Accountable Care Communities for Frail Elders

Joanne Lynn, MD, Altarum Institute
Brenda Schmitthenner, San Diego County Aging and Independence Services
Mimi Toomey, Administration for Community Living

December 7, 2014

Session Objectives

- To identify frail elders using available information
- To develop an adequate care plan for each frail elder
- To create an implementation plan for adapting medical and supportive services for this population
- To mock up a community dashboard for monitoring and a plan for governing
- To test the possibilities for medical care savings
Single Classic “Terminal” Disease: “Dying”

Onset incurable disease

Function

Mostly cancer

Death

Time

Often a few years, but decline usually over a few months

Prolonged dwindling

Function

Mostly frailty and dementia

Now, most Americans have this course.
The numbers will triple in 30 years.

Onset could be deficits in ADL, speech, ambulation

Death

Time

Quite variable, often 6-8 years
U.S. Consumption by Age

(Y axis: 1 = average labor income, ages 30-49)  
(X axis: Age)

- Pink: Public $ towards Health Care per capita
- Yellow: Private $ towards Health Care per capita


How are we going to keep from big trouble?
THE SAN DIEGO CARE TRANSITIONS PARTNERSHIP

Transforming Care Across the Continuum

Brenda Schmitthenner, MPA
County of San Diego, Aging & Independence Services
brenda.schmitthenner@sdcounty.ca.gov

Transformation-Competition to Coop-etition
The Community-based Care Transitions Program (CCTP)

A strategic partnership between Palomar Health, Scripps Health, Sharp HealthCare, the UCSD Health System – 11 hospitals/13 campuses, and AIS/County of San Diego

Goals of the Community-based Care Transitions Program (CCTP):

- Improve transitions from the inpatient hospital setting to community
- Improve quality of care
- Reduce readmissions for high risk beneficiaries, and
- Document measurable savings to the Medicare program

CCTP: Impact of Readmission Rates cont.

<table>
<thead>
<tr>
<th>30 Day Hospital Readmission Rate</th>
<th>2012 Target Group Baseline</th>
<th>CCTP Participants</th>
<th>CCTP Completers</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012 Target Group Baseline</td>
<td>39.8%</td>
<td>13.9%</td>
<td>11.7%</td>
</tr>
</tbody>
</table>

Target Group baseline: CCTP participants 30-day readmission rate from 2012
CCTP Participants: Those who completed services (CCTP Completers) and those who did not complete all aspects of the program
CCTP Completers: CCTP participants who completed all aspects of the program
San Diego County: Seasonally Adjusted Admissions per 1000 Beneficiaries

San Diego County: Seasonally Adjusted Readmissions per 1000 Beneficiaries
San Diego County: Seasonally Adjusted Percent Discharges w/30-Day Readmissions

Mimi Toomey
Senior Advisor
Administration for Community Living
**National Aging Services Network**

Provide Services and Supports to 1 in 5 Seniors

**Administration on Aging**
Central Office and Regional Offices

**State Units on Aging (56)**

**Area Agencies on Aging (629)**

Local Service Providers (29,000)

Consumers

- 240 Million Meals
- 29 Million Hours Personal Care
- 700,000 Caregivers Assisted
- 69,000 Caregivers Trained
- 6.4 Million Hours Respite Care

Tribal Organizations (228)

Governors & State Legislators

Units of Local Government

**National Aging Organizations**

State Advisory Councils

Area Advisory Councils

**State Units on Aging (56)**

**Area Agencies on Aging (629)**

**Local Service Providers (29,000)**

Consumers

- 455,000 Ombudsman Consultations
- 4 Million Hours Case Management
- 28 Million Transportation Rides

**Institutional Services**

- Preventive health services
- Voluntary organizations
- Nutrition services
- Community services
- Information & access services
- Caregiver supports
- Elder rights services
- In-home services

**Institutional Services**

- Managing chronic disease
- Activating patients
- Preventing hospital (re)admissions
- Avoiding long-term NF stays

**Expanding Scope to Meet Client Needs**

Traditional Scope of LTSS Services
- Home-delivered and congregate meals
- Transportation
- Medication reconciliation
- Respite/Caregiver support
- Falls/Home risk assessments
- Information and assistance
- Personal care
- Employment-related supports
- Homemaker
- Shopping
- Money management

