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# A Prescription for Innovative Healthcare Delivery in the Senior Living setting:

## Case Study: The Chelsea at Brookfield

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Dr. John Hopkins

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Background - John Hopkins, DO

- Board Certified Emergency Physician
- Fellow American Academy of Emergency Medicine
- Work Experience - 2 Countries - 5 States
- Co-Founder CCS Healthcare - 2015
    - Independent Adult & Geriatric Medical Practice

**CCS Healthcare**

Overview:

- 1 - The Problem
- 2 - Narrative
- 3 - Case Study - The Chelsea at Brookfield
- 4 - Q&A session -
    - Pat Banta - Regional Director of Health Services, The Chelsea Senior Living

The Problem:

- Facilities outside of the hospital environment are pressured to increase their health care delivery capacity due to external forces:
    - Mainly driven by value based initiatives

Facilities at all levels are being held accountable for outcomes regardless of their capabilities:

- **SNF**
  - **LTAC**
  - Subacute
- Assisted Living, etc.

Reimbursement inconsistencies based on level of care and LOS make it very difficult to design a program that can be uniformly applied to all settings

To complicate matters:

- The Medical Community has a poor understanding of the varying levels of care
- Physicians, in particular, group patient's living in all senior living settings as "Nursing Home" patients.
- Additionally pressures placed on hospital based physiciahave created a "pass the buck" mentality (get em in, get em out).

To **further** complicate matters we are dealing with:

- An Older more Co-Morbid population
- Lack of staff experience/education
- Lack of external physician support

**The end result= a fragmented healthcare ecosystem created by varying financial pressures**

For the Scope of our discussion:

The Fragmented Healthcare System -

- Ultimately place patient lives at risk
- Pose significant challenges for Senior Living Communities trying to navigate within it.

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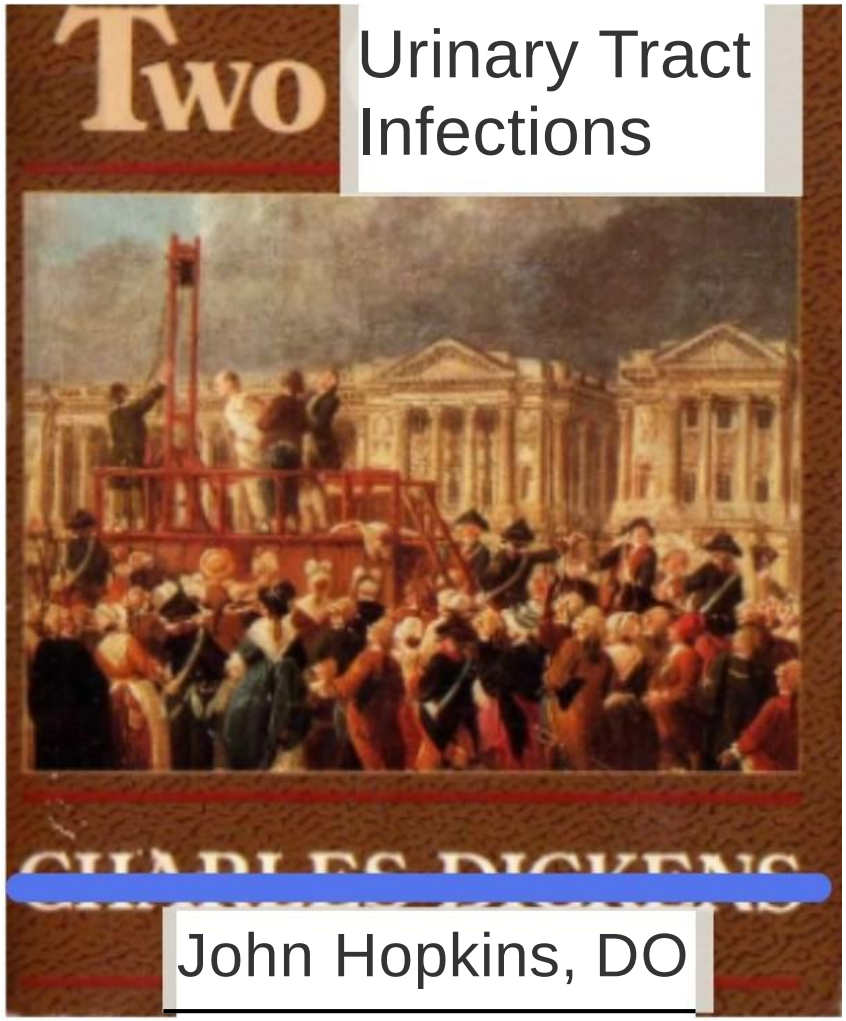


