Caring for Frail Elders: A MediCaring ACO

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SYSTEMS RESEARCH FOR BETTER HEALTH

Imagining Frailty – not just MCC or high-cost

Photo credit: http://www.telegraph.co.uk/health/elderhealth/8917142/David-Cameron-under-pressure-over-care-reforms.html

Salient Facts about Frail Older People

- Tied to their residence
- Aging Boomers will double prevalence of frailty within 20 yrs
- Survival time may increase (and thus increase prevalence)
- With LTSS, frailty costs half of lifetime health care costs
- Few have savings, insurance, or family to cover those costs
- Therefore, long-term care will require societal investments
- Current practices incur unnecessary fear and suffering
- Current practices incur unnecessary costs
- Policy is distorted by reticence to acknowledge death

STRONG CLAIMS FOR SERIOUS REFORM

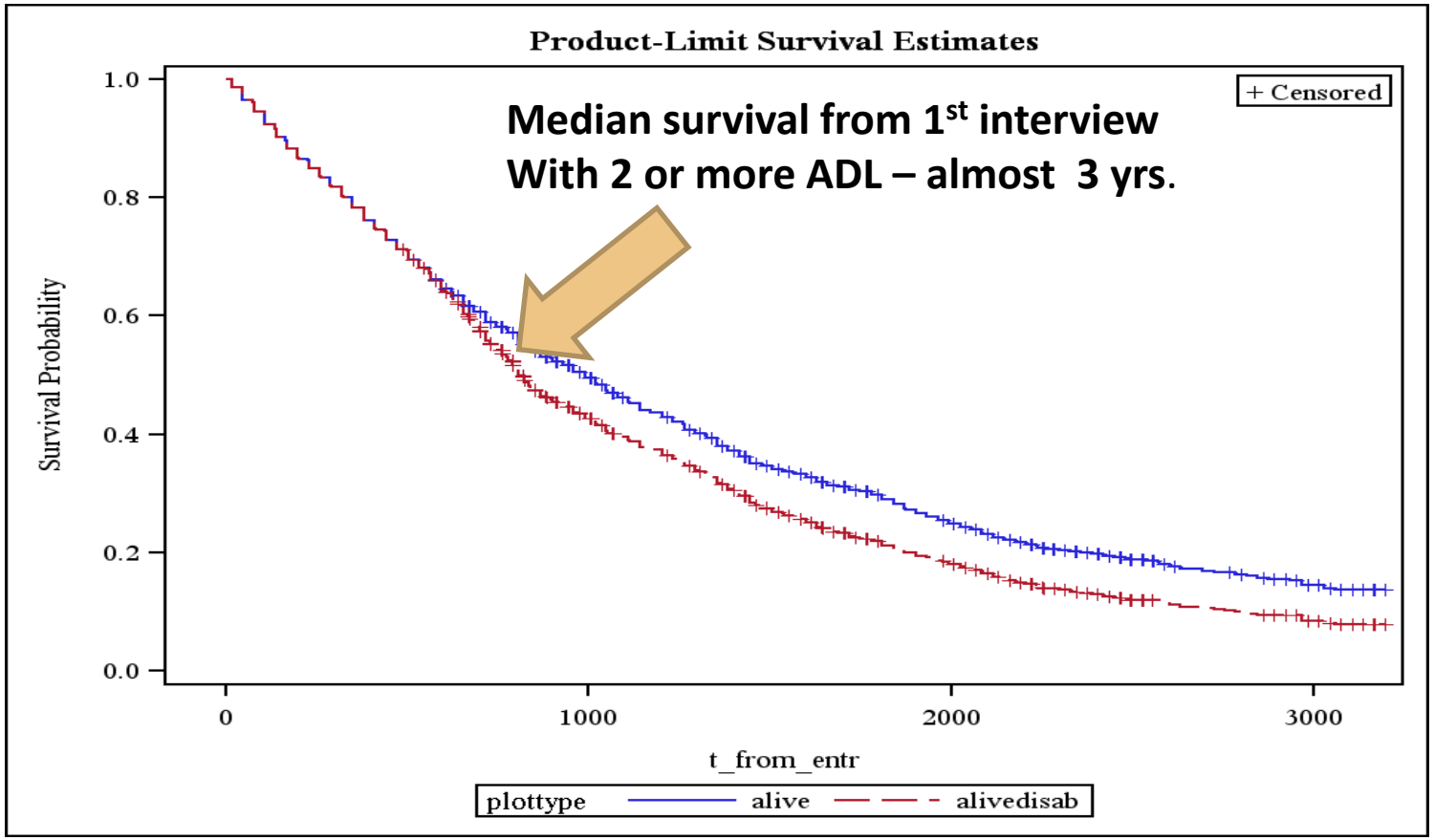
1. **We are buying the wrong product**. We should not just refinance that purchase – we should change the product!
2. We can have what we want and need when old and frail, **with a reduction in per capita cost**, but only by deliberately redesigning service delivery.
3. **We cannot keep doing what we 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.

