A Vision for Healthy Aging:

Increasing Competency for Older Adult Primary Care, in the Clinic and in the Community

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HealthReach Community Health Centers

- No financial disclosures

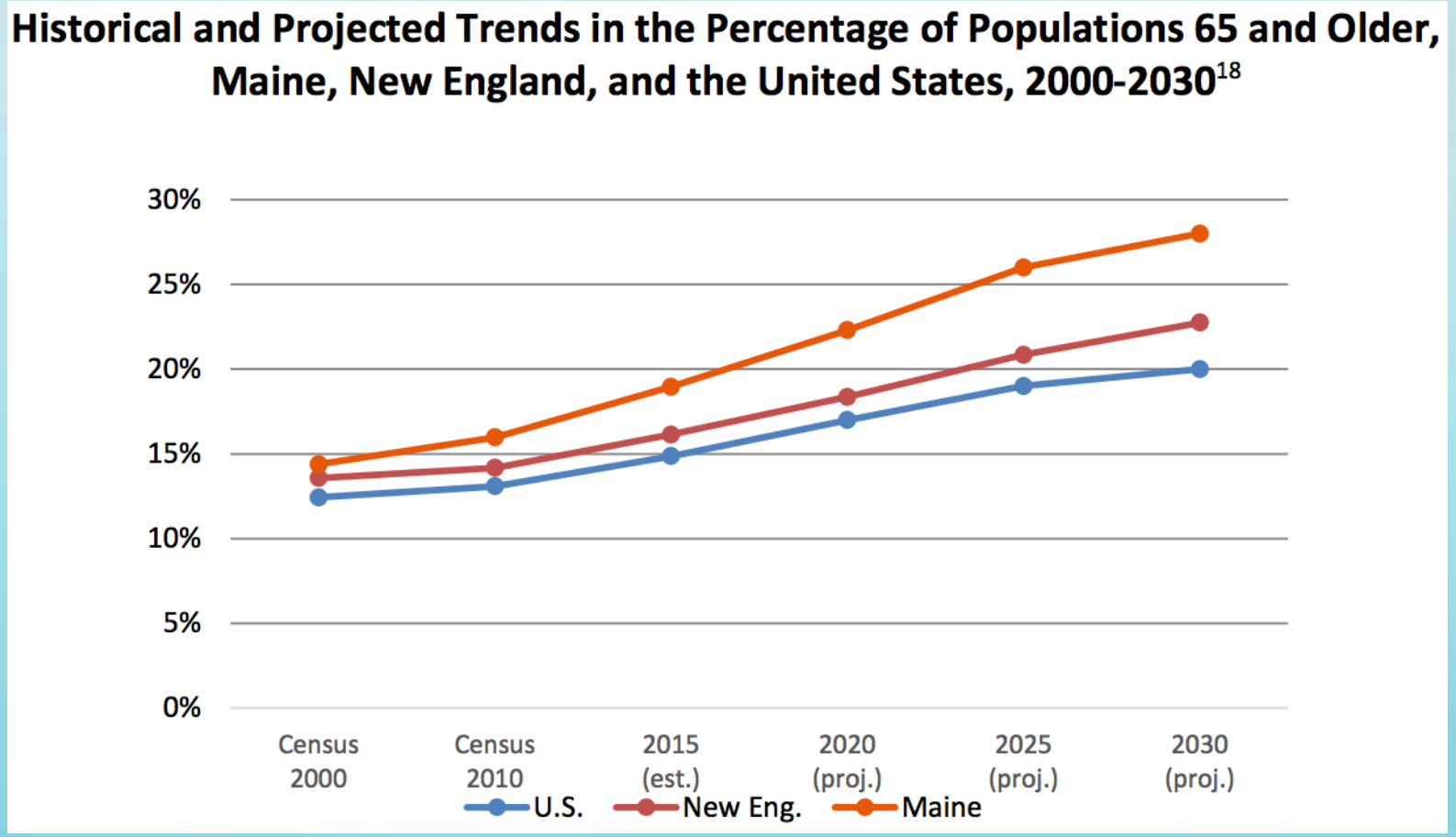
Our Mission: To provide high-quality, affordable, patient-centered healthcare in the medically underserved communities of Central and Western Maine