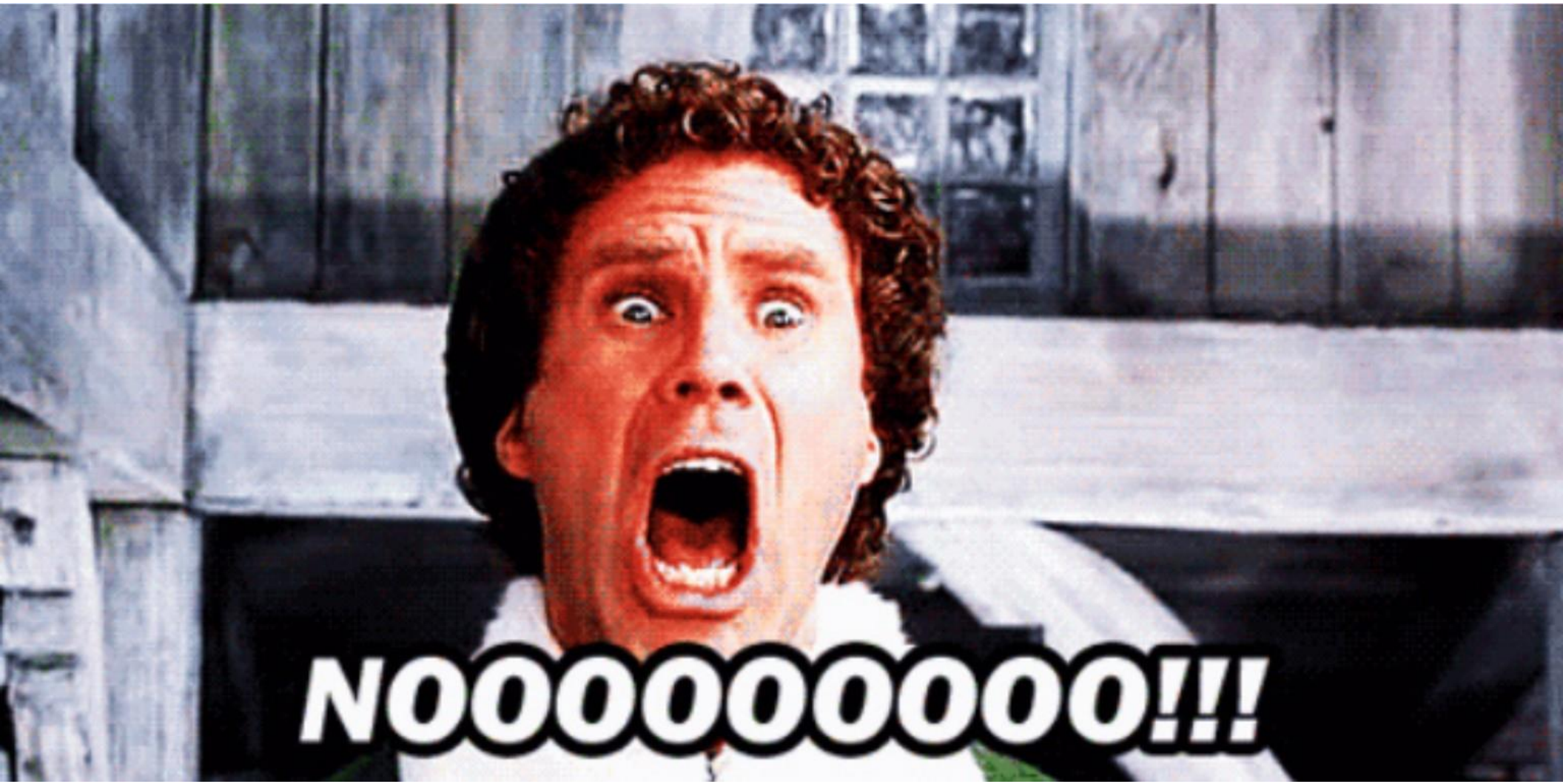
# Chapter I
# The Anatomy of an ER Visit

The Saga begins....

- **An 86 y/o pleasantly demented female seems weaker than normal.**
- **Staff appreciates she is not eating as much as normal and seems more somnolent.**
- **Staff calls her primary care physician who is unable to come see her for at least 72 hours. States if she worsens they should send her to the Emergency Department.**

- 24 hours later she begins to spike a fever and is no longer eating and drinking.
- Staff decides this is unlike her and she is in need of acute medical evaluation and treatment

Transport is called and the patient is sent to the ER.... E


NOOOOOOOOO!!!