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!

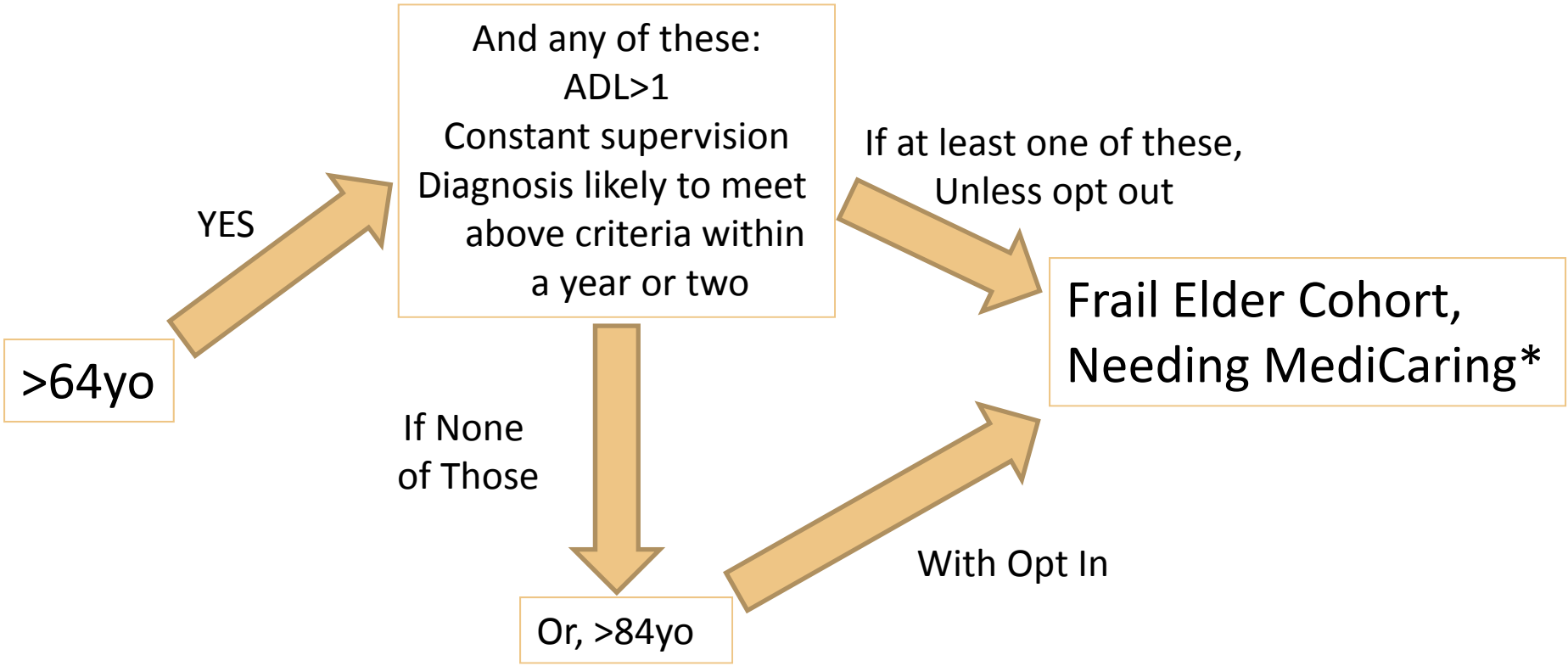
Persons >64yo with ADL>1
Course by next interview :
Died, in blue; Died or later ADL=0, in Red – so the gap = ADL recovery



