Changing Care for the Frail Elderly: Community Based, Long-Term Care and ACOs

Innovation Perspectives Series
December 5, 2013
About the Alliance

• 501(c)(3) non-profit research foundation

• Mission: To support research and education on the value home health care can offer to patients and the U.S. health care system. Working with researchers, key experts and thought leaders, and providers across the spectrum of care, we strive to foster solutions that will improve health care in America.

• [www.ahhqi.org](http://www.ahhqi.org)
Joanne Lynn, MD, MA, MS
Altarum Institute’s Center for Elder Care and Advanced Illness

Joanne Lynn, MD, MA (philosophy and public policy), MS (evaluative clinical sciences), is a geriatrician, hospice physician, health services researcher, quality improvement advisor, and policy advocate who has focused upon shaping American health care so that every person can count on living comfortably and meaningfully through the period of serious illness and disability in the last years of life, at a sustainable cost to the community. She now leads the Center on Elder Care and Advanced Illness for Altarum Institute.
Making it Safe to Grow Old & Frail: The Medicaring™ Reform

Joanne Lynn, MD, MA, MS
Director, Center for Elder Care and Advanced Illness
What We Want in Old Age....
While old age may always be challenging, we have made it unnecessarily terrifying and miserable.
U.S. consumption \((private + public)\)

Y axis, 1 = Average Labor Income Ages 30-49

How are we going to keep from big trouble?
MediCaring!  **Aim?**

Assure that Americans can live comfortably and meaningfully at a sustainable cost through the period of frailty that affects most of us in our last years.
What We Really, Really Need...

1. The Cohort – Frail elderly
2. The Care Plan – For each frail person, at all times
3. The Services – Adapted; in-home, supportive
4. The Scope – Social services equally important
5. Local Monitoring & Management

AND THE WILL TO MAKE THESE CHANGES!
Identification of Frail Elders in Need of Medicaring™

**Age ≥65**

**AND one of the following:**
- ≥1 ADL deficit or
- Requires constant supervision **OR**
- Expected to meet criteria in 1-2Y

**Frail Elderly**

**Age ≥85**

*Want a sensible care system*

**Unless Opt Out**

**With Opt In**
A Good Care Plan
How important is it?

A good care plan at all times is the keystone of good care

Services without a plan are reactive, dangerous, and terrifying
And then evaluate

For individuals –

- Presence
- Known by all affected, continues across settings, implemented
- Satisfaction with the process
- Patient/client report: helping to pursue goals
- Patient/client report of confidence
- Outcomes (life lived) evaluated against priority values

For systems –

- Regular performance for individuals
- Feedback upstream – self-correcting process
- [use of care plans to manage the service supply and quality]
About Customized Service Plans

Articulated Values → Goals → Plan → Integration → Implement → Outcomes

Feedback → Feedback → Evaluation of Quality

Evaluation of Quality

Evaluation of Quality
What about an "Advance Care Plan?"

△ Natural to consider lifespan and dying as part of care planning

△ Include emergency plans like POLST

△ Designate surrogate decision-maker(s)

△ Document along with care plan

△ Update and feedback as for other plan elements
Geriatricize Medical Care

- Continuity
- Reliability, 24/7 to the end of life
- Enabling self-management around disabilities
- Respecting and including family and other caregivers
- Attend to the burden of medical care
- Move services to the home
- Prevent falls, wrong actions
- Enhancing relationships, activities, meaningfulness
- Enduring dementia
Health-service and social-services expenditures for OECD countries (%GDP - 2005)

BMJ Qual Saf 2011;20:826e831.
Health-service and social-services expenditures for OECD countries (as Ratio – 2005)

Disaster for the Frail Elderly: A Root Cause

**Social Services**
- Funded as safety net
- Under-measured
- Many programs, many gaps

**Medical Services**
- Open-ended funding
- Inappropriate "standard" goals
- Dysfx quality measures

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**No Integrator**

- Inappropriate
- Unreliable
- Unmanaged
- Wasteful “care”
Local level— not just state/federal (and provider)

▲ Frail elders are tied to where they live
▲ Local leadership responds to geography, history, leadership
▲ Localities can engender and use largely off-budget services
▲ Localities can address environmental issues
▲ Localities can address employer issues for caregivers
▲ Local management is politically plausible now
Encourage Geographic Concentration?

**YES!**

▲ Services to homes will be more efficient if allowed to be geographically concentrated

▲ Can utilize local strengths, solve local issues

▲ However - Must address risks of monopolies
What will a local manager need?

▲ Tools for monitoring – data, metrics
Cincinnati Area Readmissions Over Time

Readmissions per 1,000 Beneficiaries

- **Observed**
- **Seasonally Adjusted**
Patient-Reported Pursuit of Goals
Uneven interval, multiple reporting strategies

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Ideal Score = 4
BÄTTRE LIV FÖR DE MEST SJUKA ÄLDRE I JÖNKÖPINGS LÄN – KOMMUNER OCH LANDSTING TILLSAMMANS
[better life for the elderly people in Jonkoping}
Äldres läkemedelsanvändning i Jönköpings län

Jonköping hospitals and municipalities
Pressure ulcer rate for People living in service homes

Pressure ulcer risk assessment In service homes

Andel personer som fått riskbedömning i Senior alert i SÄBO i Jönköpings län, 08-2012
What inputs would you need to optimize service production?