- The Emergency Department receives an 86 y/o female unknown to them with impaired cognition, fever, and decreased PO intake.
- She presents Confused and Alone.
    - Family lives 2 hours away and is unable to get to the Emergency Department

# What Happens Next?

The facility did call the ER when the patient was being transferred however they did not talk to the Physician on shift at the time of arrival.

Currently all he has is the paper work received from the facility.

- He attempts to call the family and gets no answer.
- He calls the facility to get further information on the patient because she is demented
- The nurse who sent her out is now off shift and will not be back until the following morning.
- The nurse on the phone does not know any further details

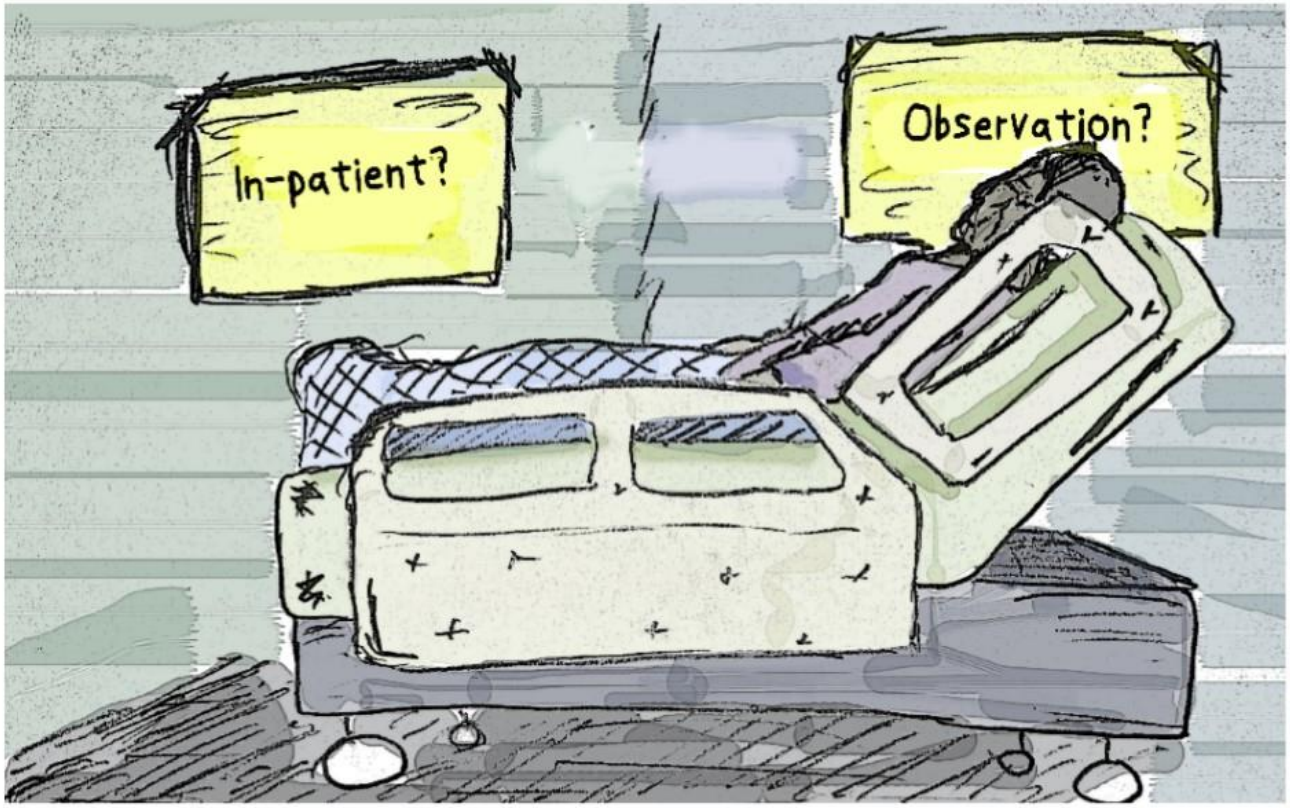
**Her labs come back and show the following:**

- **Mild dehydration**
- **A mildly elevated White Blood Cell Count**
- **Negative head CT**
- **Negative CXR**
- **A urinalysis that is positive for a urinary tract infection.**

To Admit or Not to Admit - That is the Question?

- **The physician is on the fence about admitting the patient – he does not think she meets “admission” criteria.**

- **And he lacks the time and resources to find out**



He is able to reach the family

They decide since since she may only be an observation they want her mother to go back to the facility.
She is improving and they don’t want her to be stuck with a large hospital bill.