Defining Frail Elders – HRS data

- About 10% of those over 65 y.o. have 2 or more ADL dependencies at any one time, about half of us are frail eventually (the rest die younger, mostly of single illnesses)
  - Of those with 2+ ADL, only 1/10 ever improve to having no ADL dependencies (probably having a predictably short-term health problem)
- Median age, 83 years
- Median life expectancy, about 3 years from first report
- And Medicare costs per month are about 4 times as great as people who do not yet have ADL dependency

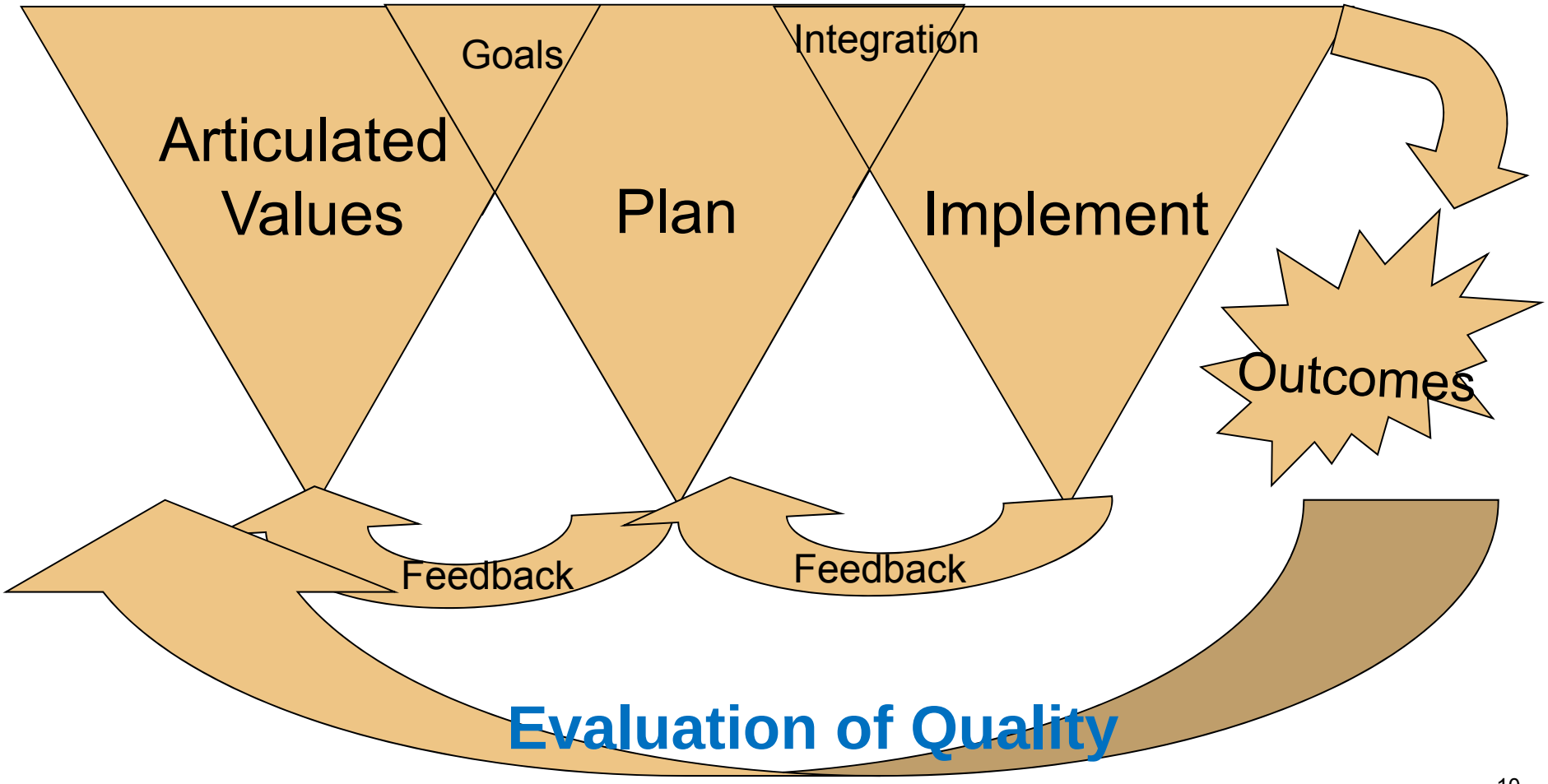
Pragmatic Definition of Frail Elders



*MediCaring™ denotes comprehensive services customized to frail elders, including care planning, continuity, 24/7 on-call, services to the home, caregiver support