HealthReach Community Health Centers

Objectives

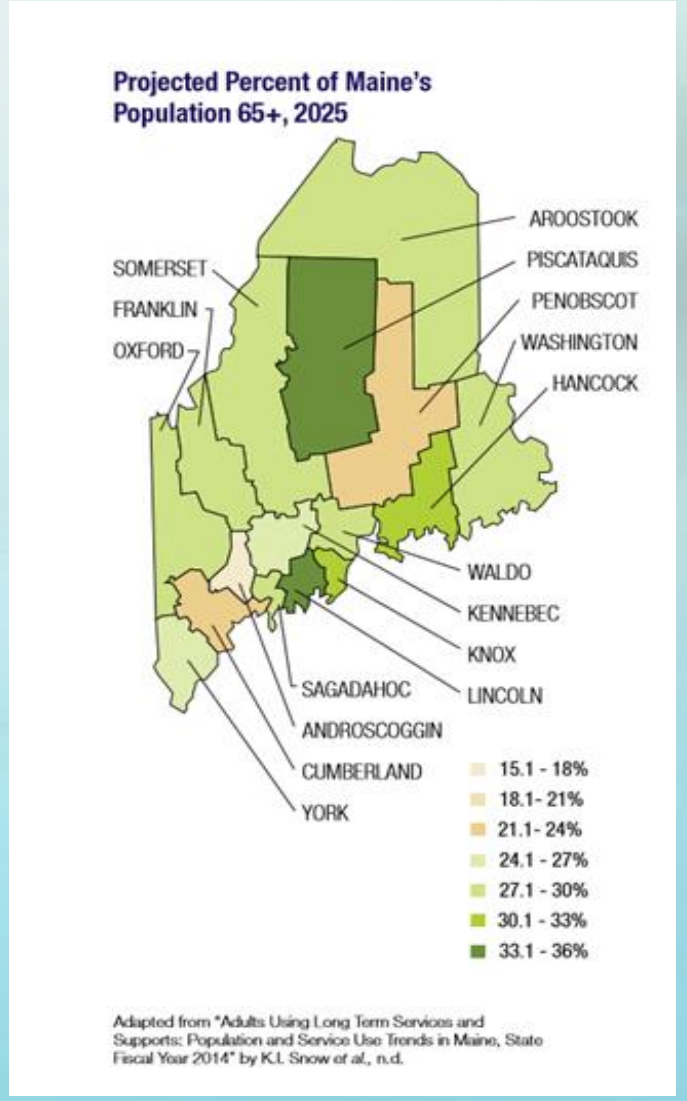
- Discuss aging in Maine and the implications this has for healthcare systems
- Review an initiative to improve primary care of older adults in one Maine health center network
- Discuss the importance of community partnerships to address the needs of older adults

Maine vs NE vs US Aging Projections
(Maine's State Plan on Aging 2016-2020)



Maine's demographics

- We have the highest median age in the country at 44.6 (2017)
- Our death rate exceeds our birth rate (along with West VA)
- Healthreach's overall Medicare population is about 22%, with the highest percentage being at Rangeley (32%) and Mt. Abram (25%)



From: Griffin and Gattine, 2017. Charting a Pathway Forward: Redesigning and Realigning Supports and Services for Maine's Older Adults

Maine projected to have more old than young people by 2020

With its 65-and-older population expected to grow by 55 percent by 2026, Maine needs more nurses, more home-care workers and more physicians than ever to keep pace with demand for long-term-care services.

