Why Develop Some Local Management of Services for Frail Elderly Persons?

1. Local entities could integrate social supports and health care
2. Local entities could monitor and manage some issues better than state/federal
3. Having a local role is politically plausible
Driver: Manage Local Production System

Manage a trustworthy, effective, responsive local service production system with a competent, thriving workforce

- Provide information system to monitor supply, practices, and quality
- Enable governance of the local care system in the interest of frail elders
- Develop appropriate numbers and skills of workforce; reasonable rewards and career ladders
- Reflect appropriate priorities: Reliability, continuity, endurance, dignity

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 TRANSITIONS: 10 OR MORE
CINCINNATI AREA READMISSIONS OVER TIME

Patient-Reported Pursuit of Goals
Uneven interval, multiple reporting strategies

<table>
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<th>Date</th>
<th>Score</th>
<th>Ideal Score</th>
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BÄTTRE LIV FÖR DE MEST SJUKA ÄLDRE I JÖNKÖPINGS LÄN – KOMMUNER OCH LANDSTING TILLSAMMANS
[better life for the elderly people in Jonkoping]

MÄTTAVLA
[dashboard]

Äldres läkemedelsanvändning i Jönköpings län

Jonkoping hospitals and municipalities

Oliämliga läkemedel1 hos personer 65 år eller äldre i Jönköpings län, 06-2012

Antipsykotiska läkemedel hos personer 65 år eller äldre i Jönköpings län, 06-2012
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
An Ideal Service Production System

- What inputs would you need to optimize service production?
- What follows is an untested “alpha version” - many important elements not yet included, but models a very appealing approach.
- With good care plans for a population, one could model the production system.

“Alpha” Optimal Production System
- How many frail elderly?

- In a community of 600,000 residents, about 6000 die each year, about 5000 in old age, and about half have frailty as their last phase of life.
  - 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

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

Attendance around the clock and 3 hrs direct services daily

"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

4000 X 6 = 24,000 visits needed

▲ 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

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

<table>
<thead>
<tr>
<th></th>
<th>1000 NH Elders</th>
<th>1500 Community Elders</th>
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</thead>
<tbody>
<tr>
<td>Direct care workers</td>
<td>500</td>
<td>1500 (½-3 per person)</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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</table>

Stepping Stones to Local Monitor/Manager  
– Interim Models in place

1. A voluntary coalition of health care and social service providers, with consensus governance  
2. A regional direct service Medicare provider contracting with at-risk payers  
3. A regional direct social services provider contracting with at-risk payer  
4. A voluntary coalition of health care and social service providers convened by government and organized in part as contractor with at-risk payers
Stepping Stones
– Interim Model #1: Voluntary Coalition

- Health Care Providers
- Social Service Providers
- Flexible Local Resources

- Steering Committee
- Monitoring population well-being
- Guiding projects
- Generating networks
- Encouraging commitments

Stepping Stones
– Interim Model #2: Home/Hospice provider

Service Array

- Local MDs
- Community Services, e.g., AAAs

Home Health Care Service Provider Working with Private Physicians Providing:
- ✓ Nursing
- ✓ Education
- ✓ Caregiver Support
- ✓ Social Services Coordination
- ✓ Small scale fill-in services
Growing from hospice roots

$\text{ACOs}$

$\text{Medicare Adv, Including Special Needs}$

$\text{Managed Care for Dual-eligible}$
Stepping Stones
– Interim Model #3: Social Services provider

Bi-Directional Services & $$$

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<th>$$$</th>
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<td>Home Social Services Provider</td>
<td>ACOs</td>
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<tr>
<td>Working with Health Care Providers</td>
<td>Providing:</td>
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<tr>
<td>Working with other Social Service Providers</td>
<td>✓ Coordination</td>
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<tr>
<td>Providing:</td>
<td></td>
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<tr>
<td>Growing from community service roots</td>
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Stepping Stones
– Interim Model #4: County Social Services provider

Services and $$$

<table>
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<tr>
<td>Community Social Services</td>
<td>Integrated Health Care Systems</td>
</tr>
<tr>
<td>County Government/AAA/ADRC</td>
<td>Managed care Insurers</td>
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<tr>
<td>Contracting with both medical care &amp; social services providers</td>
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</tr>
<tr>
<td>Providing:</td>
<td></td>
</tr>
<tr>
<td>✓ Coordination</td>
<td></td>
</tr>
<tr>
<td>✓ Transportation services</td>
<td></td>
</tr>
<tr>
<td>✓ Poverty and gap services</td>
<td></td>
</tr>
<tr>
<td>✓ System monitoring</td>
<td></td>
</tr>
<tr>
<td>✓ Coalition formation</td>
<td></td>
</tr>
<tr>
<td>Growing from public health &amp; social services</td>
<td></td>
</tr>
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</table>
Organizing to manage locally

- Which teams already do some local management?
- What works in organizing a local coalition?
- What are the strengths and weaknesses of a dominant medical care provider?
- Who needs to be “at the table?”
- What entities already have an obligation to assess community health care?