Expanded Scope of Services
- Stanford model of chronic disease self-management
- Diabetes self-management
- Nutrition counseling
- Education about Medicare preventive benefits
- Evidence-based care transitions
- Person-centered planning
- Chronic disease self-management
- Benefits outreach and enrollment
- Nursing facility transitions (Money Follows the Person)
- Person-centered planning
- Assessment/pre-admission review
HOW TO FIND US:
Eldercarelocator.gov

My Contact Information:
Mimi Toomey
Mimi.Toomey@acl.hhs.gov

MediCaring:
An “Accountable Care Community”
for Frail Elders

Joanne Lynn, MD
Director, Center for Elder Care and Advanced Illness
Altarum Institute
At IHI Forum, Wednesday, December 10, 2014
Single Classic “Terminal” Disease: “Dying”

- Onset incurable disease
- Often a few years, but decline usually over a few months
- Mostly cancer

Prolonged dwindling

- Onset could be deficits in ADL, speech, ambulation
- Quite variable, often 6-8 years
- Mostly frailty and dementia
- Now, most Americans have this course.
- The numbers will triple in 30 years.
- Death
Components of Frailty

- Multiple chronic conditions
- Sensory and Motor impairments
- Sarcopenia
- Osteopenia
- Dysregulation
  - Hypothalamic-pituitary axis
  - Inflammation
  - Immune system function
  - Decreased heart rate variability

Identification of Frail Elders in Need of MediCaring™

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

**Frail Elderly**

**Age >65**
- **Want a sensible care system**

**Age >85**
- Unless Opt Out

**Use what you have to defining frailty**

- ▲ Age
- ▲ Disability
- ▲ Hospitalization / ED visits
- ▲ Nomination from clinicians (or self)
- ▲ Braden Scale (proxy)

- ▲ And improve upon it!
About the frail phase of life

- Average disability – nearly 3 years if alive at age 65
- Few have private long-term care (LTC) insurance (about 1/10)
- Fewer have saved enough for average costs
- Baby Boomers have
  - Fewer, nearby adult children to serve as caregivers
  - Adult children who work outside the home and must continue
  - Family caregivers face economic risk (lost wages, lost benefits, inadequate retirement savings, difficult re-entry to work)
- Increasing reliance on Medicaid paying for LTC
  - Medicare and supplemental insurance generally does not cover LTC
  - Private assets, and spend down for low and middle income, pay first

So will we abandon frail elders…. or will we create an alternative?

SDCTP – Patient Centered Care

[Diagram of SDCTP – Patient Centered Care]

11/25/2014
Mimi Toomey
Senior Advisor
Administration for Community Living

National Aging Services Network
Provide Services and Supports to 1 in 5 Seniors

Tribal Organizations (228)
Governors & State Legislators
Units of Local Government

Administration on Aging
Central Office and Regional Offices

State Units on Aging (56)

Area Agencies on Aging (629)

Local Service Providers (29,000)

Consumers

240 Million Meals
29 Million Hours Personal Care
700,000 Caregivers Assisted
69,000 Caregivers Trained
6.4 Million Hours Respite Care

455,000 Ombudsmen Consultations
4 Million Hours Case Management
28 Million Transportation Rides

Consumers
Expanding Scope to Meet Client Needs

Traditional Scope of LTSS Services
- Home-delivered and congregate meals
- Transportation
- Medication reconciliation
- Respite/Caregiver support
- Falls/Home risk assessments
- Information and assistance
- Personal care
- Employment-related supports
- Homemaker
- Shopping
- Money management

Expanded Scope of Services

Managing chronic disease
- Stanford model of chronic disease self-management
- Diabetes self-management
- Nutrition counseling
- Education about Medicare preventive benefits

Avoiding long-term NF stays
- Evidence-based care transitions
- Care coordination
- Medical transportation
- Evidence-based medication reconciliation programs
- Evidence-based fall prevention programs
- Caregiver support

Acting patients
- Evidence-based care transitions
- Person-centered planning
- Chronic disease self-management
- Benefits outreach and enrollment

Preventing hospital (re)admissions
- Nursing facility transitions (Money Follows the Person)
- Person-centered planning
- Assessment/pre-admission review

How to Find Us:
Eldercarelocator.gov

My Contact Information:
Mimi Toomey
Mimi.Toomey@acl.hhs.gov
MediCaring: An “Accountable Care Community” for Frail Elders

Joanne Lynn, MD
Director, Center for Elder Care and Advanced Illness
Altarum Institute
At IHI Forum, Wednesday, December 10, 2014

Single Classic “Terminal” Disease: “Dying”

- Mostly cancer
- Often a few years, but decline usually over a few months

Function
Onset incurable disease
Time
Death
Prolonged dwindling

Mostly frailty and dementia
Now, most Americans have this course.
The numbers will triple in 30 years.

