IMPORTANT ISSUES FACING GERIATRIC CARE

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Learning Objectives:
- Understand the paradigm shift in long term care services.
- Will be able to list the three laments that guide the changes.
- Become familiar with the successful innovations in chronic disease management.

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Medical Director, SCAN Health Plan

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Health care for persons with chronic conditions is “a nightmare to navigate.”

Crossing the Quality Chasm, IOM 2001

Main Challenges

- Chronic disease management
- System of care re-engineering
- Providing care for the right persons at the right place and for the right price
Chronic Disease Management: The New Geriatric Medicine?

- Involves older adults with multiple disease
- Associated with functional limitations
- Involves complex psychological and social problems

Outline:

- Epidemiology
- Work Force and Caregiver Issues
- LTC Services
- Paradigm Shift
- Care Model Innovations
- Specific Interventions
- Implication to your practice

Demographics


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A Short Look At Long-Term Care For Seniors

As a Result of Physical and Cognitive Impairments, 70% of Seniors Will Need Long-Term Service and Support

7 IN 10 AMERICANS AGED 65 YEARS OR OLDER

THE AVERAGE LENGTH OF TIME A SENIOR ADULT WILL NEED ASSISTANCE WITH ACTIVITIES OF DAILY LIVING IS 3 YEARS

87% of the 12 Million Americans Who Need Long-Term Care Receive It From Unpaid Family Caregivers

TYPES OF PAID LONG-TERM CARE PROVIDERS

- 20%–30% physicians, nurses, and therapists
- 70%–80% home health aides, certified nursing assistants, and personal care aides

*Estimated annual value of unpaid care in 2009: $450 billion
Care Giving is Multigenerational

Today, 9.4 million Americans of all ages provide care to relatives and friends.
Thirty-eight percent of those providing care are 55 years of age or older.
Sixty-five percent of family caregivers are women (not shown).

Family Caregivers by Age

- 45-54: 25%
- 55-64: 18%
- 65-74: 12%
- 75+: 8%
- 25-44: 30%
- 15-24: 7%
- 7%


Medicaid Is the Primary Payer for Long-Term Care

Contrary to popular perception, Medicare does not provide extensive long-term care coverage. Medicaid is only available to individuals with limited incomes and assets.

Medicaid Spending on Long-Term Care Has Been Shifting Toward Community-Based Care

Nonelderly individuals with disabilities account for more than half (54%) of Medicaid long-term care expenditures, and 63% of their expenditures are for home and community-based services.
People With Chronic Conditions

- In 2005, 133 million Americans had one or more chronic conditions.
- This number is projected to increase by more than one percent each year through 2030.
- Between 2000 and 2030, the number of Americans with chronic conditions will increase by 37 percent, an increase of 46 million people.

Chronic Conditions and Functional Limitations

- 104 million Chronic Illness Only
- 33 Million Activity Limitation Only
- 5 Million Both Chronic Illness and Activity Limitation

Source: Medical Expenditure Panel Survey, 2001

Medicare Spending on Chronic Conditions

- Ninety-nine percent of Medicare expenditures are for beneficiaries with at least one chronic condition.
- Ninety-six percent of Medicare expenditures involve individuals with multiple chronic conditions.

Percent of Medicare Expenditures

- 0 Chronic Conditions: 1%
- 1 Chronic Condition: 16%
- 2 Chronic Conditions: 6%
- 3 Chronic Conditions: 4%
- 4 Chronic Conditions: 10%
- 5 Chronic Conditions: 12%
- 5+ Chronic Conditions: 48%

Medicare Benefit and Functional Limitation


Health care work force issues

- Insufficient number of geriatricians
- Shrinking pool of primary care providers
- Existing workforce is lacking the competencies to care for older Americans

Physician Preparedness for Management of Chronic Conditions

- Coordinate in-home and community services (66%)
- Educate patients with chronic conditions (66%)
- Manage the psychological and social aspects of chronic care (64%)
- Provide effective nutritional guidance (63%)
- Manage chronic pain (63%)

Site of Care
- Hospital
- Sub acute and/or Post Acute care
- Skilled Nursing Facility
- Patient’s Home
- Primary and Specialty Care Office
- Other Long Term Care
  - Nursing Home
  - Residential
  - Community and home based

