Integrating Geriatric Care Management into Primary Care Practice

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Statement of Problem

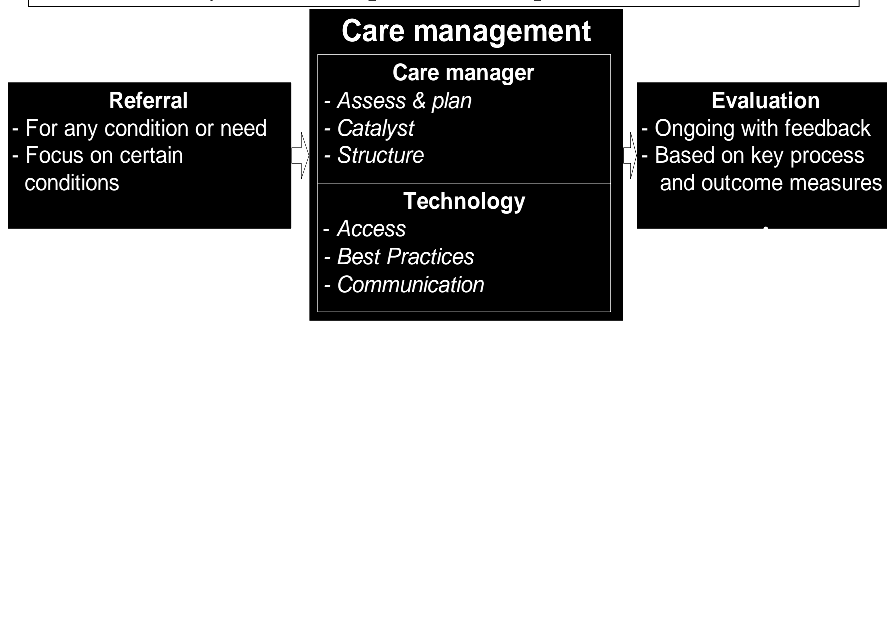
For seniors with multiple chronic conditions and variable social, emotional, or physical support, creating a evidence-based, patient-specific plan and facilitating self-management can be difficult.

Frequently, primary care physicians have *limited time, tools and training* in education, coaching, motivating, and problem solving with these patients

For those most in need, a flexible, interdisciplinary approach with **people** and **technology** may help.

We sought to implement a program to provide geriatric care management in primary care, explore benefits, and model successes.

Figure 1. Model of multidisease, flexible Care Management system development and implementation



PEOPLE

Core principle: The right people **on the team with the right training**

Patients are taught to self-manage and have a **guide** through the system.

Care managers create / receive special training in

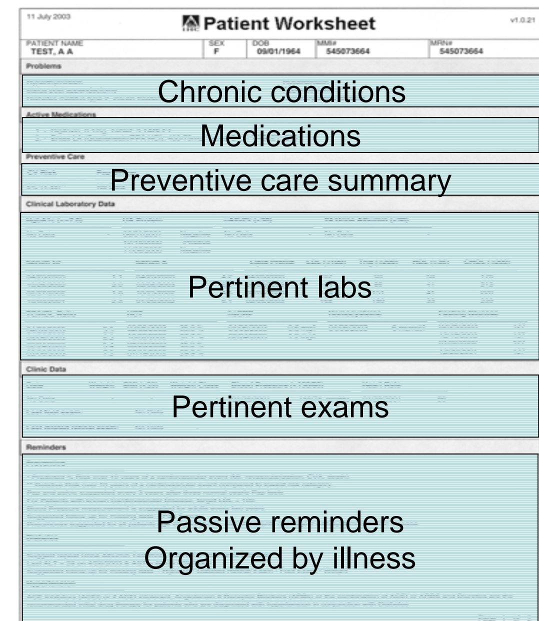
- •Education, motivation/coaching
- •Disease specific protocols (**all staff included**)
- •Care for seniors / Caregiver support
- •Connection to community resources

Other team members (physicians, MAs, pharmacists) participate in training, protocol development and implementation,

INFORMATION AND COMMUNICATION TECHNOLOGY: Match workflow and needs

Team-wide: Patient worksheet summarizes patient information and provides printed reminders

