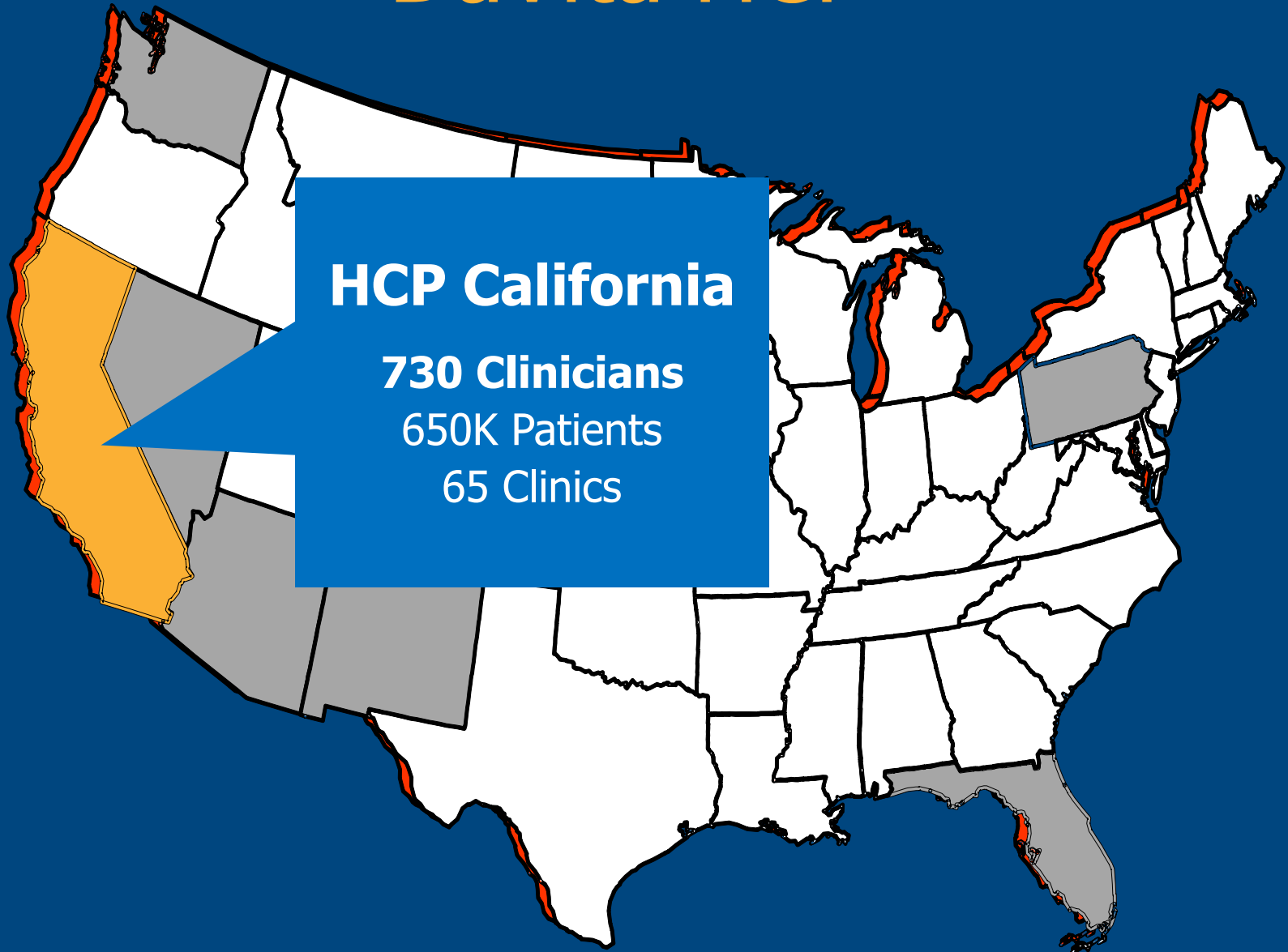


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# DaVita HCP





# Care-coordination: Key Components

- Team approach
- Care management
- Hospital/Skilled Nursing Facility programs
- Transition of Care activities
- Comprehensive Care Programs



# Case

85 year old female, Ms. M, with Alzheimer's dementia, diabetes and congestive heart failure who fell at home and had a hip fracture. She is transferred to the local hospital.

She lives with her daughter and has a caregiver during the day.

# HCP Model: Hospital Care

- HCP-Hospital partnerships
- Team-based approach
- Daily Rounds
  - Often HCP-employed hospitalists
  - Contracted specialists
  - HCP-employed care managers and social workers
- Palliative Medicine (supportive care specialist)

Ms. M is evaluated by an HCP hospitalist in the ER and optimized for surgery. She has surgery to repair her hip within 24 hours.

After the surgery, she is noted to be more confused.

A HCP Palliative Medicine physician and care manager are able to speak with the daughter.

--Prior level of function: Ms. M was walking short distances in the home and had been falling more.

--Her memory was getting worse. Goals of care were discussed and POLST completed. A trial of rehab therapy is desired.