Onset could be deficits in ADL, speech, ambulation

Quite variable, often 6-8 years

INTACT FUNCTION
Cognitive, Physical & Social

IMPAIRED FUNCTION
Cognitive, Physical, Social

ROOM TO SPARE

NO MARGIN FOR ERROR

NO MARGIN OF RESERVE
Components of Frailty

- Multiple chronic conditions
- Sensory and Motor impairments
- Sarcopenia
- Osteopenia
- Dysregulation
  - Hypothalamic-pituitary axis
  - Inflammation
  - Immune system function
  - Decreased heart rate variability

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
  - With Opt In

- **Unless Opt Out**
Use what you have to defining frailty

- Age
- Disability
- Hospitalization / ED visits
- Nomination from clinicians (or self)
- Braden Scale (proxy)

- And improve upon it!

About the frail phase of life

- Average disability – nearly 3 years if alive at age 65
- Few have private long-term care (LTC) insurance (about 1/10)
- Fewer have saved enough for average costs
- Baby Boomers have
  - Fewer, nearby adult children to serve as caregivers
  - Adult children who work outside the home and must continue
  - Family caregivers face economic risk (lost wages, lost benefits, inadequate retirement savings, difficult re-entry to work)
- Increasing reliance on Medicaid paying for LTC
  - Medicare and supplemental insurance generally does not cover LTC
  - Private assets, and spend down for low and middle income, pay first

So will we abandon frail elders…. or will we create an alternative?
Distribution of Community Residents and Health Care Spending Among the Top 5% of Spenders by Select Groups (2006)

Overview of Community Residents with Functional Limitations and Chronic Conditions by Age Group

<table>
<thead>
<tr>
<th></th>
<th>Number of Community Residents (Millions)</th>
<th>Percent of Age Group with Chronic Conditions &amp; Functional Limitations</th>
<th>Total Health Care Expenditures (Billions)</th>
<th>Average Annual Health Care Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Ages</td>
<td>42</td>
<td>14%</td>
<td>$473</td>
<td>$11,283</td>
</tr>
<tr>
<td>Age 65 &amp; Older</td>
<td>18</td>
<td>48%</td>
<td>$235</td>
<td>$12,880</td>
</tr>
<tr>
<td>Under Age 65</td>
<td>24</td>
<td>9%</td>
<td>$239</td>
<td>$10,068</td>
</tr>
</tbody>
</table>


Who We Serve: The Poor and Near Poor
The Aging Network Serves Nearly 1 in 5 Older Adults

<table>
<thead>
<tr>
<th></th>
<th>US Population</th>
<th>OAA Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>60+</td>
<td>57.8 million</td>
<td>11 million*</td>
</tr>
<tr>
<td>Poverty</td>
<td>9.30%</td>
<td>30%</td>
</tr>
<tr>
<td>Near Poor**</td>
<td>15-20%</td>
<td>73-85%</td>
</tr>
</tbody>
</table>

* 3 million OAA clients receive intense services such as home-delivered nutrition and homemaker services.
** Near poor is defined as below 150% of poverty.
Note: $77,000 per year for private room nursing home care, $35,000 per year for assisted living (2007 dollars)
Who We Serve: The Frail & Vulnerable

<table>
<thead>
<tr>
<th></th>
<th>US Population 60+</th>
<th>OAA Clients (In Home Service)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lives Alone</td>
<td>27%</td>
<td>55% - 69%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>22%</td>
<td>26% - 35%</td>
</tr>
<tr>
<td>Heart Condition</td>
<td>29%</td>
<td>43% - 53%</td>
</tr>
<tr>
<td>Minority**</td>
<td>20%</td>
<td>25%</td>
</tr>
<tr>
<td>Rural**</td>
<td>13%</td>
<td>37%</td>
</tr>
</tbody>
</table>

* Includes such services as homemaker, case management, and home-delivered nutrition.
** US Minority & Rural figure is for the 65+ population

Who We Serve:

- OAA Clients are at risk for ER visits & Hospitalization:
  - Over 90% of OAA Clients have Multiple Chronic Conditions
    - Compared to 73% of general older adult population (age = 65+)
  - 69% of Case Management Clients take 5 or more medications daily

- OAA Clients are at Risk for Nursing Home Admission:
  - 35% of Home-Delivered Nutrition Clients have 3+ Activities of Daily Living (ADL) Impairments
  - 69% of Home-Delivered Nutrition Clients have 3+ Instrumental Activities of Daily Living (IADL) Impairments
## Talk with your table

- How can you find your cohort of frail elders?
- What data is available?
- How many do you think there are?
- How long do they live?
- What proportion of care needs to be in facilities? In the home?