**The Doc feels this is reasonable.**
**She is on the mend - with antibiotics, fever control, and oral hydration she should do well.**

***After all she lives in a Nursing Home!***

*It is now 7:30 pm...*

*The Emergency Department clerk calls for transport back to the facility – Eta is two hours*

*Physician A leaves for the evening and signs out to Physician B who is coming on for night shift.*

*He discussed our patient - she is stable and just awaiting transport back to the facility….*

# NTD

***Our patient has a hx of sun-downing especially if she misses her evening medications and is outside of her normal environment.***

***Shortly after Physician A leaves for the evening, the nurse approaches Physician B to ask for something for sedation.***

***He does a quick "fly by" because he has a line up of 10 patients to see and orders 1 milligram of Ativan to calm the patient down.***

***It is somewhat helpful***

*The nurse returns*

*"The patient keeps trying to get out of bed can we give her some more to make sure she stays in bed and doesn't fall – It's late anyway and it will help her sleep through the transport."*

*The physician writes for another milligram of Ativan with the thought process she is going back to a supervised environment…*

*It is now 10 pm.*

***11 pm – Transport arrives with the patient back at the Facility.***

- ***The patient is taken to her room.***
- ***Report is given to the MA and she is placed in her bed.***

- Day shift arrives around 8 am, and is given report.
- The overnight MA was given report from the transportation company and doesn't have much to offer.
- All the nurses have to work off in the am is essentially the discharge paperwork from the ED.

- The nurse notices the patient was not up for breakfast
- She assumes she was in the hospital very late, is fragile and most likely exhausted.
- However, she takes her vital signs and notes the patient has a fever of 101.1.
- They have nothing written for fever control and reach out to the primary care provider for a Tylenol order at 9:30 am
- While awaiting the order she tries to get the patient to drink some fluids.

- The patient seems very somnolent and is not able to get her to drink much.
- She looks at the ED med sheet and notices that she received 2 doses of Ativan in the ED and assumes this is adding to her somnolence.
- She figures once the Ativan wears off - she is more awake - and gets some Tylenol - she will be better.

Additionally, the patient is supposed to have antibiotics twice per day, once in the morning and once at night.

But...Since her script did not get sent to pharmacy until early this morning her meds will not come until next delivery in the evening

Due to this she will miss a dose of antibiotics…

12 noon.

- The patient is now awake
- Her fever is still present.
- The Primary Care Provider has not called back with the Tylenol order.
- She is drinking very little.
- She seems very sluggish.
- Says she just wants to sleep..

# To make matters worse...

The Med tech gave her normal am and pm blood pressure medications

- There were no hold parameters

4:30 pm - An aide checks on the patient and she is not rousable

The Nurse assesses her and...

- HR 130
- BP 80/palp

- 911 Called

The patient returns to the same ER from the day before

- The patient survives after a two day stay in the ICU on IV antibiotics, IV fluids, and Vasopressors.
- She remains in the hospital for 5 more days and it is recommended she goes to rehab due to deconditioning.

The patient goes to rehab, but never fully recovers.

Her mental status is now poor, she won't eat or drink much.

She does not participate in therapy.

and

3 weeks later she passes away...

This is the current system.

This is not melodrama

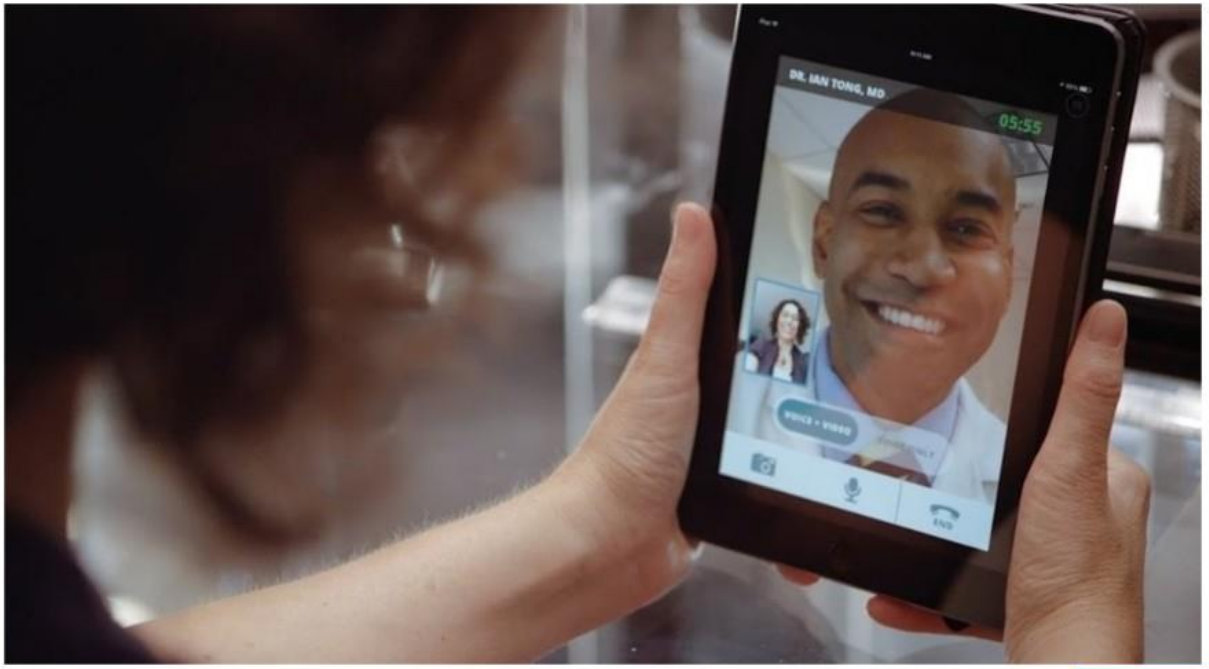
It happens every day.