Bangor Daily News, 2018

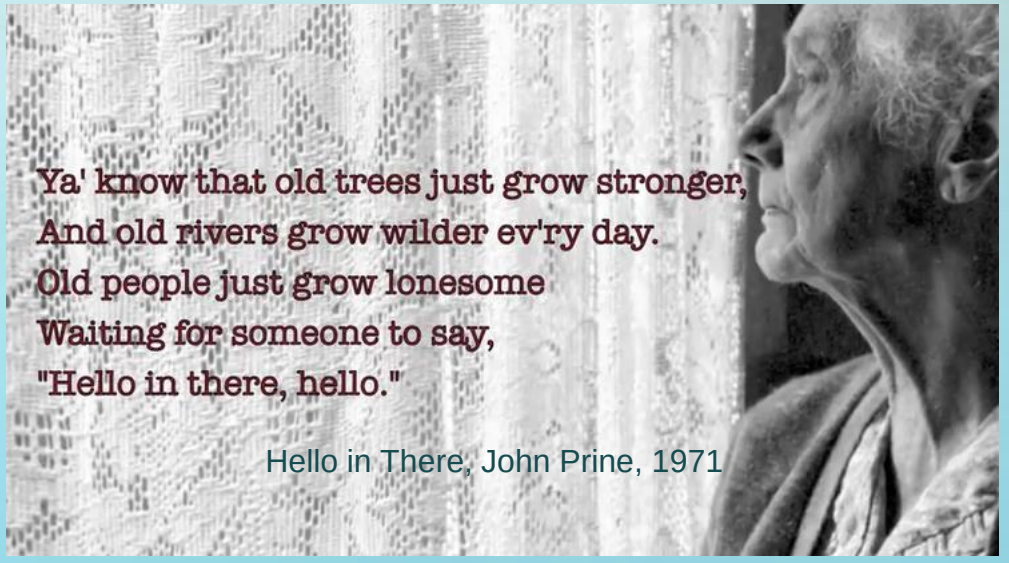
Business

'This will be catastrophic': Maine families face elder boom, worker shortage in preview of nation's future