## Assessment and care plan

- **Domains to understand**
  - Medical, social, environmental, financial
  - Priorities, fears, aspirations, goals
  - Past, present, AND FUTURE
- Care planning process
- Care planning evaluation
Geriatricize Medical Care

▲ Continuity
▲ Reliability, 24/7 to the end of life
▲ Enable self-management around disabilities
▲ Respect and include family and other caregivers
▲ Reduce the burden of medical care
▲ Move services to the home
▲ Prevent falls, wrong actions
▲ Enhance relationships, activities, meaningfulness
▲ Be steadfast with dementia
The Care Plan (Concerns, Goals, Interventions, and Care Team), along with Risk Factors and Decision Modifiers, iteratively evolve over time.

A Model Service Production System

▲ 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.
“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
  ▪ 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

1000 Nursing Home

2500 Family Provided Care

1500 Community Provided Care

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!
“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?

<table>
<thead>
<tr>
<th></th>
<th>1000 NH Elders</th>
<th>4000 Community Elders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct care workers</td>
<td>500</td>
<td>1500 (½-3h 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>
</tr>
<tr>
<td>Hospital Beds</td>
<td>50</td>
<td>250</td>
</tr>
</tbody>
</table>
Long Term Services and Supports (LTSS) Care Planning

- Begins with a comprehensive, functional and psychosocial in-home assessment
- Planning includes:
  - LTSS needs assessment
  - Coordination with the patient’s care team
  - Development of an individualized care plan-patient goals
  - Referral to and coordination of LTSS
  - Case active-short or long term
  - Home visits and follow-up phone calls are not limited and are determined by the need/risk of the patient

Long Term Services and Supports

- Technology
- Transportation
- Homemaker assistance
- Personal care assistance
- Durable medical equipment
- Copayments for medications
- Home delivered meals
- Respite care
- Assistance with applying for benefits
Profile of LTSS Recipient

Assessed Risk

Demographics
- 59% of patients are female
- 44% fall at or below the Federal Poverty Level
- 31% receive SSI
- 53% are Dual Eligibles
- 25% are Hispanic
- 23% speak Spanish only

Top Admitting Diagnosis
- 38% Chest Pain
- 31% Shortness of Breath
- 11% Abdominal Pain
- 11% Congestive Heart Failure
- 9% Syncope

Coordinated Services

Advanced Care Planning
Advanced Care Planning is a tool that empowers the patient to manage their lives/health and their wishes. It’s about putting the patient in the driver’s seat to make the decisions that are required as they navigate through changes in their health. It is a “Soft” landing for a difficult conversation.

The discussion:
- Puts the patient’s voice on paper
- Ensures that family is aware of wishes
- Encourages patient to start thinking about their wishes
- Facilitates family communication and acceptance of their loved one’s decision
- Reduces in family stress and emotional turmoil at having to “guess” in a crisis

Tools given to patient:
- 5 Wishes booklet
- Advanced Directives
- Contact information for clinical specialists - Palliative Care and Hospice
- POLST
Connections to LTSS During Transitions

9,053 people connected to 12,131 services and supports

- Nutrition Services or Counseling: 2.1%
- Home Delivered Meals: 18.5%
- Other LTSS: 11.5%
- CDSMP: 14.9%
- DSMP: 3.3%
- Exercise Program: 2.6%
- Falls Management and Prevention: 4.6%
- Medication Management: 5.2%
- Mental Health and Substance Misuse: 1.4%
- Alzheimer's Programs: 1.9%
- Home Injury/Risk Screenings: 0.8%
- Other Health Prevention Programs: 0.5%
- Transportation: 14.7%
- Caregiver Support: 3.9%
- Personal care/homemaker/choremaker services: 14%