***Lack of care coordination leads to poor outcomes.***

# *Chapter II*
# *An Alternative Approach*

***86 y/o pleasantly demented female seems weaker than normal.***

- ***Staff appreciates she is not eating as much and is more somnolent than usual.***
- ***Staff calls her primary care physician who is unable to come to the facility for at least 72 hours however he is part of a group that utilizes virtual visits.***



***The facility staff schedule a virtual visit with the on call physician.***

***1/2 hour later the patient and staff are communicating with the physician via an Ipad.***

***The on call physician has access to the patient's complete medical history, recent lab work, as well as current medications.***

- ***During the visit it is the staff mentions the patient is wanting to go to the bathroom more frequently and voiding in small amounts***

- ***The physician suspects a diagnosis of an urinary tract Infection***

- ***Antibiotics are initiated***

***To confirm - Labs are ordered including:***

- ***urinalysis and culture***
- ***CBC***
- ***Chem 14***

***The Physician also writes for the following orders***

1. ***4 - 8 oz cups of water per day***

2. ***AM/PM vital signs for the next 72 hours and to call the on call service to report***

3. ***Hold the patient's diuretics for two days***

4. ***Tylenol for fever control***

***After the encounter the physician calls the family and lets them know the patient's current status and the plan***

- ***The On call Physician alerts the care team of her case at daily am rounds***

- ***The care coordinator ensures the labs are collected and reported.***

*The next day..*

*24 hours later the patient spikes a fever of 101, and does seem sluggish in the am.*

*She is given her Antibiotics and Tylenol as ordered.*

*Within 2 hours she is awake and alert eating and drinking normal amounts*

***Her labs are returned from the previous day and reveal:***

- ***Slight dehydration***
- ***Slightly elevated WBC count***
- ***Urinary Tract Infection as the source***

***Within 72 hours the patient is much more awake.***

***She appears back to normal.***

***All meds are restarted and she is to continue to hydrate and finish her antibiotics.***

***The weekly on-site provider will do an in person visit to ensure full recovery.***

***This patient never left the comfort of her home remaining under the care of the people she knows.***

***She was not impacted by medication mismanagement***

***She did not suffer any transfer trauma.***

***And she saved a lot of money on her car insurance by switching to Geico***

# Is this possible?

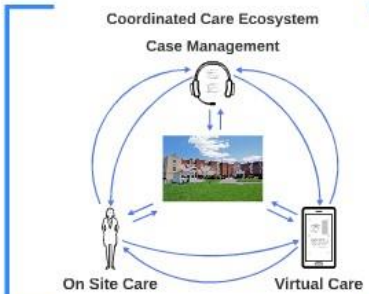
In the fall of 2016 - CCS Healthcare partnered with The Chelsea at Brookfield to implement a Coordinated Care Model.