Required: Individual Care Plan

About Customized Service Plans



URGENT NEEDS for CARE PLANS

- **Develop demand** for multi-dimensional understanding of the situation, and person-centered care plans
- Develop processes that **regularly produce them**
- Develop feedback loops for **real-time evaluation** of merits
- Develop quality measures that **assess system performance**
- **Use good care plans in system design**

What about an "Advance Care Plan?"

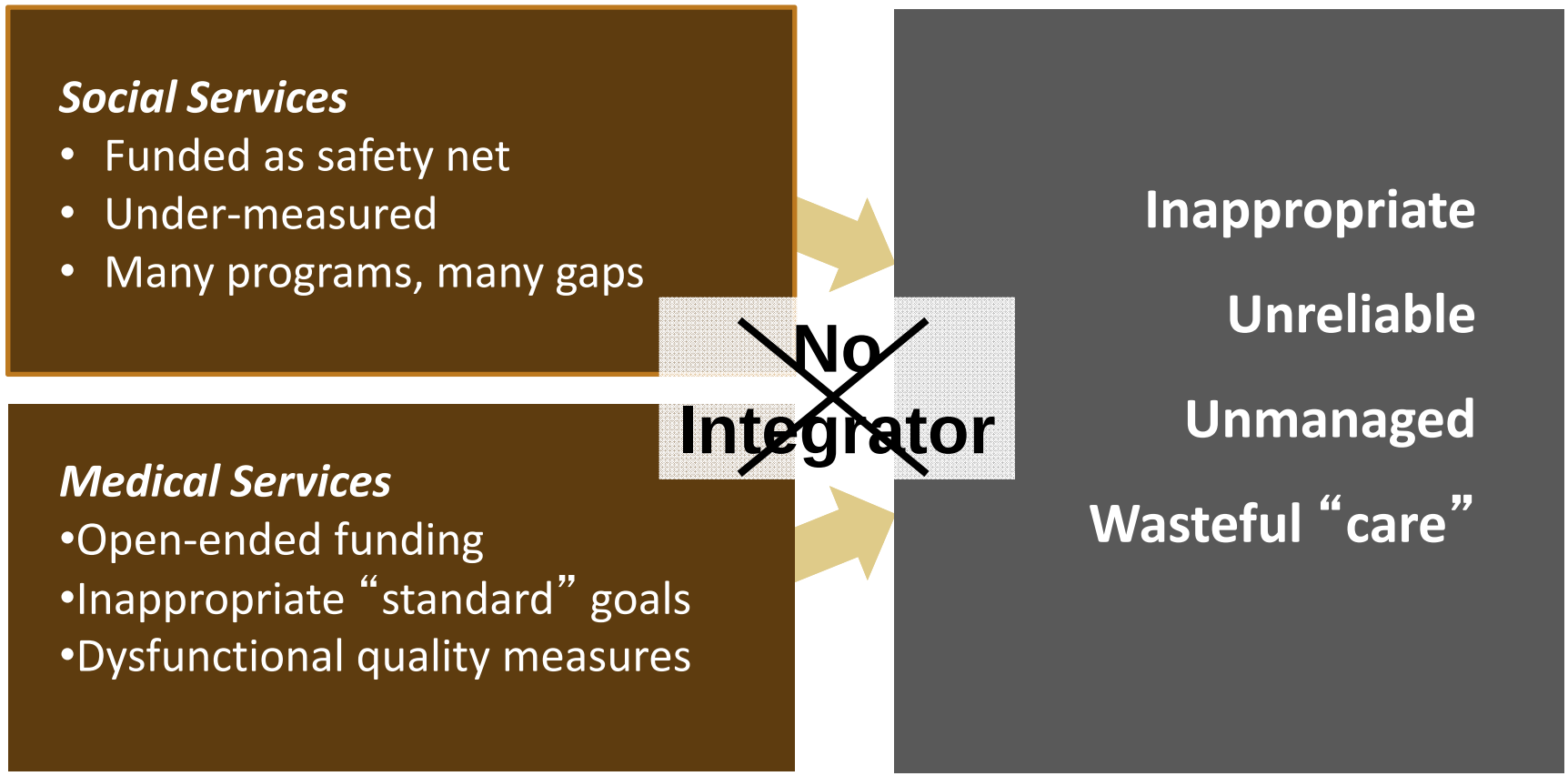
- Natural to consider lifespan and dying as part of care planning
- Include emergency plans like POLST
- Designate surrogate decision-maker(s)
- Document along with care plan
- Update and feedback as for other plan elements

