Care to Count on for Our Frail Years: The MediCaring™ Reform

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“It’s paradoxical that the idea of living a LONG LIFE appeals to everyone, but the idea of GETTING OLD doesn’t appeal to anyone.”

- Andy Rooney
What We Want in Old Age …
... What We Get

While old age may always be challenging, we have made it unnecessarily terrifying and miserable
▲ Post-WWII “baby boom”
▲ Since Jan 1, 2011 turning 65 at a rate of 10,000 per day
▲ By 2030 in the U.S. ~20% of population will be ≥65 - and
▲ Twice as many people will be frail, compared with today
How are we going to keep from big trouble?
MediCaring™! Key Components of Reform

1. Customize services for frail elderly
2. Generate care plans
3. Geriatricize medical care
4. Include long-term services and supports
5. Develop local monitoring and management
6. Fund added services and management from medical efficiency

Channel the public’s fear and frustration into the will to change
Identify Frail Cohort

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INTACT FUNCTION
Cognitive, Physical & Social

IMPAIRED FUNCTION
Cognitive, Physical, Social

ROOM TO SPARE

NO RESERVE
Where’s Waldo???
About the Frail Elder Cohort

Three common definitions:
1. Multiple chronic conditions
2. Losing muscle strength
3. Functional disability

All definitions overlap a lot, Practically, combine some of these:
 a. Age (or Medicare)
 b. Functional disability
 c. Serious chronic condition
 d. Hospitalization or equivalent
Must we be exact in finding the cohort?

- Redesign and adaptation will not add hefty expenses
- Nothing in medical care becomes unavailable – just used more thoughtfully and with more attention to the elderly person’s perspective
- More reliable supportive services
- So – neither the client or the community are put at substantial risk
- And the category only needs to be “about right” – some over-inclusion is easy to accommodate
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 >80**

- Want a sensible care system

Unless Opt Out

With Opt In
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COMPREHENSIVE EVALUATION

PERSON-CENTERED CARE PLAN
What’s essential in developing a good care plan?

- Thorough understanding of the person/family situation
- Reasonable prognostication
- Availability and acceptability of services
- Effective communication, sensitive but honest
- Person (and family) priorities, fears and hopes
- Involvement of all key service providers
- Discussion/negotiation –
- Time and event triggers for re-evaluating
- Document
## Traditional vs Ideal Assessment Frail Elderly

<table>
<thead>
<tr>
<th></th>
<th>Ideal</th>
<th>Traditional</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Focus</strong></td>
<td>Functional status &amp; person’s preferences</td>
<td>Medical</td>
</tr>
<tr>
<td><strong>Scope</strong></td>
<td>Comprehensive</td>
<td>Focused</td>
</tr>
<tr>
<td><strong>Domains</strong></td>
<td>Proactive assessment of expanded domains</td>
<td>Reactive attention to non-medical issues</td>
</tr>
<tr>
<td><strong>Person-Centered</strong></td>
<td>Totally focused on person-centered goals</td>
<td>Sometimes</td>
</tr>
<tr>
<td><strong>Providers of Care</strong></td>
<td>Well-trained collegial IDT</td>
<td>Independent providers; untrained ad hoc IDT</td>
</tr>
<tr>
<td><strong>Care Plan</strong></td>
<td>Dynamic, negotiated &amp; comprehensive</td>
<td>Medical focus, “doctor’s orders”</td>
</tr>
</tbody>
</table>
About Customized Service Plans

Articulated Values → Goals → Plan → Integration → Implement → Feedback

Outcome

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
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What’s Wrong with Medical Services?
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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Inappropriate
Unreliable
Unmanaged
Wasteful “care”

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No Integrator
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
United States Ranking in Health vs. Social Spending

2009 Health and Social Expenditures as Percentages of GDP

*Switzerland and Turkey are both missing data for 2009*

United States Ranking in Health vs. Social Spending

Ratio of Social to Health Service Expenditures (% of GDP) using 2009 Data

Also in The American Health Care Paradox: Why Spending More is Getting Us Less, by Elizabeth Bradley and Lauren Taylor.
About Grand Rapids

▲ Medical systems have more geriatricians than most (still recruiting!)
▲ An array of small programs
▲ The local property tax
▲
▲ Very little monitoring and measurement for the population overall
▲
Disaster for the Frail Elderly: A Root Cause

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Channel the public’s fear and frustration into the will to change
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

<table>
<thead>
<tr>
<th>Date</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/1/2012</td>
<td>2</td>
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<td>8/3/2012</td>
<td>4</td>
</tr>
<tr>
<td>8/8/2012</td>
<td>3</td>
</tr>
<tr>
<td>10/12/2012</td>
<td>1</td>
</tr>
<tr>
<td>2/28/2013</td>
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</tr>
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<td>3/2/2013</td>
<td>3</td>
</tr>
<tr>
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<tr>
<td>6/1/2013</td>
<td>3</td>
</tr>
<tr>
<td>6/30/2013</td>
<td>4</td>
</tr>
</tbody>
</table>

Ideal Score = 4
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”
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>
<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>
</tr>
</thead>
<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>
</tr>
<tr>
<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>
</tr>
</tbody>
</table>

For more on financial estimates, see [http://medicaring.org/2013/08/20/medicaring4life/](http://medicaring.org/2013/08/20/medicaring4life/)
The MediCaring Reforms

ENCOURAGE EFFECTIVE COMPLAINING & ADVOCACY

Get Angry!

Complain Effectively
“You never change things by fighting the existing reality. To change something, build a new model that makes the existing model obsolete.”

--Buckminster Fuller

MUST HAVE THE WILL TO MAKE CHANGES!!!
Unless someone like you cares a whole awful lot
Nothing is going to get better … it’s not!"

Dr. Seuss

*The Lorax*
Could we build a reliable and efficient system?
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Useful resources

△ 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/)
Cincinnati, OH Provider Network Analysis

Providers connected by a minimum of 10 transitions (CY 2011)
Michigan Hospital Referral Regions
Community Data Palooza

DATA DRIVING COMMUNITY CHANGE

Find Your Community | Our Data | Our Partners | About Us

Having data about your community helps create change! This site provides Medicare and other data about elderly and disabled persons to communities, and provides an easy way to post data from those communities. Read more about us...
Find Your Community

Communities sorted alphabetically by state:

- Arizona: Tucson
- Arkansas: Arkansas Delta
- California: San Diego
- California: Santa Cruz
- Louisiana: Monroe
- Louisiana: Shreveport
- Maryland: Baltimore
- Michigan: Detroit
- Michigan: Grand Rapids
Send your emails to

Clark@tandem365.com