# YES

THE CHELSEA
AT BROOKFIELD

Assisted Living
Memory Care

Coordinated Care Ecosystem




The Hybrid Model

On-site Care

Virtual Care

Case Management

- The Chelsea at Brookfield was subject to constant inconsistency from the community medical providers.
- Leading to dissatisfaction with patient care and accessibility.
- In turn this produced poor numbers related to hospitalization and readmissions
- CCS Healthcare was asked to develop a model to provide increased access to care and facilitate better coordination with patients, staff, and family

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THE CHELSEA
AT BROOKFIELD

# Assisted Living
# Memory Care

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# The Hybrid Model

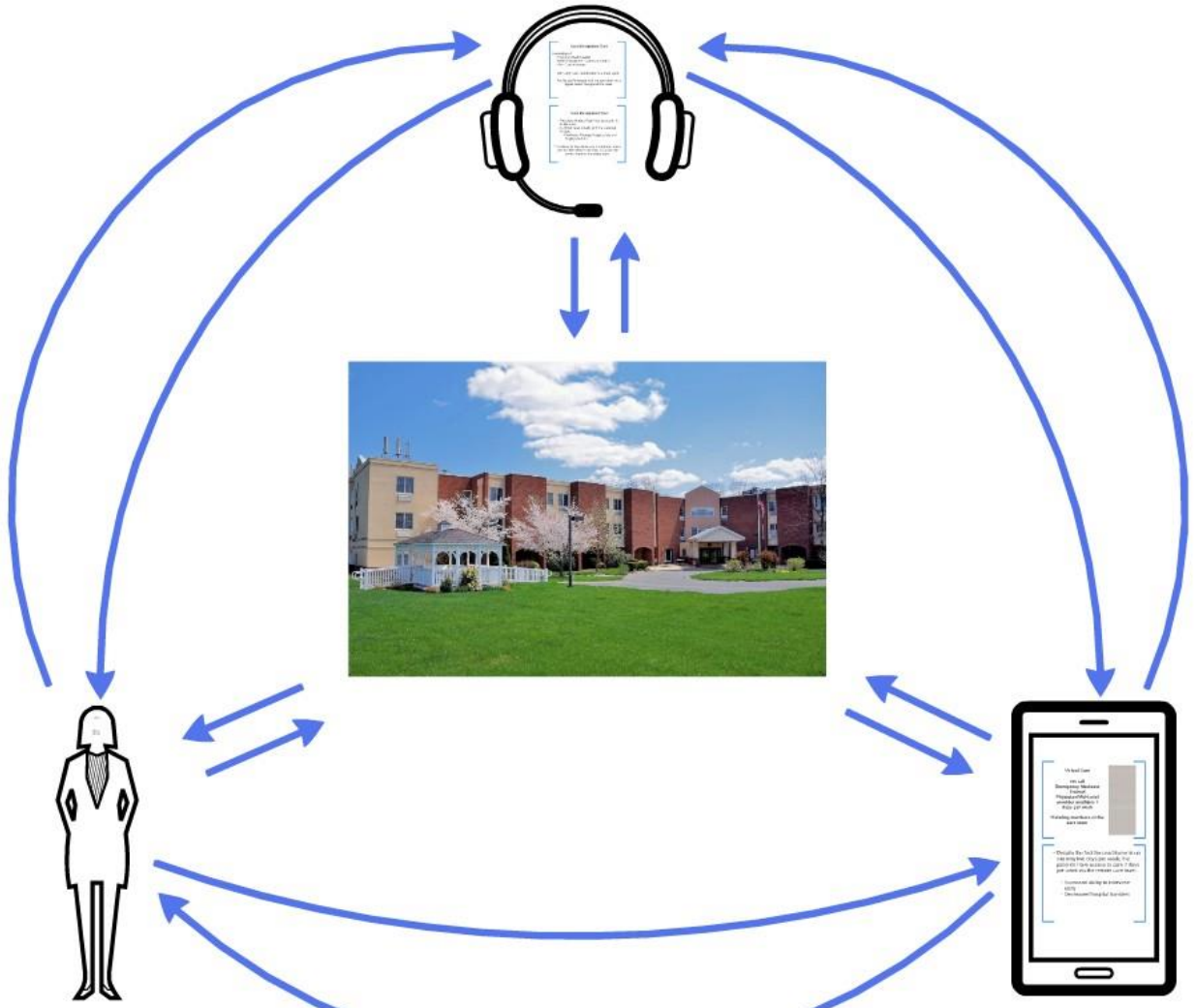
## On-site Care


## Virtual Care

## Case Management

# Coordinated Care Ecosystem

## Case Management



On Site Care