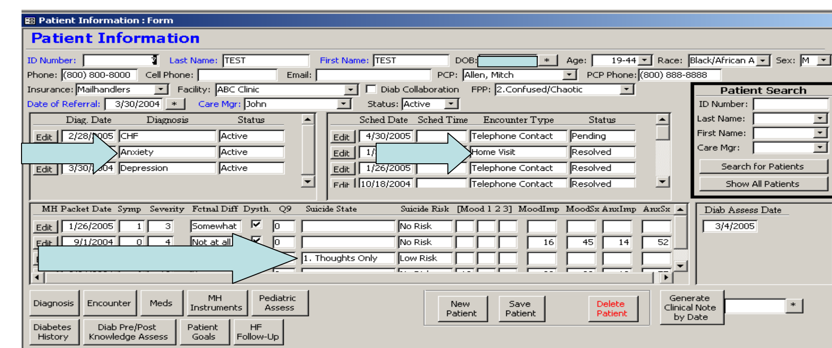
Care manager specific: Care manager tracking helps structure care plan, follow protocols, and generate reports and tickler lists.



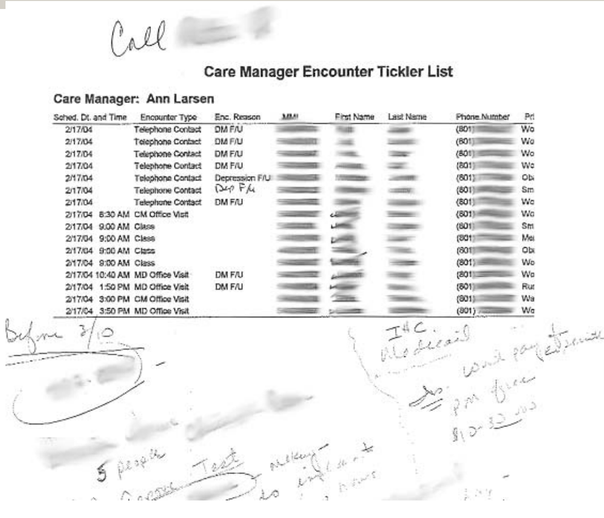
Patient population

In all, 4,735 patients (1,582 seniors) were seen in 2004-05, receiving 22,899 services (9,434 for seniors).

Service category	All patients	Seniors
ALL	22,899	9,434
Following evidence-based protocols	12,955 (56.6%)	4,421 (46.9%)
General education	6,808 (29.7%)	2,252 (23.9%)
Communication	6,789 (29.7%)	4,199 (44.5%)
Motivating patients	6,243 (27.3%)	2,247 (23.8%)
Social issues / barriers	8,221 (35.9%)	3,608 (38.2%)



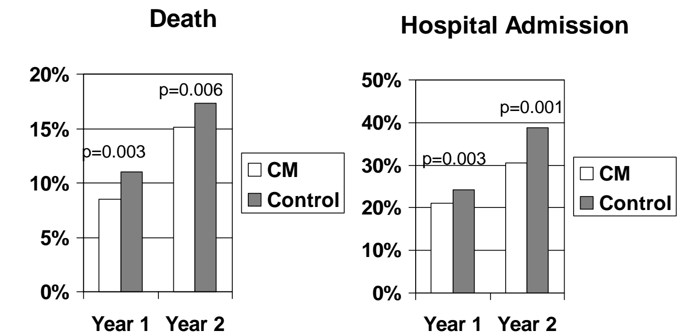
Generate daily tickler and other reports



Senior retrospective study

Patients matched on age, gender, comorbidities, and other key variables; looked at disease control, mortality, and hospitalizations

Results For 1026 patients with diabetes > 65 compared to 2052 controls. 50% had >1 chronic condition, with diabetes, mental health, and cardiovascular conditions most frequent.

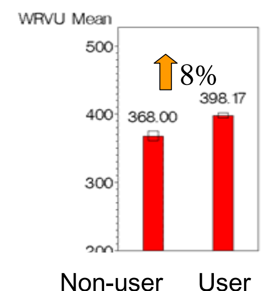


Deaths were reduced by 15-20%, and admissions by 20%.

Productivity / Satisfaction

Primary care physician productivity increased from 5-12% in a multivariable time-series model.

Physicians felt care managers helped make visits with patients more efficient.



Conclusion and next steps

- • Protocols for the needs of complex senior patients can be enacted in primary care environments and improve patient care.
- •Partnerships to promote use of Geriatric Care Management in other clinics; support is available.
- •See www.intermountainhealthcare.org/cmt .