Appropriate Services

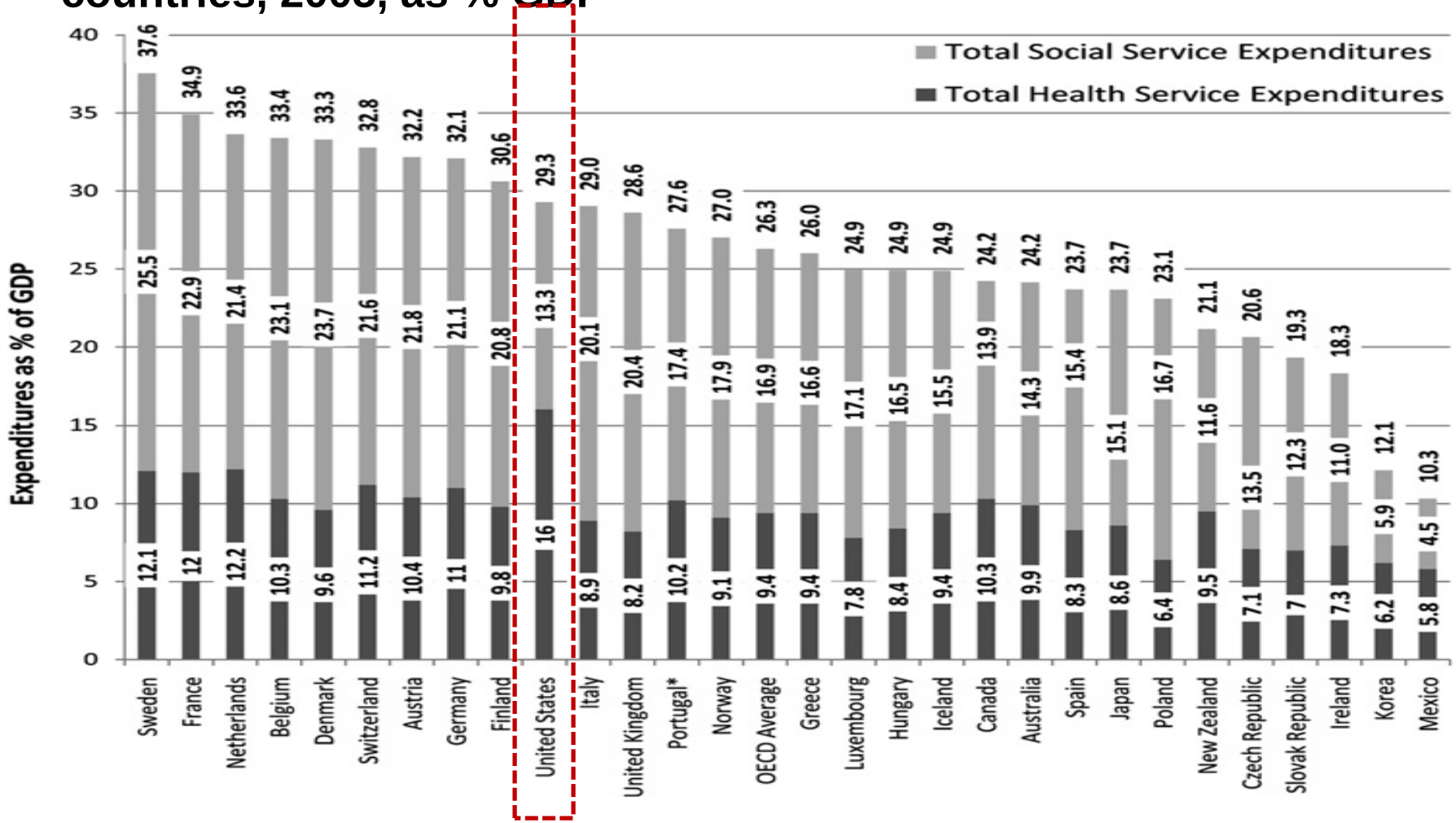
- Continuity, reliability, trustworthiness
- Planning ahead
- Caregiver assessment and support