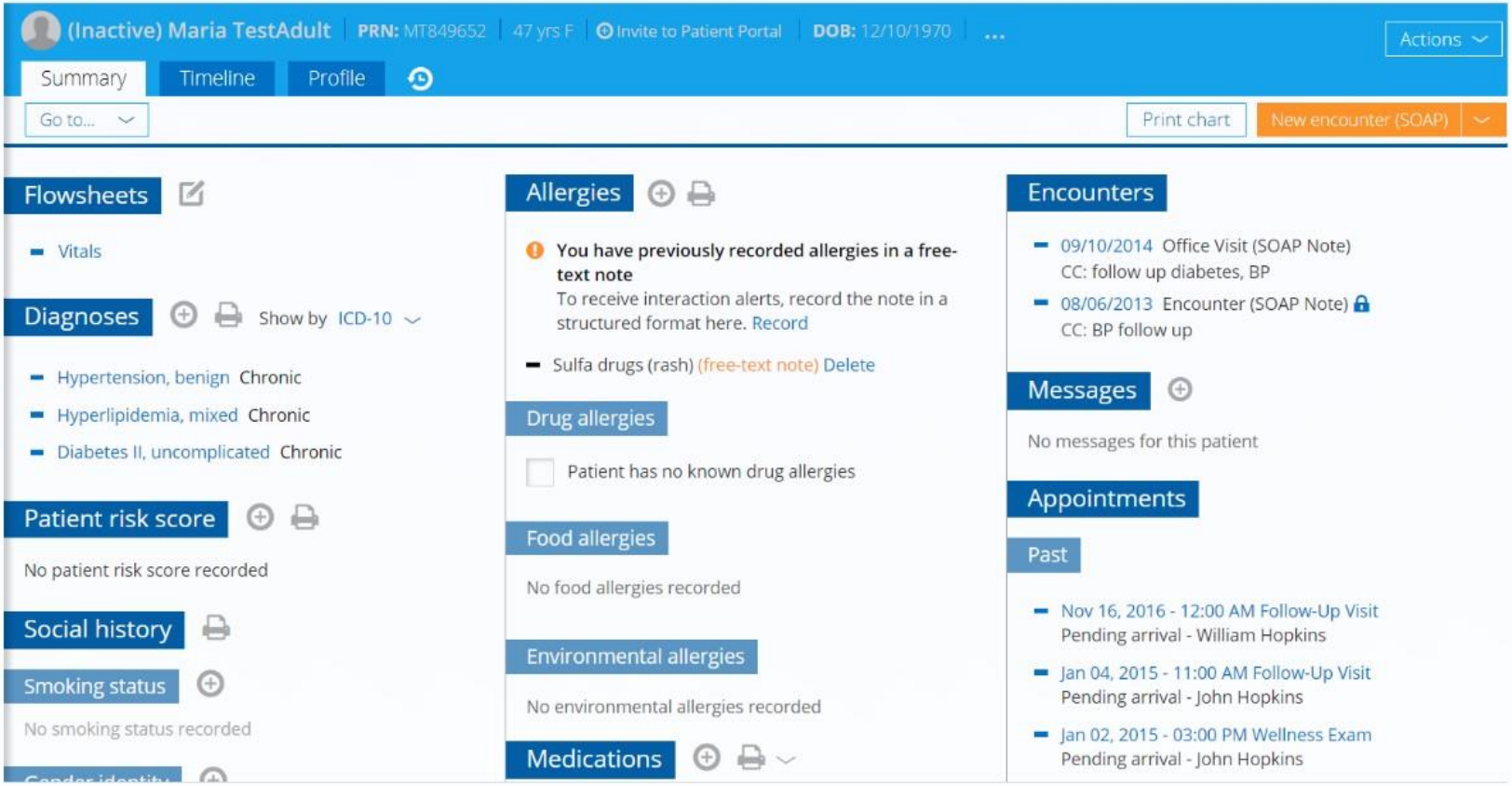
Virtual Care

# On Site Care

- CCS deployed an On site provider bi-weekly:
  - Acts as traditional Primary Care Provider
    - On site provider is a mid-level provider - Nurse Practitioner/ Physician Assistant

# On Site Care

## The patient encounters are recorded in a central cloud based EHR accessible to the group



# Case Management Team

Consisting of

- Physician Team Leader
- Nurse Practitioner - Care Coordinator
- RN - Case Manager

Ultimately care coordination is a team sport.

Facility staff interacts with the care team on a regular basis throughout the week.

# Case Management Team

- The offsite Medical Team has access to the facility EHR
- Communicates directly with the preferred Vendors
    - Pharmacy, Therapy, Hospice, lab, and imaging vendors.

This allows for load balancing throughout various communities while maintaining a sustainable environment for the onsite team.