Community & Home Based SVC
- Home services
  - Meals of wheels
  - Homemaker
  - Personal care
  - Home delivery
  - Friendly visitor, call
  - Emergency Response System
- Community
  - Respite care
  - Adult day care
  - Care manager
  - Congregate meal site

Paradigm Shift
- Home and Community Based Services
- Care Coordination
- Focus on
  - Quality
  - Efficiency
  - Patient satisfaction
  - Cost
Chronic care is:

- Fragmented
- Discontinuous
- Difficult to access
- Inefficient
- Unsafe
- Expensive

Marian Chen

- 79 year old widow
- Retired teacher
- Lives alone
- Income: SS, small pension
- Daughter lives 10 miles away with 3 teenagers
- Five chronic conditions
- Three physicians
- Eight medications

Mrs. Chen

- Confused by care, meds
- Quality of life is poor
- Out-of-pocket costs are high

Mrs. Chen’s Daughter

- Stressed out
- Reduced work to half-time
- Considering nursing homes

Source: Chad Boult, MD
In 2007, Mrs. Chen had...

Other Examples

- CHF Exacerbations
- Multiple diagnoses and meds
- Disease management
- Multiple providers
- Multiple settings
- Expresses preferences
- Hip fracture
- Frail older demented male
- Requires care from diverse professionals
- In diverse settings
- Cannot express preferences

Leading cause of elderly hospitalizations

- Congestive heart failure
- Pneumonia
- Coronary atherosclerosis
Back Again: Disease with highest 30 day re-hospitalization rates

<table>
<thead>
<tr>
<th>Disease</th>
<th>30 day Re-hospitalization Rate</th>
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</thead>
<tbody>
<tr>
<td>Heart Failure</td>
<td>26.6%</td>
</tr>
<tr>
<td>Psychosis</td>
<td>24.8%</td>
</tr>
<tr>
<td>COPD*</td>
<td>15.8%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>13.3%</td>
</tr>
<tr>
<td>Gastro-intestinal</td>
<td>14.9%</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td>14.3%</td>
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<tr>
<td>Cardiac stent placement</td>
<td>14.2%</td>
</tr>
<tr>
<td>Other vascular surgery</td>
<td>13.9%</td>
</tr>
<tr>
<td>Major hip, knee surgery</td>
<td>13.9%</td>
</tr>
<tr>
<td>Other hip, femur surgery</td>
<td>12.6%</td>
</tr>
<tr>
<td>Major bowel surgery</td>
<td></td>
</tr>
</tbody>
</table>

*Chronic obstructive pulmonary disease

Source: The New England Journal of Medicine

Chronic Care Model

- Health System
- Delivery System Design
- Decision Support
- Clinical Information Systems
- Self-Management Support
- Informed, Activated Patient
- Productive Interactions
- Prepared, Proactive Practice Team
- Outcomes
- Improved Outcomes

Approaches for Care Delivery

- Accountable Care Organization
- Targeting (segmentation)
- Patient Centered Medical Home, Guided Care, GRACE
- Centers of excellence (CareMore Model)
- Dementia care programs
- Self Management
- Other
Specific Interventions
- Care transitions Intervention (CTI)
- Care coordination (care management)
- Guided Care Nurse
- INTERACT III
- Office Re-Engineering

The Care Transitions Intervention
- Designed to facilitate successful transitions across settings of care
- Simple, adaptable, low cost intervention
- Consists of 4 Pillars

Four Pillars
- Medication self-management
- Use of patient-centered health record (PHR)
- Follow-up with PCP/Specialists
- Knowledge of warning signs-symptoms and how to respond
Care Transitions Intervention  
Summary of Key Findings

- Significant reduction in 30-day hospital readmits (while coached)
- Significant reduction in 90-day and 180-day readmits (sustained effect of coaching)
- Net cost savings of $300,000 for 350 pts/12 months

Coleman, MD, MPH

Care Coordination/ Care Management

- Collaborative model
- Helping chronically ill and their families to assess problems, communicate with healthcare providers and navigate the health-care system
- Care managers are usually employees of health insurers or capitated healthcare providers
- Associated with better satisfaction with care, quality of care, quality of life and survival
- Evidence demonstrating better functional autonomy is weaker
- Results on use of health services and cost are mixed