<u>Test your system</u>:
What can you promise that matters,
From now to the end of life?

Disaster for the Frail Elderly: A Root Cause



Health-service and social-services expenditures for OECD countries, 2005, as % GDP



BMJ Qual Saf 2011;20:826e831.

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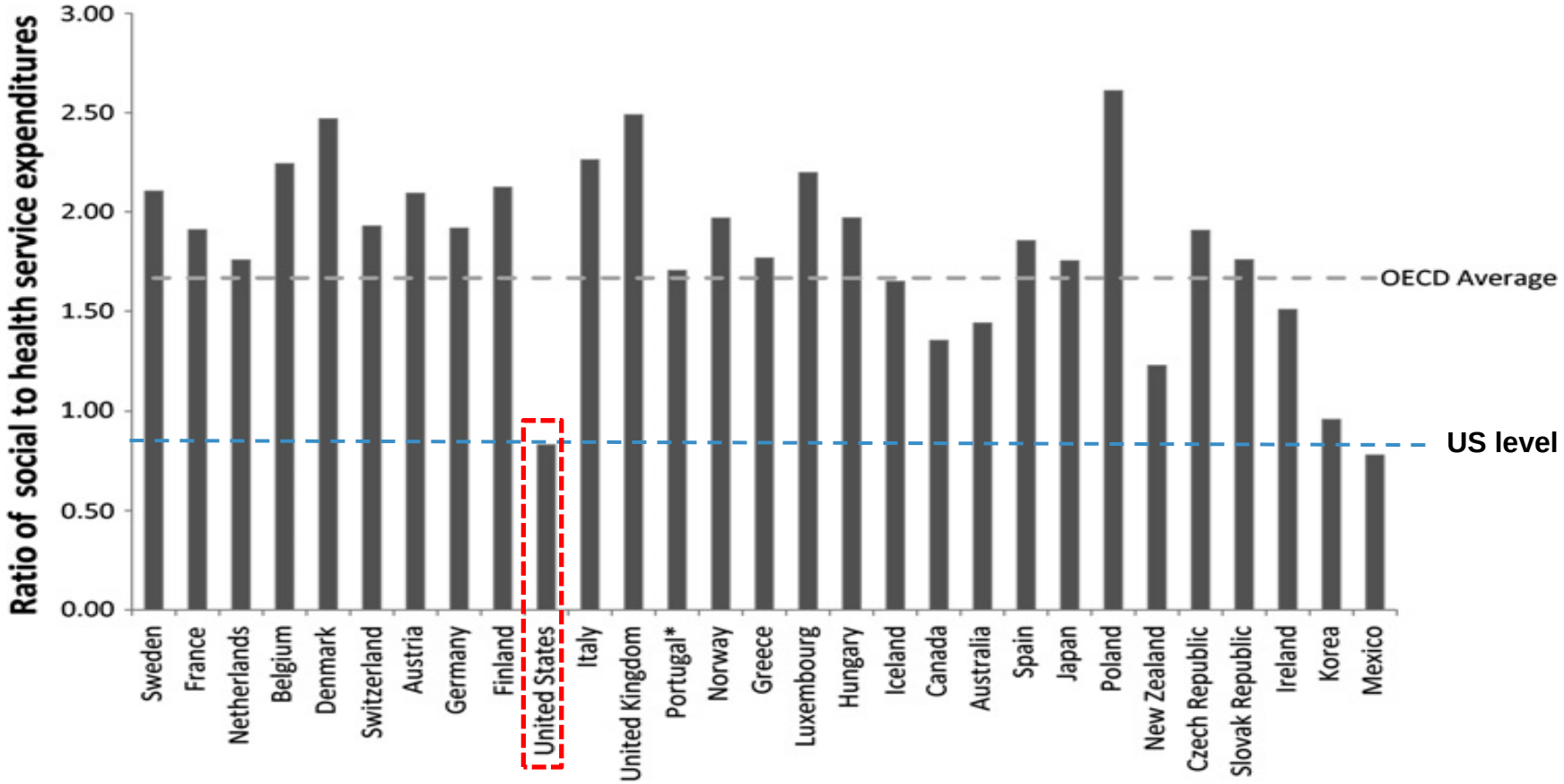

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The Veterans Health System Experience

- For veterans "too sick to come to clinic"
- Moved services to the home
- Identified, screened, trained, and paid caregivers
- Assured housing and personal care
- Reduced hospital utilization by 30-60%
- Reduced nursing home days by more than half

Frail Elderly People Need Some New Spending…

- Housing
- Nutrition
- Personal Care
- Caregiver training, respite, income
- As well as new drugs and other treatments

Where will it come from?

Estimating Potential Savings in Medical Care

- Estimate frail as 10% of over-65 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

Net Savings for CMS Beneficiaries	***Yr 1***	***Yr 2***	***Yr 3***	***3-Yr***
Before Deducting In-Kind Costs	*-$2,449,889*	*$10,245,353*	*$19,567,328*	*$27,362,791*
After Deducting In-Kind Costs	*-$3,478,025*	*$8,463,101*	*$17,629,209*	*$22,614,284*

For more on the finances, see http://medicaring.org/2013/08/20/medicaring4life/

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

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
- Skills in coalition-building and governance
- Visibility, value to local residents
- Funding – e.g., from shared savings
- Some authority to speak out, cajole, create incentives and costs
- A commitment to efficiency as well as quality

Drivers of Improvement for Frail Elderly People

1. **INFORMED CHOICE**: Follow a well-developed care plan
2. **MAKE IT EASY TO PROVIDE BEST HEALTH CARE**: Reliable and appropriate health care services, to the person's residence
3. **MAKE IT EASY TO SUPPORT FRAIL ELDERS IN THE COMMUNITY:** More substantial, appropriate, and reliable social supports
4. **INCENTIVES AND SUSTAINABILITY**: Develop an entity to manage local service production and earn special purpose shared savings on a modified ACO model

We can have what we want and need When we are old and frail….

But only if we deliberately build that future!