# HCP Model: Post-Acute Care

- Designated HCP Post-Acute Program
- Team
  - Employed MDs and NPs/Independent contractors
    - ▶ Frequent visits
  - On-site HCP care managers
  - SNF team: Rehab director, social services, care manager
- Partnership with SNFs
  - Bed leases
  - Regular meetings to review re-admits, outcomes
- Interdisciplinary Team (IDT) meetings



# Post-Acute Care

- Ms. M is transferred to a nearby skilled nursing facility (SNF) for rehab.
- With appropriate pain management, Ms. M is able to walk 25 ft with her walker with assistance.
- At the interdisciplinary team meeting, rehab therapist recommends that the daughter receive hands-on training
- HCP care manager meets with the daughter who also recognizes the need for more caregiver hours upon discharge



# Transfer of Care Outcomes

## National Data

- After discharge 19%-23% of patients will experience an adverse event
- 1/3 preventable—due to an error
- 1/3 ameliorable—closer monitoring could have reduced severity
- 50% of medication errors occur at transitions

*Forster AJ, et al. CMAJ. 2004;170:345-349.*

*Forster AJ, et al. Ann Intern Med. 2003;138:161-167.*

# Transitions of Care

- Patient discharge instructions
  - Medication reconciliation
  - Electronic Health Records
- PCP and specialist follow-up appointments
- HCP care managers conduct post-discharge phone calls
- “Virtual” pharmacist-conducted medication review at patient’s home



# Comprehensive Care Programs



# Comprehensive Care Programs

An extra layer of support to the patient's PCP, by prioritizing the patient's needs.

1. Comprehensive Care Centers
  - Manage complex medical conditions in clinic setting with multidisciplinary team to prevent recurrent ER/hospital visits
2. End-Stage Renal Disease (ESRD)
  - Primary care to ESRD patients at Dialysis Centers
3. House Calls
  - Care specifically delivered for functionally home bound patients (difficulty accessing care due to physical or psycho-social issues)
4. Palliative Medicine consults
  - Advance symptom management communication with patients and families to weigh the burdens and benefits of treatment and determine goals of care.



# Comprehensive Care Programs: Common Patient Traits

- “Frail” Seniors
- High risk commercial, ACO, Dual Eligible patients
- Multiple Acute or Post-Acute admissions (> 2/yr)
- High risk for readmission
- Multiple ED or UCC visits
- End of life non-hospice care
- Complex psycho-social situations

- Ms. M transitions home successfully:
  - She has her front-wheeled walker
  - Home Health PT is scheduled
  - Pharmacy services:
    - ▶ New meds, including her pain meds, were delivered to her home.
    - ▶ Medication nurse with “Virtual” pharmacist counsels daughter on her meds within 24-48 hours

- Ms. M transitions home successfully:
  - HCP SNF care manager makes a post-discharge phone call within 24-hours
  - House Calls NP does a post-discharge home visit within 72 hours

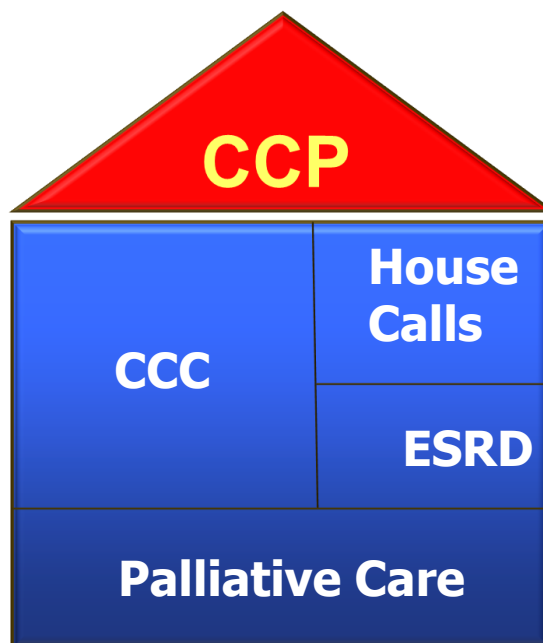
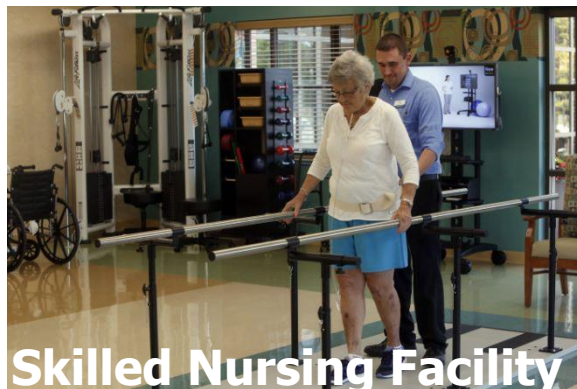
# Case

- Unfortunately, Ms. M stood up by herself while her caregiver was in the bathroom. She injured her R wrist. Of course, this occurred in the early evening hours.
- Ms. M's daughter was able to reach the on-call house calls NP. The NP was able to gather information and triage the patient to HCP's 24-hour urgent care center. Ms. M was found to have a mild R wrist sprain.





# Continuum of Care





# Care-coordination: Key Components

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