Key components for success of Care Coordination

- Targeting
- In person Contact
- Access to timely information on hospital & Emergency room admission
- Interaction between care Coordinator and PCP
- Diligently monitor medications
- Administer strong self-care education programs to help patients better manage their conditions
The Guided Care Model

- Specially trained RNs based in primary physicians’ offices
- RNs assist physicians in caring for high-risk patients with chronic conditions and complex health care needs

_Boyd et al., Gerontologist 2007; 47(5):697-704_

The Theory

Guided Care

- Improves quality
- Improves access
- Improves self-care

Improves outcomes:

- Use/cost of care
- Health Satisfaction

Nurse/physician team

- **Assesses** needs and preferences
- Creates an evidence-based “care guide” and an “action plan”
- **Monitors** patients proactively
- Supports chronic disease self management
- ** Communicates** with providers in EDs, hospitals, specialty clinics, rehab facilities, home care agencies, hospice programs, and social service agencies in the community
- **Smoothes transitions** between care sites
- Educates and supports caregivers
- Facilitates access to community services

_Source: Chad Boult, MD_
Who is Eligible?

All Patients Age 65+

- 25% High-Risk
- 75% Low-Risk

Review previous year’s claims data with HCC software

Source: Chad Boult, MD

Effects on Quality of Care at 6 Months

<table>
<thead>
<tr>
<th>PACIC scales:</th>
<th>GC</th>
<th>UC</th>
<th>aOR*</th>
<th>95% CI</th>
<th>P</th>
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<tbody>
<tr>
<td>Goal setting</td>
<td>24.6</td>
<td>11.6</td>
<td>2.4</td>
<td>1.5-3.7</td>
<td>&lt;0.001</td>
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<tr>
<td>Coordination</td>
<td>14.2</td>
<td>7.1</td>
<td>2.3</td>
<td>1.3-4.0</td>
<td>0.005</td>
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<tr>
<td>Decision support</td>
<td>42.7</td>
<td>33.1</td>
<td>1.5</td>
<td>1.1-2.1</td>
<td>0.014</td>
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<td>Problem solving</td>
<td>33.4</td>
<td>24.7</td>
<td>1.4</td>
<td>1.0-1.9</td>
<td>0.096</td>
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<tr>
<td>Patient activation</td>
<td>26.6</td>
<td>23.0</td>
<td>1.1</td>
<td>0.7-1.5</td>
<td>0.763</td>
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<tr>
<td>Aggregate</td>
<td>17.4</td>
<td>8.5</td>
<td>2.0</td>
<td>1.2-3.4</td>
<td>0.006</td>
</tr>
</tbody>
</table>

Adjusted for baseline socio-demographics, health, function, PACIC scores, and site. Boult et al., J Gerontol Med Sci 2008;63A(3)

Annualized Use of Services per Caseload (55 Beneficiaries)

<table>
<thead>
<tr>
<th>Services:</th>
<th>Guided Care N = 415</th>
<th>Usual Care N = 394</th>
<th>GC – UC Difference</th>
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</thead>
<tbody>
<tr>
<td>Hospital days</td>
<td>223</td>
<td>306</td>
<td>-83</td>
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<tr>
<td>Hospital admissions</td>
<td>208</td>
<td>228</td>
<td>-20</td>
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<tr>
<td>SNF days</td>
<td>135</td>
<td>267</td>
<td>-133</td>
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<tr>
<td>SNF admissions</td>
<td>46</td>
<td>69</td>
<td>-23</td>
</tr>
</tbody>
</table>

Leff et al. (in preparation)
### Annualized Cost of Services per Caseload (55 Beneficiaries)

