Implementing a Modified Comprehensive Elder Exam Model for High-Risk Admissions

MultiService Unit, Tsehootsooi Medical Center

Introduction and Background

- I-CAN Project, Leadership & Organizing to Improve Population Health
- Mission Statement:
  - To organize hospital and community-based resources to improve patient care management and facilitate transitions of care for high-risk patients through the provision of an inpatient-based, holistic, interdisciplinary intervention.
  - Our Facility
    - Indian Health Service 638 (self-determined) facility
    - Located within the Navajo Nation
    - Medical center and satellite clinic
    - 54 inpatient beds
    - Outpatient clinics, Pharmacy, Ancillary services
    - Other programs and services
  - Rationale and Motivation
    - Community Needs Assessment
    - Regulatory compliance
    - Patient request
    - Improvements in patient care management
    - Response to changing environment of healthcare
    - Cultural considerations
  - Target population: establishing criteria, includes patients with metastatic cancer, end-stage liver disease, CHF, COPD, dementia, failure to thrive, pressure ulcers, other criteria TBD
  - Our growing project team encompasses almost 20 clinical and nonclinical professionals from both hospital and community-based resources
  - Community-based stakeholders include patients, family members, Community Health Representatives, and community-based programs
  - Leadership Structure Development: completed by identifying key stakeholders and champions. Focused on developing interdisciplinary team.

Methods

- Asset based approach
- Interdisciplinary, Holistic, and Comprehensive
- Patient and family involvement in POC
- Integration with community resources
- Close collaboration with Discharge Planning Process
- Embedding process with other QI Projects
- Process
  - Initial screening upon admission
  - Process triggered and team alerted
  - Referrals and consults entered
  - Process and intervention communicated to patient & family, referrals completed & need for additional services identified
  - DME provided, follow up appointments made, community based services coordinated
  - Family meeting scheduled when discharge anticipated
  - Family meeting completed with involvement of all applicable services & departments
  - POC mutually developed and follow up communicated
  - Patient discharged and handoff with outpatient case manager completed
  - Outpatient follow up with physician completing discharge and hospital and community based services

Leadership Team

- Cristina Stuefen, BSN, RN-BC
  - Lead Clinical Nurse, MSU
  - UCSF HEAL Initiative Fellow

- Lucinda Waseta, MSW
  - Licensed Master of Social Work
  - Medical Social Worker

- Aaron Price, MD
  - Hospitalist
  - Chief of Medical Staff
  - Chief of Internal Medicine
  - UCSF HEAL Initiative Fellow

- Lynnette Velez, BSN, RN
  - Discharge Planning Care Coordinator

Outcomes

- Potential for short and long term improved health outcomes
- Next Steps
  - Continue strategic planning
  - Maximize interdisciplinary collaboration
  - Determine outcome measurements
- Goal
  - Improve quality of care and provision of holistic, patient-focused rather than problem-focused care
- TMC has the resources to improve service delivery to our highest-risk populations through coordination of services
- Meeting the World Health Organization (WHO) definition of health
- Guided by social medicine principles

Key Learning

- Addressing deficits using available resources and assets
- Strategic Planning
- Systems Thinking
- Team building and Mobilizing Collective Action
- Stakeholder and asset mapping
- Relational Strategizing
- Development of framework and Processes
- Moving forward
  - Establishing process
  - Addressing inherent and emergent challenges
  - Adapting this process for other patient populations
  - Needs analysis for re-establishment of original outpatient model
  - Strengthening relationships with community-based programs
- How forum attendants can help
  - Insights regarding improving services in a resource-limited settings
  - Suggestions for improving rigor of data related to outcomes and measurements
  - Information sharing regarding effective interventions for the targeted population

Challenges

- Distance learning with QI as a specialty area
- Maintaining focus on project with multiple shifting priorities
- Engaging with advisors
- Refocusing and adapting initial aim and measurements
- Additional Challenges
  - Lack of Hospice Services, Respite Services, Adult Daycare
  - Lack of Long Term Care and inpatient Rehabilitation services
  - High staff turnover and vacancy rates
  - Limited home caregiver hours paid
  - Lack of medical training for home caregivers
  - Billable services and reimbursement
  - Consistent communication and collaboration with multiple departments and services
  - Defining measurements
  - Adapting a former outpatient model for and inpatient-based intervention
  - Coordination of multiple departments and individuals
  - Developing definition of high-risk with regards to target population

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