Some tips on Community

- Expect to have to re-start (or re-organize) a few times
- Governance starts with consensus – and has to grow strong enough to proceed with some discord
- Funding is important, but can drive parties apart quickly
- Keep the door open to late arrivals (or “returns”)
- Civic leaders are helpful
- Affected patients/clients/families are essential (consider “owners” rather than “patients” or “beneficiaries”)
Competition and Cooperation

- What works?
- What sinks cooperative endeavors?
- How much of an issue is anti-trust? How can you mitigate the risks?
- Collective monitoring and system management

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?
**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)
▲ Assume it will take 2 years to get to full impact
▲ Adjust for expected deaths, assume no mortality effect
▲ Adjust for inflation
▲ Ignore moving in and out of area (assume balance, and modest)

**How it comes out…**

▲ For four geographic communities, enrolling 15,000 caseload
▲ With many waivers on benefit rules
▲ And $17million for patient care, $13million for start-up/evaluation
▲ $23 million ROI in first 3 years

<table>
<thead>
<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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<tbody>
<tr>
<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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<tr>
<td>After Deducting In-Kind Costs</td>
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<td>$8,463,101</td>
<td>$17,629,209</td>
<td>$22,614,284</td>
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For more on the finances, see [http://medicaring.org/2013/08/20/medicaring4life/](http://medicaring.org/2013/08/20/medicaring4life/)
STRONG CLAIMS FOR SERIOUS REFORM

1. **We are buying the wrong product.** We should not just refinance that purchase – we should change the product!

2. We can have what we want and need when old and frail, **with a reduction in per capita cost**, but only by deliberately redesigning service delivery.

3. **We cannot keep doing what we now do.** Without reform, costs will force us to turn away from elderly people who have no other options, through no fault of their own.

But how to motivate the changes, and sustain them?

▲ In 3rd year – convert each locality 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
What do you think?

△ Plausible somewhere?
△ Plausible in your community?
△ Which one(s)? What other models might work for you?

1. A voluntary coalition of health care and social service providers, with consensus governance
2. A regional direct service Medicare provider contracting with at-risk payers
3. A regional direct social services provider contracting with at-risk payers
4. A voluntary coalition of health care and social service providers convened by government and organized in part as contractor with at-risk payers

“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 in the US

▲ For Data
  ▪ [www.communitydatapalooza.org](http://www.communitydatapalooza.org) (check out Cincinnati)
  ▪ Your QIO – (ask for help with “care transitions”)
▲ For Community Organizing
  ▪ [http://www.cfmc.org/integratingcare/learning_sessions.htm](http://www.cfmc.org/integratingcare/learning_sessions.htm)
▲ For Workforce in Elder Care
▲ For more on Financing
  ▪ [http://medicaring.org/2013/08/20/medicaring4life/](http://medicaring.org/2013/08/20/medicaring4life/)

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At Home Support™ AIM Model

[Diagram of At Home Support™ AIM Model]

Tier 3A

At Home ANALYTICS
  • Predictive Modeling
  • Outcomes Analytics

At Home SUPPORT
  • In-Home Services 24/7/365

At Home TRANSITIONS
  • ER & Hospital At Home COACHES

At Home SENSORS
  • 24/7/365

At Home TELESUPPORT
  • 24/7/365

At Home SUPPORT
  • 24/7/365

At Home COACHES
  • 24/7/365

At Home COACHES
  • 24/7/365
AIM Service Delivery Model – 24/7 Home-Based Care

Predictive Modeling Analytics – Accurate Patient Identification
Outcome Analytics – Concurrent Quality & Cost Monitoring

- **Quality**
  - Pain and Symptom Management
  - Patient Quality of Life Measures
  - Family Caregiver Burden Measures
  - Patient/Family/Physician Satisfaction

- **Utilization Measures**
  - Census
  - Hospitalizations
  - Hospital Readmissions
  - ER Visits
  - ER Visits Prevented
  - Polypharmacy

- **Cost**
  - Total Net Cost/Pt. Day

AIM Service Delivery Model – One-Stop Shopping

At Home TELESUPPORT 24/7/365
Table Discussion

- Discuss the possibilities for local monitoring and management
- If any participant is from another country, be sure to learn what sort of local engagement that country has – and how it merges LTSS and medical care