<table>
<thead>
<tr>
<th>Services</th>
<th>GC – UC Difference</th>
<th>Average Expenditure</th>
<th>Total Savings (Spending)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital days</td>
<td>-83</td>
<td>$1,519/day</td>
<td>$126,077</td>
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<tr>
<td>SNF days</td>
<td>-133</td>
<td>$305/day</td>
<td>$40,565</td>
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<tr>
<td>Home health episodes</td>
<td>-47</td>
<td>$1331/episode</td>
<td>$62,557</td>
</tr>
<tr>
<td>Physician visits</td>
<td>8</td>
<td>$41/visit</td>
<td>($328)</td>
</tr>
<tr>
<td>Outpatient Lab tests</td>
<td>103</td>
<td>$31/lab test</td>
<td>($3,193)</td>
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<tr>
<td>Savings</td>
<td>-----</td>
<td>-----</td>
<td>$225,678</td>
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<tr>
<td>NET SAVINGS</td>
<td>-----</td>
<td>-----</td>
<td>$129,773</td>
</tr>
</tbody>
</table>

Leff et al. (in preparation)

### Six-month insurance costs

- Control patients: $5,964
- Guided Care patients: $4,586
- Savings: $1,378*

*S Not statistically significant

Sylvia et al. Dis Manag 2008;11(1)

### The INTERACT Program: What is It and Why Does It Matter?

- **“BOOST”**
  - Better Outcomes for Older Adults Through Safe Transitions
  - [http://www.hospitalmedicine.org](http://www.hospitalmedicine.org)
  - [“Project RED”](http://www.bu.edu/fammed/projectred)

- **“Bridge Model”**
  - [http://www.interact2.net](http://www.interact2.net)

- **“Care Transition Program”**
  - [http://www.interact2.net](http://www.interact2.net)

- **“POLST”** (or “MOLST”)
  - [http://www.fredericksburg.org](http://www.fredericksburg.org)

- **“Transitional Care Model”**
  - [http://www.transitionalcare.info/index.html](http://www.transitionalcare.info/index.html)

- **“INTERACT”** (Interventions to Reduce Acute Care Transfers)

High Quality Care Transitions for Older Adults & Caregivers

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INTERACT

- Strategies to reduce potentially avoidable hospitalizations
- A collaborative quality improvement program designed to reduce potentially avoidable hospitalizations
- Strategies to implement the INTERACT III tools into everyday practice in the NH
- Engaged nursing homes reduced rehospitalization by 24%

Stratification/Segmentation

- Level and intensity of services
- Utilization of Hospitalization/ED Visits
- Functional decline
- Death

Levels of Risk/Need

- Healthy older persons
  - Primary medical care
  - Health assessment/promotion/prevention
- Early frail/low risk/chronic disease
  - Preventive home visits
  - Primary medical care
  - Single chronic disease management
- Medium risk/early disability
  - Primary medical care
  - Annual geriatric assessment
  - Complex chronic disease management
- Disability + co morbidity
  - “Complex” systems of integrated care

Courtesy: H. Bergman MD
A Geriatric Perspective
Finding the Appropriate Balance and the Right Plan

Increasing age and frailty

Changing Outcomes Requires Fundamental Practice Change

- Better use of non-physician team members
- Enhancements to information systems
- Planned encounters
- Modern self-management support for ambulatory patients

Geriatric Care Model

Community Resources & Policies
Exercise, Alzheimer support, Depression support

Health System
Health Care Organization

Self-Management Support
CDSMP PST

Delivery System Design
CCA Pharmacy review, transition care

Decision Support SRT on site

Clinical Information Systems
Shared Care Plan

Informed, Activated Patient

Prepared Practice Team

Informed, Activated Caregivers

Senior Resource Team

Improved Outcomes
Scheduling the AWV

Starting the AWV

Preventing for the visit

Day of the Visit

Starting the Questionnaire

Scheduling Requirements

Concluding the visit

Providing care for the right persons at the right place and for the right price

- Targeting the “dose” of care
- Selecting the site of care
- Soliciting patient goals and preferences
- Changing the practice work flow
  - Delegate care to non-physicians
  - Share information (e.g., EHR)
  - Utilize evidence and or consensus based approaches
- QI
Summary

- Health care environment is dynamic and ever changing
- Chronic Disease management is the new frontier
- Clinical practice and behavior responding to fiscal mandate
- Efficiency and innovation in practice are timely
- Opportunities for physician leadership, increased involvement and accountability
- No single approach has been found to be perfect
- ACA has more surprises to come
- It may be a rollercoaster - fasten your seat belts and enjoy the ride

African Wisdom

- “If you wish to get somewhere fast go alone, but if you wish to get farther join others, and walk together...”