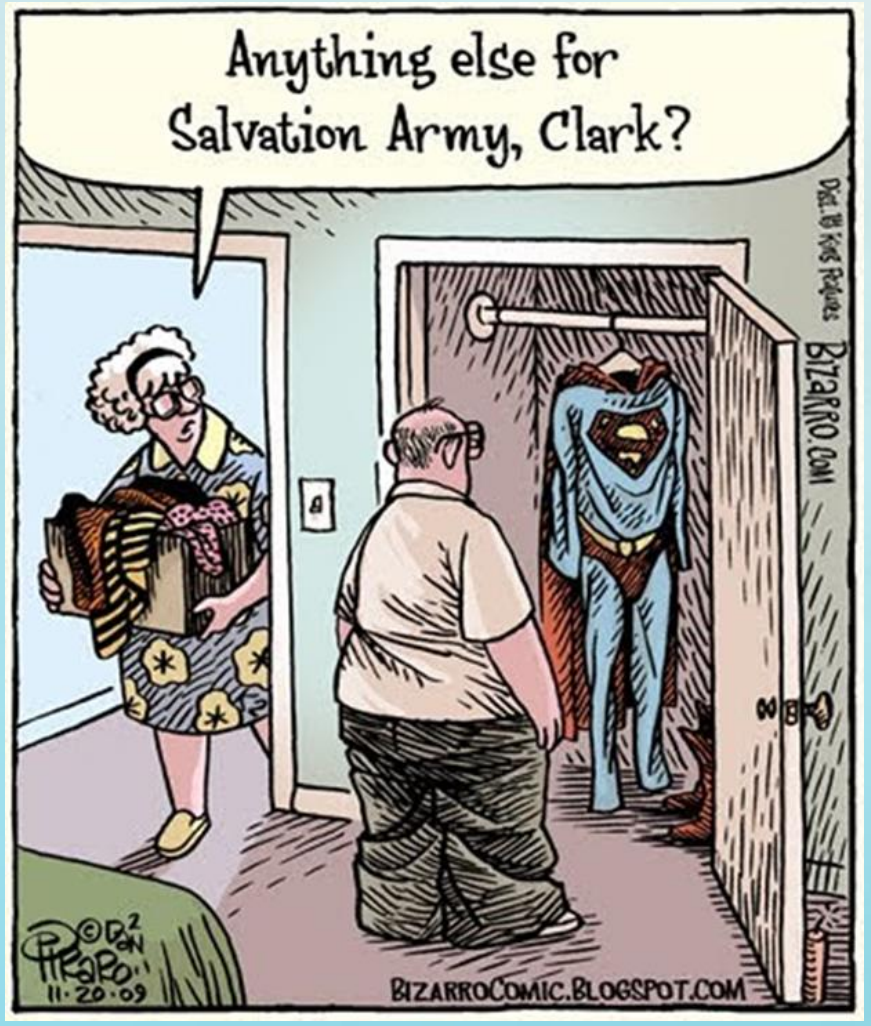
Washington Post 8/19

Not Just Aging…

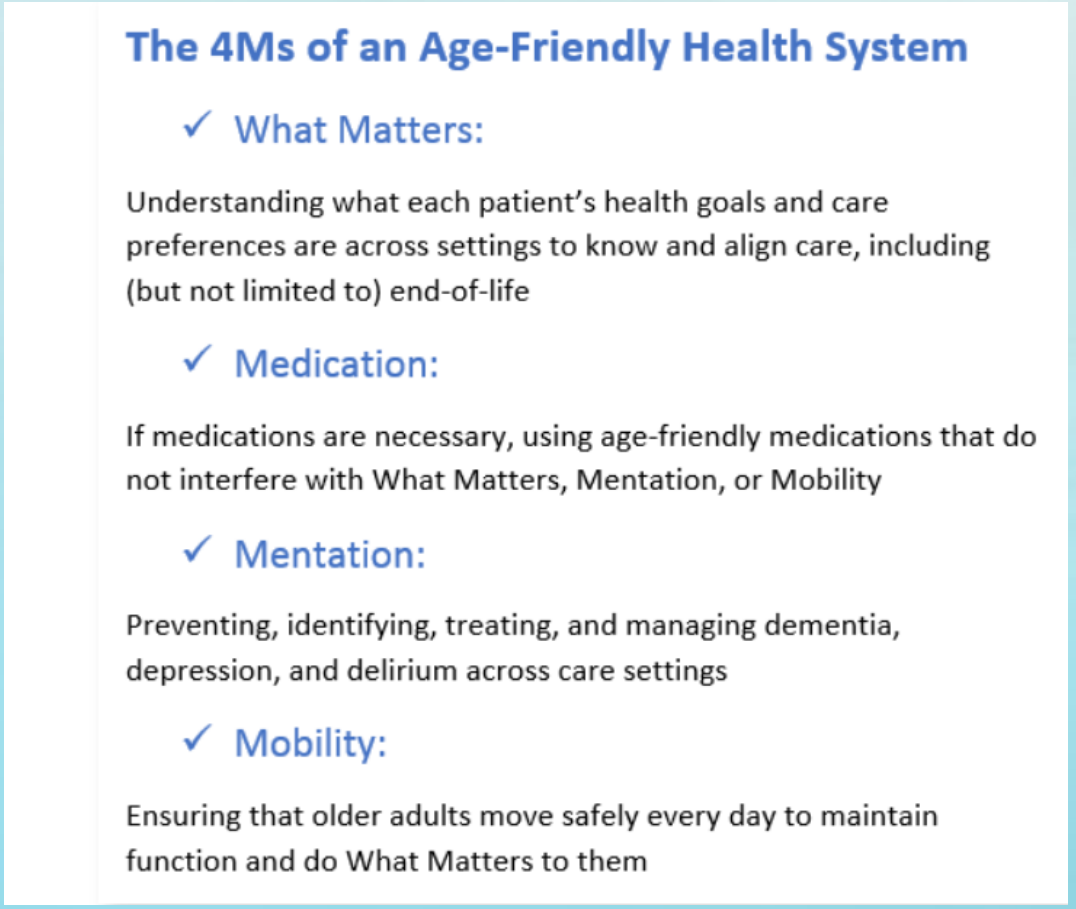
- About 9% of Mainers age 65+live in poverty, a much higher percentage is considered “low income”
- Transportation
- Access to services
- “The Golden Years” myth
- Loneliness: The Un-befriended Older Adult
- Cultural views on aging



