr. Stock.

Dr. Stock and the group at the SHWC also developed the "Team Bundle." This is a description of the four components that must be in place for successful implementation of the model. These are:

- Healthcare leadership must make a commitment to the team care approach.
- Team development measures should be used to provide feedback to the team about "teamness" and areas for improvement.
- There needs to be a focus on training clinic staff to communicate better amongst themselves.
- All teams need to practice team skills, which is one of the roles of the weekly patient care conference.

To encourage even wider dissemination of the model, SHWC is developing a business model based on demonstrating that the SHWC team care model provides higher quality cost efficient care, and that it can realistically be implemented in a community health system outside of an academic setting. The successful implementation of this model has allowed the group at PeaceHealth to leverage the Hartford Foundation support and receive additional funding from several sources. These include the following:

- Robert Wood Johnson Foundation
- Agency for Healthcare Research and Quality
- Sacred Heart Medical Center Foundation
- Collins Foundation
- Northwest Health Foundation
- Spirit Mountain Community Fund
- Lane County United Way 100% Access Coalition

## "Working as a team is the only way to take care of a geriatric population."

Kathleen Chinn, FNP Senior Health and Wellness Center PeaceHealth Medical Group