What follows is a “proof of concept” - many important elements not yet included

With good care plans for a population, one could model the production system.
In a community of 600,000 residents, about 6000 die each year, about 5000 in old age
- 2500 – single overwhelming disease
- 2500 – frailty

Substantial self-care disability will last an average of 2 years before death

Thus, at any one time, about 5000 frail adults ≥65 years of age will be in need of supportive services
“Alpha” Optimal Production System – Where, what & how will needed care be provided?

5000 Frail Elders

4000 Community Residents

2500 Family Provided Care

1500 Community Provided Care

1000 Nursing Home

Needs that cannot reasonably be met in the community

Attendance around the clock and 3 hours direct services daily

Currently without pay and with little or no training or support!

Currently without pay and with little or no training or support!
"Alpha" Optimal Production System
–Primary Care Provider home visits

▲ Number of home visits
  ▪ 4000 people living with serious frailty in the community
  ▪ Routine visit every 4 months
  ▪ Urgent visit 3/year

▲ Primary Care Provider
  ▪ Can see ~10 visits/day (with assistant/driver)
  ▪ ~240 days per year
  ▪ The community needs 10 full-time PCPs (and 10 full-time assistants/drivers)
  ▪ Plus 24/7 coverage for urgent situations

4000 X 6 = 24,000 home visits needed

10 X 240 = 2400 visits / PCP / year
## “Alpha” Optimal Production System – Summary of needs?

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<tr>
<th></th>
<th>1000 NH Elders</th>
<th>4000 Community Elders</th>
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<tbody>
<tr>
<td>Direct care workers</td>
<td>500</td>
<td>1500 (½-3 per user)</td>
</tr>
<tr>
<td>Nurses</td>
<td>100</td>
<td>500</td>
</tr>
<tr>
<td>Therapists</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Primary Care Providers</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>PCP Assistants</td>
<td></td>
<td>10</td>
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<tr>
<td>Hospital Beds</td>
<td>50</td>
<td>250</td>
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What will a local manager need?

- Tools for monitoring – data, metrics
- Skills in coalition-building and governance
- Visibility, value to local residents
- Funding – perhaps shared savings
- Some authority to speak out, cajole, create incentives and costs of various sorts
- A commitment to efficiency as well as quality
Frail Elderly People Need Some New Spending…

$ Housing
$ Nutrition
$ Personal Care
$ Caregiver training, respite, income
$ New drugs and other treatments

Where will it come from?
My Mother’s Broken Back
"The Cost of a Collapsed Vertebra in Medicare"
Estimating Potential Savings in Medical Care

▲ Estimate frail as 10% of >64 population in a geographic area

▲ Estimate PMPM total costs (except for unpaid caregiving)
  ▪ Use CMS HRR and county data for aggregate costs, population, utilization
  ▪ Use sources in literature for LTC costs and small ancillary costs

▲ Estimate realistic goals of reducing medical care, delaying Medicaid, reducing use of nursing homes - generally, about half of the maximal effect (e.g., 25% reduction in hospital, 5% in LTC)
A Winning Possibility: MediCaring ACOs…

▲ Four geographic communities - 15,000 frail elders as steady caseload
▲ Conservative estimates of potential savings from published literature on better care models for frail elders
▲ Yields $23 million ROI in first 3 years

<table>
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<tr>
<th>Net Savings for CMS Beneficiaries</th>
<th>Yr 1</th>
<th>Yr 2</th>
<th>Yr 3</th>
<th>3-Yr</th>
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<td>Before Deducting In-Kind Costs</td>
<td>-$2,449,889</td>
<td>$10,245,353</td>
<td>$19,567,328</td>
<td>$27,362,791</td>
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<td>After Deducting In-Kind Costs</td>
<td>-$3,478,025</td>
<td>$8,463,101</td>
<td>$17,629,209</td>
<td>$22,614,284</td>
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For more on financial estimates, see [http://medicaring.org/2013/08/20/medicaring4life/](http://medicaring.org/2013/08/20/medicaring4life/)
But how to motivate the changes … and sustain them?

- 3rd year – convert to a special purpose ACO
- Allowed to enroll only frail elderly persons
- Only those who live in a particular area
- Measured by population well-being and costs, as well as enrollee experience
- Plans of care on-line, used, feedback upstream, and regulating the production system
- Dashboard to monitor local quality and costs
- Governance and authority can be local government, voluntary coalition, or strong lead organization – needs testing
Customize services for frail elderly cohort
Generate good patient-centered care plans
Adapt medical care  Geriatricize
Include long-term services
Develop local layer of monitoring and management

Channel the fear and frustration into the will to change
“You never change things by fighting the existing reality. To change something, build a new model that makes the existing model obsolete.”

---Buckminster Fuller
Useful resources

▲ For Data
  ▪ www.communitydatapalooza.org (check out Cincinnati)
  ▪ Your QIO – (ask for help with “care transitions”)
    http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1144767874793

▲ For Community Organizing
  ▪ http://www.cfmc.org/integratingcare/learning_sessions.htm

▲ For Workforce in Elder Care
  ▪ http://www.eldercareworkforce.org/

▲ For more on Financing
  ▪ http://medicaring.org/2013/08/20/medicaring4life/
A look into frailty

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Discussion & Questions

• Submit questions to “Teresa Lee” at the Fuze Chat Box.

• Presentation slides will be available at http://ahhqi.org/education/innovation-perspectives
Thank You!