Hello in There, John Prine, 1971


Anything else for Salvation Army, Clark?
BIZARRO.COM
BIZARROCOMIC.BLOGSPOT.COM
11-20-09

HealthReach's Geriatric Collaborative



John A. Hartford Foundation/IHI

Overview

- June 2018: introduction, Annual Wellness Visits

- July ‘18-Sept ‘18: Falls prevention, evaluation, management **(Mobility)**
  - CDC STEADI initiative

- Oct ‘18-Dec ‘18: Advance Care Planning **(what Matters)**
  - Aging in place, Advance Directives, living wills, POAs, POLST

- Jan ‘19-Mar ‘19: Polypharmacy/appropriate prescribing **(Medication)**

- April ‘19-June ‘19: Cognitive impairment detection, evaluation, management **(Mentation)**

HealthReach’s Geriatric Collaborative

- Key factors:
  - Multidisciplinary
  - Team-based
  - Partnerships
  - Metrics
- Included:
  - Education at leadership and regional meetings and in clinical newsletter
  - Development of data sets for assessing older adult health
  - Centralized, online clinical resources
  - Patient education resources

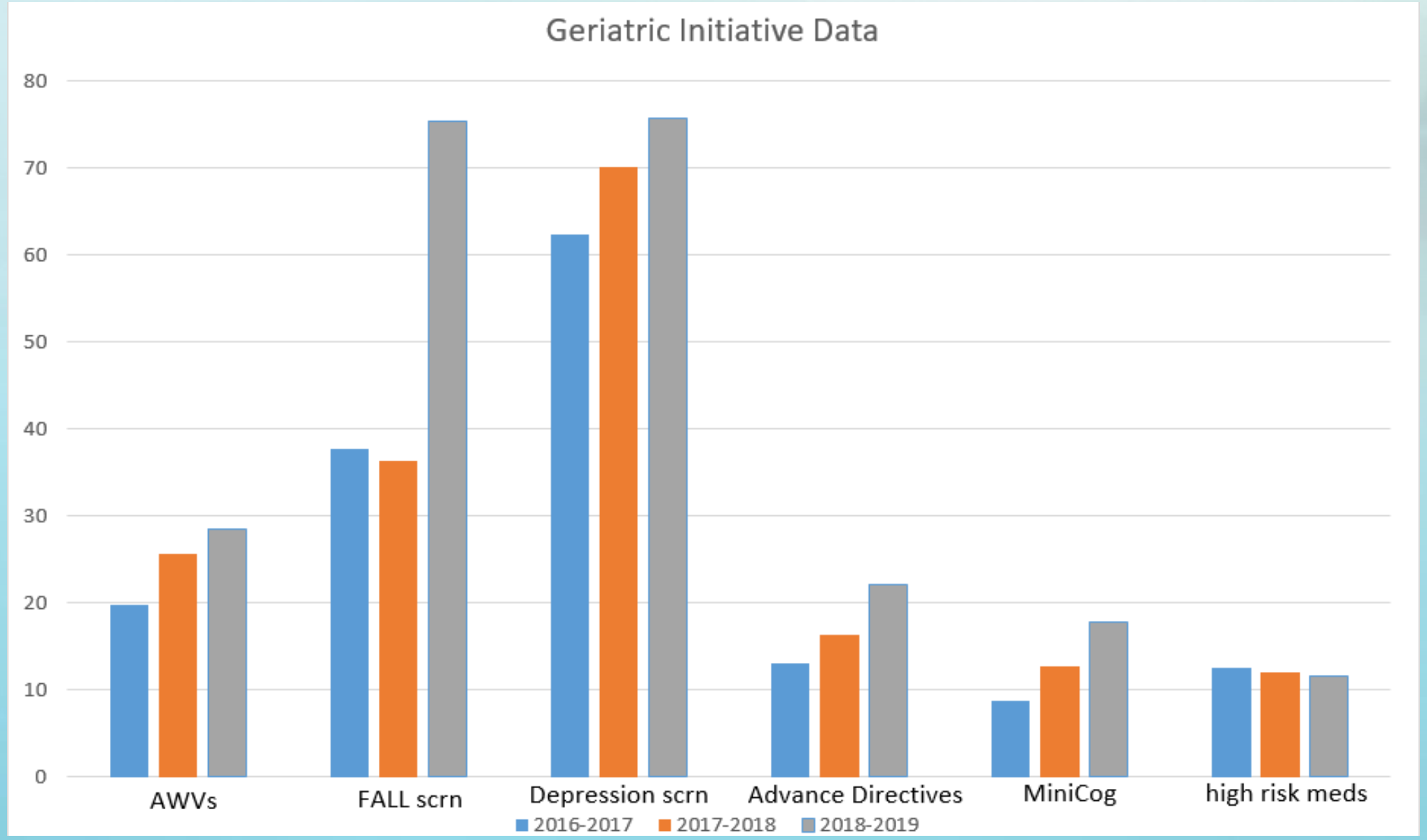
Polypharmacy

- Medication reconciliation procedures: clinical staff, care managers, clinicians
- Developed a data set to look at use of high risk medications
- Contracted with a clinical pharmacist to offer case review and medication management recommendations
- Geriatrician-led clinician education at regional meetings on polypharmacy reduction
- Education resources: Clinical newsletter articles and tools, ie reducing benzodiazepine use in older adults
- Patient education on waiting room closed circuit TV
- Information for drug disposal specific to each site