# Virtual Care

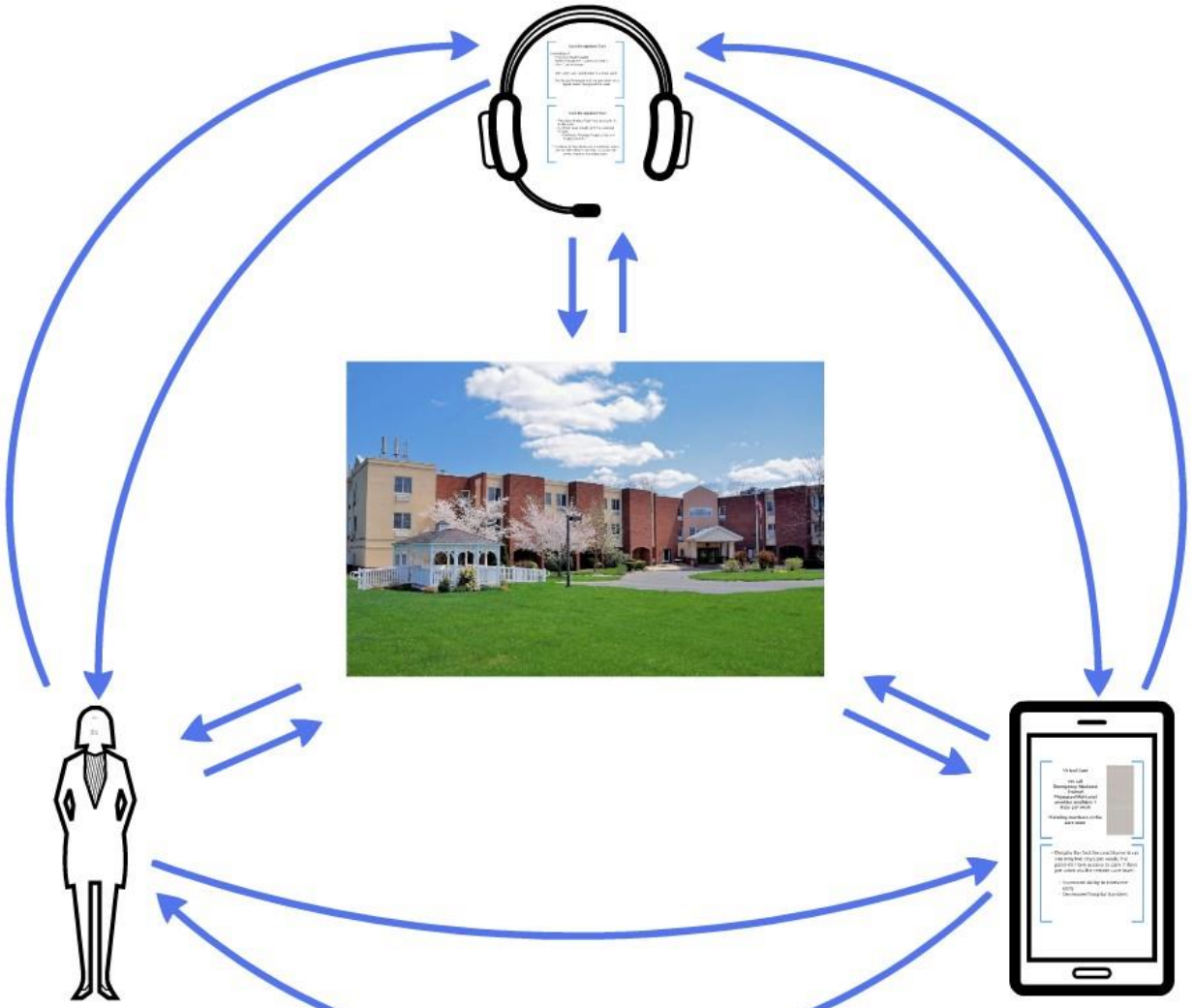
## On call Emergency Medicine Trained Physician/Mid-Level provider available 7 days per week

## *Existing members of the care team

- Despite the fact the practitioner is on site only two days per week; the patient's have access to care 7 days per week via the remote care team
    - Increased ability to intervene early
    - Decreased hospital transfers

# Coordinated Care Ecosystem

## Case Management



On Site Care

Virtual Care


REPORT
CARD

Facility earned NCAL Quality Initiative Recognition in 2017

- 15% readmission reduction

106 Virtual Visits performed in the first 6 months of 2017

- 93% Cared for in place

# Cost to the facility?

- Medical Director stipend paid to CCS Healthcare for population health oversight
- No further cost incurred by the facility.  Patient insurance was billed for care.

# Keys to program success

What does it take to ensure program success?

- Corporate Commitment
- Staff buy in
- Open lines of communication
- Shared responsibility for cultural change

## *Question and Answer Session*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