Examples of Long Term Service and Support Needs During Transitions

| Adult Day Care | Home Delivered Meals |
| Adult Literacy Programs | Home Injury/Risk Screenings |
| Adult Protective Services | Hospice |
| Alzheimer's Programs | Housing Assistance |
| Assistive Technology | IHSS |
| Blood Pressure Monitor | Legal Support |
| Care Management | Low cost RX program |
| Caregiver Support | LTC Assistance |
| CDSMP | Medicaid |
| CHF Education | Medication Management |
| Community Clinics | Mental Health and Substance Misuse |
| Dental Care | Nutrition Services or Counseling |
| DSMP | Personal care/homemaker/choremaker |
| Exercise Program | Respite Care |
| Falls Management and Prevention | Rx coverage |
| Financial Services | Smoking Cessation |
| Food stamps/food bank | Social Security |
| Health Eating | Support Groups |
| Health Information | Telephone Reassurance |
| Heating Assistance | Transportation |
Talk with your table

▲ How can you judge an adequate assessment?
▲ What makes a good care plan?
▲ Who needs access to the care plan? When?
▲ Build a quick care plan for a frail elderly person – one participant pretend to be the elderly person
▲ How could your provider setting make good care plans standard?

Break!

▲ Come back by 3pm
Fixing the service array

- Geriatricizing medical care
  - Much more thoughtful about merits of standard care
  - Reliable access to the care plan
  - 24/7 ability to evaluate and treat at home
  - Attention to falls, depression, delirium, behavioral issues
  - Care planning and advance care planning
- Balancing investments in social and supportive services

---

2009 Health and Social Expenditures as Percentages of GDP

![Chart showing 2009 Health and Social Expenditures as Percentages of GDP](chart.png)

*Both Switzerland and Turkey are missing data for 2009 and have been excluded from the chart.*
Ratio of Social to Health Service Expenditures Using 2009 Data

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

Inappropriate
Unreliable
Unmanaged
Wasteful “care”
Three strategies for integration

- Established mission, vision, goals
- Three strategies for integration

- Began 1999
- Today over 800 stakeholders

Long Term Care Integration Project (LTCIP)

TEAM SAN DIEGO

Home and Community-Based Brokerage

- Resource for healthcare providers for their medically and socially complex patients
- Facilitates access to a network of quality HCBS providers
- Prevents duplication in services and fills service gaps
- Streamlines fiscal and administrative functions for both healthcare providers and HCBS providers
- Ensures an adequate network of HCBS providers to meet the growing aging population
Talk with your table partners

▲ What are major shortcomings in geriatric care where you are? How could you know?
▲ What are the major shortcomings in LTSS where you are? How could you know?
▲ Are there local taxes or other local or state supports for LTSS, other than just Medicaid, where you live?
▲ What do you see as options for your community when the number of frail elderly people doubles within 20 years?

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 off-budget or less expensive services
▲ Localities can address employer issues for caregivers
▲ Local management is politically plausible now
Can MediCaring save enough to make it work?

Projected Savings in 4 Communities (2013)

PBPM Savings over Time

PBPM – Per Beneficiary Per Month

What should the community monitor?

▲ Basics of good medical care, of course
▲ But also – food, housing, caregiver, transportation
▲ And meaningfulness, social engagement
▲ Specifically –
  ▪ Reliability of the care system
  ▪ Alignment of the care plan with personal priorities
  ▪ Financial effects
▲ And for the geographic community
The *MediCaring* Service Delivery Model

- Frail elders enrolled in a geographic community
  - (>65 w/2+ ADLs or dementia, or 80+; opt in)
- Longitudinal, elder-driven care plans
- Tailored, more efficient medical care to frail elders (including at home)
- Incorporate health, social, and supportive services
- Ongoing monitoring and improvement guided by local Community Board
- Core funding from Medicare savings in a modified ACO structure

---

**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**

![Diagram of Jönköping hospitals and municipalities]

**Pressure ulcer rate for People living in service homes**

![Graph showing pressure ulcer rate for people living in service homes]

**Pressure ulcer risk assessment in service homes**

![Graph showing pressure ulcer risk assessment in service homes]
Build the dashboard you want

- Work alone or with a neighbor or two
- Mock up the priority domains
- Name the data source to use for one of them
- Sketch out the X and Y axes and make up the data you want to see
- Who should be monitoring this?

We can have what we want and need when we are old and frail

But only if we deliberately build that future!