DATA

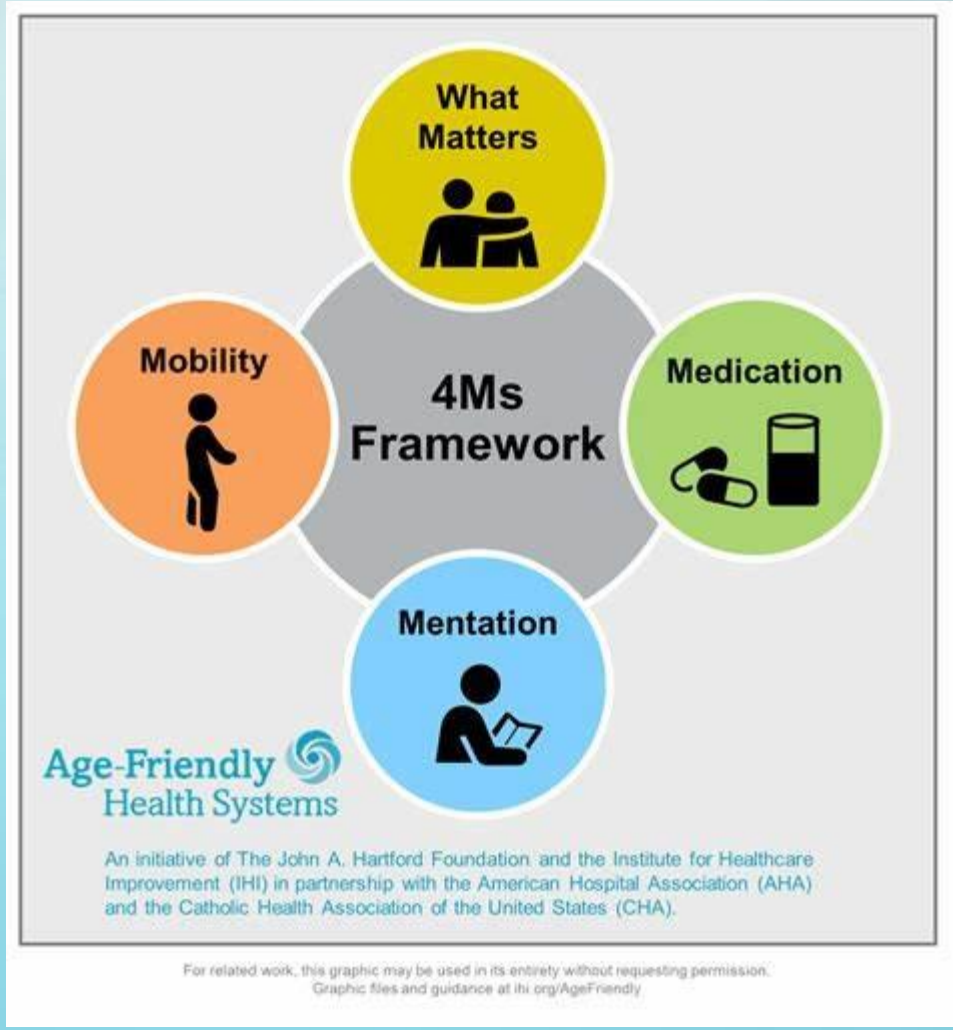
Initiative: Geriatric Collaborative

Date Range:	10/5/2018 - 10/5/2019		10/5/2017 - 10/5/2018		10/5/2016 - 10/5/2017		10/5/2015 - 10/5/2016	
Item	Value	%	Value	%	Value	%	Value	%
1. Geriatric Care:								
A. Patient Panel								
1. Active Patients	2505	100%	2506	100%	2506	100%	2506	100%
2. Active Patients 65 or Older	673	26.87%	620	24.74%	566	22.59%	515	20.55%
a. DENOMINATOR: Active Patients 65+ with a Medical Visit in the Past 12 Months	585	86.92%	536	86.45%	386	68.2%	335	65.05%
B. Medicare Wellness Visit								
1. Patients with a Medicare Annual Wellness Visit in the Past 12 Months	239	40.85%	135	25.19%	42	10.88%	51	15.22%
2. Screening:								
A. Fall Risk Screening								
1. Patients with a Completed Fall Risk Assessment in the Past 12 Months	551	94.19%	385	66.49%	365	78.49%	180	41.96%
2. Patients Identified as Being at Risk for Falls	119	20.34%	44	7.6%	54	11.61%	27	6.29%
a. Patients at Risk for Falls Without Number of Falls Reported	29	24.37%	14	31.82%	3	5.56%	0	0%
3. Patients Who Reported 2 or More Falls in the Past 12 Months	31	5.3%	13	2.25%	18	3.87%	10	2.33%
B. Depression Screening								
1. Patients with a Completed Depression Screening in the Past 12 Months	532	79.05%	518	76.97%	361	53.64%	268	39.82%


Geriatric Initiative Data
80
70
60
50
40
30
20
10
0
AWVs
FALL scrn
Depression scrn
Advance Directives
MiniCog
high risk meds
2016-2017
2017-2018
2018-2019

Partnerships

- Clinical Pharmacist
- Community Paramedics
- Area Agency on Aging



Clinical Pharmacist

- Contracted with clinical pharmacist to do pharmacy case review
- Clinicians drove selection of cases
- Received report of medications to stop or decrease along with rationale and alternative options
- Ongoing relationship

Community Paramedics

- Delta Ambulance covers most of our service area
- What do they offer?
  - Highly trained pre-hospital medical clinicians
  - Fill “gaps” of when person may need care at home but doesn’t qualify for home-based services
- Services:
  - Home safety assessment
  - Medication Reconciliation
  - Lab draws/specimen collection
  - Basic assessment (vitals, weight, exam)
  - Etc.

Community Paramedic Workflow

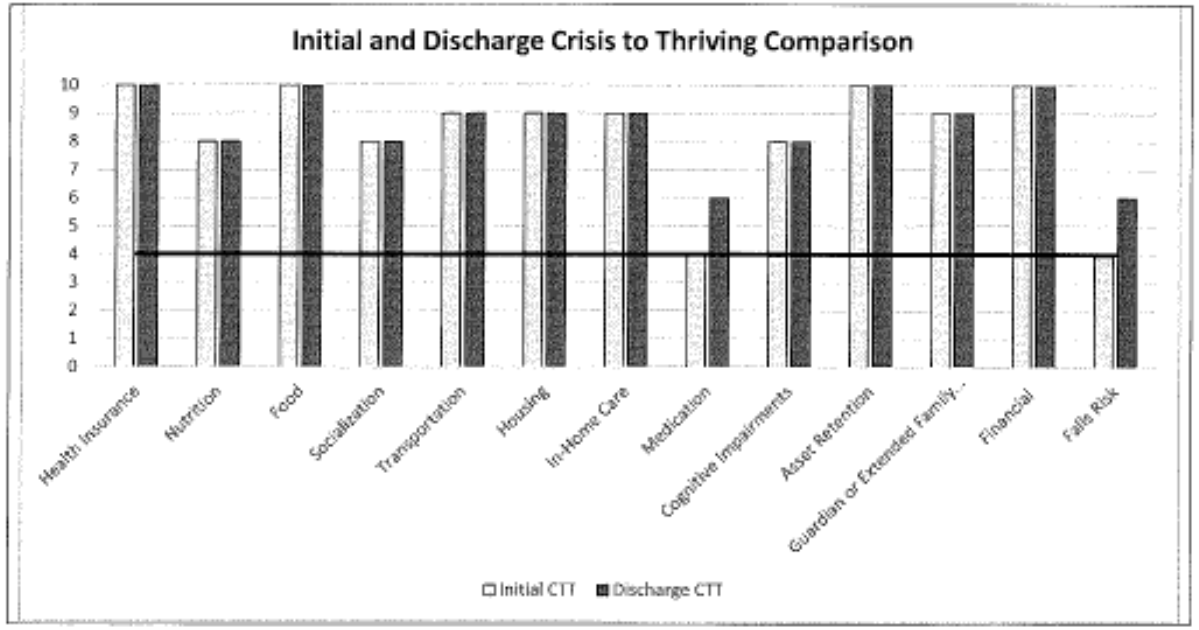
- CP order can be initiated in the PCP's office (most common), hospital, ED, etc.

Area Agency on Aging

- Spectrum Generations covers most of our service area
- Collaborative relationship on Living Well series
- Contracted on new project:
  - Community Resource Specialist outreach
  - HealthReach patients >65 yo
  - Crisis to Thriving assessment with feedback to clinical team
  - Connection to community resources
  - 45 day intervention period
  - Belgrade, Madison, Bingham, Lovejoy, Sheepscot

Crisis to Thriving Assessment

The following a bar graph displaying a comparison of where your client scored when they were first referred to us, and where they scored when they were discharged at the end of our contract with them.



Note: Areas the consumer scores less than a 4 in are vulnerable, or in crisis.

Explanation of Range:

9-10	Thriving
7-8	Stable
5-6	Safe
3-4	Vulnerable
1-2	Crisis

To enable our population to age well, we need:

- Age-friendly health systems
- Partnerships with expert community agencies and others
- Engaged local, state, and federal leadership

Questions?

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